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

### Ratings

<table>
<thead>
<tr>
<th>Overall rating for this service</th>
<th>Inadequate</th>
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<tr>
<td>Are services safe?</td>
<td>Inadequate</td>
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<tr>
<td>Are services effective?</td>
<td>Inadequate</td>
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<tr>
<td>Are services caring?</td>
<td>Good</td>
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<tr>
<td>Are services responsive to people’s needs?</td>
<td>Good</td>
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<tr>
<td>Are services well-led?</td>
<td>Inadequate</td>
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This practice is rated as inadequate overall.

The key questions are rated as:

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

We carried out an announced comprehensive inspection at Collingwood Medical Centre on 26 September 2018. Defence Medical Services (DMS) are not registered with the CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014 and are not required to be. Consequently DMS services are not subject to inspection by the CQC and the CQC has no powers of enforcement. This inspection is one of a programme of inspections that the CQC will complete at the invitation of the Surgeon General in his role as the Defence Authority for healthcare and medical operational capability.

At this inspection we found:

- The majority of the workload for Collingwood Medical Centre is musculoskeletal and mental health. The delivery of care to meet this need was responsive and effective.
- A small proportion of the practice workload (less than 10% of activity) involved chronic disease management and this required improvement. High risk drugs management required immediate attention.
- The practice had systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them.
- The practice fostered an ethos of patient centred care.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Due to inconsistent clinical coding, the practice was limited in its review of the effectiveness and appropriateness of the care it provided. The practice had not assured itself that care and treatment was always delivered according to evidence-based guidelines.
- Patients found the appointment system easy to use, but a number reported waiting over three weeks to see an aviation qualified clinician.
- There was scope to deliver a wider programme of quality improvement work and to achieve improved outcomes for some patients.
- Communication across the practice was regular but fragmented. As a result staff did not always receive key messages and innovation may be stifled.

We saw one area of notable practice:

Collingwood Medical Centre was proactive in identifying the unmet needs of their patients. They had written an information leaflet targeted at and circulated to patients over 40 years old. It details the importance of reducing risks associated with type 2 diabetes, heart disease, stroke, high blood pressure and dementia through positive lifestyle choices. We saw evidence that the direct engagement with this age group of patients had led to an increase in patients enrolling for health checks. Recently two patients had been diagnosed with type 2 diabetes as a result. Yoga and
relaxation classes had been provided for patients experiencing anxiety and all pregnant women were offered advice by the PCRF around maintaining their fitness.

The Chief Inspector recommends:

• Maintain a clear record of all patients who are vulnerable (including patients who are also carers) and ensure that clinicians know what system is in place to identify these patients.
• Extend safeguarding arrangements to include the needs of patients who are permanent staff.
• Standardise use of Read coding and clinical templates to facilitate accurate clinical searches and so deliver a reliable recall system for reviewing patients with a long term condition.
• Implement a safe system to ensure that Central Alerting System (CAS) alerts are taken into account and acted upon at patient level.
• Implement a safe system to manage patients who are prescribed high risk drugs, including the use of shared care protocols where appropriate.
• A review of formal governance arrangements including systems for assessing and monitoring risks and the quality of service provision should be embedded and understood by all staff.
• Ensure clinical oversight of notes summarising for all new patients.
• Widen peer review of medical records and prescribing decisions to ensure that national best practice guidance is adhered to.
• Ensure that the programme of clinical improvement work is targeted to maximise improvements in patient outcomes and that proposed changes are discussed and implemented.
• Ensure that shared cover arrangements for the field gun race are embedded and understood by all stakeholders in order to adequately meet the potential needs of personnel and public.

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

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

Background to Collingwood Medical Centre

Collingwood Medical Centre is located in Fareham near Portsmouth. The treatment facility offers care only to forces personnel. Dependents and children must register at an NHS practice. At the time of inspection, the patient list was approximately 2200. The practice holds an out of hours clinic once a month for the provision of Reservists.

In addition to routine GP services, the treatment facility offers physiotherapy services and travel advice. The medical centre does not provide minor surgery. Family planning advice is available, with referral onwards to NHS community services. Maternity and midwifery services are provided by NHS practices and community teams.

At the time of our inspection, the facility had a Principal Medical Officer (PMO is a lead GP), A Deputy Primary Medical Officer (DPMO) and four civilian GPs, two practice nurses, a locum pharmacy technician who worked in the practice dispensary and nine medics (the work of a military medic has greater scope than that of a health care assistant found in NHS GP practices). The facility was led by a military practice manager, supported by a deputy and a number of administrative staff. The facility was also attached to a primary care rehabilitation service (PCRF) which provided physiotherapy and exercise rehabilitation. The PCRF was led by a band 7 physiotherapist and employed a further three physiotherapists and two exercise rehabilitation instructors. A Regional Clinical Director assumes overall accountability for quality of care at the Medical Centre.

