Bicester Quality report

Date of inspection visit: 14 June 2018
Date of publication: 17 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>
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<tr>
<td>Are services well-led?</td>
<td>Good</td>
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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

We carried out an announced comprehensive inspection at Bicester Medical Centre on 14 June 2018. 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.

Letter from the Chief Inspector of General Practice

We carried out an announced inspection at Bicester on 14th June 2018. Overall, the practice is rated as good. Our key findings across all the areas we inspected were as follows:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice fostered an ethos of patient centred care.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Systems and processes to keep patients safe were not fully embedded at the practice; the management of laboratory results was not failsafe.
- The systems in place to keep patients safe and safeguarded from abuse were effective.
- The arrangements for managing medicines, including obtaining, prescribing, recording, handling, storing, security and disposal in the practice minimised risks to patient safety.
- The practice worked collaboratively and shared best practice to promote better health outcomes for patients.
- Audits and regular reviews of the service were undertaken to drive improvements to patient outcomes.
- Data showed patient outcomes in some areas were lower compared to the national average. For example, the management and recall of asthmatic patients and the review of patients with a diagnosis of depression.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
• Results from the patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
• Information about services and how to complain was available. The practice had received one complaint within the past year and it had been managed well and in line with the practice policy.
• The practice was responsive to the needs of their population and offered a wide access of health promotional material, support and advice was readily available.
• Patients we spoke with said they found it easy to make an appointment with a GP and there was continuity of care, with urgent appointments available the same day.
• Facilities and equipment at the practice were sufficient to treat patients and meet their needs.
• The practice proactively sought feedback from staff and patients which it acted on.
• The provider was aware of the requirements of the duty of candour.
• Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. It was clear that the practice team enjoyed working together and staff told us that their team was strong, committed and reliable.

The Chief Inspector recommends:

• Formal governance arrangements including systems for assessing and monitoring risks and the quality of the service provision should be strengthened, embedded and understood by all staff. This should include the management of shared care agreements, the management of test results and ensuring all clinical discussion and actions are recorded in patients notes (patient injury management (PIM)).
• Ensure that recall of patients with long term conditions maximises improvements in patient outcomes.
• 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.
• Introduce a home visit policy.

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

Our inspection team

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

Background to Bicester

Bicester Medical Centre is located in Bicester near Oxford. The treatment facility offers primary care only to forces personnel. Dependants and children must register at an NHS practice. At the time of inspection, the patient list was approximately 900. Occupational health services are also provided to personnel and a small number of reservists.
The medical centre has one full time Senior Medical Officer (SMO) and one part-time GP. There are two civilian locum nurses, one health care assistant, one administrative staff and one physiotherapist. There was one Exercise Rehabilitation Instructor (ERI). Three medics, who were not Defence Primary Healthcare staff, but were part of the regiment also worked out of the medical centre when not deployed.

In addition to routine GP services, the treatment facility offers physiotherapy and rehabilitation services. Family planning advice is available at the practice and maternity and midwifery services are provided by NHS practices and community teams. Mental Health referrals are made to Brize Norton located approximately 23 miles away.

The practice is open from Monday to Thursday 0800 to 1630 hours and on Friday between 0800 and 1600 hours. After this duty cover is provided by RAF Halton which is 23 miles away. Outside of these times, patients were referred to NHS 111 or local out of hours’ services.

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We rated the practice as good for providing safe services.

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.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient’s welfare. There was a lead member of staff for safeguarding and this was the GP. Effective deputising arrangements were in place.

- 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).

- Ninety-eight per cent of patient’s 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 infection control lead nurse post had been vacant for eight months, this role was being undertaken by the senior nursing officer who undertook weekly inspections of the practice to check that good standards of cleanliness were upheld. The practice had an infection control policy, had completed infection control audits and staff had attended annual infection control refresher training.

- All single use items were stored appropriately and were within their expiry date. Specific equipment was cleaned daily and daily logs were completed. Spillage kits were available and clinical waste was stored appropriately and securely and was collected from the practice by an external contractor.

- The full range of recruitment records for permanent staff was held centrally at Regional Headquarters (RHQ). However, 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**

- 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).

