Swanton Morley Medical Centre

Quality report

Swanton Morley
Norfolk
NR20 4TX

Date of inspection visit:
5 June 2019

Date of publication:
5 August 2019

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, information given to us by the practice and patient feedback about the service.

Ratings

Overall rating for this service	Requires improvement
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires improvement

Chief Inspector's Summary

This practice is rated as requires improvement overall

The key questions are rated as:

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

We carried out an announced comprehensive inspection of Swanton Morley Medical Centre on 5 June 2019. Defence Medical Services (DMS) are not registered with the CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014 and are not required to be. Consequently, DMS services are not subject to inspection by the CQC and the CQC has no powers of enforcement. This inspection is one of a programme of inspections that the CQC will complete at the invitation of the Surgeon General in his role as the Defence Authority for healthcare and medical operational capability.

At this inspection we found:

- Safe and effective systems were in place to safeguard and support patients who were vulnerable.
- Processes for the safe management of medicines needed to be strengthened.
- High risk medicines were being appropriately managed. Shared care agreements were in place for patients who needed them.
- The clinical audit programme did not include the Primary Care Rehabilitation Facility (PCRF).
- A system for managing incidents and significant events was in place. Not all staff had electronic access to the system to report an event.
- Duty of candour principles were consistently adhered to.
- Staffing levels at the practice were sufficient to meet the needs of the patient population at all times.
- Staff had limited awareness of the functionality of the electronic clinical record system (referred to as DMICP) which meant patient care was not always recorded in accordance with Defence Primary Health Care (DPHC) policy.
- Staff received clinical supervision, appraisal and participated in peer review.
- Medical cover was in place on weekdays between the times when the practice closed and NHS 111 commenced providing medical cover.
- Staff understood the Mental Capacity Act (2005) and how it applied in the context of the service they provided.
- Staff respected the privacy, dignity and confidentiality of patients.

The Chief Inspector recommends:

- The arrangements for contract monitoring are reviewed, strengthened and a record of contract monitoring meetings maintained.
- Governance processes are reviewed and strengthened taking account of:
    - the arrangements for practice management;
    - staff access to and understanding of DPHC policy and processes;
    - risk management systems to ensure the safety of patients, including the management of significant events, summarisation of records, specimen management and medicines management;
    - clinical audit, including ensuring it takes account of population need by involving the PCRF in the audit programme;
    - processes to monitor that staff are up-to-date with training to undertake their role.
- Staff are provided with training and support in the functionality of DMICP so they can effectively use the system to monitor the health care needs of patients. The training should incorporate Read coding.
- The practice develops a standard operating procedure (SoP) to ensure a consistent approach is taken with the management of patients using life firearms.

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Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

The inspection was led by a CQC lead inspector with the team comprising specialist advisors including, a GP, a practice nurse, a practice manager and physiotherapist.

Background to the Swanton Morley Medical Centre

Swanton Morley Medical Centre provides a primary care, rehabilitation and occupational health service to a patient population of 365 service personnel located at the barracks. Service provision is based on a nurse practitioner-led model of care provided through a contract with Elmham Group of Practices (referred to as the 'group practice' throughout the report), an NHS primary care service located in Swanton Morley.

Families and dependants of service personnel are not registered at Swanton Morley Medical Centre with many registered with Elmham Surgery, the hub practice.

A Primary Care Rehabilitation Facility (PCRF) is located on the premises, with physiotherapy sub-contracted from the NHS.

The practice is open Monday to Thursday from 08:00 to 16:00 hours and on Friday from 08:00 to 13:00 hours. Outside of these hours patients can access medical care through North Elmham Group Practice, and NHS 111 from 18:30 each day and at weekends/public holidays.

The staff team

Position	Numbers
Nurse manager/Nurse manager	One
Regimental Medical Officer	One
GP partners	Two (one lead GP)
Advanced Nurse Practitioner (ANP)	One
Practice nurses	Two
Health care assistant	One
Dispensing lead	One
Administrative staff	Two
Practice manager (contract management)	One
PCRF team	Two physiotherapists
Medics	Numbers vary (four at the time of the inspection)

Are services safe? | Inadequate

Safety systems and processes

Processes to keep patients safe, including safeguarded patients from abuse were in place.

