

Defence Medical Services

# Deepcut Medical Centre

## Quality Report

The Princess Royal Barracks  
Deepcut  
Camberley  
GU16 6RW

Date of inspection visit: 26/04/2018  
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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 from the provider 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?	Inadequate 
Are services well-led?	Inadequate 

# Summary of findings

## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced inspection at Deepcut Medical Centre on 26 April 2018. Overall, the practice is rated as inadequate. Our key findings across all the areas we inspected were as follows:

- Staffing levels and skill mix at the practice were inadequate to meet the needs of the patient population. There was no doctor in post. The duty doctor at Pirbright Medical Centre was not always available in a timely way when contacted by the practice nurse for clinical advice.
- A clear and effective system was not in place for the management of patients on high risk medicines.
- The system for managing incidents and significant events was not being used in accordance with operational policy. Not all serious incidents were being managed through this system.
- The systems in place to keep patients safe and safeguarded from abuse were not effective.
- A fail-safe system was not established for the management of tissue samples.
- Effective arrangements were not in place for infection prevention and control and the management of clinical waste.
- Patients with mental health needs were at risk as they were not receiving appropriate follow-up and/or review of their mental health status and treatment.
- Mandated training could not be confirmed for all staff working at the practice.
- Effective medical cover was in place on weekdays between the times when the practice closed and NHS 111 commenced providing medical cover.
- Staff understood the Mental Capacity Act (2005) and how it applied in the context of the service they provided.
- Staff respected the privacy, dignity and confidentiality of patients.
- Responding to patient need was inhibited by the inconsistent availability of a doctor at the practice, and complex access, transport and escort arrangements to consult with a doctor at Pirbright Medical Centre.
- Effective governance of the practice was limited by the lack of clinical leadership. There was no evidence of quality improvement activity. Clinical audit was lacking and underdeveloped.
- Lines of communication between the practice and the Commanding Officer for the base regarding the health and welfare of service personnel had weakened since the departure of the Senior Medical Officer (SMO) for the practice.

**The Chief Inspector recommends:**

- A review of formal governance arrangements including systems for assessing and monitoring risks and the quality of service provision. Arrangements should be embedded and understood by all staff.
- A review of staffing levels and skill mix at the practice to ensure sufficient skill and expertise is available to meet the needs of the patient population.
- Assess the processes to safeguard vulnerable patients, including patients with mental health needs, so that patients are clearly identified as vulnerable on the system. Ensure effective measures are put in place to monitor that they are reviewed in accordance with their plan of treatment and care.
- A programme of relevant and targeted clinical improvement work should be developed to improve patient outcomes and care.
- Review the arrangements for sharing and learning from national guidance so that a consistent approach is adopted and includes all relevant members of the staff team.
- Review and address the barriers for patients attending Pirbright Medical Centre so that access is improved and patients are seen in a timely way based on need.

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

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

### Are services safe?

The practice is rated as inadequate for providing safe services.

- The system for managing incidents and significant events was not being used in accordance with operational policy.
- The systems in place to keep patients safe and safeguarded from abuse were not effective.
- A fail-safe system was not established for the management of tissue samples.
- Adequate monitoring arrangements were not in place for patients on high risk medicines.
- Effective arrangements were not in place for infection prevention and control and waste management.
- Staffing levels and skill mix were not adequate to meet the needs of the patient population.
- Facilities and equipment at the practice were sufficient to treat patients and meet their needs.

Inadequate



### Are services effective?

The practice is rated as inadequate for providing effective services.

- Patients with mental health needs were at risk as they were not receiving appropriate follow-up and/or review of their mental health status and treatment.
- Lines of communication between the practice and the Commanding Officer for the base regarding the health and welfare of service personnel had weakened since the departure of the Senior Medical Officer (SMO) for the practice.
- Clinical quality improvement work was underdeveloped and no audits had been undertaken since September 2017.

Inadequate



- Patients were actively supported to live healthier lifestyles through a proactive approach to health promotion and wellbeing.
- Summarisation of patient records was up-to-date.
- Evidence of mandated training, clinical supervision and peer review was not in place for all staff.

### Are services caring?

The practice is rated as good for providing caring services.

