RAF High Wycombe Medical Centre

Quality report

Station Medical Centre
No.3 Site
Walters Ash
High Wycombe
HP14 4UE

Date of inspection visit:
24 May 2018

Date of publication:
22 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

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

Chief Inspector's Summary

This practice is rated as good overall.

The key questions are rated as:

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

We carried out an announced comprehensive inspection at RAF High Wycombe Medical Centre on 24 May 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:

- The practice had 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 system for managing specimens had recently been reviewed and revised. It was not yet failsafe.
- The infection prevention and control audit was not fully effective as it had not identified issues we found.
- Elements of the medicines management processes needed strengthening, including high risk drugs.
- The practice fostered an ethos of patient centred care.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- A small proportion of the practice workload involved the management of long term conditions (LTC) and this required improvement. The lead for LTCs had not received training in interrogating the system therefore searches were not being undertaken. Recall systems were not effective.
- Inadequate levels of clinical staff meant that vaccination and audiometry uptake was below the regional and national average. The practice was in the process of addressing this.
- Practice was delivered in accordance with best practice guidance.
- Patients found the appointment system easy to use. The telephone system acted as a barrier to patients trying to access appointments. This was a longstanding issue related to the infrastructure and outside of the control of the practice.
- Whilst there was a recent focus on learning and improvement, there was scope to deliver a wider programme of quality improvement work, including clinical audit.

- Recent leadership changes at the practice had brought a change in culture. Despite initial resistance to change, staff spoke highly of the leadership and recognised now the benefits of the changes being made.

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.
- Medicines are managed effectively, including high risk drugs and affiliated shared care agreements.
- The programme of clinical improvement work continues to develop and is targeted to maximise improvements in patient outcomes.
- Ensuring staff are suitably informed and skilled for their role and responsibilities.
- That station staff support the practice with making improvements to the telephone system to ensure patients can access care when they need to.

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

Our inspection team

Led by a CQC inspector, the inspection team included four specialist advisors; a GP, physiotherapist, practice manager and pharmacist.

Background to RAF High Wycombe Medical Centre

Located in Walter Ash, Buckinghamshire, RAF High Wycombe Medical Centre is a primary health care service for HQ Air Command. The medical centre provides care only to service personnel. Families and dependants of personnel are not registered at the practice and are signposted to local NHS practices. At the time of inspection the patient list was approximately 1880.

In addition to routine GP services, the practice provides physiotherapy and travel advice. Occupational health services are also provided for personnel and for small number of reservists. Family planning advice is available with referral onwards to NHS community services. Maternity and midwifery services are provided by NHS practices and community teams.

At the time of our inspection the staff team included a locum Senior Medical Officer (SMO), Deputy Senior Medical Officer (DMSO), two part time civilian GPs, a locum practice nurse and health care assistant (HCA). A practice manager was responsible for the day-to-day running of the service supported by two administrators and a medic. 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.

Although not co-located, the Primary Care Rehabilitation Service (PCRF) team, comprising a lead physiotherapist, locum physiotherapist and locum exercise rehabilitation instructor (ERI), worked closely with the medical centre. A Regional Clinical Director (RCD) assumed overall accountability for quality of care at the Medical Centre.

Are services safe?	Inadequate

We rated the practice as inadequate for providing safe services.

Safety systems and processes

The practice systems to keep patients safe and safeguarded from abuse needed to be improved in some areas.