- A framework of regularly reviewed safety policies was established and accessible to staff. Staff received safety information about the practice as part of their induction and refresher training.
- Access to Defence Primary Health Care (DPHC) and local NHS adult and child safeguarding policies and information safeguarding policies were in place. All staff had received up-to-date safeguarding training at a level appropriate to their role. All clinical staff had completed level 3 training in adult and child safeguarding. A safeguarding lead and deputy were identified for the practice.
- Codes were used on the electronic patient record system (referred to as DMICP) to identify vulnerable patients. Regular searches of DMICP were undertaken to inform the register of vulnerable patients.
- Patients who were vulnerable were discussed at the Unit Health Committee (UHC) meetings, attended by one of the GPs, who could also discuss patients with the unit welfare officer outside of the UHC meetings. Families and dependants registered with the group practice, and who were deemed vulnerable, were discussed at the weekly multi-disciplinary meetings. The practice had good relationships with local safeguarding organisations.
- All staff had received chaperone training and notices advising patients of the chaperone service were displayed. Staff had been subject to safety checks to ensure they were suitable to work with young people and vulnerable adults.
- The full range of recruitment records for permanent staff was held centrally at the group practice. The nurse manager provided evidence to 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.
- Arrangements were in place to monitor the registration status of clinical staff with their regulatory body. All staff had professional indemnity cover. Information was in place to confirm staff had received the relevant vaccinations required for their role at the practice.

- A process was established to manage infection prevention and control (IPC). The practice nurse was the IPC lead and was suitably skilled and experienced for the role. An annual IPC audit had taken place in November 2018 and an action plan subsequently developed. The audit had not identified that the acupuncture needles in the PCRF were out-of-date or that the sharps bin was incorrectly labelled.
- Environmental cleaning was undertaken twice a day by a dedicated cleaning team. Cleaning schedules and monitoring arrangements were established. A deep clean of the practice was undertaken in March 2019.
- A system was in place for the management of healthcare waste. Consignment notes were retained at the practice and an annual waste audit was carried out. The last waste audit was undertaken in November 2018.
- Measures to ensure the safety of facilities and equipment were in place. Electrical and gas safety checks were up-to-date and completed by the unit. Water safety tests were undertaken each week and a water assessment was undertaken at unit level. A fire risk assessment of the building was undertaken annually. Firefighting equipment tests were current. Staff were up-to-date with fire safety training and were aware of the evacuation plan.
- The last annual equipment care inspection was completed in July 2018.Testing of portable electrical appliances and medical equipment was in-date.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

- Staff advised us that staffing levels were sufficient to meet the needs of the patient population. If regular staff were not available due to leave or unplanned absence then the group practice could cover this through its large team of staff. Locums were not used at the practice.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. An emergency kit, including a defibrillator, oxygen with adult/child masks and emergency medicines were accessible to staff in a secure area of the practice; all staff knew of its location. A first aid kit and accident book were available. Weekly checks were in place to ensure the required kit and medicines were available and in-date.
- Staff were up-to-date with the required training for medical emergencies. They also had received training regarding the recognition and management of sepsis. A sepsis aide memoir was held with the emergency kit. Equally, staff had received training in thermal injuries and gave an example of how a patient with a heat injury was managed. The management of the patient was subject to a peer review after the event.

Information to deliver safe care and treatment

Information processes to support staff with providing patients with safe care needed to be improved.

- Read coding was not accurate in most of the 28 clinical records we looked at on DMICP. For example, incorrect coding assigned to cervical smear reports had led to recalls showing inaccurately as overdue. In addition, review templates and DMICP diary entries were not consistently used. Staff confirmed they were not confident with using DMICP and had not received formal training in its functionality. This was evident throughout the inspection.
- The new guidance on registering and deregistering patients (DPHC standard operating procedure GN28), which includes a summarisation section, had not been fully implemented.

Staff described a process for summarisation that started with the patient completing a new patient registration form which was then forwarded to the nursing team for summarisation. The relevant Read code was not being used so we were unable to confirm the status of summarisation. The cervical screening clinical records we looked at had not been summarised.