Are services safe?  | Inadequate
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We rated the practice as inadequate for providing safe services.

Safety systems and processes

- The practice had systems to keep patients under 18 years of age safe and safeguarded from abuse. However, there was scope to bolster the arrangements for safeguarding patients who are permanent staff.
- The practice had safety policies including safeguarding policies for adults and under 18s which were reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. Policies were regularly reviewed and were accessible to all staff, including locums. They outlined clearly who to go to for further guidance.
- Some clinical staff we spoke with were unaware of the system which was recently implemented to highlight vulnerable patients in clinical records and clinical staff could not point us to a risk register of vulnerable patients. The practice manager showed us that one patient had recently been identified as vulnerable and an alert added to their DMICP record.
- The practice worked with other agencies to support patients who are trainees and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. However, the arrangements in place to protect patients who are permanent staff were less clear and there were no regular meetings with welfare teams and Chain of Command to discuss the needs of this population group. There
was therefore potential for the safeguarding requirements around permanent staff to be overlooked.

- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.

- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Most Disclosure and Barring Service (DBS) checks were undertaken where required. However, we found an anomaly where three agency staff had lapsed DBS checks. The practice told us this was due to an ongoing dispute over who should pay for the checks to be undertaken. Following our inspection, the practice has told us that the DBS checks have now been requested. (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).

- There was an effective system to manage infection prevention and control.

- There were systems for safely managing healthcare waste.

- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers’ instructions.

**Risks to patients**

- There was scope to improve some elements of the system to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. There was an effective approach to managing staff absences and for responding to epidemics, sickness, holidays and busy periods.

- There was an induction system in place for temporary staff, but this was not tailored to their role. We looked at recently inducted staff records and noted that records had not been completed to show that staff understood what was required of them. There was no evidence that practice leaders had checked that packs were completed.

- Clinicians adhered to military guidance around sickness periods for personnel. They communicated effectively with Chain of Command so that line managers knew which tasks personnel could safely undertake.

- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.

- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.

- When there were changes to services or staff the practice assessed and monitored the impact on safety.

**Information to deliver safe care and treatment**

- Staff did not always have the information they needed to deliver safe care and treatment to patients. Individual care records were not always written and managed in a way that kept patients safe. Read coding errors meant that the medical centre could not easily search for cohorts of patients to ensure best delivery of care.

- The system to manage hospital letters was effective. Hospital letters were scanned and tasked to a clinician for their review. The system to manage pathology results was effective.
• There was no significant backlog in electronic summarising at the practice. Summarising was undertaken by medics who passed on information to clinicians about patients with a long term condition or who are currently downgraded. The notes of new patients without obvious pre-existing conditions were summarised by medics and a Read code applied to show that this had been done. There was no oversight of these notes by a clinician and there was therefore a risk that patients’ issues could be overlooked.

• The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. There was a documented approach to the management of test results.

• Referrals and hospital appointments were managed well by the administrative team and patients were well supported to obtain the most timely access to secondary care. A standard referral template letter was in use by clinicians, but there had been no audit to ensure that referrals were being written in the most effective way.

• Access to clinical records in DMICP was sometimes delayed due to connection issues at Collingwood Medical Centre and staff told us that there was a time lag, specifically on medication pages. However, staff did not report any significant periods where they had had no access to the system.

Safe and appropriate use of medicines

The practice’s systems for appropriate and safe handling of medicines were inadequate in some areas:

• The systems for managing and storing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised some risks. The practice had carried out an appropriate risk assessment to identify medicines that it should stock. The practice kept prescription stationery securely and monitored its use. However, storage of some medicines was not adequate. A doctor’s medicine bag containing medicines was stored in a treatment room. On the day of inspection, the maximum temperature on the thermometer showed 39C, the current temperature was below 25C. No record of previous temperature recordings was found in this area. No action had been taken, given that the recommended storage guidelines for the medicines in the bag suggested temperatures no higher than 25 degrees Celsius. The medical centre had received an exemption certificate from the local Police Constabulary Controlled Drug Liaison Officer which stated that storage of controlled drugs was exempt from the requirements set down by The Misuse of Drugs Act 1973 (safe custody regulations).

• There was a named GP responsible for the dispensary. Arrangements for dispensing medicines at the practice kept patients safe.

• Access to the dispensary was restricted to authorised staff only. However, there was scope to ensure that access to the vaccine fridges was secure during working hours by keeping them locked.

• Written procedures (SOPs) were in place to support safe dispensing practice. There was a system for staff to record that they had read and understood them. However, the locum pharmacy technician told us they had not read the SOPs in their entirety and consequently had not signed the proforma.

