Blandford

Quality report

Blandford Garrison
Blandford Forum
Dorset
DT11 8RH

Date of inspection visit: 26 June 2018
Date of publication: 1 August 2018

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, and information given to us by the practice and patients.

Ratings

<table>
<thead>
<tr>
<th>Overall rating for this service</th>
<th>Good</th>
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<tr>
<td>Are services safe?</td>
<td>Good</td>
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<tr>
<td>Are services effective?</td>
<td>Requires improvement</td>
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<tr>
<td>Are services caring?</td>
<td>Good</td>
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<tr>
<td>Are services responsive to people’s needs?</td>
<td>Good</td>
</tr>
<tr>
<td>Are services well-led?</td>
<td>Good</td>
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Blandford Quality Report 26 June 2018
Chief Inspector’s Summary

This practice is rated as good overall.

The key questions are rated as:

Are services safe? – Good
Are services effective? – Requires improvement
Are services caring? – Good
Are services responsive? – Good
Are services well-led? – Good

Letter from the Chief Inspector of General Practice

We carried out an announced inspection at Blandford Medical Treatment Facility on 26 June 2018. Overall, the practice is rated as good. Our key findings across all the areas we inspected were as follows:

At this inspection we found:

• There was an open and transparent approach to safety. All staff knew how to raise and report an incident and were fully supported to do so. We saw the management of significant events included clear indication that a root cause analysis had been completed and actions were identified to address what had occurred and actions put in place to reduce the likelihood of re-occurrence.

• The assessment and management of most risks was well embedded and recognised as the responsibility of all staff. However, some areas required improvement. There was good evidence to show collaborative working and sharing of best practice to promote better health outcomes for patients.

• Whilst overall the management of infection control was good, the practice had not been deep cleaned and the lead nurse responsible for infection control had not received adequate training to fulfil this role.

• There was evidence to demonstrate that quality improvement was embedded in practice, including clinical audits.

• The arrangements for managing medicines, including emergency medicines and vaccines, in the practice, minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal). However, no member of clinical staff had oversight of medicines management.

• Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. Whilst staff had access to guidelines from NICE, there was no evidence to show they were being formally discussed as a clinical group.

• Staff had been trained and had the skills and knowledge to deliver effective care and treatment.

• Feedback from CQC comment cards and patient surveys showed patients were treated with compassion, dignity and respect. We saw that the practice was responsive to patients’ needs. Patients we spoke with said they found it easy to make an appointment,
with urgent appointments available the same day.

- Information about services and how to complain was available.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.
- There was a clear strong leadership structure and staff felt engaged, supported and valued by management.

The Chief Inspector recommends:

- Ensure that best practice guidance is followed with regard to the management of infection prevention and control.
- Ensure that a formal meeting be introduced in which staff discuss and record relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.
- Ensure that all waiting patients can be observed by practice staff.
- Review the premises to establish whether improvements can be made to support better patient confidentiality and privacy, and to ensure that care is always delivered in an environment that minimises risk for the patient.

Professor Steve Field  CBE FRCP FFPH FRCGP
Chief Inspector of General Practice

Our inspection team

Our inspection team was led by a CQC inspector. The team included a GP specialist advisor, a practice manager specialist advisor, a nurse specialist advisor and a physiotherapist specialist advisor and a pharmacy specialist advisor.

Background to Blandford

Blandford Medical Treatment Facility provides primary care and occupational health primarily to Phase 2 and 3 training for the Royal Corps of Signals. The patient population includes a small number of under 18’s but does not cater for dependants. Due to the varying length and complexity of Phase 2 and 3 courses, the population at risk can fluctuate throughout the year with some trainees being based at Blandford for over a year. The practice provides a primary care service for approximately 1100 permanent staff and course personnel the majority of which are aged between 18 and 55 years old.

The medical centre has one full time Senior Medical Officer (SMO), two part-time civilian GPs (0.8 and 0.6 whole time equivalent), a general duties medical officer (GDMO), one senior nurse, two practice nurses (one of whom is a locum), one practice manager, one practice administrator, one full time pharmacy technician and four medics (the work of a military medic has greater scope than that of a health care assistant found in NHS GP practices).

There is also a Primary Care Rehabilitation Facilities (PCRF) department located on camp which
is staffed by physiotherapists and ERIs (Exercise Rehabilitation Instructors).