- Shortly after the inspection the nurse manager confirmed a strategy to address the backlog of summarisation had been agreed. This included support from with understanding the DPHC summarisation guidance and the functionality of DMICP. A standard operating procedure (SoP) regarding summarisation, searches and use of Read codes was put in place. A process to regularly audit clinical records was not in place; this would likely have identified the concerns we found with clinical record keeping.
- A member of the administrative team was responsible for the management of referrals, including internal referrals and those to external secondary care services. A hardcopy log was in place to monitor the status of referrals. Urgent referrals were followed up after two weeks. The physiotherapists managed and monitored their own referrals.
- Clinicians managed their own test results and monitored these during colleague absence. Although a SoP was in place for the management of specimens, it lacked detail in terms of clarifying all stages of the process, including staff responsibilities. The nurse manager said they would revise and develop the SoP further. The management of specimens was audited in accordance with DPHC policy.

Safe and appropriate use of medicines

Processes to ensure the safe management of medicines needed to be improved.

- The nurse manager was also the lead for medicines management at the practice. The dispensing assistant for the group practice was responsible for the management of stock. Dispensing was outsourced to a local pharmacy. Procedures for the safe management and storage of medicines, including vaccines, medical gases, emergency medicines and equipment minimised risks. A process was in place for the safe management of blank prescription forms
- A record of dispensary stock was held and expiry dates routinely checked. Medication requiring refrigeration was monitored twice a day to ensure it was stored within the correct temperature range. Prescription pads were securely stored and their use monitored.
- Patient Group Directions (PGD) had been developed to allow one of the nurses who was not a prescriber to administer immunisations and the flu vaccination. These were up-to-date and signed by the lead GP. We noted that the basic DPHC treatment PGDs had expired. The nurse manager confirmed the practice had just ceased using PGDs and instead non-medical prescribers (advanced nurse practitioners) would prescribe for the non-prescribing nurse.
- Patient Specific Directions (PSD) were in place for the medics to treat patients. We noted the prescriber details confirming PSD training had been undertaken was not completed. Medics were undertaking immunisations and had not completed the refresher training. The nurse manager confirmed that they would no longer treat patients until this training had been completed.
- The non-medical prescribers kept up-to-date through annual clinical updates arranged through the local Clinical Commissioning Group (CCG), through clinical meetings, peer review and clinical supervision.
- The process to ensure patients collected their prescriptions in a timely way was not effective as we found two uncollected prescriptions; one for antibiotics from 13 May 2019 and one for medicine to stop smoking from 18 May 2019. The latter prescription was prescribed by a non-

prescriber, which is not in accordance with DPHC policy. Immediately following the inspection, the nurse manager took action, including raising a significant event and starting an investigation.

- Repeat prescriptions were agreed in writing or in person. Prescribing audits were undertaken quarterly by the regional pharmacist and included the prescribing of antibiotics.
- We reviewed the clinical records for two patients prescribed high risk medicines. Alerts were appropriately used to identify these patients on the system and the clinical records were being monitored appropriately. The Read code was not accurate for one patient, suggesting that a shared care agreement (with secondary care) was not in place. Staff later confirmed the agreement was in place.
- A meeting was held each month to discuss medicines management, including prescribing and medicine updates.

Track record on safety

The practice had a good safety record but there was scope for improvement.

- A lead for health and safety was identified and they were suitably trained for the role. Safety processes for the practice were monitored and reviewed, which provided a clear, accurate and current picture that led to safety improvements. Risk assessments pertinent to the practice were in place, including those for hazardous substances. There were no risk assessments in place for the PCRF, such as assessments for the use of equipment.
- The waiting area could not be observed by reception staff. In addition, the system for staff to summon assistance in an emergency was not adequate. We were advised portable panic alarms were available in clinical rooms for staff. The portable alarm could not be found in one of the treatment rooms. After the inspection, the nurse manager confirmed that portable alarms had been procured.

Lessons learned and improvements made

The practice had a process to learn lessons when things went wrong. There was scope for further improvement.

- Staff used the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events, incidents and near misses. However, the physiotherapists did not have access to the system. If they needed to report an event then the nurse manager logged onto the system for them.
- Staff provided several examples of significant events they had raised demonstrating there was a culture of effectively reporting incidents. Significant events were discussed at the practice meetings.
- The nurse manager was responsible for managing medicine and safety alerts. They were managed at the NHS practice, were forwarded to and signed off by staff once read. Copies of alerts were retained on file.