- The practice had safety policies, including adult and child safeguarding policies, which were communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. Policies were regularly reviewed and were accessible to all staff including locums. They outlined clearly who to go to for further guidance.
- There was an alert system on clinical records to highlight vulnerable patients and a risk register of vulnerable patients was maintained.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check. A DBS check identifies 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.
- The practice carried out recruitment and periodic staff checks, including checks of professional registration if relevant.
- An infection prevention and control (IPC) lead was identified for the practice. We found that the process to manage IPC was not fully effective. Damp on a wall in the stock room alongside where specimen bottles were stored had not been identified on the IPC audit undertaken in March 2018. We noted the store room floor was not clean. Records showed the fridges had been cleaned in May 2018. However, we observed a fungal growth on the condensation plate and residue in the fridge's collecting reservoir. One of the fridge seals was not clean as debris and dirt were evident on the top seal. A plan for the deep clean of clinical areas was identified on the management action plan (MAP).
- The sharps boxes located in an infrequently used treatment room had not been disposed of within three months of use. This had been missed on the IPC audit.
- There were systems for safely managing healthcare waste.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions.

Risks to patients

The systems to assess, monitor and manage risks to patient safety needed to be improved in some areas.

- The numbers and mix of staff was regularly monitored by the SMO because of the risk associated with vacant posts and the high use of temporary posts. This risk was identified on the risk register. At the time of the inspection three of the GP posts (including the SMO) were filled by locums, one of the practice nurse posts was vacant due to deployment and the other post was filled by a locum. One of the physiotherapy posts and the exercise rehabilitation

instructor post were being undertaken by locums. Two administrative posts were vacant. The vacant posts were subject to recruitment. Staff said there was insufficient administrative staff to complete tasks in a timely way and to the required standard. We collected 10 CQC patient feedback cards and interviewed six patients. Some patients commented on the low staffing levels, particularly in relation to reception/administrative staff. They said the phone often went to answerphone but all said they said this had seen improvement in recent months.

- The management of specimens was identified on the practice MAP and indicated the system had recently been handed over by clinicians to the healthcare assistant (HCA) who had received training for the role. Although the system was very recently subject to a revision, it was not fully fail safe. We found a number of samples had not been signed off and no evidence that the pathology reports had been filed in the patient's record. A specimen handling audit undertaken in May 2018 showed the practice at 80% compliance and had not identified the concerns we found.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. We noted the automated external defibrillator (AED) chest pads were out of date at the PCRF and staff rectified this during the inspection.
- 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.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

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 completed 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 service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.
- Eighty-nine per cent of electronic patient records had been summarised.

Safe and appropriate use of medicines

The practice's systems for appropriate and safe handling of medicines needed to be improved.

- The SMO was the medicines management lead for the practice. Some elements of the process had been devolved to the practice manager who was responsible for the ordering of the medicines, and to the healthcare assistant who monitored the fridge and ambient temperatures each day.
- The practice was not following the Defence Primary Health Care (DPHC) standard operating procedure (SOP) in relation to high risk drugs. The system for monitoring patients prescribed such drugs did not provide all the necessary details required by clinicians, including the use of coding and application of alerts.
- Medical emergency medicines were correct and in-date. The two pharmaceutical fridges had calibrated thermometers and were being effectively monitored.

- We found some medicines and medical devices had exceeded their expiry date. For example, pregnancy tests that expired in October 2017 and suture removal kits that had expired in March 2018. Incorrect test strips were in place for the blood glucose monitor meaning a patient's blood glucose could not be checked at the practice. The hose for the medical gas was missing which meant it could not be administered if required. The warning signs for compressed gas and oxidising were also missing from the door to the nurses' treatment room.
- Patient Group Directions (PGD) had been adopted by the practice to allow nurses to administer medicines in line with legislation. The nurse had completed the required training, including vaccination training. Most PGD items were stored correctly. We found a medicine without a pre-printed label (referred to as over-labelled) and this was removed as it was not in accordance with DPHC policy.
- We noted a prescription for antibiotics that had been awaiting collection for 20 days and staff had not followed this up. There were also two prescriptions for emergency medicines prescribed in the event of life-threatening allergic reaction which had not been collected. No attempt had been made to contact the patients.
- The outsourcing procedure with the local pharmacy put into place recently was not being followed. Two of the GP's had declined to sign the generic substitution letter for the providing pharmacy; this is an agreement between the pharmacy and DPHC to substitute generic medication when a proprietary has been prescribed if it does not compromise safety. The log for prescriptions faxed to the pharmacy was being completed. However, we observed a patients' medication was recorded as received from the pharmacy but could not be found at the practice. It transpired the log had been incorrectly completed and the medicine was still at the pharmacy.
- The controlled drugs register in the old dispensary showed a stock of a controlled medicine. However, it was not in stock as it had been removed following closure of the dispensary.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues. The practice manager, supported by a physiotherapist, had the lead for health and safety. The practice manager had not yet completed fire training and had planned to complete this by the end of May 2018.
- 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 place for staff to summon assistance in an emergency. The physiotherapists and ERI worked in a separate building and occasionally worked alone. They had an alarm system in several locations of the building. They also carried mobile alarms that alerted the medical centre and guardroom in an emergency.