• Staff had access to British National Formulary (BNF) and prescribing formulary. The last antibiotic prescribing audit was undertaken by the CMP (Civilian Medical Practitioner) in October 2017. They recommended an audit to be completed six months after the review but this had not been done. There had been no recent input from a regional pharmacist in terms of prescribing and dispensing support and oversight (due to a gapped post). There was no peer review of prescribing at the practice.
Patients’ health was not always monitored to ensure medicines were being used safely and followed up on appropriately. There was no register of patients taking high risk drugs and alerts were not in place in DMICP records. Staff we spoke with were unaware of the Defence Primary Health Care (DPHC) DMARDs policy. Patients who took DMARDs (disease-modifying anti rheumatic drugs) did not have shared care protocols uploaded into their notes and there was no evidence of recall dates being set for blood testing. For one patient, we noted that the secondary care consultant had stipulated monthly blood sampling but this had not been undertaken. A significant event had been raised as a result of the inappropriate deployment of an individual prescribed a DMARD.

The medical centre had not conducted searches to ensure that the nine patients currently using an ACE inhibitor (medicine used to treat high blood pressure, scleroderma and migraines amongst other conditions) or ARBs (used to manage high blood pressure, treat heart failure and reduce risk of stroke) had had their renal function checked in the last 12 months.

Prescriptions were signed before medicines were dispensed and handed out to patients.

The management of repeat prescriptions required review to ensure that patients taking high risk drugs had the relevant monitoring checks before their repeat prescription was issued.

PGDs (Patient Group Directions) and PSDs (Patient Specific Directions) were in use to allow non- prescribing staff to carry out vaccinations in a safe way. PGDs were appropriately managed as staff had received training and authorisation by the PMO had been recorded. Authorisation for PSDs was not in line with DPHC PSD policy as there was no evidence to show that the prescriber had carried out the required clinical checks.

Track record on safety

The practice had a good safety record, although there were areas that required attention, specifically the shared medical cover arrangements for the Field Gun Race.

The practice manager was the lead for health and safety and had completed training relevant for the role. Risk assessments were in place including needle stick injury, lifting and handling, legionella management and lone working. The PCRF had a specific risk assessment for the safe use of needle acupuncture.

Staff had been issued with personal alarms. It had been noted that the alarms were not loud enough to attract attention and the practice told us that new alarms were on order.

We asked to review the major incident plan in place to guide a response in the event of multiple casualties, but practice staff were unable to share a copy on the inspection date as the current version was under review. It was noted that HMS Collingwood hosts the Field Gun Race which involves personnel pushing a heavy field gun at pace and the presence of public observers. There has been a history of casualties both during training and on the day of the event. The responsibility for provision of cover was shared across all attending units with The Field Gun Committee holding the lead. The practice recognised the need to review the shared medical cover arrangements provided to ensure that levels were safe. Since our inspection, medical centre staff have told us the reviewed major incident plan is in place and we will review this, along with the arrangements for the Field Gun Race, when we return to undertake a follow-up inspection.

Lessons learned and improvements made

The system for delivering learning and making improvements when things go wrong requires review.

There was a system and policy for recording and acting on significant events and incidents. Most staff understood their duty to raise concerns and report incidents and near misses.
Leaders and managers supported them when they did so. However, the locum pharmacy technician, a member of the reception team and a locum GP did not have a login for the ASER system and so could not report incidents. We were made aware on the day of the inspection that near misses had occurred in relation to prescribing/dispensing, but these had not been reported and so learning opportunities overlooked.

- There were systems for reviewing and investigating when things went wrong. There was some evidence that the practice learned and shared lessons, identified themes and took action to improve safety in the practice. However not all staff could recall the learning from some recent significant events and they told us that issues tended to be discussed at a management level, rather than at practice level meetings. Welfare arrangements and the support available to patients was not routinely discussed at practice meetings and so opportunities were being missed to ensure that important information was appropriately shared across the practice team and passed on to line managers, welfare teams and Padres.

- There was no formal system for receiving and acting on patient safety alerts. CAS (Central Alerting System) alerts were not routinely forwarded to clinicians for their review and action. Recording in relation to action taken was not comprehensive. Consequently, we noted patients who were taking contra-indicated medicines and this constituted a potential risk to their safety.

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<th>Are services effective?</th>
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**Effective needs assessment, care and treatment**

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. Whilst staff had access to guidelines from NICE, we saw instances where these were not being followed to deliver care and treatment that met patients’ needs, specifically the management of DMARDs. Clinical meetings had been held and minutes contained a record of some discussion of best practice guidance. However the concerns we found during our inspection around, for example, medicines management, indicated that these discussions were not always leading to improvements in clinical practice. We were provided post inspection with examples of some peer review between GPs, specifically review of medical records, but we were not reassured that this work was picking up the types of concerns that our inspection work has uncovered. There was no peer review of prescribing.

