

# Birmingham Medical Facility

## Quality report

Floor 2 Heritage Building  
Queen Elizabeth Hospital  
Mindelsohn Way  
Birmingham  
B15 2WB

Date of inspection visit:  
21 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, information from our ongoing monitoring of data about services, and information given to us from the provider, patients, the public and other organisations.

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

# Chief Inspector's Summary

## **This practice is rated as Good overall**

The key questions are rated as:

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

We carried out an announced comprehensive inspection at Birmingham Medical Facility on 21 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.

## **At this inspection we found:**

- There was an open and transparent approach to safety. An effective system was in place for managing significant events and staff knew how to report and record using this system.
- The assessment and management of risks was comprehensive, well embedded and recognised as the responsibility of all staff.
- The arrangements for managing medicines, including obtaining, prescribing, recording, handling, storing, security and disposal in the practice minimised risks to patient safety. There was an effective approach to the monitoring of patients on high risk medicines.
- Staff were aware of current evidence based guidance. They had received training so they were skilled and knowledgeable to deliver effective care and treatment.
- The practice worked collaboratively and shared best practice to promote better health outcomes for patients.
- There was clear evidence to demonstrate quality improvement was embedded in practice, including a programme of clinical audit used to drive improvements in patient outcomes.
- The practice proactively sought feedback from staff and patients which it acted on. Results from the Defence Medical Services 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. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients we spoke with said they found it easy to make an appointment.
- Facilities and equipment at the practice were sufficient to treat patients and meet their needs.
- There was a clear strong leadership structure and staff felt engaged, supported and valued by management.

- The practice had been subject to significant organisational, governance and leadership changes in the last eight months. Staff were engaged and working well with the changes.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

**We identified the following notable practice, which had a positive impact on patient experience:**

Significant risk to patient safety and quality of care was identified in 2017 leading to the practice closing temporarily in October. During the closure, a new operational model was introduced, leadership revised and staffing levels and skill mix increased. Processes and systems were reassessed, amended and systematically piloted before being put in place. We found the staff culture was inclusive, patient-centred and focused on improvement and innovation. New systems and processes were fluid, relevant and staff were confident with using them. Despite only reopening in March 2018, this demonstrated a meticulous and well-led approach had been taken to implementing organisational change.

**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, practice nurse specialist adviser and a practice manager adviser. A representative of CQC's senior management team also participated in the inspection.

## **Background to Birmingham Medical Facility**

Located in the Heritage Building of the Queen Elizabeth Hospital, the Birmingham Medical Facility (BMF) provides a primary care service to the Royal Centre for Defence Medicine (RCDM). A tri-service establishment, the RCDM provides medical support to military operational deployments and coordinates secondary and specialist care for service personnel. The RCDM is based at the Queen Elizabeth Hospital with defence personnel fully integrated with NHS staff to treat both military and civilian patients. The BMF also provides a service to the Defence School of Healthcare Education (DSHE), which administers pre and post registration education for nurses and a variety of Allied Health Care Professionals.

The practice closed temporarily in October 2017 and following an operational review was subject to a staged reopening in March 2018. The practice now forms part of the DMS Whittington Group Practice; a hub and spoke model with DMS Whittington the hub practice and BMF the spoke practice. There is one Senior Medical officer (SMO) for the group who has overall responsibility for the singular governance structure across both practices.

The practice is open from 08:00 to 17:00 Monday, Tuesday and Wednesday; 08:00 to 1600 on Friday and closed all day Thursday for training. A duty medic was available for telephone enquiries from 16:00 to 17:00 on Friday and all day Thursday. On Thursdays and the other days until 18:30 an arrangement was in place for patients to access a local walk-in centre. From 18:30 weekdays, weekends and public holidays patients were advised to use NHS 111.

There were 723 tri-service personnel registered at the practice at the time of the inspection. Families and dependants are not treated at the practice and are signposted to local NHS practices.

In addition to routine GP services, the practice provides occupational health, immunisations, travel advice, smoking cessation, cervical cytology and chronic disease management. Family planning advice is available with referral onwards to NHS community services. Maternity and midwifery services are provided by NHS practices and community teams. Pharmacy services are outsourced to a local pharmacy. Physiotherapy and rehabilitation was provided from DMS Whittington with a physiotherapist facilitating an assessment clinic at the BMF one day per week.

