Dishforth Medical Centre

Quality report

Thirsk,
North Yorkshire
YO7 3EZ

Date of inspection visit:
11 & 18 October 2018

Date of publication:
28 November 2018

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information given to us by the practice and patient feedback about the service.

Ratings

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

Chief Inspector's Summary

This practice is rated as Good overall

The key questions are rated as:

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

We carried out an announced comprehensive inspection at Dishforth Medical Centre on 11 October 2018. For reasons of availability, the physiotherapy service was inspected on 18 October. Defence Medical Services (DMS) are not registered with the CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014 and are not required to be. Consequently, DMS services are not subject to inspection by the CQC and the CQC has no powers of enforcement. This inspection is one of a programme of inspections that the CQC will complete at the invitation of the Surgeon General in his role as the Defence Authority for healthcare and medical operational capability.

At this inspection we found:

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

- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

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

The Primary Care Rehabilitation Facility (PCRF) measured clinical outcomes through a musculoskeletal health questionnaire and injury specific questionnaires. Outcome measures were repeated every two weeks and displayed in a graph format on DMICP. This was shown and discussed with the patient so they could see how their treatment was progressing.

In addition, the PCRF maintained a spreadsheet of all patients which included baseline data, start/end outcome measures and length of treatment. It was used to undertake monthly caseload reviews in which PCRF staff discussed each patient to make decisions on management and onward referral. This spreadsheet was also used to inform the annual service evaluation and to plan for quality improvement. For example:

- In response to high rates of ankle injuries for 4 Regiment Royal Artillery, the PCRF developed the RAMP (Rise Activate Mobilise and Potentiate) warm up for the physical training instructors (PTI) to use before training sessions to prepare the body for the demands on the ankles.

The PCRF built effective working relationships with the commanders on the base and used evidence-based audits and statistical analysis to influence the delivery of physical training which was having a positive impact on the population. For example:

- High rates of lower back pain for 21 Engineer Regiment led to the PCRF developing the Alternative Core Training (ACT) to be used by the PTI for that regiment. This saw a reduction in lower back pain presentation by 50%. The ACT was developed using thorough application of evidenced based practice.

The Chief Inspector recommends:

Reviewing the system for managing audit so that all clinical audit activity is captured, including current and previous audits.

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

Our inspection team

Our inspection team was led by a CQC lead inspector**.** The team on the first inspection day included a GP adviser, practice nurse adviser and a practice manager adviser. A physiotherapist advisor inspected the Primary Care Rehabilitation Facility (PCRF) on the second day of the inspection.

Background to Dishforth Medical Centre

Dishforth Medical Centre provides routine primary care and occupational health to three regiments located across three military bases in North Yorkshire; Alanbrooke (Topcliffe), Claro (Ripon) and Dishforth. There were 1600 registered patients at the time of the inspection; the majority army personnel, male and aged between18 and 39. Families and dependants are not treated at the practice and are signposted to local NHS practices.

In addition to primary care services, the practice provides occupational health, force preparation occupational diving medicals, aviation medicals and minor surgery. A PCRF is located on the premises, with physiotherapy and rehabilitation staff fully integrated with the medical centre. Family planning advice is available with referral available to NHS community services. Maternity and midwifery are provided by NHS practices and community teams. Pharmacy services are outsourced to a local pharmacy. An occupational health service was also provided to a small number of reservists.

The practice is open from 08:00 to 17:00 Monday to Thursday and 08:00 to 16:00 on Friday. When closed during the week, medical cover is provided by Leeming Medical Centre up until 18:30. From 18:30 weekdays, weekends and public holidays patients are advised to use NHS 111.

At the time of our inspection the staff team comprised a mix of civilian and military staff, including full and part time staff. The team included a civilian Senior Medical Officer (SMO), a civilian GP, four practice nurses, two physiotherapists, an exercise rehabilitation instructor (ERI), two Combat Medical Technicians (CMT). A CMT or medic is a soldier trained to provide medical support on various operations and exercises. In a medical centre setting, their role is similar to that of a health care assistant in NHS GP practices but with a broader scope of practice. A practice manager was responsible for the day-to-day running of the practice supported by four administrators. A Regional Clinical Director (RCD) assumed overall accountability for quality of care at the practice.