- The practice worked hard to manage with depleted staffing levels. At the time of the inspection they had one practice nurse post vacant and were awaiting the arrival of a new receptionist. The existing staff had a good mix of skills and experience. The practice had a record of the minimum number of GP sessions needed per week and used this to manage GP staffing levels. Staff had a flexible approach towards managing the day to day running of the practice.

- The layout of the practice meant not all patients in the waiting area could be observed by reception staff. This was particularly important in the event of a medical emergency. The nursing officer confirmed that a statement of need had been submitted for CCTV to be installed and the practice had accessed CQC’s policy on the use of CCTV.

**Information to deliver safe care and treatment**

Staff did not always have the information they needed to deliver safe care and treatment to patients.

- Individual care records were not always written and managed in a way that kept patients safe. However, when looking at the patient injury management (PIM) clinic notes, including the discussions and actions made by clinicians, we saw these were not recorded in patients’ medical notes.

- The system to manage hospital letters was failsafe and there was documentation on the medical record to show who had read and actioned these letters for patients.

- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.

- We looked at the procedures used by GPs that should ensure test results were reviewed daily. We noted that although there were no outstanding results left unactioned there was no clear failsafe system in place to ensure that test results were looked at in a timely way and no set processes for reviewing blood results of absent doctors (through leave or it being a non-working day).

**Safe and appropriate use of medicines**

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• The practice carried out regular medicines audits, for example, an antibiotic audit, to ensure prescribing was in line with best practice guidelines for safe prescribing. Prescription pads were held securely and the arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe. This included arrangements for obtaining, prescribing, recording, handling, storing and the security of medicines. There was no dispensary at the practice, this service was outsourced to a local pharmacy who delivered medicines back to the practice and patients could collect them between 1530 and 1630 hours daily.

**Track record on safety**

• There were comprehensive risk assessments in relation to safety issues.
• The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.
• All clinical rooms had personnel attack alarms including reception, and there was a policy in place in their use.

**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.
• There were good systems in place for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice.

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<td><strong>We rated the practice as requires improvement for providing effective services.</strong></td>
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**Effective needs assessment, care and treatment**

• Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.
• The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients’ needs. We looked at the minutes of a recent clinical update meeting and saw that NICE guidance was a standard agenda item at weekly clinical meetings. The Defence Primary Health Care (DPHC) Team produced a newsletter that was circulated to clinicians providing further information and a summary of relevant safety updates.

**Monitoring care and treatment**

Performance around chronic disease management had historically been below average mainly due to staff shortages. The practice was working hard to make improvements and 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 and extensive chronic disease management register. The practice carried out chronic disease audits to ensure they provided care for patients with chronic disease in line with NICE guidelines. This audit was undertaken every six months.
Management, monitoring and improving outcomes for people

- 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 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 practice provided the following patient outcomes data to us from their computer system on the day of the inspection:

- There was one patient on the diabetic register. We reviewed the treatment and care offered to this patient and found that current NICE guidance had been followed. The last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. The last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.

- There were 18 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, seven had a blood pressure reading of 150/90 or less.

- The number of patients with long term physical or mental conditions, who smoke and whose notes contained a record that smoking cessation advice, or referral to a specialist service had been offered within the previous 15 months was 39 which is 100% of the smoking patient population. The NHS target for this indicator is 90%.

- There were 19 patients with a diagnosis of asthma. We reviewed the treatment and care offered to these patients and found that current NICE/SIGN guidance had been followed. Of these five had had an asthma review in the preceding 12 months which included an assessment of asthma control using the 3 Royal College of Physicians questions. The practice was working hard to proactively recall these patients for a review of their condition.

- There were 11 patients with a new diagnosis of depression in last 12 months. Five had been reviewed within 10-35 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 above average compared to DPHC 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 (every two years). Data from May 2018 showed:

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

- 93% of patients’ audiometric assessments were in date (within the last two years) compared to 86% regionally and 85.5% for DPHC nationally.