- Some staff told us that they recognised the need for a more formal system for reviewing NICE guidance.

- The Defence Primary Health Care (DPHC) Team produced a newsletter that was circulated to clinicians providing further information and a summary of relevant safety updates. Staff we spoke with could refer to this and gave examples of updates they had acted on and discussed within the practice. Nevertheless, our review of patient’s records showed that key patient safety alerts had not been acted upon at patient level.

**Monitoring care and treatment**

Management, monitoring and improving outcomes for people:

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

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

- There were five patients on the diabetic register. We reviewed the treatment and care offered to these patients and found that current NICE guidance had been followed. For three of these diabetic patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For four diabetic patients, the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.

- There were 41 patients recorded as having high blood pressure and 41 patients had a record for their blood pressure taken in the past nine months. 15 of these patients had a blood pressure reading of 150/90 or more. We reviewed the treatment and care offered to these patients and found that current NICE guidance had not always been followed. We found that some hypertensive patients who were prescribed medication to manage their condition had not been appropriately recalled. We also noted Read coding errors.

- There were 26 patients with a diagnosis of asthma. Due to inaccurate Read coding, only 15 of these asthmatic patients were showing as having had an asthma review in the preceding 12 months which included an assessment of asthma control using the three Royal College of Physicians questions. We asked the practice to look at the information in detail and they noted that four patients had actually not been reviewed. The practice has subsequently recalled these patients. We reviewed three sets of patient notes. There was inconsistency of approach as staff were using multiple templates to record asthma reviews. Each of the four templates in use asked for slightly different information and some templates prompted decision making around immunisations, others did not. We reviewed one asthmatic patient who required a change in their inhaler prescription to meet with national guidance. Whilst the need to discuss this with the patient had been noted in clinical records, the patient had subsequently been seen three times yet the issue had not been discussed or resolved.

- Due to the number of different Read codes in use, the practice could not easily provide information about patients with a new diagnosis of depression. We therefore reviewed the care given to three patients who were recorded as having depressive disorder and found that the care and treatment offered was in line with best practice guidance.

- The practice last reviewed its antibiotic prescribing in October 2017. The review described the intention to repeat the work on a six-monthly cycle, but this had not been done. There was a need for the practice to proactively support ongoing good antimicrobial stewardship in line with local and national guidance.

Information from the Force Protection Dashboard, which uses statistics and data collected from military primary health care facilities, was also used to gauge performance. Data from the Force Protection Dashboard showed that instance of audiometric hearing assessment was slightly below average compared to DPHC practices nationally. Service personnel may encounter damaging noise sources throughout their career. It is therefore important that service personnel undertake an audiometric hearing assessment on a regular basis (every two years). Data from May 2018 showed:

- 79% of patients’ audiometric assessments were in date (within the last two years) compared to 86% for DPHC nationally. We conducted a search on the day of our inspection and found anomalies in recording within DMICP. For six patients, the JMES (Joint Medical Employment Standard: a means of communicating personnel’s employability) was complete for the HCP (Hearing Conservation Programme), yet there was no record in DMICP to show that an
audiology test had actually been undertaken for these patients. We fed this back to practice staff who have agreed to look into these recording errors.

There was evidence of limited quality improvement work including clinical audit, but this did not always lead to improved outcomes for patients:

- An internal quality assurance tool, the Defence Medical Services (DMS) Common Assurance Framework (CAF) was used to monitor safety and performance. The DMS CAF was formally introduced in September 2009 and since that time has been the standard healthcare governance assurance tool utilised by DMS practices to assure the standards of health care delivery within DMS. When we reviewed the CAF, we saw that a few areas that had been highlighted, remained problematic. Our inspection has highlighted additional areas where action is required.

- Some clinical audit work had been undertaken but when we spoke with staff, it was unclear how the practice approach to this work had been decided. No lead staff member had been appointed. There was no evidence of discussion to ensure that clinical audit was relevant to the practice population and would drive ongoing improvement in outcomes. Examples of work that we reviewed were more akin to data collection than audit review. A significant event had triggered a review of DMARD management shortly before our inspection. However key requirements had been overlooked, such as the need to Read code patients taking high risk drugs and the need for shared care arrangements.

**Effective staffing**

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. However, we noted gaps in training for practice staff, specifically Basic Life Support, AED (automated external defibrillator) use, anaphylaxis training and fire awareness.

- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, mentoring, clinical supervision and support for revalidation.

- Nursing staff had established a strong regional peer network which facilitated extended learning and sharing of best practice.

- The locum pharmacy technician was registered with the General Pharmaceutical Council. They told us that they had completed mandatory training, including use of DMICP. We were told there was no evidence of this to hand on the day of our inspection, but the practice has since forwarded evidence to us. The locum agency provided formalised competence assessment for the locum pharmacist.