Are services safe? | Good

We rated the practice as good for providing safe services.

Safety systems and processes

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

- A framework of regularly reviewed safety policies was in place and accessible to staff, including locum staff. Staff received safety information for the practice as part of their induction and refresher training.
- Measures were in place to protect patients from abuse and neglect. Adult and child safeguarding policies were available to all staff. All staff had received up-to-date safeguarding training appropriate to their role and knew how to identify and report concerns. The SMO was the safeguarding lead and had completed level 3 update training in December 2017. The lead physiotherapist had expressed an interest in becoming a deputy safeguarding lead and was in the process of sourcing the appropriate training.
- A register of vulnerable patients was maintained and was regularly reviewed at welfare meetings with the Chain of Command. Codes were used on the electronic patient record system to identify patients who were vulnerable. Alerts were not used. The day after the inspection the practice manager confirmed that all vulnerable patients had an alert added to their record.
- Staff who acted as chaperones were trained for the role and had been subject to safety checks to ensure they were suitable to work with young people and vulnerable adults. Notices were displayed advising patients that a chaperone was available.
- 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. Arrangements were in place to monitor the registration status of clinical staff with their regulatory body. All staff had professional indemnity cover. Information was in place to confirm staff had received all the relevant vaccinations required for their role at the practice.

- There was an effective system to manage infection prevention and control (IPC). One of the practice nurses was the lead for IPC and had completed training relevant for the role. All staff had received IPC training. IPC audits were completed throughout the year for each clinical area. For example, the medic's treatment room was audited in September 2018 and the PCRF in October 2018. Arrangements were in place for environmental cleaning. A deep clean of the clinical areas took place twice a year.
- Systems were in place for the safe management of healthcare waste. Consignment notes were retained at the practice. The last waste audit was carried out in February 2018.
- The practice ensured that facilities were safe. Electrical safety checks were completed within the last 12 months and water safety checks were undertaken each month. The station fire officer was responsible for fire safety at the practice and carried out an annual risk assessment of the building annually. Firefighting equipment tests were all in-date. Staff were up-to-date with fire safety training and were aware of the evacuation plan.
- Equipment was checked and maintained according to manufacturers' instructions. Testing of portable electrical appliances and medical equipment was in-date. The PCRF maintained a spreadsheet of equipment checks. On the day of the inspection one of the physiotherapy couches was out-of-date for servicing. The lead physiotherapy arranged for the servicing company to visit the following week.

Risks to patients

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

- The SMO confirmed the practice was sufficiently staffed to ensure patient's needs were met in a timely way. The PCRF were flexible with staffing to accommodate the movements of military personnel with more staff present when a regiment returned from deployment.
- All staff had received a detailed induction, which included both generic and role-specific induction. We were provided with examples of a GP and physiotherapist induction pack. The ERI was newly qualified and a programme of support, including observed practice was in place. In addition, there was an effective induction system for locum staff to ensure they were familiar with systems and ways of working in defence primary care.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures, including regular simulation exercises. A resuscitation trolley was in place and records confirmed it was checked monthly and all items were in-date. A process was in place for managing thermal injuries and clinical staff were familiar with this. The SMO said the practice rarely dealt with thermal or spinal injuries. With incidents like this, the practice would contact the emergency services.
- 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. Guidance on how to manage sepsis was available in clinical areas.

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. The care records we looked at on electronic patient record system (referred to as DMICP) showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way. Staff described occasional loss of connectivity with DMICP but said this did not have a significant impact on patient care.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. A process was in place for the management of specimens, including the transport of specimens to the laboratory and the use of Lab Links to manage test results. Test results were tasked to a doctor for action. An audit of the transportation of specimens was undertaken in October 2018 to confirm the system was working effectively.
- Choose and Book was used for patients to book appointments in secondary care services. Internal referrals were made electronically, such as those to the physiotherapist. In situations where electronic referral was not available, a system was in place to ensure letters were scanned and included in the patient's clinical record.