- The patient experience survey showed that patients were satisfied with the care and attitude of staff at the practice.
- Information for patients about the service was available and accessible. Systems were in place to maintain patient and information confidentiality.
- We received 44 comment cards. The majority of feedback from patients was positive about the standard of care received. Comments suggested patients were treated with compassion, dignity and respect, and were involved in decisions about their care and treatment.
- Staff were unaware that a translation service was available should the need arise.

Good 

### Are services responsive?

The practice is rated as inadequate for providing responsive services.

- Responding to patients' specific appointment requests was hampered by the inconsistent availability of a doctor at the practice, and complex access, transport and escort arrangements to consult with a doctor at Pirbright Medical Centre.
- The absence of consistent medical cover and experienced locum cover meant there had been delays with service medicals and reviews. This in turn had led to an increase in the non-productive time for units.
- Telephone consultations could be provided as an alternative to visiting the practice.
- Effective medical cover was in place on weekdays between the times when the practice closed and NHS 111 commenced providing medical cover.
- Arrangements were in place for the management of complaints.

Inadequate 

### Are services well-led?

Inadequate 

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The practice is rated as inadequate for providing well-led services.

- Effective governance of the practice was limited by the lack of clinical leadership. There was no evidence of quality improvement activity. Clinical audit was lacking and underdeveloped.
  - Lines of communication between the practice and the Commanding Officer for the base regarding the health and welfare of service personnel had weakened since the departure of the Senior Medical Officer (SMO) for the practice.
  - The practice sought feedback from staff and patients but did not always act on it.
  - Regular practice meetings took place to ensure effective communication within the team.
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# Deepcut Medical Centre

## Detailed findings

### Our inspection team

Our inspection team was led by a CQC inspector. The team included three specialist advisors; a GP, practice manager and practice nurse.

### Background to Deepcut Medical Centre

Deepcut Medical Centre is located in The Princess Royal Barracks and provides a service to a registered patient population of 659, including a large number of phase 2 and phase 3 trainees. There is a constant through flow of trainees with the turnover averaging 12-50 a week. The medical centre is a satellite practice of Pirbright Medical Centre located at Alexander Barracks 1.5 miles away.

In addition to routine primary care, the medical centre provides Force Protection including vaccination clinics, hearing conservation programmes and service medicals. Occupational health services, including medical boards, grade reviews and other task specific medicals such as HGV and boxing are also undertaken.

The medical centre was open from 08:00 to 16:30 Monday to Thursday and 08:00 to 12:30 on a Friday. Pirbright Medical Centre provided shoulder cover when the when the practice was closed and before NHS 111 commenced. A duty doctor at Pirbright Medical Centre was available to provide clinical advice to the practice nurse when they were working at the practice in the absence of medical cover.

### Why we carried out this inspection

The Care Quality Commission (CQC) carried out this inspection as one of a programme of inspections at the invitation of the Surgeon General in his role as the Defence Authority for healthcare and medical operational capability. Defence Medical Services (DMS) are not required to register with CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. Consequently, DMS services are not subject to inspection by CQC and CQC has no powers of enforcement. However, where CQC finds shortfalls in the quality of services during inspection, we will report them by making a recommendation for action to the Surgeon General's office.

### How we carried out this inspection

Before visiting we reviewed information we were provided with about the service. We did not receive the full range of information we requested.

During the inspection we:

- Spoke with the Senior Medical Officer (SMO) from Pirbright Medical Centre, a previously employed locum GP, the Commanding Officer for the base, the practice manager, the practice nurse, physiotherapist and two administrators.
- Patients were not available to speak with on the day of the inspection.
- Reviewed 44 comment cards completed by patients who shared their views and experiences of the service.
- Looked at information, including patient records and information the practice used to deliver care and treatment.
- Looked at information used to monitor the quality and safety of services.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

## Are services safe?

### Our findings

#### Safe track record and learning

The system for reporting and managing significant events was not being effectively used to manage risk.