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, incidents and near misses. Staff understood their duty to raise concerns and report incidents. Locum staff who recently joined the practice did not have log-in permissions to access the system. While the practice manager was looking into access for them, locum staff could complete a paper form to report a significant event.

- There were adequate systems for reviewing and investigating when things went wrong. The practice learned from and shared lessons; identified themes and took action to improve safety in the practice. For example, a prescription was left in a van overnight. This was investigated and a change was made to the management of prescriptions. It was discussed at a practice meeting and staff were made aware of system change. Significant events were also discussed at the clinical meetings.
- 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?	Inadequate

We rated the practice as inadequate for providing effective services.

Effective needs assessment, care and treatment

- Clinical staff were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. A record of NICE guidance presented at clinical meetings was maintained, including the key points. For example, guidance on pancreatic cancer discussed in April 2018 highlighted that surveillance for this condition should be offered to patients with hereditary pancreatitis. However, we did find that long term conditions were not being managed in accordance with current evidence based guidance.
- We noted that doctors only attended the clinical meetings. Other clinical staff and health professionals did not attend. The practice nurse had been in post since February 2018 and said they had not had the opportunity to attend a meeting as improving systems had taken priority.
- The DPHC produced a newsletter that was circulated to clinicians providing further information and a summary of relevant safety updates. Staff we spoke with could refer to this and gave examples of updates they had acted on and discussed within the practice.

Monitoring care and treatment

The practice had a process in place to use information 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 patient population was generally stable with few patients deploying. We were provided with the following patient outcomes data as part of the pre-inspection data pack and some data we received after the inspection:

- There were 11 patients on the diabetic register. For six of these diabetic patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. This number was below the QOF target of 75%.
- For the six diabetic patients, the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control. This number was below the QOF target of 93%.

- There were 104 patients recorded as having high blood pressure. Of these patients, 78 had a record for their blood pressure in the past nine months. Sixty nine patients had a blood pressure reading of 150/90 or less. This was below the QOF target of 80%.
- There were 22 patients with a diagnosis of asthma. Of these, 14 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 system showed no new patients had been coded as having a depressive disorder in the last 12 months. The DSMO advised us there had been patients diagnosed with depression in this timeframe but the code used was not a Read Code that triggers QOF. The DSMO showed us the records for two patients diagnosed with depression in the last 12 months and it was clear their care was being effectively and safely managed in conjunction with other relevant parties, such as the welfare team and the Department of Community Mental Health (DCMH).

We were advised that QOF indicators were below target mainly due to the vacancy for a regular practice nurse. This meant the recalling of patients had not been happening. The practice was addressing this and a system to manage recalls was in the early stages of development since the arrival of the practice nurse in February 2018. The practice nurse was the identified lead for long term conditions and the monitoring of QOF data. They had not yet received training in undertaking searches of the system so were unable to provide the data on the day of the inspection. In addition, some of the low figures related to the use of incorrect Read coding.

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 below average compared to DPHC practices regionally and nationally. We were advised that these low figures were due to an effective recall system not being in place. A recall system had recently been developed. 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 100% regionally and 100% for DPHC nationally.
- 61% of patients' audiometric assessments were in date (within the last two years) compared to 86% regionally and 85.5% for DPHC nationally.