Safe and appropriate use of medicines

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

- A medicines management lead was identified for the practice. The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment minimised risks. The practice did not have a dispensary and a policy and process was in place for the storage and monitoring of stock medicines. A list of stock drugs was supplied by the regional pharmacist and the practice carried out monthly stock checks; the results of which were sent to the regional pharmacist. Controlled drugs were not held at the practice. Medication requiring refrigeration was monitored to ensure it was stored within the correct temperature range. A vaccine storage and transportation audit was undertaken in April 2018 to confirm the system was working effectively.
- Prescription pads were securely stored and their use monitored. Patient Group Directions (PGD) had been adopted by the practice to allow nurses to administer medicines in line with legislation These were current and signed. Patient Specific Directions (PSD) were signed by the SMO prior to the medics undertaking a vaccination clinic. A PSD is a recorded prescriber instruction for a medicine to be given to a named patient, including the dose, route and frequency. Medics had received appropriate training and competency checks by the SMO in relation to the administration of medicines.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.
- There was an effective and consistent approach to the management of patients taking high risk medicines. Management of these medicines took into account the deployment of patients. The care records for two patients prescribed a high-risk medicine showed their care was effectively monitored and managed. Shared care agreements were in place. We noted that alerts were not used to identify patients on high risk medicines. Shortly after the inspection the manager confirmed this had been set up.
- The practice followed the 2017 NHS North Yorkshire antibiotic prescribing guideline for primary care. The SMO advised us there were low rates of antibiotic prescribing at the practice. An audit to ensure Lithium, a medicine used to treat mood disorders, was prescribed in accordance with policy was undertaken in 2016. An audit of Naproxen, a pain relieving medicine, was completed in 2017. The SMO was undertaking a further prescribing audit with

the intention to complete it by 19 November 2018. According to the audit programme, a non-medical prescribing audit was also due to be undertaken in November 2018.

Track record on safety

The practice had a good safety record.

- The practice manager was the lead for health and safety. They had attended training relevant for the role. The practice monitored and reviewed safety processes. This supported staff with understanding risks and provided a clear, accurate and current picture that led to safety improvements. Risk assessments pertinent to the practice were in place including risk assessments for acupuncture, needle stick injury and lone working.
- All staff had a personal alarm to summon assistance in an emergency.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Adequate systems were in place for reviewing and investigating when things went wrong. There was an electronic organisational-wide system (referred to as ASER) for recording and acting on significant events, incidents and near misses. All staff had electronic access to the system. Staff provided several examples of significant events demonstrating they were effectively reporting incidents. For example, a medication administration error led to a change in protocol and there had been no reoccurrence since.
- Significant events and other incidents were discussed at both the health care governance meetings and practice meetings. Significant events reported for the PCRF were also discussed at the PCRF team meeting.
- A lead member of staff was identified for managing medicine and safety alerts. They maintained a log of all alerts received and forwarded them to clinicians. Alerts were discussed at the practice meetings if applicable. The SMO provided an example of how a search had been undertaken in response to an alert to identify if any patients had been affected. No patients were deemed to be at risk.

Are services effective? | Good

We rated the practice as good for providing effective services.

Effective needs assessment, care and treatment

The practice assessed needs and delivered care in accordance with relevant and current evidence based guidance and standards.

- Clinical staff were aware of evidence based guidance and standards, including guidance from the National Institute for Health and Care Excellence (NICE). Staff referred to this information to deliver care and treatment to meet patients' needs. They described how updates on NICE and medicines management were outlined in a newsletter circulated to clinical staff by the DPHC each month. Staff told us the NICE guidance on hearing loss was discussed recently with the team.
- Although staff we spoke with confirmed that health care governance (HCG) meetings were held each month, only two sets of meeting minutes could be located; one from a meeting in 2017 and another from 2018. The SMO advised us that the HCG meetings included discussions about patients with complex needs. The practice manager advised us that the

meetings would be formalised and in the future and they would ensure minutes were made and retained.

- The practice nurses held weekly meetings and clinical matters were discussed at this forum. Nurses also attended the nurse development meetings at Catterick Medical Centre. The SMO and lead physiotherapist had informal meetings each day to discuss patient care. The lead physiotherapist attended quarterly regional PCRF meetings to look at current clinical care and how it could be improved upon.

Monitoring care and treatment

The senior nursing officer was the lead for chronic disease management and carried out regular chronic disease searches, recalling patients when appropriate.