- The practice manager was the lead for managing the standardised Defence Medical Services (DMS) wide electronic system (referred to as ASER) used for reporting and managing incidents, significant events and near misses. The practice manager was completing part 1 and part 2A of the reporting form which was not in accordance with DMS policy. During the inspection we identified some issues that should have been reported as a significant event or near miss but had not, such as a missing tissue sample.
- Although significant events were a standing agenda item at the practice meetings, staff said not all were discussed with the wider staff team which meant there was no consistent forum to share any learning or lessons learnt.
- National patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) and the Department of Health Central Alerting System (CAS) were received to the group email. They were logged and stored on the shared drive (MOSS) Staff provided examples of alerts received to the practice. We noted alerts were a standing agenda item at practice meetings. The practice nurse provided two examples of the action taken on receipt of an alert.
- When unintended or unexpected safety incidents happened patients received reasonable support, truthful information, a verbal and written apology, and were advised about any action taken to improve processes in order to prevent the same thing happening again.

#### Overview of safety systems and processes

Systems in place to keep patients safe and safeguarded from abuse were not effective.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Information was displayed and included contact details of designated safeguarding teams in the local area. The practice nurse was the safeguarding lead and had completed level three training in child safeguarding. Staff were trained in safeguarding to a level relevant to their role.
- The practice monitored the number of young people registered. The most recent search on 24 April 2018 identified 36 patients under the age of 18 registered at the practice. This number corresponded with that list held by the Commanding Officer for the base. Although an alert was used on electronic patient records to identify patients under the age of 18, alerts

were not routinely used to highlight patients who were vulnerable, such as patients with mental health needs. We were advised that a patient presenting as vulnerable would be assessed by the nurse if a doctor was unavailable. The nurse had access to the duty doctor at Pirbright Medical Centre for advice. However, we were informed that there was at least one occasion when the duty doctor was not available when contacted for advice. If the patient needed to attend Pirbright Medical Centre to see a doctor then this could be delayed as access was dependent on the availability of transport and possibly a suitably screened escort.

- Unit Health Committee (UHC) meetings were held at the station each month to discuss the health and welfare needs of patients. In the absence of an SMO, the last UHC had not taken place as there was no representation from the practice. The Commanding Officer advised us the presence of a Senior Medical Officer (SMO) or a delegated representative was essential for these meetings. We were advised the SMO from Pirbright Medical Centre would be attending the meetings going forward.
- Information was available advising patients that a chaperone was available if required. Chaperones had received a Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.
- A fail-safe system was not established for the management of tissue samples. The practice nurse managed all the samples without a register or recorded monitoring system. A specimen's audit undertaken in February 2017 had not identified this concern and recommended no change was required. We were told about a missing urine sample that the practice had followed up two weeks previous. There was no record of this as a significant event.
- The practice nurse was the lead for infection prevention and control (IPC) having taken over the role from the outgoing SMO. Besides mandated IPC training, the nurse had not undertaken any additional training for the role of IPC lead. The staff team had completed the mandated IPC training. The most recent IPC audit was undertaken in January 2018 resulting in a compliance score of 63.2%. There was no evidence provided to suggest an action plan was developed following this audit. We noted that handwashing sink was not available in one of the patient treatment rooms. Effective arrangements were in place for the cleaning of equipment and the environment. A deep clean was undertaken each Wednesday.
- Arrangements were in place to minimise the risk of legionella, including a legionella risk assessment, monitoring of water temperatures and the flushing of water outlets. We did not have access to this information as we were advised it was held centrally at the station.
- Arrangements for the management of waste, including clinical waste and sharps were not fully effective. Consignment notes were not available and a pre-acceptance waste audit had not been undertaken. The practice manager said there were problems with the waste contract and that they were due to address this with senior management.
- The arrangements for the management of medicines were not fully effective. There was a lack of clarity as to who was the medicine management lead was for the practice. In the absence of an SMO at Deepcut, the SMO for Pirbright said it was the pharmacy technician at Pirbright Medical Centre who was responsible. The practice nurse at Deepcut advised us they were the medicines management lead.
- Medicines were ordered by the practice manager and arrived over-labelled. Medicines including controlled drugs were stored securely and appropriate documentation was maintained to ensure it was accounted for and received by the patient safely. Effective arrangements were in place for the management and monitoring of controlled drugs.