Evidence of quality improvement activity was limited, and specifically limited to 2018. This was due to a lengthy period of governance review and subsequent organisational restructure, including significant staff changes and a shift in leadership. The DMSO acknowledged that the practice was in the infancy stage of development and still had some way to go.

There was no defined programme of clinical audit in place and this was identified as a development need for the practice going forward. The only clinical audit we were provided with was in relation to the use of a high risk medicine, Methotrexate. The audit was undertaken to check if any patients who were taking Methotrexate were also taking a named antibiotic as the two medicines combined were contraindicated. This audit had been circulated to clinical staff.

The PCRF had established processes to measure outcome for patients. The PCRF annual report showed that referral activity was monitored on a monthly basis alongside the unutilised time for patients who failed to attend their appointments. Key performance indicators were monitored including, waiting times, average number of physiotherapy and ERI sessions and average length of time a patient attended the PCRF. In addition, the PCRF undertook a clinical records audit in

2018 and achieved a high score in line with DMCIP expectations for record keeping. The team were in the process of completing an onward referral audit to establish if a correct diagnosis had been made.

Effective staffing

Not all staff had the skills and knowledge to deliver effective care and treatment in accordance with their role. This was being addressed as part of the practices' development plan going forward.

- The practice had a generic induction programme for all newly appointed staff that included the mandated training, such as safeguarding, health and safety and information governance. There was a separate induction for locum staff. Relevant competency checks were undertaken before staff engaged in practice or a procedure that was new to them.
- Staff had access to e-learning training and in-house training. Up to date records of skills, qualifications and training were maintained. Staff told us there was a culture of continuous learning and further education was promoted at the practice. For example, there were doctors trained in aviation medicine, sports medicine and audiology. Staff administering vaccines and taking samples for the cervical screening programme had received specific training, including an assessment of competence if appropriate. However, the practice nurse was the lead for LTCs but was unable to undertake QOF searches during the inspection as they had not received training in this area. The practice manager had received no specific training for the role and was being supported by an experienced RAF medic in the role.
- Learning and support needs of staff were identified through appraisal, meetings and reviews of practice development needs. All relevant 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. However, there were gaps.

- The practice met regularly with the welfare team and Chain of Command to discuss vulnerable patients.
- The medical centre and PCRF were located in separate buildings. The PCRF team worked closely with clinicians at the practice regarding patient care. They also attended the practice meetings. 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 and found a shared care agreement was not in place for one patient in line with the formulary requirement. Another patient did not have a shared care agreement in place in accordance with specific DMS policy. 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 identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.
- All new patients were asked to complete a health questionnaire on arrival. The practice nurse followed up any areas of concern, such as raised blood pressure.

- The practice offered basic sexual health advice including the issue of free condoms and referred on to local clinics in the community for more comprehensive services including family planning.
- Patients had access to appropriate health assessments and checks. It was unclear if the practice had systems in place to engage with the national screening programmes and had a mechanism to ensure that eligible patients were referred into the bowel cancer or abdominal aortic aneurysm (AAA) screening programs. Staff we spoke with did not know if routine searches took place to identify eligible patients.
- The nurse advised us that a system for over-40 health checks had recently been developed; searches had taken place and letters were due to be sent to patients.
- 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 318 out of 334 eligible women. This represented an achievement of 95%. The NHS target was 80%.
- Patients who did not attend for their cervical screening test received a reminder. The practice demonstrated how they encouraged uptake of the screening programme by using public health information posters and they ensured a female sample taker was always available.