Are services effective?	**Requires improvement**

Effective needs assessment, care and treatment

The practice had processes to keep clinicians up to date with current evidence-based practice.

- Clinical staff assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. A meeting schedule was established for the group practice with each weekly meeting having a different focus. The 'clinical discussion' meetings facilitated peer review as it provided the opportunity to discuss the care and treatment of individual patients.
- The meeting schedule also provided the opportunity to discuss NICE (National Institute for Health and Care Excellence) and other practice guidance. For example, a contraception update was presented at the meeting in May 2019 and the management of sciatica in April 2019. Minutes of these meetings were available for staff on-line.
- The PCRF team referenced best practice guidelines in their treatment of patients, such as the Defence Rehabilitation website. They had regular meetings with the nurse manager, a specialist in musculoskeletal injuries, to discuss patients referred and their care pathways.

Monitoring care and treatment

Processes to monitor that patients were receiving effective care and treatment needed improving.

- The practice used data collected for the Quality and Outcomes Framework (QOF) 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 Defence Medical Services (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 DPHC practices, we are not using NHS data as a comparator. The nurse manager was the lead for the management of long term conditions.
- As part of our inspection, we looked at QOF data for diabetes, hypertension and asthma. Staff advised us that there were no patients diagnosed with these conditions and searches carried out on 31 May 2019 confirmed this. However, we identified a patient with hypertension when reviewing clinical records. This patient did not show on any search for hypertension due to inaccurate Read coding. Staff said that the patient registered at the practice in April 2019 and coding had been completed at the patient's previous medical centre. We looked at the patient's clinical record and confirmed they had been appropriately monitored and reviewed. Staff confirmed promptly after the inspection that the coding error had been rectified for this patient.
- Because of the anomalies with Read coding, inconsistent use of templates and limited understanding of DMICP in general, we looked in detail at a broad selection of records for patients (8% of the patient population) with long term conditions, those with mental health needs, patients eligible for national screening and patients referred for rehabilitation. The clinical records assured us that these patients were receiving care that met their needs, and patients with a long term condition were being reviewed and treated appropriately.
- Information from the Force Protection Dashboard, which uses statistics and data collected from military primary health care facilities, was also used to gauge performance. 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 (every two years). Audiometric assessments were in date for 89% of patients.
- An audit meeting was held monthly at the group practice and staff presented clinical audits for discussion. Examples of audit activity for 2018/19 specific to Swanton Morley Medical

Centre included: a PGD audit; non-attendance audit; antibiotic prescribing audits and a repeat medicines audit. A clinical record keeping audit had been undertaken but it only looked at chaperoning and prescribing, and it did not follow the DPHC audit structure. A physiotherapy service provision audit was due to take place. However, audit activity led by the PCRF was limited to a patient satisfaction survey and the team was not engaged with the wider audit programme for the practice. A formal clinical records audit for the PCRF had not been undertaken.

Effective staffing

Continuous learning and development were promoted at the practice but there was scope for improvement.

- All staff working at the practice had been inducted through the group practice. Staff said there had not been a specific induction for Swanton Morley Medical Centre which included training about DPHC systems and processes. This was evident as we found staff had a limited understanding of the functionality of DMICP. Staff advised us that a specific induction pack had recently been developed. As part of their induction, one of the GPs spent time at two military bases to understand the impact of operational activity on the health of service personnel.
- Although mandated training was monitored and the contracted staff team were in-date for all required training, training for medics was not being monitored. We found that medics were not in-date with their immunisation refresher training.
- All staff had an identified workplace supervisor and had access to one-to-one meetings, mentoring and support for revalidation. Clinical staff were given protected time for professional development. The physiotherapists attend quarterly training at the Regional Rehabilitation Unit (RRU).

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment but there was room for improvement.