- The cold storage unit for medicines, including vaccinations was monitored daily to ensure temperatures were within the correct parameters. Measures were in place in the event of a break in cold store chain. The procedure was activated last year due to a power cut. Vaccines were transported for storage at Pirbright Medical Centre. The way in which the vaccines were transported was not in accordance with DMS policy.
- Prescription pads were securely stored and there were systems in place to monitor their use. Patient Group Directions (PGD) had been adopted by the practice to allow the nurse to administer medicines in line with legislation. The SMO from Pirbright Medical Centre had revalidated the nurse in April 2018 for the continued use of PGDs. The PGDs were signed and in-date. A PGD audit had not been undertaken.
- The system to monitor and manage patients on high risk medicines was unclear. In the absence of an SMO or pharmacist on site, there was no list held of patients taking high risk medicines, including disease-modifying anti-rheumatic drugs (DMARDs). We were advised that the regional pharmacy visited the practice the day before our inspection to put alerts on the system as previously these had not been in place. The SMO from Pirbright Medical Centre said a list of high risk medicines was in place for Pirbright but they could not confirm if some of these patients were registered with Deepcut Medical Centre.
- 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. Information was in place to confirm staff had received all the relevant vaccinations required for their role at the practice. A process was not in place to routinely monitor the currency of clinical staff's registration status with their regulatory body.
- All locum staff were provided by Pirbright Medical Centre. The practice manager had not sought information to assure locums were safely recruited, including the relevant recruitment checks.

### Monitoring risks to patients

Effective risk management processes were in place to minimise the risks to patients and others.

- Policies and procedures were in place in relation to the management of risks at the station, including a health and safety policy that took account of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). The practice manager was identified as the lead for health and safety and they were suitably qualified for the role.
- Electrical testing, gas safety and portable appliance testing were all current. An equipment care inspection had been undertaken in June 2017. Specific equipment was cleaned daily and daily logs were completed. Single use items were stored appropriately and were within their expiry date. Arrangements to minimise the risk of fire were in place, including checks of the fire system and firefighting equipment
- A range of recently updated risk assessments specific to health and safety of the medical centre were in place, including those in relation to needle stick injury, fire and slips, trips and falls. A lone working policy was not in place and we were advised that staff did not work in the building alone. The layout of the building and the absence of an effective alarm system meant the nurse or physiotherapist working alone at one end of the building may not be heard by other staff if they summoned assistance in an emergency using a personal hand-held alarm.

- The practice nurse frequently worked in isolation of any other clinical support. Although access to a duty doctor by telephone was available, they told us they felt vulnerable in the absence of medical cover on site. The practice nurse gave us an example of an emergency medical situation involving a patient. They had to manage and make decisions alone as the duty doctor had not responded to their call.

### **Arrangements to deal with emergencies and major incidents**

The practice had arrangements in place to respond to emergencies and major incidents.

- A resuscitation trolley was in place and records confirmed it was checked monthly and all items were in-date. It included the appropriate equipment and emergency medicines as described in recognised guidance, including oxygen. The SPN confirmed that all regular staff were in date for basic life support (BLS) training on an annual basis. Evidence that the GPs had completed this training was confirmed shortly after the inspection.
- The waiting room could not be observed by staff at all times.
- A comprehensive and current business continuity plan was in place and accessible to all staff.

# Are services effective? (for example, treatment is effective)

Inadequate



## Our findings

### Effective needs assessment

The practice was unable to provide assurance it assessed needs and delivered care in accordance with relevant and current evidence based guidance and standards.

- In the absence of an SMO on site, clinical meetings did not take place at the practice. The practice nurse sometimes attended the clinical meetings at Pirbright Medical Centre. They were aware of evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE). They said emails or active updates regarding best practice guidance were not in place. The three sets of practice meeting minutes we were provided with did not demonstrate that NICE or other guidance were discussed at this forum.

### Management, monitoring and improving outcomes for people

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

The practice provided the following examples of patient outcomes data to us from their computer system on the day of the inspection. The previous SMO had monitored QOF data and the practice nurse was in process of familiarising themselves with this role. The data we were provided with by the practice was incomplete and we were uncertain of its accuracy. After the inspection the DMS provided us with the QOF data.

- There were two patients registered at the practice with diabetes. For one of these patients the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For both patients the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.
- There were 17 patients recorded as having high blood pressure. Staff were unable to confirm how many of these patients had a record of their blood pressure being recorded in the past nine months. Ten had a blood pressure reading of 150/90 or less.
- There were six patients with a diagnosis of asthma. Of these, two had received an asthma review in the preceding 12 months which included an assessment of asthma control using the 3 Royal

College of Physicians questions. Staff were unable to confirm why the remaining four patients had not been reviewed.