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 most recent data available provides vaccination data for patients using the practice:

- 88% of patients were recorded as being up to date with vaccination against diphtheria compared to 94.5% regionally and 95% for DPHC nationally.
- 88% of patients were recorded as being up to date with vaccination against polio compared to 94.5% regionally and 95% for DPHC nationally.
- 62% of patients were recorded as being up to date with vaccination against Hepatitis B compared to 75% regionally and 77% for DPHC nationally.
- 96% of patients were recorded as being up to date with vaccination against Hepatitis A, compared to 93% regionally and 91% nationally.
- 88% of patients were recorded as being up to date with vaccination against Tetanus, compared to 94.5% regionally and 95% for DPHC nationally.
- 41% of patients were recorded as being up to date with vaccination against Typhoid, compared to 38% regionally and 52% for DPHC nationally.

The shortage of Hepatitis B vaccine may account for the low uptake. We were advised the other low vaccination rates in comparison to regional and national figures was due to low staffing levels and an ineffective recall system. Recent improvements had been seen in the rates as staffing levels had increased and a recall system initiated.

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.

When providing care and treatment for young recruits aged between 16 and 18 years, staff carried out assessments of capacity to consent in line with relevant guidance.

Are services caring?	Good

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- 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.
- We received 10 patient CQC comment cards and interviewed six patients on the day. Patients were positive about the clinical care and treatment they received. Some patients said that reception staff could be brusque in manner and felt this may be due to being under pressure as there were not enough staff.
- We observed staff were supportive and caring in the way they interacted with patients, including on the telephone.

The practice manager advised us that a Patient Experience Survey was currently underway. The available survey (undated) results were based on a return of 90% of the 50 questionnaires issued. Results in relation to a kind, respectful and compassionate service included:

- Sixty four percent of patients said the practice was good at listening to any compliments, comments or complaints.
- Ninety one percent of patients said if family, friends and colleagues could use the practice, they would recommend it to them.

The 2017 PCRF patient survey was fully positive about the caring and respectful attitude of the staff.

Involvement in decisions about care and treatment

- Patient feedback via the comment cards and patients we spoke with indicated clinicians involved them in decision making about the care and treatment they received. They said their views were considered; they felt listened to and had sufficient time to make an informed decision about the choice of treatment available to them.
- The practice's Patient Experience Survey showed that 87% of patients said they felt involved in decisions regarding their care.
- A translation service was available to clinicians if required. The practice leaflet could be made available in alternative languages should the need arise.

- The Choose and Book service had been implemented and was used to support patient choice as appropriate. Choose and Book is a national electronic referral service which gives patients the choice of date and time for their first outpatient appointment in a hospital.
- The practice had a system in place to identify patients who were also carers. A code could be added to their records in order to make them identifiable and so that extra support or healthcare could be offered as required. The DSMO or their representative 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 advising 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.

Privacy and dignity

The practice respected patients' privacy and dignity.

- There was a good gender mix of clinical staff so patients had the option of being seen by a male or female.
- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- A chaperone service was available to patients. PCRF staff offered a chaperone if a patient was required to remove clothing.

Are services responsive to people's needs?	**Requires improvement**

We rated the practice as requires improvement 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.

- A wide range of services and clinics were available to service personnel.
- Patients could have 15 minute appointments with the GP and up to 30 minute appointments with the practice nurse or longer if needed. Patients usually received a routine appointment with the doctor within 10 days.
- The practice had not adopted the option of permitting patients to self-refer to the PCRF team. We were advised that this system of self-referral had not been put in place as patients may avoid seeing the doctor in case they were downgraded. The average wait time to see an ERI was one day and less than 10 days to see a physiotherapist. This reflects patient choice rather than the first available appointment.
- Patients were able to receive travel vaccines when required.
- Same day appointments were available for those patients who needed to be seen quickly.
- There were accessible facilities for patients with mobility needs.
- Transport for patients to hospital appointments was available if needed.