At the time of our inspection the staff team included the group practice SMO, two GPs, one of whom was a locum and a practice nurse. A practice manager was responsible for the day-to-day running of the service supported by an administrator and two medics. The work of a military medic is similar to that of a health care assistant in NHS GP practices but with a broader scope of practice. A Regional Clinical Director (RCD) assumed overall accountability for quality of care at the practice.

**Are services safe?**

**Good**

**We rated the practice as good for providing safe services.**

### **Safety systems and processes**

The practice had clear systems to keep patients safe and safeguarded from abuse.

- The practice had a framework of safety policies which were regularly reviewed and communicated to staff. Policies were regularly reviewed and were accessible to all staff, including locums. Staff received safety information for the practice as part of their induction and refresher training.
- Measures were in place to protect patients from abuse and neglect. Adult and child safeguarding policies were available at the practice. A safeguarding lead and deputy were identified. They both had the appropriate training for the role and all staff had received up-to-date safeguarding training appropriate to their role. They knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff. Staff provided an example of when they had appropriately made both a child and adult safeguarding referral to social services.
- Staff who acted as chaperones were trained for the role and had been subject to safety checks to ensure they were suitable to work with young people and vulnerable adults. A notice was displayed on clinic doors advising patients that a chaperone was available.
- There was a system to highlight vulnerable patients on clinical records and a risk register of vulnerable patients was maintained. The register was reviewed at the regularly held clinical meetings; the minutes from May 2018 confirmed this. The practice worked with other services to support patients and protect them from neglect and abuse. For example, minutes of April and May 2018 Defence Health Education (DHE) welfare meetings showed the practice manager and a GP were in attendance. Vulnerable patients were discussed at this forum.
- The full range of recruitment records for permanent staff was held centrally. 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. They also monitored each clinical member of staff's registration status with their

regulatory body. All staff had professional indemnity cover. Information was in place to confirm staff had received all the relevant vaccinations required for their role at the practice.

- There was an effective system to manage infection prevention and control (IPC). The practice nurse was the lead for IPC and had completed training relevant for the role. All staff had received IPC training in January 2018. The IPC audit undertaken in January 2018 showed the practice was 98% overall compliant. The Trust was responsible for environmental cleaning. A cleaning schedule and log was in place and this was monitored by the IPC lead
- Systems were in place for the safe management of healthcare waste. The Trust was responsible for the removal of clinical waste. Consignment notes were retained at the practice. The last waste audit was carried out in February 2018.
- The practice ensured that facilities were safe. The NHS Trust was responsible for water and electrical safety checks and these were completed within the last 12 months. The duty medic also carried checks of water safety. The Trust was also responsible for fire safety; a fire risk assessment, fire plan, firefighting equipment tests and fire drills were all in-date.
- Equipment was maintained according to manufacturers' instructions. Testing of portable electrical appliances was undertaken in June 2018. Medical equipment had been checked in February 2018.

## **Risks to patients**

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

- When the practice closed temporarily in October 2017 it was subject to a review and revision of all systems, processes and local policies. Whilst closed, new systems were piloted to ensure they were fit for purpose and failsafe; the downgrading and associated recall system as an example. This stringent approach to system testing was evident as we found the systems well embedded and understood by all staff despite the practice only reopening in March 2018.
- Historically the practice had been short of skilled staff and this had impacted on the safety and timeliness of patient care. Now the practice was under the umbrella of the DMS Whittington Group Practice, the SMO had oversight of the resource needed and could move staff between the two practices to ensure patient need was met and in a timely way. For example, rehabilitation services were located at the Whittington practice but the physiotherapist now spent one day every two weeks at BMF to undertake assessments of patients referred. The SMO and practice manager, in conjunction with the regional team, coordinated staffing shortfalls and secured staff through Defence Primary Healthcare (DPHC) headquarters and locum employment.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. The emergency trolley was an asset of the Trust. Staff advised us they would contact the hospital crash team if needed.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.

## **Information to deliver safe care and treatment**

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- There was a documented approach to the management of test results. A specimen log was maintained. Results were checked and a record made when the patient was informed.
- Referral letters included all of the necessary information.