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

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

- There were six patients on the diabetic register. For five patients, their last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For six patients, their last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.
- There were 18 patients recorded as having high blood pressure. Thirteen patients had a record for their blood pressure taken in the past nine months. Thirteen patients had a blood pressure reading of 150/90 or less.
- There were 27 patients with a diagnosis of asthma. Eighteen patients had an asthma review in the preceding 12 months which included an assessment of asthma control using the three Royal College of Physicians questions.

QOF data submitted pre-inspection indicated that there were no patients with a coding of mental illness. We discussed this with the SMO and established that patients were being treated for depression. The SMO said that the coding of ‘adjustment disorder’ was used at the practice prior to a formal diagnosis of depression by the Department of Community Mental Health (DCMH). However, this meant patients being treated for depression who were not referred to the DCMH would continue to be coded as having an adjustment disorder. This could lead to gaps in care provision, particularly when a patient moves to a new practice.

We undertook a search for ‘self-harm’ on DMICP and yielded a negative result; yet we reviewed a patient’s records which clearly indicated evidence of self-harm. Despite the anomalies with coding, the care records we looked at provided assurance that patients were being effectively managed. The SMO advised that as ‘self harm’ is not a diagnosis, patients who present with this are coded with the most appropriate clinical diagnosis instead. A structured mental health assessment was used. A search of the system identified that 84 patients were referred to the DCMH in the last 12 months. Shortly after the inspection the practice manager confirmed alerts had been added to patient records which meant searches could be readily undertaken. Evidence

of a search that had been built and undertaken was provided. The practice intended to routinely undertake this search to identify and monitor patients with a mental health need.

The PCRF measured clinical outcomes through a musculoskeletal health questionnaire and injury specific questionnaires. Outcome measures were repeated every two weeks and displayed in a graph format on DMICP. This was shown and discussed with the patient so they could see how their treatment was progressing.

In addition, the PCRF maintained a spreadsheet of all patients which included baseline data, start/end outcome measures and length of treatment. It was used to undertake monthly caseload reviews in which all PCRF staff discussed every patient to make decisions on management and onward referral. This spreadsheet was also used to inform the annual service evaluation of the PCRF.

Information from the Force Protection Dashboard, which uses statistics and data collected from military primary health care facilities, was also used to gauge performance. Service personnel may encounter damaging noise sources throughout their career. It is therefore important that service personnel undertake an audiometric hearing assessment on a regular basis (every two years). Data we were provided with showed:

- Audiometric assessments were in date for 94% of patients compared to 92% regionally and 85.5% for DPHC nationally. Audiometric assessments were appropriately recorded in accordance with the Hearing Conservation Programme.

The SMO was the lead for audit. An annual audit programme was in place that identified what audit was to be undertaken each month and who would complete it. It didn't include audits undertaken by the PCRF and didn't usefully identify which cycle each audit was on.

We identified 16 audits that had taken place since June 2017. They took into account population need based on occupation and activity. Audits undertaken included those in relation to rheumatoid arthritis, diabetes, weight management, cervical cytology and contraception. The SMO identified that asthma was the most common chronic condition among the population so an asthma audit had been undertaken in 2016 and again in 2017. We highlighted that this audit would benefit from being repeated in light of a change to the population, including an increase in the numbers of patients with asthma. Shortly after the inspection the practice manager provided evidence to confirm a repeat asthma audit had been completed.

Audits undertaken by the PCRF included a lower back pain (LBP) audit which identified patients with an acute episode that had improved by the time the patient was seen by the physiotherapist. As a result, advice sheets had been developed and medical centre staff, mainly the medics, instructed in how to provide advice and initial management for LBP. The audit indicated the PCRF was looking at the entire musculoskeletal (MSK) pathway for LBP starting with the medics and GPs. This demonstrated an effective collaborative approach. An ankle injury audit and tendinopathy audit were undertaken to ensure patients were receiving the correct rehabilitation programmes.

During the last 12 months, the SMO identified that minor surgery had been performed on 10 patients for occupational reasons. This mainly included the removal of skin tags and moles that interfered with clothing and/or equipment. The medical centre had identified that the risk of infections was low and so a minor surgery audit not been undertaken. Shortly after the inspection the practice manager submitted this on 7 November 2018.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, the ERI had just completed a six-month course at Headley Court, a rehabilitation centre.