**Coordinating care and treatment**

Staff worked well together and with some other care professionals to deliver effective care and treatment. However, there were gaps.

- When we asked for information during our inspection around working with key stakeholders to safeguard vulnerable patients, it was not provided in full at that time. Since our inspection the medical centre has provided further information that confirmed the safeguarding arrangements in place. The practice met with welfare teams and line managers to discuss vulnerable patients who were trainees. However, the system to discuss the welfare needs of permanent personnel was less clear. Staff told us that they had forged some strong links with other stakeholders,
including the Collingwood Welfare and Education Steering Group, RNRM Welfare service and Collingwood Chaplaincy. With a view to safeguarding dependants and minors, there was scope to better liaise with local NHS Accident and Emergency departments to facilitate protection plans when required. There is no formalised process for a nominated Link worker at DCMH. Primary care clinicians were required to contact DCMH and discuss patients with different named clinicians or a duty CPN.

- PCRF staff fostered close working relationships with Naval line managers to ensure that trainees were appropriately supported to recover. Patients we spoke with highlighted how this supported them to get back into training, but only when the risk of re-injury was reduced.

- The Medical Centre is located within the same building as the PCRF service which provides physiotherapy assessment and treatment. An exercise rehabilitation service is also available for patients, a five-minute walk from the medical centre. Referral into the service is via a primary care clinician. Patients were able to obtain swift access to the PCRF and strong partnership working arrangements resulted in co-ordinated and person-centred care for patients.

Helping patients to live healthier lives

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

- Patients at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. The medical centre liaised with Queen Alexandra Hospital and referred diabetic and asthmatic patients to clinics and study days run by the hospital.

- The practice offered basic sexual health advice including the issue of free condoms and referred on to local clinics in the community for more comprehensive services including family planning.

- Medical centre staff attended unit open days and manned stalls to provide health promotion information to personnel.

- Patients had access to appropriate health assessments and checks. A monthly search was undertaken for all patients aged 50 to 64 years who were entitled to breast screening. The practice also engaged with all national screening programmes and had a mechanism to ensure that eligible patients were referred into the bowel cancer or abdominal aortic aneurysm (AAA) screening programs.

- The number of women aged 25 to 49 and 50 to 64 whose notes recorded that a cervical smear had been performed in the last three to five years was 148 out of 165 eligible women. This represented an achievement of 94%. The NHS target was 80%.

- There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using public health information posters and they ensured a female sample taker was always available.

It is important that military personnel have sufficient immunity against the risk of contracting certain diseases. The World Health Organisation sets a target of 95% for vaccination against diphtheria, tetanus, pertussis and polio and measles, mumps and rubella. The data below from December 2017 provides vaccination data for patients using this practice:

- 96% of patients were recorded as being up to date with vaccination against diphtheria compared to 95% for DPHC nationally.
• 96% of patients were recorded as being up to date with vaccination against polio compared to 95% for DPHC nationally.
• 61% of patients were recorded as being up to date with vaccination against Hepatitis B compared to 77% for DPHC nationally.
• 84% of patients were recorded as being up to date with vaccination against Hepatitis A, compared to 91% nationally.
• 96% of patients were recorded as being up to date with vaccination against Tetanus, compared to 95% for DPHC nationally.
• 86% of patients were recorded as being up to date with vaccination against Typhoid, compared to 52% for DPHC nationally.

The Typhoid vaccine has a lower uptake than other vaccinations. Current guidance state DMS practices should offer the Typhoid vaccination to personnel before deployment and not to routinely vaccinate the whole population.

Consent to care and treatment

Staff sought patients’ consent to care and treatment in line with legislation and guidance. Verbal consent was recorded in DMICP in a free text box. PCRF staff took written consent for acupuncture procedures. We discussed with the practice that there was scope to Read code consent for more invasive procedures.

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

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

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<td>We rated the practice as good for caring.</td>
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Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

• Staff explained that they saw patients from a variety of cultural backgrounds and who spoke English as a second language. The medical centre had taken account of patients’ personal, cultural, social and religious needs.

• The practice gave patients timely support and information.

• Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

• We received 72 patient Care Quality Commission comment cards in total. Of these, 63 were entirely positive about the service experienced, two were mixed and seven were negative. Patients praised the, ‘great support from the nurse with weight management’, the ‘excellent bespoke building which is always spotless’ and ‘the sensitivity of my GP in helping me adjust to new health circumstances’. However, some patients stated that they had experienced ‘long waits in the waiting room’ and four patients said that they had needed to wait in excess of three weeks to see an aviation trained clinician.