### **Safe and appropriate use of medicines**

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment minimised risks. The practice did not have a dispensary and a policy and process was in place for the storage and monitoring of stock medicines, such as nicotine replacement therapies, olive oil, contraceptive implants and local anaesthesia. An appropriate risk assessment had taken place to identify medicines that the practice should stock. Controlled drugs were not held at the practice. Medication requiring refrigeration was monitored 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 adopted by the practice to allow nurses to administer medicines in line with legislation.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.
- There was an effective and consistent approach to the management of patients taking high risk medicines.

### **Track record on safety**

The practice had a good safety record.

- The practice manager was the lead for health and safety. They had attended training relevant for the role in March 2018. Risk assessments pertinent to the practice were in place including patient handling, needle stick injury and lone working.
- The practice monitored and reviewed activity. This helped staff to understand risks and gave a clear, accurate and current picture that led to safety improvements.
- An alarm system was in all the clinical areas and corridors for staff to summon assistance in an emergency. Reception staff carried mobile alarms.

### **Lessons learned and improvements made**

The practice learned and made improvements when things went wrong.

- There was an electronic organisational-wide system (referred to as ASER) for recording and acting on significant events, incidents and near misses. They all had access to the system and provided numerous examples of significant events demonstrating they were effectively

reporting incidents. For example, a missing prescription reported through ASER was investigated, training provided for staff and a standard operating procedure developed to minimise the chance of a similar incident occurring.

- There were adequate systems for reviewing and investigating when things went wrong. The practice learned from these and shared lessons widely, identified themes and acted to improve safety in the practice.
- There was a system for receiving and acting on medicine and safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts.

## **Are services effective?**

**Good**

**We rated the practice as good 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.

- Clinical staff were aware of evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE). Staff referred to this information to deliver care and treatment that met patients' needs. They described how updates on NICE and medicines management were outlined in a newsletter circulated to clinical staff by the DPHC each month.
- Health care governance meetings were held each month at both BMF and the hub practice, DMS Whittington. The SMO described an integrated approach and meeting minutes for May 2018 confirmed this. Minutes showed the SMO attended both meetings. The practice nurse and a medic from BMF attended the DMS Whittington meeting. Some of the agenda topics included NICE guidance, pharmacy updates, health promotion, recalls and quality improvement.

### **Monitoring care and treatment**

The practice nurse was the chronic disease lead and carried out monthly chronic disease searches, recalling patients when appropriate.

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.

We were provided with the following patient outcomes data during the inspection:

- There were two patients on the diabetic register. For both patients, their last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For one patient, their last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control. The second patient had been reviewed and treatment prescribed to manage their blood pressure.

- There were 17 patients recorded as having high blood pressure. All patients had a record for their blood pressure taken in the past nine months. One patient had a blood pressure reading of 150/90 or more.
- There were four patients with a diagnosis of asthma. All patients had an asthma review in the preceding 12 months which included an assessment of asthma control using the three Royal College of Physicians questions.
- A search of the system identified 13 patients who were being treated for a depressive disorder. We reviewed the clinical records for all 13 patients and were assured their care was being effectively and safely managed, sometimes in conjunction with other relevant stakeholders such as the welfare team and the Department of Community Mental Health (DCMH).

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). Data we were provided with showed:

- 99% of patients had a record of audiometric assessment, compared to 100% regionally and 99% for DPHC nationally.
- 85% of patients' audiometric assessments were in date (within the last two years) compared to 92% regionally and 85.5% for DPHC nationally. Staff highlighted that figures were slightly lower than the regional average because audiometry recall had not happened before the closure. When the practice reopened in March 2018 the required equipment was broken and unavailable for four weeks. Patients were now being recalled and uptake was improving.

The decision to close the practice October 2017 was made due to low staffing levels and inadequate skill mix, complaints from patients, dangerous practices and ineffective leadership. During the closure governance systems were reviewed, revised and piloted before and during the staged reopening of the practice that commenced on 5 March 2018. Therefore, from a quality improvement perspective, all systems and processes had been reviewed to ensure they were fit for purpose. For example, a tracker system was introduced to monitor patients who were downgraded to ensure they were recalled for assessment in a timely way.