In addition to routine GP services, the treatment facility offers physiotherapy and rehabilitation services. Family planning advice is available within the practice and maternity and midwifery services are provided by NHS practices and community teams. Mental health referrals are made to the Defence Community Mental Health Team at Tidworth.

<table>
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<tr>
<th>Are services safe?</th>
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<td><strong>We rated the practice as good for providing safe services.</strong></td>
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**Safety systems and processes**

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role.

- The practice had safety policies including adult and child safeguarding policies which were reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. Policies were regularly reviewed and were accessible to all staff, including locums. They outlined clearly who to go to for further guidance. There was a system to highlight vulnerable patients on clinical records and a risk register of vulnerable patients.

- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.

- There was good interaction with the Civilian Medical Practitioners (CMP) and the regiments. Their relationship was longstanding which promoted and unpinned good practice and continuity of care. In particular we saw evidence of strong guardianship and care given to patients, many of whom were under 18 years old.

- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.

- Notices in the waiting room and consultation rooms advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role, and had received a Disclosure and Barring Service (DBS) check (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

- All clinical notes were complete and had been summarised.

- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the lead for infection control and checked that good standards of cleanliness were upheld. The practice had an infection control policy and all staff had received mandatory annual training. No deep clean of the
building had been undertaken in the past 12 months.

- All single use items were stored appropriately and were within their expiry date. Specific equipment was cleaned daily and daily logs were completed. Clinical waste was stored appropriately and securely, and was collected from the practice by an external contractor. However, the contract for the practice was insufficient for its needs, for example sharps bins used for particular items were not made available.

- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.

- The full range of recruitment records for permanent staff was held centrally at Regional Headquarters (RHQ). The practice manager could demonstrate that relevant safety checks had taken place at the point of recruitment, including a Disclosure and Barring Service (DBS) check to ensure staff were suitable to work with vulnerable adults and young people. DBS checks were renewed every five years.

- The practice manager confirmed all staff had professional indemnity cover. Information was in place to confirm practice staff had received all the relevant vaccinations required for their role at the practice.

Risks to patients

Risks to patients were assessed and well managed.

- There was a failsafe system in place for the monitoring of laboratory results.

- There were procedures in place for monitoring and managing risks to patient and staff safety. The practice had up to date fire risk assessments and carried out regular fire drills. The fire equipment was checked by an external contractor on a monthly basis. Fire alarms were tested weekly and all electrical equipment was checked on a regular basis to ensure the equipment was safe to use. Clinical equipment was checked in line with Defence Medical Services policy to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

- There was a designated lead for Primary Care Rehabilitation Facilities (PCRF) equipment. All the medical equipment had an annual inspection and this was up to date. The building was clean and had good temperature controls in place.

- The practice had a comprehensive business continuity plan in place for major incidents, such as power failure or building damage and this had been tested.

- The layout of the practice meant not all patients in one of the waiting area could be observed by reception staff. This was particularly important in the event of a medical emergency. There was no risk assessment in place.

Safe and appropriate use of medicines

- We saw the arrangements for obtaining, prescribing, recording, handling, storing and the
security of medicines was safe. Whilst we found no issues or concerns regarding medicines management, no medicine lead had been appointed and so it was unclear who staff needed to go to if they required support with medicines and lines of accountability for medicine safety were unclear. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.

- The pharmacy technician had a good procedure for keeping records. We saw patients were informed of the side effects and were given good instruction by the pharmacy technician to ensure they took their medicines safely.

- The practice had a defibrillator available on the premises and oxygen with adult masks. A first aid kit and accident book were available.

- The practice carried out regular medicines audits for example an antibiotics audit, to ensure prescribing was in line with best practice guidelines for safe prescribing. We saw evidence to show the regional pharmacist had undertaken regular reviews.

- Prescription pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.

**Track record on safety**

There was an effective system in place for reporting and recording significant events.

- The SMO was the dedicated lead to oversee significant events and staff said they would approach them if they were unsure of any issues in relation to significant events. All staff were familiar and confident with policy and with using the standardised Defence Medical Services (DMS) wide electronic system the practice used to report, investigate and learn from significant events, incidents and near misses. There was a strong culture of reporting and learning from incidents at the practice.

- Staff provided a number of examples and described how the incidents were managed. They highlighted any changes made as a result of the investigation. We saw that once discussed at the health governance meetings, actions were transferred onto an action log and put onto the risk register if needed. Significant events were shared at practice meetings.