- The practice manager had a system in place and checked each month that staff were up-to-date with mandated training, competencies and appraisals.
- Records of skills, qualifications and training were maintained for all staff. Staff were encouraged and given opportunities to develop. Staff had access to one-to-one meetings, appraisal, mentoring, clinical supervision and support for revalidation.
- Clinical staff were given protected time for professional development and evaluation of their clinical work. Peer review was embedded in practice both on a formal and informal basis.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

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

- New patients to the practice had their medical record details checked and clinical notes summarised. Summarisation was up-to-date.
- Clinical records showed that all appropriate staff, including those in different teams, services and organisations were involved in assessing, planning and delivering care and treatment. Shared care agreements were in place for patients where both the hospital and the GP where providing care to a patient.
- Processes were in place to monitor referrals to other services and ensure they did not get lost in the system. For example, referrals to the Regional Rehabilitation Unit and referrals to orthopaedics were monitored monthly at the PCRF meeting.
- Patients received coordinated and person-centred care. This included when they moved between services and were referred to another service. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The SMO, lead physiotherapist and ERI attended the Unit Health Committee (UHC) meetings held monthly for each regiment. The meetings reviewed patients who were medically downgraded and those who were vulnerable. In addition, analysis of patient data held on the PCRF spreadsheet was used to illustrate the most prevalent injuries and which regiments had more of which injury type. Referral patterns were also tracked. For example, a spike in injuries following periods of leave could indicate that personnel require a graded return to training after leave. This information was shared at the UHCs and had led to commanders altering the physical training for regiments.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives. Based on population characteristics and need, this involved a focus on injury prevention.

- The lead physiotherapist described a close working relationship with the physical training leads for each regiment. The PCRF team referred to the DoFit programme, which supports weight

loss through exercise and education to address lifestyle issues. During quieter periods the PCRF focussed on injury prevention work, such as foot care and exercise advice.

- Clinical records showed that staff encouraged and supported patients to be involved in monitoring and managing their health. Staff also discussed changes to care or treatment with patients as necessary. The practice had direct contact with specialist teams for advice and patient referral, including the diabetes specialist team, retinopathy and podiatry.
- The practice supported national priorities and initiatives to improve the population's health including, stop smoking campaigns and tackling obesity. A health promotion display board was available to patients and it was regularly refreshed. At the time of the inspection, there was a sexual health and smoking display. The practice also provided support with health fairs held by the gym staff each year.
- Patients had access to appropriate health assessments and checks. Routine searches were undertaken for patients eligible for bowel and breast screening and appropriate action taken if patients met the criteria.

It is important that military personnel have sufficient immunity against the risk of contracting certain diseases. The World Health Organisation sets a target of 95% for vaccination against diphtheria, tetanus, pertussis and polio and measles, mumps and rubella. The following illustrates the current 2018 vaccination data for patients using the practice:

- 94% of patients were recorded as being up to date with vaccination against diphtheria compared to 95% regionally and 95% for DPHC nationally.
- 94% of patients were recorded as being up to date with vaccination against polio compared to 94% regionally and 94.5% for DPHC nationally.
- 96% of patients were recorded as being up to date with vaccination against hepatitis B compared to 78% regionally and 77% for DPHC nationally.
- 91% of patients were recorded as being up to date with vaccination against hepatitis A, compared to 93% regionally and 91% nationally.
- 94% of patients were recorded as being up to date with vaccination against tetanus, compared to 95% regionally and 95% for DPHC nationally.

Searches of the system were undertaken each month and a list sent to unit commanders of personnel who were due to have vaccinations. Regular searches were also undertaken for patients eligible for screening.

Consent to care and treatment

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

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Are services caring?	Good

We rated the practice as good for caring.

Kindness, respect and compassion

- Throughout the inspection staff were courteous and respectful to patients arriving for their appointments.
- Results from the September 2018 Patient Experience Survey (61 respondents) indicated that one patient did not feel their comments and complaints were listened to. The 37 CQC comment cards completed prior to the inspection were very complimentary about the caring attitude of staff.
- The practice had an information network available to all members of the service community, known as HIVE. This provided a range of information to patients who had relocated to the base and surrounding area. Information included what was available from the local unit and from civilian facilities, including healthcare facilities.