• 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**

- The clinicians and staff at the practice demonstrated that they recognised that the trainee personnel they provided care and treatment for, could be making decisions about treatment for the first time. We asked staff for examples of trainees they had seen and they provided a number of examples to demonstrate that they had supported younger people to access the treatment they required in an appropriate way. We spoke with patients who were attending for physiotherapy appointments and they told us that they were well supported to understand their injury, to set realistic personal goals and to commit to their care plan in order to achieve best results in terms of their recovery.

- Interpretation services were available for patients who did not have English as a first language. Staff demonstrated to us that they could access this service and gave examples of when they had used the system.

- The Choose and Book service had been implemented and was used to support patient choice as appropriate. (Choose and Book is a national electronic referral service which gives patients the choice of date and time for their first outpatient appointment in a hospital).

- Results from the practice’s Patient Experience Survey (75 responses were collated) showed patients felt they were involved in their treatment:
  - 87% of patients said they felt involved in decisions about their care.
  - 92% of patients said they would recommend the medical centre to others.

  The data presented by the practice was not benchmarked against regional and national averages for DMS, or against the previous year’s performance.

- Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of organisations. We saw information that was age appropriate and relevant to the patient demographic which was prominently displayed and accessible. For example, we saw posters for symptoms that may suggest a sexual health screening appointment would be useful and on the importance of vaccinations, spotting potential signs of sepsis and the significance of health checks for over 40s.

- The practice acted in a compassionate way toward any patient that had to be discharged on health grounds. We saw that the practice reassured these patients and signposted to personnel within the military who could guide them through the exit process and transition to NHS care and other support functions.

- Practice staff told us that they had recently started to identify patients who were also carers, although codes were not yet added to their records in order to make them identifiable and so that extra support or healthcare could be offered as required. One carer had been identified to date. The DPMO had recently started attending a carers’ meeting.

**Privacy and dignity**

The practice respected patients’ privacy and dignity.

- Staff recognised the importance of patients’ dignity and respect. Patients we spoke with confirmed this.
• The practice had identified the fact that conversations with receptionists could be overheard by patients in the waiting room, due to the open plan nature of the waiting area. Music and television had been provided to assist with privacy.

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**Responding to and meeting people's needs**

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

• The practice understood the needs of its population and tailored services in response to those needs. For example, the language support requirements for international personnel, proactive support and advice for patients over 40, access to telephone consultations and quick access to physiotherapy and exercise rehabilitation. Furthermore, we saw examples of the medical centre proactively finding ways to meet the health and wellbeing needs of certain patient groups. Yoga and relaxation sessions were being provided for patients experiencing anxiety and pregnant women were all invited to access general advice about exercising during pregnancy and activity adjustments from the PCRF. The practice had written an information leaflet targeted at and circulated to patients over 40 years old. It detailed the importance of reducing risks associated with type 2 diabetes, heart disease, stroke, high blood pressure and dementia through positive lifestyle choices. We saw evidence that the direct engagement with this age group of patients had led to an increase in patients enrolling for health checks. Recently two patients had been diagnosed with type 2 diabetes as a result.

• The facilities and premises were bespoke and appropriate for the services delivered.

• The medical centre did not routinely offer home visits to its patients and there was no policy available to staff or patients around when a home visit might be necessary and appropriate. However, staff could refer to 'standing orders' which briefly described the process to follow if a patient requested a home visit. There was scope to extend this guidance to ensure that staff knew how to meet the needs of vulnerable patients who may not attend an appointment.

**Timely access to care and treatment**

• Routine appointments are usually available within two weeks. We checked on the day of our inspection and the next available routine appointment was in seven days. Urgent appointments are available on the same day. We discussed feedback received from four patients who had filled out CQC comments cards and stated that they had only been able to secure a routine appointment with an aviation trained clinician three weeks in advance. We also spoke with two patients during our inspection who reported similar issues. The medical centre explained that there was a six week wait for patients to book an Annual Aircrew Medical with an Aviation Medical Officer, but that emergency or routine advice was delivered more quickly. The PMO is currently the only qualified clinician and he told us that the medical centre is looking into additional resource at other medical centres locally.

• Outside of routine clinic hours, cover was provided by a medic, with back up telephone support provided by a GP. From 18.30 hours, patients were given a mobile number to contact the duty medic who provided overnight cover. The medic provided basic advice and triaged patients, diverting them to the NHS 111 service as appropriate. Line managers of phase two trainees valued the input of duty medics at night if a trainee became ill. However, duty medics were unable to visit patients after hours and so were triaging by telephone only. If the practice closed for an afternoon for training purposes, patients were diverted to a local medical centre. In this
way, the practice ensured that patients could directly access a GP between the hours of 08.00 and 18.30, in line with DPHC’s arrangement with NHSE.

- The practice leaflet gave clear directions on local accident and emergency unit access. The nearest accident and emergency department was located at Queen Alexandra Hospital.