An audit programme was in place and was managed by the practice nurse. Thirteen audits had been completed in the last 12 months. All clinicians were actively engaged with clinical audit and we saw some good examples of audit activity linked to NICE guidelines. For example, an audit to identify patients at risk to specific cancers (May 2018), a two-cycle hypertension audit (February and June 2018) and two-cycle cytology audit (February 2017 and June 2018). A gout audit was undertaken in March 2018 and medicines management audit in May 2018. Safe prescribing audits were also carried out with input from the regional pharmacist.

Staff were reviewing whether a weight management clinic would be of benefit based on population need so were considering undertaking an obesity audit.

### **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.

- Records of skills, qualifications and training were maintained for all staff. Staff were encouraged and given opportunities to develop. For example, the practice manager had attended a management course relevant to their role.
- The induction pack for new staff had recently been revised to reflect the group practice model, patient population and environment. It had involved the NHS Trust, the RCDM and the DSHE and DMS Whittington Medical Centre.
- Staff had access to one-to-one meetings, appraisal, coaching and mentoring, clinical supervision and support for revalidation.
- Clinical staff were given protected time for professional development and evaluation of their clinical work. Peer review took place internally and the group practice model also facilitated peer review with clinical colleagues at DMS Withington. For example, the nurse had weekly telephone calls and met each month with the nurses at DMS Whittington
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

### **Coordinating care and treatment**

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- New patients to the practice had their medical record details checked and clinical notes summarised. A system template was used to ensure patient coding was used correctly to describe the patient's treatment and care. Ninety eight percent of the notes had been summarised at the time of the inspection.
- Records showed that all appropriate staff, including those in different teams, services and organisations were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, were referred to another service. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The SMO and practice staff attended unit health committee and welfare meetings to discuss any vulnerable patients and review medically downgraded patients. Minutes of these meetings were made available during the inspection.
- The practice did not have a primary care rehabilitation facility (PCRF) so patients were referred to the PCRF at DMS Whittington. Patient feedback indicated there was timely access to this service.
- Shared care agreements were in place for patients where both the hospital and the GP were providing care to a patient.
- A system was in place for monitoring the progress of samples sent to the laboratory, including following up on outstanding results.

### **Helping patients to live healthier lives**

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients at risk of developing a long-term condition and carers.

- Records showed us, and patient feedback confirmed, 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 practice supported national priorities and initiatives to improve the population's health including, stop smoking campaigns and tackling obesity. A health promotion display board was available to patients and it was refreshed each month.
- Patients had access to appropriate health assessments and checks. Routine searches were undertaken for patients eligible for bowel and breast screening and we could see that patients identified had been referred appropriately. No patients over the age of 60 were registered at the practice.
- The number of eligible women whose notes recorded that a cervical smear had been performed in the last three to five years was 296, which represented an achievement of 96%. 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 following illustrates the current 2018 vaccination data for patients using the practice:

- 94% of patients were recorded as being up to date with vaccination against diphtheria compared to 95% regionally and 95% for DPHC nationally.
- 94% of patients were recorded as being up to date with vaccination against polio compared to 94% regionally and 95% for DPHC nationally.
- 49% of patients were recorded as being up to date with vaccination against hepatitis B compared to 77% regionally and 83% for DPHC nationally.
- 95% of patients were recorded as being up to date with vaccination against hepatitis A, compared to 91% regionally and 95% nationally.
- 94% of patients were recorded as being up to date with vaccination against tetanus, compared to 95% regionally and 100% for DPHC nationally.
- 40% of patients were recorded as being up to date with vaccination against typhoid, compared to 52% regionally and 53% 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.

There was a monthly recall process in place for patients who did not attend for either screening or vaccinations which continued until the patient responded.

### **Consent to care and treatment**

The practice obtained consent to care and treatment in line with legislation and guidance.

- 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 practice monitored the process for seeking consent appropriately.