Involvement in decisions about care and treatment

- Staff supported patients to be involved in decisions about their care. In relation to physiotherapy and rehabilitation, expectations were discussed with each patient to ensure bespoke goals and a treatment plan was identified for the patient.
- Interpretation services were available for patients who did not have English as a first language. Notices were displayed in clinical areas and on the notice board TV in reception informing patients this service was available.
- The September 2018 Patient Experience Survey showed all but one of the respondents felt involved in decisions about their care. Feedback on the CQC patient feedback cards highlighted that patients received information about their treatment to support them with making informed decisions about their treatment and care.
- The practice proactively identified patients who were also carers. There were systems in place to identify patients who had caring responsibilities. A carer's register was established for the practice.

Privacy and dignity

The practice respected patients' privacy and dignity.

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

Are services responsive to people's needs? | Good

We rated the practice as good for providing responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patient needs and preferences.

- Staff understood the needs of its population and tailored services in response to those needs. For example, clinics were organised around the occupational health needs of deployable units.
- The September 2018 Patient Experience Survey showed that 10 of the 61 respondents were not satisfied with the location of their appointment. Similarly, the CQC feedback reflected this with a small number of patients commenting on the inconvenience of travelling to Dishforth for an appointment. These views related to the closure of the medical centres at Topcliffe and Ripon and the transfer of patient care to Dishforth Medical Centre. The services closed in 2016/17 and both stations are approximately eight miles from Dishforth.
- Although an access audit as defined in the Equality Act 2010 had not been completed for the premises, reasonable adjustments had been made to accommodate patients. Doctors and nurses were based on the ground floor so were accessible for patients who were wheelchair users or who had limited mobility. The PCRF was located on the first floor that was accessed by stairs. PCRF staff said patients on crutches could manage the stairs. If needed, PCRF staff could see patients on the ground floor. The practice had a dedicated parking space for patients with a disability.

Timely access to care and treatment

Despite concerns about the location, patients' needs were met in a timely way.

- Patients with an emergency need were seen that day and the waiting time for a routine appointment was one to three days. The April 2018 Patient Experience Survey showed that all relevant respondents had received their appointment at a time that suited them.
- Home visits and telephone consultations were available. Arrangements were in place for patients to access primary care when the practice was closed, including emergency care.
- Waiting times for patients referred for an aviation medical was less than a week and for diving medicals the wait was two to three weeks. The waiting time for grading medicals was approximately four weeks.
- Direct access to a physiotherapist was available. A self-referral protocol provided inclusion/exclusion criteria along with the process of self-referral. Patient feedback indicated that the self-referral was a good system as it reduced waiting times.
- At the time of the inspection the next available routine physiotherapy appointment was in four working days. The waiting time for an ERI was extended due to the absence of the ERI for training. The next available ERI appointment was in 20 working days. The ERI facilitated group rehabilitation sessions at Topcliffe and Rippon to limit the travel times for patients. Group sessions were also available for each of the regiments at Dishforth.

Listening and learning from concerns and complaints

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

- Information was available to help patients understand the complaints process. The practice managed complaints in accordance with the DPHC complaints policy and procedure.
- The practice manager was the designated responsible person who handled all complaints. A record of complaints was maintained, including verbal complaints. No complaints had been made in the last 12 months.

Are services well-led?	Good

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

Leadership capacity and capability

The management team had the experience and skills to deliver high-quality sustainable care.

- The practice manager, SMO and lead physiotherapist had worked at the practice for many years and were familiar with the needs of the patient population, and how to manage those needs. They had developed very effective working relationships with the physical training instructors (PTI) and Chain of Command for the regiments.
- The closure of Topcliffe and Ripon medical centres meant an increase in the patient population for Dishforth Medical Centre. The practice had managed the transition well and accommodated the increase in population.

Vision and strategy

- The practice worked to the DPHC mission statement of:

  "Delivering a unified, safe, efficient and accountable primary health care for entitled personnel to maximise their health and to deliver personnel medically fit for operations".
- The strategy was in line with health priorities across the region and the service was organised to meet the needs of the patient population. Specifically, for the PCRF, the lead physiotherapist described the strategy as striving for good quality evidence based care and the flexibility to respond to the needs of a specific group. It was clear from our discussions with staff that they were committed to supporting the strategy.