- The Defence Rehabilitation Headquarters collates a dashboard of information in relation to waiting times and patients who do not attend for their appointment. These are key performance indicators as timely access to physiotherapy and rehabilitation are important for effective patient recovery. Collingwood PCRF was performing ahead of regional and defence-wide peers for access to physiotherapy, but below average for access to an ERI.

- For January to March 2018, 69% of new patients referred to see a physiotherapist were seen within five working days. This compares to the South West Region average of 68% and an overall PCRF average of 55%. Collingwood PCRF does not operate a direct access approach, allowing patients to self-refer. Where other PCRFs have adopted this approach, some patients have reported that they have been more inclined to seek support.

- However, 0% of new patients referred to see an exercise rehabilitation instructor (ERI) at Collingwood PCRF were seen within KPI target of 5 working days, compared to a South West region average of 55% and an overall PCRF average of 49%. It should be noted that patient choice can impact performance against these KPIs as the patient may opt to delay making an appointment. On the day of our inspection we looked to see the next available appointment with an ERI and saw that it was in eight days. However we noted that one ERI was on a course at the time of our inspection which was impacting waiting times.

- The PCRF proactively managed DNA (patient who did not attend) rates for their clinics and had achieved above average results with 3% of patient appointments lost to DNAs in January to March 2018, compared with a PCRF average of 7%.

- Results from the practice’s patient experience survey (75 responses were received) showed that patient satisfaction levels with access to care and treatment were generally high. For example:
  - 92% of patients said that their appointment was at a convenient time and in a convenient location.

- We spoke with six patients in the waiting room on the day of our inspection. They all told us that they could secure appointments when they needed them and were confident that they would be seen quickly if they had an urgent concern. However, two patients who were instructors stated that they found it difficult to get leave of absence from their job role during medical centre opening hours. They had reported this to the medical centre, suggesting that routine appointments after 16:30 would be helpful, but they told us that they had not seen any change as a result. Since the inspection, medical centre staff state that a MOOG (Medical Officer of the Guard) clinic has now been introduced which extends access for patients Monday to Thursday until 18:00 and on Fridays until 15:30. However, on the day of our inspection the patient leaflet did not contain this information and the opening hours on the medical centre door did not show these extended opening times. The Deputy Practice Manager had organised both blister management and flu clinics out of hours, to accommodate the needs of trainees and instructors alike.

**Listening and learning from concerns and complaints**

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

- Defence Primary Health Care had an established policy and the practice adhered to this.
• The practice manager was the designated responsible person who handled all complaints in the practice.

• We saw that information was available to help patients understand the complaints system.

• We spoke with six patients who told us that they felt comfortable and knew how to complain if the need arose. They confirmed that military rank would not be a barrier to them raising issues with the practice.

We reviewed complaints that had been submitted by patients in the past 12 months. We saw that there were processes in place to share learning from complaints. Complaints were not currently saved electronically due to the temporary site on Sharepoint. Complaints management was comprehensive.

**Are services well-led?**  
**Inadequate**

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

**Leadership capacity and capability**

Some leaders at the medical centre had been in their current roles for less than a year and were working hard to address some areas they had identified as requiring improvement. Some systems required additional work in order to ensure that care for patients was safe and effective. On the day of our inspection we met with a staff team who were open and transparent about the issues they needed to address. They listened to the feedback we gave and offered reassurance that risks and concerns would be addressed as a priority.

Staff we spoke with referred to a ‘positive working environment’ and told us that they enjoyed coming to work. All staff felt that they could raise concerns if they had them. However, we noted that the absence of a practice-wide meeting where all staff could get together may have led to more fragmented communication with some staff missing out on key messages. Leaders did not always have the appropriate experience to address risks and implement safe systems:

- The Principal Medical Officer’s time was divided across three practices including Collingwood and so his leadership capacity was thinly spread. He was also the only aviation qualified clinician at Collingwood.

- Leaders were not always knowledgeable about issues and priorities relating to the quality of services. As a result, there were gaps in addressing some key risks.

- The Deputy Principal Medical Officer had recently come into post and was already due to deploy overseas. With this planned loss of permanent staff and additional reliance on locum staff, we identified a need to implement effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

**Vision and strategy**

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

- The practice worked to the DPHC mission statement: ‘Safe Practice by Design’ and staff told us that they aimed to provide occupationally focussed primary care and high-quality force protection.

- Staff were aware of and understood the vision, values and strategy and their role in achieving them.

- The medical centre planned its services to meet the needs of the practice population.
Culture
The practice had a culture of high-quality sustainable care, but some key systems were not failsafe or effective and required review:

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- However, we noted examples where leaders and managers had not taken action to address gaps in the performance of the practice. There was a need to ensure that all leaders were trained and confident to assess current delivery of care and to performance manage staff.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed. However opportunities for staff to have positive influence on the practice may be limited due to the absence of a regular practice wide forum.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work. We noted that medics were well trained and supported to deliver their roles.
- 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.
- There were positive relationships between staff and teams.