## Are services caring?

Good

**We rated the practice as good for caring.**

### 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.
- Results from the April 2018 Patient Experience Survey (30 responses) indicated that 26 patients felt their comments and complaints were listened to. The 45 CQC comment cards completed prior to the inspection were very complimentary about the practice. A theme identified from the feedback was that patients felt respected, listened to and well cared for. The two patients we spoke with echoed this view.
- 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. We saw notices in the reception areas informing patients this service was available.
- The April 2018 Patient Experience Survey showed 100% of patients felt involved in decisions about their care. Feedback on the CQC patient feedback cards highlighted that patients were involved in decision making about the care and treatment they received. They also felt listened to and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- The practice proactively identified patients who were also carers. There were systems in place which when patients identified themselves as carers so that additional support or healthcare could be offered as required.

### Privacy and dignity

The practice respected respect 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 the seats in the waiting area meant that conversations between patients and reception could not be easily overheard. A radio was playing to minimise conversations being overheard. Reception staff said that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- The practice could facilitate patients who wished to see a GP of a specific gender.

## Are services responsive to people's needs?

Good

**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.

- Staff understood the needs of its population and tailored services in response to those needs. For example, the practice texted or emailed patients depending on their preferred method of communication.
- The facilities, premises and opening hours were appropriate for the services delivered and met patient need.
- The practice was accessible for patients who were wheelchair users or who had limited mobility.
- A 'You Said, We Did' was displayed on the notice board, demonstrating that staff responded to concerns raised by patients. For example, feedback submitted indicated a patient did not feel their complaint was listened to. The response displayed provided a brief overview of how complaints were managed at the practice.

### **Timely access to care and treatment**

- Home visits and telephone consultations were available.
- Sufficient arrangements were in place for patients to access primary care when the practice was closed, including emergency care.
- The April 2018 Patient Experience Survey showed 100% of patients had access to the service when they needed it. This view was supported by the patient responses CQC received through its pre-inspection feedback cards.
- The physiotherapist carried out initial assessments at the practice to avoid patients travelling to DMS Whittington.

### **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 DPHC had an established complaints policy and procedure that the practice worked with.
- The practice manager was the designated responsible person who handled all complaints. A record of complaints was maintained. Two complaints had been made since 2017 and they were well managed. Although the practice manager said they would be logged, no verbal complaints had been received about the practice.
- A system was in place to review complaints. An annual complaints audit had not been undertaken due to the small numbers received.

**Are services well-led?**

**Good**

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

### **Leadership capacity and capability**

The management team was new to the practice and we found they had the capacity, experience, skills and tenacity to deliver high-quality sustainable care.

- A significant risk to patient safety and quality of care was identified in 2017 resulting in the practice closing temporarily in October. In the interim, arrangements were made for patients to receive a primary care service at an alternative medical centre.
- Following a period of review, the practice was subject to a staged reopening in March 2018. Systems and processes had been reassessed, revised if appropriate and systematically piloted before being put in place. The fluidity of the systems and staffs' confidence with using them demonstrated a meticulous approach had been taken to ensuring they were fit for purpose.
- The practice reopened as part of the newly formed DMS Whittington Group Practice; a hub and spoke model with DMS Whittington the hub practice and BMF the spoke practice. The SMO for DMS Whittington had taken on responsibility for the leadership of the group practice and had overall responsibility for the singular governance structure.
- The practice manager was new to the role and was well supported by the SMO and regional management team with their development. They had completed a management course relevant to the role, had participated in other training opportunities and were being mentored by the experienced practice manager at DMS Whittington.
- The regional management team had worked closely with the SMO and practice manager to address a significant number of issues mostly due to low staffing levels and an inadequate skill mix. They also had taken steps towards fostering a positive culture and improving staff morale and the working environment. Staff we spoke with were extremely positive and spoke highly of the new management structure, leadership and improved morale.
- The management team understood the risks to the service and kept them under scrutiny through the risk register. The risks included staffing levels and skill mix, staff morale and continuity of staff.
- Staff told us everyone worked well together and that the management team, including the regional team were approachable and supportive. They said 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.

### **Vision and strategy**

- The practice had a clear vision and credible strategy to deliver high quality and sustainable care. It developed its vision, values and strategy taking account of the needs and views of patients, staff and external partners. The strategy was in line with health priorities across the region and the service was organised to meet the needs of the patient population.
- The vision and strategy was displayed in reception, the waiting room and in the practice information leaflet.
- The practice took account of the overarching DPHC Vision: 'Safe practice – by design'. Specifically in relation to BMF, the aim of the service was to: 'Provide safe, high quality patient centred care and best practice, responsive to patients needs and supported by clear focus on excellent service'. All staff we spoke with were committed to supporting the strategy.