- QOF data showed there were no new patients with a new diagnosis of depression identified in last 12 months. The Commanding Officer had advised us phase 2 and 3 trainees were particularly vulnerable with four currently identified on the vulnerable risk management (VRM) system due to mental health concerns. We therefore undertook a detailed DMCIP data search of the registered patient population, taking into account all Read codes for mental and psycho-social health, and also medication prescribed for treating mental health related conditions. This search identified 21 patients, including those with a diagnosis of depression. Of these, we determined seven patients had not received appropriate follow up and/or review of their mental health status and treatment.

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). Evidence provided showed 97% of the patient population were in-date for an audiometric assessment (within the last two years). Regional and national comparative data was not provided.

There was no evidence of quality improvement activity (QIA) at the practice. The previous SMO had been the lead for audit. Aside from a recent IPC audit, the practice nurse had not undertaken any other audits. An audit register was in place which showed eight audits had been undertaken between February and September 2017; three of which were clinical in nature rather than quantitative system checks. No audits had taken place since September 2017.

### **Effective staffing**

Evidence was not in place to confirm all staff had the skills and knowledge to deliver effective care and treatment.

- The generic induction programme included mandated training, such as safeguarding, health and safety and information governance. A bespoke induction relevant to the practice was not in place, including an induction for locum staff. There was no specific induction and training for new staff depending on their role.
- A staff database was used to monitor the status of staff mandatory training. It showed mandated training was not up-to-date for all staff. For example, 60% of the team were out-of-date for refresher basic life support and 80% for anaphylaxis. The practice nurse had undertaken training relevant to their role, including cytology, immunisation and ear syringing.
- In the absence of an SMO, the practice nurse said they were closely supported by the regional nurse lead who visited the practice and provided clinical supervision sessions. Staff were up-to-date with their appraisals.

### **Coordinating patient care and information sharing**

Systems to ensure effective coordination of patient care were not effective.

- Ensuring the fitness and welfare of the trainees was paramount for unit commanders. The multi-disciplinary UHC meetings held each month were structured, taking into account seven pillars: injury prevention, mental wellbeing, oral health, sexual health, nutrition, substance misuse and smoking prevention/cessation. In military settings the SMO for a medical practice would usually

attend these meetings to discuss patient's needs. In the absence of an SMO these meetings had been put on hold.

- The Commanding Officer expressed concern about the lack of continuity of care for trainees at Deepcut and how this was critical from a vulnerable risk management perspective. From our search of DMCIP, we identified two patients with complex mental health needs who had been seen by a number of health professionals from different services. For example, it was unclear from the records who was overall clinically responsible for one patient who was receiving input from multiple clinicians from two medical centres.
- When patients moved or were deployed, their medical records were transferred electronically. Summarisation of records was the responsibility of the practice nurse and was up-to-date.
- A system was in place for making referrals and the progress of referrals was monitored by a dedicated administrator.

### Consent to care and treatment

Staff sought patient consent to care and treatment in line with legislation and guidance.

- The practice nurse said verbal consent was always obtained and recorded on the patient's record. The nurse understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (MCA) 2005. They said if they had any concerns about a patient's ability to consent then they would seek the input of a doctor.

### Supporting patients to live healthier lives

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

- New patients were subject to checks and screening for lifestyle behaviours such as smoking and alcohol use. Family history was taken into account as part of the screening process.
- The practice demonstrated a pro-active and committed approach to health prevention and promotion. Relevant information leaflets and displays were up-to-date at the practice. The nurse had completed a health and wellbeing course and offered advice to patients regarding health issues such as smoking. The practice was represented at the annual station health fairs.
- The nurse was not aware of any national screening programmes the practice was involved with, such as bowel cancer, breast cancer or abdominal aortic aneurysm (AAA) screening programs. Despite asking before the inspection and during the inspection, we were not provided with the age range of the registered patients so were therefore unable to determine whether any of these screening programmes were applicable.
- Forty-one patients were eligible for a smear test and five tests were outstanding. This represented an achievement of 88%. The NHS target was 80%. Effective systems were in place to follow-up patients who failed to attend for a cytology check.