- The clinical records we reviewed showed appropriate staff, including those in different teams, services and organisations were involved in assessing, planning and delivering care and treatment. The GPs and Regimental Medical Officer (RMO) took different approaches to patients who were assessed as unfit to handle live firearms. After the inspection the nurse manager confirmed that the RMO and lead GP had started discussing the development of a SoP for consistency in this area.
- Unit Health Committee (UHC) meetings were coordinated by the unit. A GP and physiotherapist attended these when they could. These meetings were used to review the needs of patients who were medically downgraded and those who were vulnerable. Representation from the medical centre was limited as the unit often changed the date/time of the meetings at short notice. This matter was being addressed by the nurse manager and unit commander.
- Not having an Exercise Rehabilitation Instructor (ERI) left a gap in rehabilitation provision and communication as ERIs provided the link between the PCRF and physical training instructor's (PTI) for the unit. This deficit was acknowledged in the RRU advisory visit from October 2018. The operations manager had met with the physiotherapists and the PTIs to discuss how to resolve this.

- Staff had a good awareness of and had developed effective working relationships with health and social care organisations. They were mindful of the potential social isolation of patients and could refer patients to local organisations, such as the 'Men's Shed'. The practice also worked closely with the welfare team for the unit.
- Patients leaving the military patient received a leaving medical and a summary of their health needs to pass to their new GP. Patients were also referred to the welfare team for support with the transition. Staff advised us that patients leaving who settled in the local area remained with the group practice.

Helping patients to live healthier lives

Systems to support patients to live healthier lives needed further development.

- Clinical records showed that staff encouraged and supported patients to be involved in monitoring and managing their health. Staff also discussed changes to care or treatment with patients as necessary.
- The nurse manager was the lead for health promotion. The practice supported national priorities and initiatives to improve the population's health including, smoking and alcohol use. A health promotion schedule was in place and topics refreshed quarterly. Information on alcohol, sexual health and climatic injuries were available for patients in the waiting area. The practice was represented at the last health fair held on the base two years ago.
- The nurse manager was also the lead for sexual health. They had not completed the recognised training (STIF programme) so patients were referred to the sexual health clinic in Norwich. We noted the sexual health information available to patients was out-of-date with leaflets dated 2006 and 2010. Condoms were available for patients.
- There was no recognisable system in place to identify, monitor and manage patients who met the criteria for the national screening programme. Cervical screening was our priority concern. With the lead nurse unavailable and no other member of staff familiar with the role, we undertook our own search. The system showed most of the 11 eligible patients were out-of-date for cervical screening. We interrogated some of the clinical records and determined the patients were in-date for cervical screening recalls but that processes within DMICP were not being used correctly (Read codes, diary dates and templates) giving an inaccurate impression that cytology screening was out-of-date. We asked how patients were being monitored and were advised they were being recalled through the Open Exeter system. This is a national screening recall system that gives access to patient data so eligible patients can be invited to participate in the screening programme.
- The day after the inspection, the nurse manager interrogated the system and provided assurance that all patients were in-date for cervical screening. They also developed a SoP to support staff in this area. Searches for the other national screening programmes were also undertaken and assurance provided that no patients met the eligibility criteria.
- 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. Based on clinical records, the following illustrates the current 2018 vaccination data for military patients:
    - 82% of patients were up to date with vaccination against diphtheria.
    - 82% of patients were up to date with vaccination against polio.
    - 88% of patients were up to date with vaccination against hepatitis B.

- 81% of patients were up to date with vaccination against hepatitis A.
- 82% of patients were up to date with vaccination against tetanus.
- 65% of patients were up to date with vaccination against typhoid.

- A system was in place to monitor the vaccination status of patients. Monthly searches were carried out, patients telephoned and invited to make an appointment. Patients who failed to respond could be captured opportunistically when they attended the practice for another reason.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance but the process needed improving.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. The staff team received training regarding the Mental Capacity Act (2005) in August 2018.
- Read coding was not always used to indicate consent was being taken.

Are services caring?	Good

Kindness, respect and compassion

Staff supported patients in a kind and respectful way.

- Throughout the inspection staff were courteous and respectful to patients arriving for their appointments.
- Results from the Patient Experience Survey (2018; quarter 3) showed that 37 of the 38 respondents would recommend the practice to family and friends (the remaining patient gave a neutral answer the question). The eight CQC comment cards completed prior to the inspection were very complimentary about the caring attitude of staff.
- 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.