- We reviewed safety records and patient safety alerts, including the minutes of meetings where these were discussed. The Medicines and Healthcare products Regulatory Agency (MHRA) alerts were received via the automated system from DPHC HQ and managed by the pharmacy technician. All alerts were checked against equipment registers and DMICP (Defence Medical Information Capability Programme) patient records/stock reports. Alerts were shared with practice staff as appropriate, they signed to confirm they had read them and they were documented in meeting minutes.

**Lessons learned and improvements made**

The practice learned and made improvements when things went wrong.

- There was a system and policy for recording and acting on significant events and incidents.
Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.

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<th>Are services effective?</th>
<th>Requires improvement</th>
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We rated the practice as requires improvement for providing effective services.

**Effective needs assessment, care and treatment**

- The practice assessed needs and delivered care in accordance with relevant and current evidence based guidance and standards.

- Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. Whilst staff had access to guidelines from NICE, there was no evidence to show they were being formally discussed as a clinical group. Clinical meetings were informal and had been held but no minutes were taken to record any discussion of best practice guidance or changes to practice in light of newly issued guidance. Peer review between GPs did not take place to further ensure that guidelines were followed. The three sets of practice meeting minutes and two healthcare governance meetings that we were provided with did not demonstrate that NICE or other guidance were discussed. We did see evidence that practice meetings agendas included audit activity, some of which was associated with NICE guidelines and long term conditions. Staff were asked to refer to these audits but there was no evidence they were discussed or used to improve patient care.

**Monitoring care and treatment**

The practice used information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. QOF is a system intended to improve the quality of general practice and reward good practice. It is used across many NHS practices. The DMS have a responsibility to deliver the same quality of care as patients expect in the NHS. The QOF provides a useful way of measuring this for DMS. Because the numbers of patients with long term conditions are often significantly lower at DMS practices, we are not using NHS data as a comparator.

- At the time of our inspection there were no patients receiving high risk medicines. Searches for these patients were held monthly. We discussed with the practice the need to have a system in place including a register and processes for discussion when the need arose.

- The practice had a good chronic disease management plan in place, managed by the practice nurses. Patients were recalled appropriately and patients received effective, individually personalised care. There was a comprehensive chronic disease management register in place. The practice carried out chronic disease audits to ensure they provided care for patients with chronic disease in line with NICE guidelines.

The practice provided the following examples of patient outcomes data to us from their computer system on the day of the inspection.

- There were 14 patients recorded as having high blood pressure. We reviewed the treatment and care offered to these patients and found that current NICE guidance had been followed. All had a record for their blood pressure in the past nine months. Of these patients with hypertension, all had a blood pressure reading of 150/90 or less.
• There were 14 (with an additional two ongoing assessment) patients with a diagnosis of asthma. We reviewed the treatment and care offered to these patients and found that current NICE guidance had been followed. All had received an asthma review in the preceding 12 months which included an assessment of asthma control using the three Royal College of Physicians questions.

• There were nine patients with a new diagnosis of depression in the last 12 months. Eight had been reviewed within 10 to 35 days of the date of diagnosis.

Information from the Force Protection Dashboard, which uses statistics and data collected from military primary health care facilities, was also used to gauge performance. Data from the Force Protection Dashboard showed that instance of audiometric hearing assessment was higher compared to DMS practices regionally and nationally. Service personnel may encounter damaging noise sources throughout their career. It is therefore important that service personnel undertake an audiometric hearing assessment on a regular basis. Data from January 2018 showed:

• 100% of patients had a record of audiometric assessment, compared to 97% regionally and 99% for DPHC nationally.

• 93.5% of patients’ audiometric assessments were in date (within the last two years) compared to 88% regionally and 85.5% for DPHC nationally.

Management, monitoring and improving outcomes for people

There was evidence of quality improvement work including clinical audit and this led to improved outcomes for patients

• From discussions with staff, it was clear the practice was working towards continual improvements for patients. A programme of audit was in place that focussed on the needs of the population and demonstrated a commitment to improving outcomes for patients. An audit spreadsheet showed 18 clinical audits completed in the past 12 months. Audits undertaken were relevant to the needs of the patient population, including a rolling programme of audit for long term conditions. There was evidence of up to two cycles for some audits. Examples of completed clinical audits we looked at and discussed with staff included antibiotic prescribing, asthma and medicines management. The PCRF had also completed mandatory audits, including infection control. We noted that no non-clinical audits were undertaken by any other members of the staff team.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

• The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.