### **Culture**

Although the practice had only reopened in March 2018 under a new management structure, staff demonstrated a culture that lent itself to high-quality sustainable care.

- Staff told us they felt respected, supported and valued. They were proud to say they had contributed to and supported the transformation of the practice. Opportunities were in place so staff could contribute to discussions about how to run and develop the practice.
- Staff we spoke with clearly demonstrated a patient-centred focus.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints.
- 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.
- 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.
- Staff were encouraged and supported to be the best they could be through training and developing their skills and expertise. There was also a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.

### **Governance arrangements**

There was an effective overarching governance framework in place which supported the delivery of good quality care.

- The SMO was the governance lead for the practice. The staffing structure was clear and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. Terms of reference were in place to support job roles
- The practice worked to the DPHC health governance workbook, a system that brings together a comprehensive range of governance activities, including the risk register, significant events, patient safety alerts, Caldicott log, building fault log, quality improvement and audit.
- Policies from the national framework were implemented and were available to all staff. These were updated and reviewed regularly.
- There was an integrated group practice approach to meetings, including management, clinical and practice meetings. Minutes of meetings demonstrated that lessons learned from significant events, complaints and other investigations led to change and improvement in practice. Meeting minutes were comprehensive and were available for practice staff to view.
- An audit programme was established for both clinical and non-clinical audit activity. The practice nurse maintained the schedule for clinical audit. Non-clinical audit was overseen by the practice manager. Evidence demonstrated that all staff were engaged with audit. For example, the practice nurse was responsible for the IPC audit, the SMO for the prescribing audit and one of the medics for the scanning audit. Audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.

### **Managing risks, issues and performance**

There were clear and effective around processes for managing risks, issues and performance.

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety.
- Processes were in place to manage current and future performance. Performance of clinical staff was demonstrated through peer review, including review of clinical records.
- The practice manager and SMO had oversight of national and local safety alerts, incidents, and complaints.
- Plans were in place for major incidents and staff were familiar with how to respond to a major and/or security incident.

### **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. The CAF we were provided with was updated in December 2017. The practice manager was due to attend a training day regarding a new eCAF process, after which CAF information would be transcribed to the new system.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.

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

The practice involved patients, staff and external partners to support high-quality sustainable services.

- A patient participation group had recently been established and the first meeting was held shortly before our inspection. Despite displaying information advertising the meeting, no patients attended. The practice was looking at additional ways to generate patient attendance at the group.
- A patient experience survey was undertaken throughout the year and a suggestion box was located in the patient waiting room.
- A staff suggestion board was in the administrator's office.
- The practice engaged with external partners in the development of policies and procedures. For example, the plan for major incidents involved the NHS Trust. The practice had good relationships with the Trust regarding the estate and infrastructure matters.
- The practice was represented at unit welfare meetings each month. In addition, a representative from the practice attended the RCDM carer's forum held three times a year.

### **Continuous improvement and innovation**

Continuous improvement and innovation was evident in how the service had evolved and progressed since the practice reopened in March 2018 under a revised organisational structure and new leadership. The practice manager maintained a register of quality improvement activity at the practice. Some examples included:

- A patient's report from secondary care missed by the doctor was reported as a significant event and investigated. It was identified the task assigned to the GP on the electronic patient record system (referred to as DMICP) was automatically deleted by the system. This system failure was communicated across the organisation through the DPHC monthly newsletter. The practice put internal measures in place to avoid this happening again. It was discussed at a practice meeting and staff were made aware of system change.
- The introduction of texting patients with appointment reminders was starting to show a reduction in failed attendance at appointments.
- The practice patient registration form was revised to secure carer information.
- The introduction of a 'patient disposal form' so that the outcome following a patient's appointment with the clinician, including referral on to another service, could be recorded on the system and tracked. It reduces the risk of potential errors and clarifies the communication between BMF and the patient.
- Development of a navy board assessment form.
- An 'investigations required form' for patients with a diagnosis of hypertension.