There was evidence of quality improvement work including clinical audit

An internal quality assurance tool, the Defence Medical Services (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 evidence of quality improvement work including clinical audit, this led to improved outcomes for patients

From discussions with staff, it was clear the practice was pro-active in using a quality improvement approach to review its systems of care and identifying actions leading to measurable improvements in health care delivery. An active programme of audit, both clinical and non-clinical, was in place that focussed on the needs of the population and demonstrated a commitment to improving outcomes for patients. An audit spreadsheet showed 14 completed audits (both clinical and administrative) completed since November 2017. Audits undertaken were relevant to the needs of the patient population, including a rolling programme of audit for long term conditions. Examples of completed clinical audits we looked at and discussed with staff included antibiotic prescribing, chronic disease, vulnerable adults and high-risk medicines.

**Effective staffing**

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff including locum staff. This included topics such as safeguarding, infection prevention and control, fire safety, health and safety, information governance and Caldicott accountability. Staff had access to and made use of e-learning training modules and in-house training. Staff had all received mandatory training in subjects such as fire, basic life support and infection control. In addition, staff had received role-specific training. Staff who acted as chaperones had received training which had been devised and delivered by the practice themselves.

- Bicester has had a lack of permanent nursing staff for a protracted period which has been covered by locums. Whilst the locum nurses were effective and clinically sound, it was recognised that there was, over a period of eight months, no permanent member of nursing staff. The imminent arrival of a Senior Nursing Officer (SNO) has already shown marked improvements in the coordination and governance and we saw evidence that this would continue to improve once they were permanently in post later this month.

- The nurses maintained their own continual professional development and managed their own nursing update training.

- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. All staff had received an appraisal within the last 12 months.

**Coordinating care and treatment**

Staff worked well together and with some other care professionals to deliver effective care and treatment.

The practice met regularly with welfare teams and line managers to discuss vulnerable patients. The Medical Centre shares a building with the PCRF service which provides physiotherapy and exercise rehabilitation for patients. Patients were able to obtain swift access to the PCRF and strong partnership working arrangements resulted in co-ordinated and person-centred care for patients.
We reviewed two patients on high risk medicines, we found one without a shared care agreement in place. Shared care agreements are a planned way of managing a patient’s care when both the hospital and a GP are providing care to a patient.

**Helping patients to live healthier lives**

The practice did not have any dependants or children of service personnel registered with the practice.

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Those requiring advice on their diet, smoking and alcohol cessation. The practice also gave sexual health advice and referred to a sexual health clinic when required. Advice on prevention of musculoskeletal injury was also available from physiotherapy staff at the practice, as well as the GPs providing services.

- The practice had a health promotion calendar to promote specific issues relevant to the service population and its requirements. There was a women’s health fair held in May 2018 in the garrison’s gym, this included other health care professionals such as midwives and health visitors. Advice was available on topic such as breast care, mental health and sexual health.

- New patients completed on arrival a new patient questionnaire. Following this the patient was booked in for a 15 minute appointment with one of the nurses, this allowed them time to enter in the questionnaire information and also summarise their records. If at this point it was seen they had any extra medical needs they were recalled in for a further appointment

- 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. 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.

- 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 50 out of 57 eligible women. This represented an achievement of 88%. The NHS target was 80%.

- 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. Currently female patients have to travel to RAF Halton due to the locum staff not having had cervical cytology training.

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:

- 93% of patients were recorded as being up to date with vaccination against diphtheria compared to 94.5% regionally and 95% for DPHC nationally.

- 93% of patients were recorded as being up to date with vaccination against polio compared to 94% regionally and 94.5% for DPHC nationally.

- 79% of patients were recorded as being up to date with vaccination against Hepatitis B compared to 75.5% regionally and 77% for DPHC nationally.
• 91% of patients were recorded as being up to date with vaccination against Hepatitis A, compared to 93% regionally and 91% nationally.
• 93% of patients were recorded as being up to date with vaccination against Tetanus, compared to 94.5% regionally and 95% for DPHC nationally.
• 72% of patients were recorded as being up to date with vaccination against Typhoid, compared to 35% 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.