• The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, mentoring, clinical supervision and support for revalidation.
Dispensary staff were appropriately qualified and their competence was assessed regularly. They could demonstrate how they kept up to date.

**Coordinating care and treatment**

- The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice’s patient record system and their intranet system.
- We found the practice shared relevant information with other services in a timely way. For example, the practice had good relationships with the health visitors and midwives who held clinics in the NHS practice next door.
- Discharge and hospital letters were received by the medical centre and there was a good system to ensure in place that a clinician reviewed and actioned these, this included an audit trail to record what had been done.
- A register was in place for samples sent to the laboratory. It was checked daily and any outstanding results were followed up. Results received at the practice were logged, dated, stamped and scanned onto the patient’s record by the administration team. They were then passed to the doctor to review.
- There were good examples of practice seen, with regular meetings arranged between the medical centre staff, the rehabilitation staff and the chain of command. If these meetings were about patients, for example, patient injury management clinic (PIM) we saw evidence of this been accurately recorded in the patient DMICP notes, with appropriate actions.

**Helping patients to live healthier lives**

- New patients completed on arrival a new patient questionnaire. Following this the patient was booked in for a 45 minute appointment with one of the nurses. If at this point it was seen they had any extra medical needs they were recalled in for a further appointment.
- The practice identified patients who may be in need of extra support and signposted them to relevant services. For example, to Livewell Dorset a local organisation who supports people to live a happier and healthier life. Patients requiring sexual health advice and treatment were referred to the local genitourinary medicine (GUM) clinics which offered a range of services.
- One of the GPs was working to promote healthy eating during their consultations especially with the younger patients. This included discussion and the involvement of the wider camp management as the local shop on the base sold a large selection of unhealthy sugary snacks and the medical centre was trying to make change and improve this.
- Patients had access to appropriate health assessments and checks. A monthly search was undertaken for all patients aged 50 to 64 years who were entitled to breast screening. The practice also engaged with all national screening programmes and had a mechanism to ensure that eligible patients were referred into the bowel cancer or abdominal aortic aneurysm (AAA) screening programs. All patients over 50 who had not had cholesterol check in the past five years were called in to be tested. Flu vaccinations had been offered to all patients who were eligible.
There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using public health information posters and they ensured a female sample taker was always available. The number of women aged 25 to 49 and 50 to 64 whose notes recorded that a cervical smear had been performed in the last three to five years was 94%. The NHS target was 80%.

It is important that military personnel have sufficient immunity against the risk of contracting certain diseases. The World Health Organisation sets a target of 95% for vaccination against diphtheria, tetanus, pertussis and polio and measles, mumps and rubella. The data below from January 2018 provides vaccination data for patients using this practice:

- 92% of patients were recorded as being up to date with vaccination against diphtheria compared to 93% regionally and 95% for DPHC nationally.
- 92% of patients were recorded as being up to date with vaccination against polio compared to 93% regionally and 95% for DPHC nationally.
- 72% of patients were recorded as being up to date with vaccination against Hepatitis B compared to 77% regionally and 77% for DPHC nationally.
- 83% of patients were recorded as being up to date with vaccination against Hepatitis A, compared to 90% regionally and 91% nationally.
- 92% of patients were recorded as being up to date with vaccination against Tetanus, compared to 93% regionally and 95% for DPHC nationally.
- 30% of patients were recorded as being up to date with vaccination against Typhoid, compared to 43% regionally and 52% for DPHC nationally.

The Typhoid vaccine has a lower uptake than other vaccinations. Current guidance state DMS practices should offer the Typhoid vaccination to personnel before deployment and not to routinely vaccinate the whole population.

Blandford Forum’s vaccination rate was lower than the regional and national average due to a lack of integration from the training staff on the camp. Students were not being released for immunisations and vaccinations parade. This issue had been raised and a solution was being sought.

Consent to care and treatment

- Staff sought patients’ consent to care and treatment in line with legislation and guidance. The PCRF offered acupuncture. They worked to a policy which they adhered to and included ensuring the patient gave written consent.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

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<th>Are services caring?</th>
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We rated the practice as good for caring.
Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- During our inspection we observed that members of staff were courteous and helpful to patients and treated them with dignity and respect.