Culture

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

- Staff we spoke with described a leadership style that encouraged and valued everyone's contribution to developing the service. They said the team worked well together and supported each other.
- Staff described an open and transparent leadership style and said they would feel comfortable raising issues. They felt respected, supported and valued. Both formal and informal opportunities were in place so staff could contribute their views and ideas about how to develop the practice.
- The practice clearly demonstrated a patient-centred focus. Staff understood the specific occupational regiments and tailored the service to meet those needs. For example, the PCRF developed bespoke goals and treatment plans based on patient expectations and perceptions.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints.
- The practice had systems to ensure compliance with the requirements of the duty of candour, including giving those affected reasonable support, information and a verbal and written apology. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.
- Staff were encouraged and supported to be the best they could be through training and developing their skills and expertise. 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. Staff felt they were treated equally.

Governance arrangements

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

- The SMO was the governance lead for the practice and the practice manager was responsible for the day to day running of the practice. The staffing structure was clear and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. Terms of reference were in place to support job roles. The regional management team worked closely with 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.
- Policies from the national framework were implemented and were available to all staff. These were updated and reviewed regularly.
- There was an integrated group practice approach to meetings. Practice meeting minutes and the minutes of the PCRF meetings demonstrated lessons learned from significant events, complaints and other investigations led to change and improvement in practice. Meeting minutes were available for practice staff to view.
- An annual audit programme was established for both clinical and non-clinical audit activity with the programme identifying an audit to be undertaken each month. It showed that all staff were engaged with audit. Audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action taken to change practice to improve quality.
- The system to provide an overview of all audits undertaken, including what cycle the audits were on was fragmented and did not lend itself to effective monitoring of audit activity for the whole practice. Not all clinical audits could be located on the day of the inspection and were forwarded to us after the inspection.

Managing risks, issues and performance

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

- The practice manager and SMO understood the risks to the service and kept them under scrutiny through the risk register.
- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety.
- Processes were in place to manage current and future performance. Performance of clinical staff was demonstrated through peer review, including review of clinical records.
- The Regional Rehabilitation Unit (RRU) undertook advisory visits to the PCRF. For example, the regional ERI advisor undertook a visit recently to ensure the newly qualified ERI was using correct procedures.
- The practice manager and SMO had oversight of national and local safety alerts, incidents, and complaints.
- Plans were in place for major incidents and staff were familiar with how to respond to a major and/or security incident.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- An internal quality assurance tool, the DMS Common Assurance Framework (CAF) was used to monitor safety and performance. The DMS CAF was formally introduced in September 2009 and since that time has been the standard healthcare governance assurance tool utilised by DMS practices to assure the standards of health care delivery within DMS.
- The practice had recently started to use the newly introduced eCAF and staff confirmed they could all input to the system.
- The practice received a Health Governance Assessment Visit (HGAV) from the regional team in April 2017. Following the outcome of the HGAV, a comprehensive management action plan (MAP) was developed. We noted that all the actions had been addressed.

Engagement with patients, the public, staff and external partners

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

- A patient experience survey was undertaken throughout the year and a suggestion box was in the patient waiting room. The PCRF also carried out a patient specific survey.
- The practice had good working relationships with the regiment commanders and attended regular unit health committee meetings for each of the regiments to provide updates on the occupational health and welfare of personnel.
- The ERI worked closely with the physical training instructors (PTI) for each regiment and was the line of communication between the PTIs and the PCRF.

Continuous improvement and innovation

Continuous improvement and innovation was embedded in the culture of the practice. The seamless integration between the PCRF and medical centre staff, coupled with a collaborative approach with the Chain of Command and regiment PTIs had led to positive outcomes for patients. For example, evidence-based audits and statistical analysis had influenced the delivery of physical training which was having a positive impact on the population. For example:

- High rates of lower back pain for 21 Engineers Regiment led to the PCRF developing the Alternative Core Training (ACT) to be used by the PTIs for that regiment. This saw a reduction in lower back pain presentation by 50%. The ACT was developed using thorough application of evidenced based practice.

The patient data and outcome spreadsheet maintained by the PCRF was used to inform the annual service evaluation and to plan for quality improvement. For example:

- In response to high rates of ankle injuries for 4 Regiment Royal Artillery, the PCRF developed the RAMP (Rise Activate Mobilise and Potentiate) warm up for the PTIs to use before training sessions to prepare the body for the demands on the ankles.