Consent to care and treatment
Staff sought patients’ consent to care and treatment in line with legislation and guidance.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

Are services caring? | Good

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 40 CQC comment cards from patients at the practice that described their care and treatment in a highly positive way. The practice gave patients timely support and information.
• 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.
• Results from the practice’s Patient Experience Survey showed patients felt they were treated with compassion, dignity and respect. For example, from 123 surveys completed -
  o 88% of patients gave a positive response when asked if they would recommend the practice to their friends and family.
• 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

• 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.
• Data received from the patient experience survey, May 2018, showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example:
  o From 123 completed questionnaires 78% of patients said they were involved in decisions about their care and treatment.
• 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.
• Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of organisations. We saw that information that was age appropriate and relevant to the patient demographic was prominently displayed and accessible. For example, we saw posters for symptoms that may suggest a sexual health screening appointment would be useful and on the importance of completing any prescribed course of treatment.

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. 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 male GPs employed at the practice meaning if a female patient requested to see a female GP they would have to travel to RAF Halton. 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.

Are services responsive to people’s needs? | Good
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We rated the practice as good for providing responsive services

Responding to and meeting people’s needs
The practice organised and delivered services to meet patients’ needs. It took account of patient needs and preferences.

• The practice understood the needs of its population and tailored services in response to those needs. For example, advanced booking of appointments, daily ‘fresh cases’ for immediate access to a GP and telephone consultations.
• The facilities and premises were appropriate for the services delivered.
• Patients were able to self-refer themselves to physiotherapy.
• The practice stated that it made reasonable adjustments in the rare circumstances that a patient found it hard to access services and required a home visit. They had visited patients in
their own accommodation when required. However, there was scope to ensure that a policy for home visiting was in place to clearly guide both staff and patients.

**Timely access to care and treatment**

- The practice was open from Monday to Thursday 0800 to 1630 hours and on Friday between 0800 and 1600 hours. After this duty cover was provided by RAF Halton until 1830 hours. Outside of these times, patients were referred to NHS 111 or local out of hours’ services.
- The practice held ‘fresh case’ clinics once daily. All patients were triaged by medics who referred on to a nurse, physiotherapist or GP as required (a military medic delivers healthcare similar to a healthcare assistant in the NHS but has a greater scope of duties).

Results from the practice’s patient experience survey showed that patient satisfaction levels with access to care and treatment were generally high. For example:

- 91% of patients said their appointment was at a convenient time.
- 81% said their appointment was in 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 the John Radcliffe Hospital, Oxford.

The Defence Rehabilitation Headquarters collated a dashboard of information in relation to waiting times and patients who do not attend for their appointment. These are key performance indicators as timely access to physiotherapy and rehabilitation are important for effective patient recovery. Bicester PCRF was performing ahead of regional and defence-wide peers on some measures, and below on others. However, it should be noted that patient choice has an impact on performance against KPIs as, once referred by a GP, patients control when they arrange an appointment to see a physiotherapist or ERI.

For January to March 2018, 41% of new patients referred to see a physiotherapist were seen within five working days. This compares to a regional average of 40% and overall PCRF average of 55%. Similarly, 74% of new patients referred to see an ERI at Bicester were seen within a KPI target of five working days, compared to a regional average of 56% and an overall PCRF average of 49%. The PCRF did not attend (DNA) rate was slightly above national average with 8% of appointments lost to DNA’s in January to March 2018, compared to regional average of 9% and an overall PCRF average of 7%.

**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.

- Defence Primary Health Care had an established policy and the practice adhered to this.
- The practice manager was the designated responsible person who handled all complaints in the practice. The receptionist kept a spreadsheet of all compliments and complaints including verbal communications, all of which were discussed and fed back at the monthly team meeting.
- We saw that information was available to help patients understand the complaints system.
• We spoke with three patients who told us that they felt comfortable and knew how to complain if the need arised. They confirmed that military rank would not be a barrier to them raising issues with the practice.

• We reviewed 10 complaints that had been submitted by patients in the past 12 months. We saw that there were processes in place to share learning from complaints. 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.

• Results from the patient survey dated January 2018 showed that 82% of patients said they felt their comments, compliments and complaints were listened to.

**Are services well-led?**

| Good |

We rated the practice as good for providing a well-led service.