Involvement in decisions about care and treatment

Staff supported patients to be involved in decisions about their care.

- Interpretation services were available for patients who did not have English as a first language and staff were aware of how to access this.
- The Patient Experience Survey showed that, of 37 respondents, 36 felt involved in decisions about their care (one patient gave a neutral answer the question). Feedback on the CQC patient feedback cards highlighted that patients received information to support them with making informed decisions about their treatment and care.
- The practice sought to identify patients who were also had a caring responsibility. There were no carers identified at the time of the inspection.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. Clinic room doors were closed during consultations.
- The layout of the reception area and seating in the waiting area meant that conversations between patients and reception could not easily be overheard. A television was playing to minimise conversations being overheard.
- If patients wished to discuss sensitive issues or appeared distressed at reception they were offered a private room to discuss their needs.
- The practice could facilitate patients who wished to see a clinician of a specific gender.

Are services responsive to people's needs? | Good

Responding to and meeting people's needs

- Services were organised and reviewed to meet patient needs and preferences where possible.
- Breast feeding and baby changing facilities were available.
- An access audit as defined in the Equality Act 2010 had been completed for the premises and reasonable adjustments had been made to accommodate patients.

Timely access to care and treatment

Patients' needs were met in a timely way.

- Patients with an emergency need were seen by a nurse on the same day and the waiting time for a routine appointment with a GP was one to two days. Double appointments at either the request of the clinician or patient could be made. Patients could be seen by a physiotherapist within 48 hours. Home visits were available but no requests had been made for these in the last 12 months. Patients could also request a telephone consultation.
- The group practice facilitated 'Improved Access Hours' that included weekends with a duty doctor always available. Military patients had access to this scheme.
- The direct access physiotherapist service (DAPS) had not been put in place. Because the nurse manager specialised in musculoskeletal injuries, it was decided that direct access did not make best use of the limited physiotherapy time.
- Arrangements were in place for patients to access primary care when the practice was closed, including emergency care. The Patient Experience Survey showed that 37 respondents out of 38 had received their appointment at a time that suited them.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information was available to help patients understand the complaints process. The practice managed complaints in accordance with the DPHC complaints policy and procedure. Both a complaints and compliments log were maintained.

- The practice manager was the designated responsible person who handled all complaints. A record of complaints was maintained, including verbal complaints. Three complaints had been received since May 2017. They had been managed effectively and resolved to the satisfaction of the complainants. Any complaints were discussed at the practice meetings and lessons identified.

Are services well-led?	Requires improvement

Vision and strategy

- The strategy for the service was to provide a nurse/practice manager-led service to the service personnel of Swanton Morley Medical Centre as part of a group practice model. The operational arrangements for the model were outlined in the contract between the Secretary of State for Defence and Elmham Group Practice, a local NHS primary care provider that has been providing a primary care service to Swanton Morley Medical Centre since 2010. Details of day-to-day provision was defined in the service specification (schedule 5 of the contract).

The aims of the service were outlined as:

- To ensure that every serviceman and woman enjoys a level of health that is appropriate for their home base tasks.
- To maximise the numbers of servicemen and women who are medically fit for their operational tasks

Leadership capacity and capability

- The day-to-day operation of the practice was the responsibility of the nurse manager, with the practice manager taking the lead with contract monitoring. The leaders clearly understood the practice priorities. Patients' need was the focus of providing a quality and sustainable service. This was demonstrated through the leaders addressing the need for more consistency with UHC meetings and reviewing the need for an ERI.
- We identified gaps in leadership capability which affected the wider team. This mainly related to the team's understanding and application of DPHC policies and processes, such as record summarisation and the management of specimens. Staff had limited understanding of the functionality of DMICP (Defence Medical Information Capability Programme), a centralised electronic system for managing the health care of service personnel across the Armed Forces.
- We also identified a gap in leadership capacity as there was no one person providing practice management on a daily basis. This concern was raised in a 2018 systems review paper produced by the RMO for the Regional Clinical Director (RCD) and the DPHC. The report made a recommendation that "practice management responsibilities be contractually determined with a named individual". The RCD confirmed that this recommendation had not been met.
- Contract monitoring was an informal process. Although regional visits to the service were regular as were meetings with the practice manager, no formal structure was used to monitor performance against the service specification. The provision of a quarterly contract monitoring report (as required by a quality performance indicator) was no longer being submitted by the practice as data was being checked by region through the practice dashboard.
- The nurse manager positively and promptly responded to our findings and produced a plan of action the following day. Importantly, they prioritised a review of the national screening

programme and summarisation of records for patients eligible for cervical screening, providing assurance that patients had received appropriate care and treatment.