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, polio and measles, mumps and rubella. The data below provides the March 2018 vaccination data for patients. We were not provided with regional and national comparisons.

- 97% of patients were recorded as being up to date with vaccination against diphtheria.

- 48% of patients were recorded as being up to date with vaccination against hepatitis A. This was highlighted as a 'red' risk. This low uptake was due to a national shortage of the vaccine.
- 40% of patients were recorded as being up to date with vaccination against Hepatitis B. This low uptake was due to a national shortage of the vaccine.
- 96% of patients were recorded as being up to date with vaccination against polio.
- 97% of patients were recorded as being up to date with vaccination against Tetanus.

Good



## Are services caring?

### Our findings

#### Kindness, dignity, 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.
- Clinic room doors were closed during consultations. Curtains were provided in clinic rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Patients had the option of having a chaperone. If patients wished to discuss sensitive issues or appeared distressed practice staff could offer them a private room to discuss their needs.
- Although not specifically adapted for such, the building could accommodate wheelchair access. Staff advised us they would not use a translation service but would ask the patient to bring a colleague to translate for them if the need arose. This was not in accordance with organisational policy.
- A suggestion box for patients to leave feedback was located in the waiting area. Patients also were given the opportunity to participate in the patient experience survey.
- We did not have the opportunity to speak with patients during the inspection so relied on the DMS Patient Experience Survey (PET) and the 44 CQC feedback cards to understand the views of patients. Overall, feedback indicated patients were satisfied with the care provided by the practice. Themes included reference to polite and helpful reception staff, and being treated with dignity and respect.
- We looked at the results of the quarter four PET Survey. From the sample of 30 patients, 17 patients stated they would recommend the medical centre to friends, family or colleagues. Thirteen patients deemed the question not applicable.

#### Care planning and involvement in decisions about care and treatment

- The majority of feedback from patients on the CQC comment cards indicated that staff took the time to explain their condition or injury and treatment plan. The PET survey showed patients were satisfied with their involvement in decisions about treatment and care.

#### Patient and carer support to cope emotionally with treatment

- Patient information leaflets and notices were available in the patient waiting area, which advised patients about how to access a number of organisations. We saw that information that was relevant to the patient demographic was prominently displayed and accessible.
- Measures were in place to support with identifying patients who were carers.

# Are services responsive to people's needs? (for example, to feedback)

Inadequate



## Our findings

### Responding to and meeting people's needs

- Between Deepcut and Pirbright Medical Centres, a range of services were available to patients including over-40's health screening, audiology screening, family planning, sexual health, physiotherapy and travel advice.
- Usually patients were seen on the same day for urgent and routine appointments. The nurse triaged any urgent patients and referred patients on to Pirbright if no doctor was available at Deepcut. Telephone consultations were available if the patient requested that option.

### Access to the service

- In the absence of an SMO, the practice received medical support from Pirbright Medical Centre. Staff said availability of a doctor on site was piecemeal and often last minute, which made advance appointment booking difficult. For example, the Tuesday prior to our inspection staff were advised a doctor would be available to facilitate a clinic the following day, which was very short notice to book patient appointments. The first appointment was booked for 08:30 but the doctor did not arrive until 09:00. Staff advised us that patients displayed frustration at having to attend Pirbright Medical centre for an appointment due to transport and access issues. Staff also advised us they faced some resistance when trying to book patient appointments at Pirbright and were regularly informed no doctor appointments were available for the Deepcut patients.
- Insufficient doctor and nurse availability, an increase in waiting times and frustration associated with travelling to Pirbright Medical Centre for an appointment were themes emerging from the CQC comment cards.
- Trainees attending Pirbright Medical Centre were reliant on base transport so appointments were often coordinated around the availability of transport rather than the needs of the patient. Some trainees required an escort who were DBS checked which further complicated timely access to a doctor.
- The Commanding Officer for the base was also responsible for the phase 2 trainees. They said trainees were required to have a clearance medical before completing their training. Because of limited access to a doctor at Deepcut and the convoluted process of accessing care at Pirbright, 395 'holdover' days had accumulated. Holdover is a military term for non-productive time. The high rate of holdover was identified on the base risk register.
- The Commanding Officer provided an example of when 12 soldiers arrived at the base and all required driving licence medicals. The locum doctor was unable to do these so the soldiers had to be allocated out to other medical centres which caused a delay.