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

Timely access to care and treatment

- Feedback via the 10 CQC comment cards and six patients interviewed indicated a theme of dissatisfaction and frustration with the answering of telephones. Patients said they frequently received the answerphone which advised not to leave a message. We had a similar experience with the telephones. The DSMO explained that the practice had no control over the telephone system and answerphone message as this was an inherent issue with the infrastructure for the last 20 years. The practice could not change the message and if the phone lines were in use there was an automatic direction to this message. They had raised it as a concern on numerous occasions with the station but no improvement had been made.
- Patients said there were insufficient staff to manage the phone lines which is why their call frequently went to answerphone. Two patients said the reduction in staff had led to the telephones not being answered promptly. They said it was easier to call in person to the practice to make an appointment rather than use the telephone. The patient survey did not include a question about the practices' telephone system.
- Patients were satisfied with the timely access to emergency and routine primary care service. Reception staff told us that patients were generally offered a routine appointment with the doctor within two working days. More often, they could support patient requests to see the same the same doctor. Emergency appointment slots were identified each day.
- Patients said they were also more than happy with access to PCRF services. Some patients commented that accessing medicals had not always been timely but that it had improved recently.
- Outside of routine practice hours duty cover was provided by a RAF Halton Medical Centre. From 18.00 hours, patients were diverted to the NHS 111 service. If the practice closed for an afternoon for training purposes, patients were diverted to a local GP Practice. The practice leaflet gave clear directions on local accident and emergency unit access.
- The PCRF collated a dashboard of information in relation to key performance indicators (KPI) for waiting times and patients who do not attend for their appointment. The PCRF was performing well in accordance with the KPIs. For example:
    - From January to March 2018 73% of new patients referred to the PCRF were seen within 5 working days. This compared to 60% regionally and 45% nationally.
    - The PCRF proactively managed DNA (patients who did not attend appointments) rates for their clinics. They achieved below average results with 10% of patient appointments lost to DNAs from January to March 2018. This compared to 9% regionally and 7% nationally.
- Results from the practice's patient experience survey showed that overall patient satisfaction levels with access to care and treatment were high. For example, 98% of patients said they were able to obtain a suitable appointment when they needed one.
  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.

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.
- We saw that information was available to help patients understand the complaints system.
- We spoke with six patients who told us that they felt comfortable and knew how to complain.
- 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. Two complaints had been received in the last 12 months for the medical centre and none for the PCRF. One of the complaints was in relation to a patient not being recalled for a required medical. A root cause analysis identified other patients had also not been recalled in 2017 and this was immediately rectified. The recall system was revised to minimise the risk of this occurring again.

Are services well-led?	**Requires improvement**

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

Leadership capacity and capability

Those with key leadership and management roles at the practice were new to the practice. For example the DSMO had taken up post in September 2017 and the practice manager started in March 2018. Despite being relatively new to their roles, they had diligently addressed a significant number of practice issues which they inherited. We could see that significant change and improvements had been made in recent months. However, the DSMO and practice manager had not had sufficient time to embed the framework of improvements that had been identified as required. Embedding the improvements had also been hampered by staff vacancies and a degree of resistance to change within the staff team. Some newly developed systems were in the early stages and required further modification to ensure that care for patients was safe and effective. For example, the system for the management specimens and the system for recalling patients. However, it was clear the leadership team were committed to improving the practice and the direction of travel for the practice was positive.

Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. Staff told us that the change of leadership had been challenging for them as it brought changes to well established systems and working practices. They recognised now that change had been needed and were positive about the current leadership.

Vision and strategy

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

- There was a clear vision in line with the DPHC's mission statement, 'To deliver a unified, safe, efficient and accountable primary healthcare and dental care service for entitled personnel to

maximise their health and to deliver personnel medically fit for operations'. The PCRF worked to the mission statement of "improving health and injury through exercise".

- The practice and PCRF had a realistic strategy and supporting business plans to achieve priorities.
- The practice developed its vision, values and strategy jointly with patients, staff and other units such as the PCRF and welfare teams.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The practice planned its services to meet the needs of the practice population and monitored progress against delivery of the strategy.

Culture

The practice was in the early stages of nurturing a culture of high-quality sustainable care.