- We received 16 CQC comment cards from patients at the practice that described their care and treatment in a highly positive way. They said staff were kind and respectful. We also spoke with three patients sat in the waiting room. All three were happy with the care they received and described staff as helpful and friendly.

- The practice had an information network available to all members of the service community, known as HIVE. This provided a range of information to patients who had relocated to the base and surrounding area. Information included what was available from the local unit and from civilian facilities, including healthcare facilities. The information also signposted learning centres, for patients who may want to increase their fluency in English.

Involvement in decisions about care and treatment

- The feedback provided by patients indicated that clinical staff took the time to explain their condition or injury and treatment plan. We spoke with seven patients who had received treatment from the rehabilitation team, they all reported excellent interaction with the staff, and felt their care was appropriate, caring and responsive.

- Staff were observed to be supportive and responsive to patients demonstrating caring and compassion in their interactions.

- Interpretation services were available for patients who did not have English as a first language and staff knew how to access them. Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of organisations.

- The practice proactively identified patients who were also carers, there was one registered at the time of the inspection. There were systems in place which when patients identified themselves as carers, a code was added to their records in order to make them identifiable and so that extra support or healthcare could be offered as required. The GP attended monthly welfare meetings with other health professionals to discuss where extra support and care were needed.

Privacy and dignity

The practice respected patients’ privacy and dignity however improvement was needed in some areas;

- Curtains were provided in only two of the five consulting rooms meaning patients’ privacy and dignity was not maintained during investigations and treatments. One treatment room was used for two patients at a time and had only a curtain dividing them meaning conversations could be overheard.

- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
There was only one female GDMO employed at the practice meaning if a female patient requested to see a female GP and they were unavailable they were able to go to the Bovington Medical Centre which was approximately 16 miles away. The practice had recognised that this may be difficult so ensured for any intimate examinations that were to be performed by a male GP at the practice, a chaperone was always available and all staff were trained to do so.

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<th>Are services responsive to people’s needs?</th>
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We rated the practice as good for providing responsive services

Responding to and meeting people’s needs
The practice understood its population profile and had used this understanding to meet the needs of its population:

- A good range of services and clinics were available to service personnel. For example, physiotherapy and travel advice.

- Patients could have 15 minute appointments with the GP and up to 30 minute appointments with the practice nurse or longer if needed.

- Patients were able to self-refer themselves to physiotherapy and were typically seen within five days.

- Patients were able to receive travel vaccines when required.

- Same day appointments were available for those patients who needed to be seen quickly.

- There were accessible facilities which included interpretation services when required. Transport for patients to hospital appointments was available if needed.

- Eye care and spectacles vouchers were available to service personnel from the medical centre.

Timely access to care and treatment
The practice was open from Monday to Friday between 0745 and 1630 hours. Shoulder cover was provided by Tidworth Medical treatment facility between 1630 hours and 1830 hours. Outside of these times, patients were referred to NHS 111 or local out of hours’ services.

Results from the patient experience survey showed that overall patient satisfaction levels with access to care and treatment were high. A patient survey was undertaken by patients attending the medical centre during the period of December 2017 to March 2018. A total of 129 surveys were completed and returned by patients. Results showed;

- 95% of patients felt that their appointment was at a convenient time.

- 98% of patients felt their appointment was at a convenient location. The practice leaflet gave clear directions on local accident and emergency unit access. The nearest accident and emergency department was located at Dorset County Hospital.

Clinicians referred patients recovering from injury to physiotherapy teams when appropriate.
These were based at the medical centre and we saw good working relationships in place that supported patients back to full physical health.

The Defence Rehabilitation Headquarters collated a dashboard of information in relation to waiting times and patients who do not attend for their physiotherapy appointment. These are key performance indicators as timely access to physiotherapy and rehabilitation are important for effective patient recovery. Blandford PCRF was performing ahead of regional and defence-wide peers, although there were some data discrepancies:

- For January to March 2018, 52% of new patients referred to see a physiotherapist were seen within five working days. This compares to a regional average of 68% and an overall PCRF average of 55%. The PCRF’s own audit shows that 93% of patients were seen within 5 working days. The discrepancy is suggested to be a delay between patients being referred by the doctor, and then presenting or calling for a PCRF appointment.

- Similarly, 86% of new patients referred to an ERI at Blandford PCRF were seen within the KPI target of five working days, compared to a regional average of 55% and an overall PCRF average of 49%. The PCRF pro-actively managed DNA (patients who did not attend) rates for their clinics and achieved above average results with only 3% of patient appointments lost to DNA’s in January to March 2018, compared with a PCRF average of 7%.