Culture

The culture at the practice was inclusive and all staff were treated equally.

- Staff said the practice was very well led and they felt respected, supported and valued. Opportunities were in place so staff could contribute to discussions about how to develop the practice.
- Staff we spoke with clearly demonstrated a patient-centred focus and they said this ethos was promoted by leaders and embedded in practice.
- The practice had systems to ensure compliance with the requirements of the duty of candour, including giving those affected reasonable support, information and a verbal and written apology. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. A duty of candour register was in place.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- The practice actively promoted equality and diversity and provided staff with the relevant training. Staff felt they were treated equally.

Governance arrangements

There was scope to strengthen the overarching governance framework to support the delivery of good quality care.

- There was a clear staffing structure in place and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. The regional management team worked closely with the practice. Contrary to DPHC policy, the physiotherapists did not have a log in to the system for reporting significant events.
- The practice worked to the health governance workbook, a system that brings together a comprehensive range of governance activities, including the risk register, significant events tracker, lessons learnt log, training register, policies, meetings, quality improvement and audit. All staff had access to the workbook which provided links to meeting minutes, policies and other information.
- An effective range of communication streams were used at the practice. A schedule of regular themed clinical and practice meetings was well established.
- Audit was used to measure the effectiveness and success of clinical and administration of the practice. Although audit was taking place, we were not provided with an advance audit schedule. The PCRF team were not engaged with the audit programme and were not undertaking clinical audit to measure patient outcomes.

Managing risks, issues and performance

There was scope to make improvements to the management of risks, issues and performance.

- The health governance workbook contained a retired risk register and a newly introduced risk register (from April 2019). There were no risks recorded on the new register, in particular risks

the service told us about, such as inconsistency with UHC meetings and the ERI gap in PCRF provision. An issues register was not in place.

- Processes were in place to monitor national and local safety alerts, incidents, and complaints.
- A business continuity plan was in place and was last revised in 2015. The major incident plan for the camp was not available at the practice.
- A staff appraisal process was established. The physiotherapists were appraised in their NHS practice.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- An internal quality assurance tool, the DMS Common Assurance Framework (CAF) was used to monitor safety and performance. The DMS CAF was formally introduced in September 2009 and since that time has been the standard healthcare governance assurance tool utilised by DMS practices to assure the standards of health care delivery within DMS. There was one overarching CAF for the medical centre and the PCRF.
- The RRU undertook an advisory visit to the PCRF in October 2018 to monitor the performance of the team.

Engagement with patients, the public, staff and external partners

The practice involved patients, staff and external partners to support with making improvements to the service.

- There were various options in place to encourage patients to provide feedback on the service and contribute to the development of the service. A patient experience survey was undertaken throughout the year. The PCRF also carried out its own annual patient survey. A suggestion box was available in the waiting area.
- The practice had attempted to set up a Patient Participation Group (PPG) but had received no interest in this.
- The practice had good and effective links with both internal and external organisations including the Regional Rehabilitation Unit (RRU), the DCMH, CCG and local NHS primary care providers
- Staff had opportunities to feedback on the service through practice meetings and individual supervision.

Continuous improvement and innovation

The practice was keen to continually improve the service it provided to service personnel. A quality improvement register was maintained through the health governance workbook. Some of the improvements the practice identified included:

- The strengthening of links with the welfare team.
- Diarrhoea and vomiting (D&V) form devised to enable better tracking of soldiers presenting with D&V that may enable sources of outbreak to be identified, such as accommodation and catering.
- To understand a soldier's daily routine, staff had the opportunity to participate in 'A day with the army' that involved guided instruction and physical handling of kit, weapons, military vehicles etc.

- Improved collaborative working between medics, the RMO and staff in clinical practice.