Governance arrangements
The Medical Centre was in the process of consolidating and clarifying responsibilities, roles and systems of accountability to support good governance and management and the practice acknowledged that more work was required in some areas.

- Whilst joint working with the welfare team, pastoral support and Chain of Command was in place, there were gaps in the systems to safeguard vulnerable personnel and to ensure coordinated person-centred care for these individuals. Processes for supporting trainee personnel were stronger than for the permanent staff population. Nevertheless, clinicians were unaware of any system in use to identify vulnerable patients and there was no standing agenda item at clinical or management meetings to discuss vulnerable individuals. Opportunities could therefore be missed to identify and proactively support patients requiring additional input.
- The PCRF delivers rehabilitation services from building close to the medical centre. The service enables patients to access timely, holistic care. Staff working within the PCRF felt integrated within the medical centre team, but a number felt that there was scope to improve communication and to bolster the leadership arrangements.
- Shared care protocols were not in place for some patients taking high risk drugs and we identified gaps in the management of patients with a long term condition.
Practice leaders had established a number of policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. However, there were gaps that required addressing.

Clinical Audit was not designed to drive improvements in patient outcomes.

There were a number of instances during our inspection when we asked to see key information and were told that it did not exist or was not currently available. This is evidence of a lack of knowledge and effective governance. Some information has subsequently been submitted post inspection, but we found that some staff were unclear about the systems in place at this medical centre.

Managing risks, issues and performance

There were some clear and effective processes for managing many risks, issues and performance. However, we identified some areas where improvement was required.

- There were gaps in processes to identify, understand, monitor and address current and future risks including risks to patient safety.
- Practice leaders did not always have oversight of national and local safety alerts, although complaints were comprehensively managed.
- Clinical audit lacked impact on quality of care and outcomes for patients. There was an absence of clear evidence of action to change practice and improve quality.
- On the day of our inspection, the practice was unable to provide a copy of their major incident plan as it was under review. The practice has since provided a copy of the plan which we will review when we re-inspect, to ensure that new arrangements are embedded and understood by all staff. Staff had been trained for major incidents.

Appropriate and accurate information

The practice did not always have appropriate and accurate information.

- There was limited evidence to show how quality and operational information was used to ensure and improve performance. Whilst the views of patients were routinely sought in line with DPHC policy and staff provided examples of changes this feedback had triggered, there was a lack of evidence to show how changes had been implemented and effectively communicated to patients in order to improve their experience.
- An understanding of the performance of the practice was maintained. The practice manager used the Common Assessment Framework (CAF) as an effective governance tool. A number of different meetings were held regularly. However, we noted that all clinicians did not meet together at any point and there was no practice wide meeting. Minutes from meetings we reviewed demonstrated a lack of discussion around key matters including safeguarding, NICE guidance and CAS alerts. However, we saw that meetings were used for forward planning, for example, to ensure that patient needs were met during busy clinic times and periods of staff sickness. Some staff told us that the absence of a practice wide meeting meant there were few opportunities to learn about how the performance of the practice could be improved and how each staff member could contribute to those improvements.
- The information used to monitor performance and the delivery of quality care was not always accurate and useful. Staff told us that they were aware of inconsistent use of Read codes and clinical templates and they understood how this could lead to inconsistent delivery of care for patients. Staff had received training in the use of ‘Population Manager’ which is a clinical
search facility. However, staff reported issues with using this search facility as they found it to be unreliable.

- There were no collated registers of patients taking high risk drugs and clinical staff were unaware of a register of vulnerable patients. Subsequently patients being prescribed high risk drugs were not always being appropriately reviewed and we were not reassured that the practice was meeting the needs of its vulnerable patients.
- There were robust arrangements at the medical centre in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. This extended to the PCRF.

**Continuous improvement and innovation**

There was some evidence of systems and processes for learning, continuous improvement and innovation.

- We saw examples of the practice focusing on continuous learning and improvement. For example, staff had identified the need to change the blood labelling system following a significant event. In addition, services had been extended to meet patient needs, including the introduction of relaxation classes for patients experiencing anxiety and advice for pregnant women from the PCRF.
- Civilian staff provided stability and continuity of care through periods of change in military staffing. Staff contracted in from Interserve were long standing members of the practice team and had devised failsafe and effective systems for managing referrals and hospital appointments. However, there was scope to implement more of their ideas for improvement and to extend their involvement through a practice wide meeting.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements, although there was scope to extend this further.
- Nursing staff were part of a supportive interregional network which facilitated clinical supervision and ideas sharing.