**Leadership capacity and capability**

Leaders had worked hard to address a significant number of issues mostly due to reduced staffing levels. The SMO was new to their leadership role and was undergoing a comprehensive induction programme and working towards developing managerial skills. This included following a mid-term appraisal, additional courses were offered and additional support from other practices secured. We saw evidence that the practice manager, the Regional Clinical Director and lead nurse had taken steps towards fostering a positive culture and improved team environment and were providing a good level of training and support to drive improvement. Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.

Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. It was clear that the practice team enjoyed working together and staff told us that their team was strong, committed and reliable.

All staff were involved in discussions about how to run and develop the practice. We saw the practice held regular meetings and staff confirmed this. 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. Minutes were comprehensive and were available for practice staff to view.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour (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). This included training for all staff on communicating with patients about notifiable safety incidents. The GPs and practice manager encouraged a culture of openness and honesty. We found that the practice had systems to ensure that when things went wrong with care and treatment, the practice gave affected people reasonable support, information and a verbal and written apology.

**Vision and strategy**

• The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

• There was a clear vision and set of values. ‘DPHC will deliver a unified, safe, efficient and accountable primary healthcare and dental care services for entitled personnel to maximise
their health and to deliver personnel medically fit for operations’. All staff were aware of and understood the vision, values and strategy and their role in achieving them.

- The practice had a realistic strategy and supporting business plans to achieve priorities and planned its services to meet the needs of the practice population. This included the development and implementation of a Management Action Plan (MAP) for all practice members to adhere to. The plan aimed to address issues and identify actions required for the forthcoming year to improve and establish good governance throughout the practice.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice. There were positive relationships between all staff and the team worked well together.
- The practice focused on the needs of patients.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- 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.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of good quality care. There was a clear staffing structure and that staff were aware of their own roles and responsibilities.

- Joint working with the welfare team, SAFFA (The Armed Forces Charity), pastoral support and Chain of Command was interactive and led to co-ordinated person-centred care.
- The PCRF delivered rehabilitation services from the medical centre. The service was well led and enabled patients to access timely, holistic care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.

Managing risks, issues and performance

- There were clear and effective processes for managing many risks, issues and performance.
- Practice leaders had oversight of national and local safety alerts, incidents, and complaints.
- Improved management of laboratory tests was required to ensure patients received the appropriate care in a timely way.

Appropriate and accurate information

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

- An understanding of the performance of the practice was maintained. The practice manager used the Common Assessment Framework (CAF) as an effective governance tool. 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. This provided an opportunity for staff to learn about how the performance of the practice could be improved and how each staff member could contribute to those improvements.

- 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. However, we noted that the front appointment screen on the clinical computer system showed a brief summary of patient’s reasons for attending the medical centre, thus breaching patient confidentiality.

**Engagement with patients, the public, staff and external partners**

The practice had systems to involve patients, the public, staff and external partners to support high-quality sustainable services.

- The service was transparent, collaborative and open with stakeholders about performance.
- The staff team were newly formed and so it was early days in terms of building relationships, establishing embedded communication methods and ensuring good governance systems. The direction of travel was positive, challenges and barriers needed to be overcome but the new team had a plan to deliver what was required.
- The SMO attended regular Unit Health Committee and welfare meetings. They also represented at the station executive meeting.

**Continuous improvement and innovation**

Continuous improvement and innovation was evident in how the service had evolved and progressed since the new leadership took over the practice. There was clear evidence that systems and processes for learning, continuous improvement and innovation were either recently developed or in the early stages of development.

Staff shared their ideas with us around how to deliver further improvement including:

- Team building days
- Streamlining the appointments system
- Repeat audit cycles to demonstrate improved outcome for those patients with long term conditions.

Clear examples and evidence was seen of continual improvement in the PCRF service over the last year, including contributing towards the wider governance effort of the medical centre as it drove improvements. Some good examples of initiatives were:

- Modified direct access physiotherapy with intention to make the service more responsive to patients at Bicester and an audit planned in six months.
- Evidence seen of regular and accurate use of outcome measures, with audit also planned which will enable evaluation of PCRF care.
- A business case is in process for purchase of equipment as there was minimal rehabilitation equipment available on site.
- We saw a good example of setting up a regular clinical case discussion of patients; this was called ‘patient injury management (PIM) clinics’, however these discussions between clinicians did require recording in the patients’ medical notes.