- Staff had been subject to much change over the last 12 months, some of which they had not welcomed in the early stages. They now recognised that change had been needed; although some staff still felt there was insufficient staff to meet the demands of the patient population. All staff expressed that they felt respected, supported and valued. They recognised the importance of the changes being implemented and were proud to work in the practice.
- The practice focused on the needs of patients; in particular the changes being made took account of the needs of the patient population.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The practice 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.
- There were processes for providing all staff with the development they needed. This included appraisal and career development opportunities. All relevant staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff were given protected time for professional development and evaluation of their clinical work.
- There was 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.

Governance arrangements

The practice had an overarching governance framework to support the delivery of the strategy and good quality care. Some areas of the framework needed to be strengthened.

- A governance lead was identified for the practice.
- 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.

- Although there was a clear staffing structure, including identified roles and responsibilities, not all staff were aware of their assigned responsibilities. For example, the member of staff assigned the management of long term conditions was not skilled to conduct clinical searches. This meant routine searches were not being undertaken. In addition, it was unclear who the lead was for ensuring the summarisation of patient records took place.
- Policies from the national framework were implemented and were available to all staff. These were updated and reviewed regularly.
- Processes to understand and monitor performance of the practice were not strong. For example, long term conditions were not effectively monitored and there was no system to identify patients that may meet the criteria for some national screening programmes.
- The practice manager used the Common Assessment Framework (CAF) as an effective governance tool.
- Practice meetings were held regularly and were attended by the full multi-disciplinary team for the practice. The meetings were used as an additional governance communication tool. For example, to remind staff about coding and QOF searches (April 2018). Minutes were comprehensive and were available for practice staff to view.
- The PCRF also held their own regular staff team meetings that took account of issues such as, progress of patients, key performance indicators, failed attendance at appointments and key diary dates.
- In addition, regular health care governance meetings were held and minutes were produced. Not all clinical staff attended these meetings. Given the significant amount of change taking place and this being the forum for discussing NICE guidance, it would be beneficial for all clinical staff to attend.
- There was clear evidence from minutes of meetings that lessons learned from significant events, complaints and other investigations led to change and improvement in practice.
- Clinical audit was underdeveloped. Audits that had taken place had not identified concerns we found, such as the medicines and IPC audits. The practice leaders were aware of this and it was acknowledged as a development need going forward.
- The practice had plans in place and had trained staff for major incidents.

Managing risks, issues and performance

There were processes for managing risks, issues and performance. Some of these were underdeveloped.

- Systems for identifying, recording and managing risks, issues and implementing mitigating actions were in place but need further development as they had not identified concerns we found, such as the specimen management system not being fully fail safe.
- The practice had processes to manage staff performance and there was evidence that this had been used effectively to manage the resistance to change
- Practice leaders had oversight of national and local safety alerts, incidents, and complaints.

Appropriate and accurate information

Some information systems were underdeveloped to ensure the quality of patient care.

- Performance information in relation the management of long term conditions was not being used effectively to monitor performance.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice submitted data or notifications to external organisations as required.
- There were effective arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice 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 DSMO attended regular Unit Health Committee and welfare meetings. They also represented at the station executive meeting.
- A patient survey for the medical centre was underway at the time of our inspection. The PCRF carried out a quarterly patient satisfaction survey and it was displayed in the premises. A patient participation group was not established.
- With the changes the practice had been through, the DSMO promoted team building events and encouraged staff to share their views. The practice meetings in particular were used to seek feedback from staff.

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.

- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- The PCRF carried out and acted on the outcome of audit and patient feedback. For example, electronic patient exercise sheets were introduced in response to patients mislaying hardcopy versions.
- Quality improvement at the practice since the beginning of 2018 included, restructure of staff roles to ensure effective use of skill and resource; identification of leads for key activities; development of a new protocol for high risk medicine monitoring and the introduction of opportunistic screening.
- Quality improvement initiatives at the PCRF included, the introduction of a ‘reconditioning class’ for patients transitioning from PCRF to routine physical training and engaging with aircrew conditioning programme.