- In the absence of consistent and relevantly skilled medical cover, reviews of patients who were downgraded were not taking place in a timely way.

### **Listening and learning from concerns and complaints**

The practice had a system for handling complaints and concerns.

- The practice manager was the designated responsible person who handled all complaints in the practice. The last recorded complaint was in April 2015.
- Information was available in the waiting area to support patients' understanding of the complaints system. How to make a complaint was summarised in the practice leaflet.
- Staff advised us that if there was any learning from complaints then this would be shared at the practice meetings. We noted from the practice minutes that complaints and compliments was a standing agenda item.

# Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Inadequate



## Our findings

### Vision and strategy

The practice information leaflet identified that the practice worked to the DPHC mission statement outlined as:

“To deliver a unified, safe, efficient and accountable primary healthcare service for entitled personnel to maximise their health and deliver personnel medically fit for operations.”

### Governance arrangements

Delivering a service in accordance with the mission statement was hampered by the absence of a dedicated SMO and consistent clinical leadership for the practice since January 2018. We were advised that a new SMO had been identified for the practice but would not start working there until August 2019. The SMO for Pirbright Medical Centre, who took up post in March 2018, described an operational hub and spoke model whereby Deepcut Medical Centre was the spoke and Pirbright Medical Centre the hub. The SMO was therefore responsible for the risk associated with Deepcut Medical Centre.

- The practice manager was responsible for the day-to-day operation of the service. There was a staffing structure in place. Although staff were aware of their roles and responsibilities, there were no terms of reference in place for individual staff. In addition, the list indicating the areas staff had lead roles in was out-of-date. This had changed significantly as the previous SMO had assumed many of the clinical lead roles and some of these leads were now based at Pirbright Medical Centre, such as the Caldicott lead.
- There had been no formal transition of clinical responsibilities to the practice nurse since the SMO's departure in March 2018. The SMO had been the lead for chronic conditions and we found the arrangements for the management of chronic conditions was weak and fragmented.
- The common assurance framework (CAF), an internal quality assurance tool, was used to monitor safety and performance. The 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 was formally reviewed in December 2017 by the SMO and was graded amber overall with amber grading for the domains of: safety; clinical and cost effectiveness; governance; patient and accessible and responsive care. We were not provided with a management action plan (MAP) to show how the service deficits were being addressed.
- When a CAF assessment is undertaken by Regional Headquarters (RHQ) it is referred to as a Health Governance Assurance Visit (HGAV). The last HGAV was undertaken 2015.

- Practice meetings were held each month and served as the main communication tool for the staff team. The CAF structure was used as a framework for the meetings. The minutes were comprehensive and were available for practice staff to view. Informal team updates were held between practice meetings. The practice manager emailed staff with any updates.
- No clinical meetings were held at the practice. The practice nurse sometimes attended the clinical meetings at Pirbright Medical Centre.
- Quality improvement activity was not taking place. The approach to audit was underdeveloped and unstructured. We were advised by the practice manager that both clinical and administrative audits were completed on an ad hoc basis. There was no evidence of repeat audits taking place. Not all audits were effective, such as the specimen audit that had not identified the absence of a failsafe monitoring process.

### **Leadership and culture**

- Staff said they felt part of the team and confirmed they worked well together. They said it was a supportive team environment. However, the lack of clinical leadership was raised as a concern by some staff. We were given an example where the lack of clinical leadership at the practice had an impact in relation to clinical decision making about a patient's care.
- Systems were in place to support compliance with the duty of candour, and all staff we spoke with had a good understanding of what this meant and their responsibilities in relation to the requirements. Duty of candour is a legal requirement services must follow when things go wrong with care and treatment.

### **Seeking and acting on feedback from patients, and staff**

A feedback system for patients was in place. It sought feedback through:

- Patient surveys and from any individual patient feedback received.
- The suggestion box available in the waiting area for patients to leave feedback.
- Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

### **Continuous improvement**

The focus for practice staff was ensuring patients had access to a doctor either at the practice or at Pirbright Medical Centre. It was evident in the February 2018 practice meeting minutes that the staff spent time ensuring medical cover was available for patients. Beyond this focus there was limited evidence of quality improvements.