The practice held clinics every morning for those patients wishing to be seen urgently (fresh cases). All patients were triaged by medics who referred on to a nurse or GP as required (a military medic delivers healthcare similar to a healthcare assistant in the NHS but has a greater scope of duties).

The practice had its own dispensary, which was staffed by a pharmacy technician who worked in the practice dispensary. The dispensary was open 0800 to 1000 hours, 1030 to 1230 and 1330 to 1600 hours.

**Listening and learning from concerns and complaints**

The practice had a system for handling complaints and concerns.

- The practice manager was the designated responsible person for handling complaints in accordance with DPHC’s policy. All clinical complaints were forwarded to the SMO or, in their absence, one of the other doctors.

- We noted that information was available in the waiting area to support patients to understand the complaints system. How to make a complaint was summarised in a practice leaflet.

- A log was in place for recording complaints and four complaints had been received since September 2017. All complaints and compliments were shared with all staff at the monthly practice meeting.

- Complaints were audited through the Common Assessment Framework (CAF). This was used to focus on improvements to the service and to ensure that designated standards were being met on the handling of complaints.

| Are services well-led? | Good |

Blandford Quality Report 26 June 2018
We rated the practice as good for providing a well-led service.

Leadership capacity and capability

- There was a clear leadership structure and staff felt supported by management. Staff told us the practice leaders were approachable and always took the time to listen to all members of staff.

- There were clearly allocated responsibilities in the practice, with the exception of medicines management, with named deputies for cross coverage and resilience in the event of absence from the practice.

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. Consistent, safe and effective care was at the forefront of the strategy and vision for the practice and this was adopted by all members of staff. All staff we spoke with were content with their working environment. Staff also acknowledged that their opinions, observations and views were valued. Staff we spoke with throughout the day could identify with the medical centre values;

‘Blandford Garrison Medical Centre aims to provide a safe, effective, caring, responsive service delivered by a well led, valued, happy and mutually supportive team putting the patient at the centre of all we do.’

Culture

All staff were involved in discussions about how to run and develop the practice. Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. Staff indicated they felt well-supported by the management team and that they were approachable.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.

- Policies from the national framework were implemented and were available to all staff. These were updated and reviewed regularly.

- An understanding of the performance of the practice was maintained. The practice manager used the Common Assessment Framework (CAF) as an effective governance tool. Practice meetings were held regularly and were used as an additional governance communication tool, for example to remind staff to complete all paperwork in respect of significant events. Learning needs were discussed at practice meetings and appropriate training was requested and delivered through this forum. The meetings were also used for forward planning, for example, to ensure that patient needs were met during busy clinic times and periods of staff sickness. Minutes were comprehensive and were available for practice staff to view. In addition, regular health care governance meetings were held and minutes were produced of all matters discussed. Fortnightly meetings were held to discuss
vulnerable and at risk patients.

- There was clear evidence from minutes of meetings that lessons learned from significant events, complaints and other investigations led to change and improvement in practice.

Managing risks, issues and performance

There were clear and effective processes for managing many risks, issues and performance. However, we identified some areas where improvement was required.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety. Any new risk identified were added to a risk register and had actions for improvements included.

- The practice had some processes to manage current and future performance.

- Practice leaders had oversight of national and local safety alerts, incidents, and complaints.

- Clinical audit had clear impact on quality of care and outcomes for patients.

- Clinical meetings were not held at the practice for staff to discuss current evidence based guidance and standards.

- There was no dedicated clinician overseeing medicines management.

- The premises needed improvements to be made to support better patient confidentiality and privacy, and to ensure that care is always delivered in an environment that minimises risk for the patient.

Appropriate and accurate information

The practice had appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.

- There were robust arrangements at the medical centre in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- Patients through the Defence Medical Services surveys and from any individual patient feedback received.

- The practice were looking at the possibility of forming a Patient Participation Group (PPG) but were aware that limitations were inevitable due to the transient nature of the patient population and deployable status of operational staff at the practice.

- Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve
how the practice was run.

**Continuous improvement and innovation**

There was a focus on continuous learning and improvement within the practice. The clinicians conducted audits within the scope of their work, shared findings and implemented actions that improved outcomes for patients. However, the quality improvement structure was not always apparent by the lack of clinical meetings not promoting improvement initiatives.