

Regional Medical Centre Cranwell

Quality report

Sleaford,
NG34 8HB

Date of inspection visit:
24 October & 1 November 2018

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

Ratings

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

Chief Inspector's Summary

This practice is rated as Outstanding overall

The key questions are rated as:

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

We carried out an announced comprehensive inspection of the Regional Medical Centre Cranwell on 24 October 2018. For reasons of availability, the medicines element of the service was inspected on 1 November. Defence Medical Services (DMS) are not registered with the CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014 and are not required to be. Consequently, DMS services are not subject to inspection by the CQC and the CQC has no powers of enforcement. This inspection is one of a programme of inspections that the CQC will complete at the invitation of the Surgeon General in his role as the Defence Authority for healthcare and medical operational capability.

At this inspection we found:

- The practice was well-led and leaders demonstrated they had the vision, passion and integrity to provide a patient-focused service that constantly sought ways to develop and improve.
- The whole-team approach was supported by all staff who valued the opportunities available to them to be part of a forward-thinking service.
- 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 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 substantial 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. Feedback showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.

- Facilities and equipment at the practice were sufficient to treat patients and meet their needs.
- Staff were 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:

Promoting patient safety

- Development of a handover protocol to NHS primary care for vulnerable patients, including children and service personnel deemed to be vulnerable and leaving the military.
- A medic representative established for significant events to support junior ranked staff who may not feel confident approaching a higher ranked staff member for advice.
- Introduction of a 4-tier management toolkit for the dispensary which provided transparent assurance processes for all stages of work activity.
- Effective modification of the organisational high-risk medicine monitoring template thus making it clearer and easier to use for both prescribers and dispensary staff.
- Use of a range of codes for disease monitoring to support reliable searching for specific patient groups. In particular, two codes specific to mental health; 'psychiatric monitoring' and 'mental health review follow up', were effectively used to search for and monitor this patient group.
- Introduction of an aircrew logbook flowchart following an audit that identified logbooks were not being completed in line with policy for aviation medicals. Since its introduction recording of logbooks had improved.

Responding to patients

- Sourcing of vaccines for patients of who were non-meat eaters and those who did not eat pork for religious or cultural reasons.
- The use of various methods to engage with patients, including a Facebook Patient Participation Group (PPG), quarterly patient newsletter and a leaflet drop in medication bags. A token system with emoji faces was used for children to give feedback on the service.
- Development of a comprehensive information reference booklet to support reception staff had led to a more streamlined service for patients and callers, ensuring they received effective and accurate information.
- Introduction of a policy to address and manage the implications of staff registering as patients at the practice.

Effective leadership

- Development of strong external relationships including links with local safeguarding boards. The SMO was a member of the Local Medical Committee.
- A comprehensive whole-team training needs analysis led to specific role-based training. A gap in health care governance knowledge was addressed through the development of a governance training programme.
- The use of social media platforms, such as Instagram, Padlet Forums and Skype to provide training, updates and seek staff views.

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- An analysis of the reasons for the downgrading of service personnel (restricted duties) led to a programme of four healthy lifestyle clinics throughout August 2018 covering four distinct topics. Feedback on the sessions was positive.

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, practice manager adviser and a physiotherapist adviser. The dispensary was inspected by a pharmacy adviser on the second day of the inspection.

Background to the Regional Medical Centre Cranwell

The Regional Medical Centre Cranwell provides primary and emergency care to a practice population of 3098 service personnel (2140) and their registered dependants (958). Service personnel include five flying squadrons, phase 1 and 2 trainees and HQ air cadets.

Primary care services include: child immunisation; a midwifery service; chiropody; Well Woman Clinic, health visitor service; minor operations; childhood immunisation; and family planning. The practice also provides occupational health care to service personnel, including force preparation, diving medicals and aviation medicals. Entitled civilian personnel working on the station can also access emergency care and occupational health services. In addition, the practice supports flying operations at RAF Cranwell and RAF Barkston Heath.

A Primary Care Rehabilitation Facility (PCRF) is located on the premises, with physiotherapy and rehabilitation staff integrated within 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. There is a dispensary in the medical centre.

The practice is open from 08:00 to 18:30 Monday to Friday. At weekends and public holidays patients are advised to use NHS 111.

Although the staffing establishment for the practice is 51, at the time of our inspection the staff team comprised a mix of 48 full and part time civilian and military staff. The team included:

- A Senior Medical Officer (SMO), a deputy SMO and four civilian GPs;
 - A principal Nursing Officer (PNO), four practice nurses and a health care assistant;
 - A physiotherapy manager, six physiotherapists and two Exercise Rehabilitation Instructors (ERI);
 - Two pharmacy technicians and two medical board staff;
 - A practice manager, deputy practice manager and Warrant Officer were responsible for the running of the practice supported by a team of 14 administrators. Some of the administrative team were RAF medics. A medic is trained to provide medical support and airfield crash cover
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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.

The practice facilitated clinics for visiting health care professionals including a consultant psychiatrist, midwife, health visitor and chiropodist. A Regional Clinical Director (RCD) assumed overall accountability for quality of care at the practice.

Are services safe?

Outstanding

We rated the practice as outstanding for providing safe services.

Safety systems and processes

Clear systems to keep patients safe and safeguarded from abuse were in place.

- A framework of regularly reviewed safety policies was in place and accessible to staff, including locum staff. Staff received safety information about 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. A safeguarding information noticeboard was displayed in the main administration office. All staff had received up-to-date safeguarding training at a level appropriate to their role. They knew how to identify and report concerns. The SMO was the safeguarding lead and one of the practice nurses was the deputy; both had completed level 3 training.
- The practice had developed strong external links to ensure the practice worked in accordance with local adult and child safeguarding arrangements. The SMO had contacted safeguarding boards and was a member of the Local Medical Committee.
- Codes were used on the electronic patient record system to identify patients who were vulnerable or subject to formal safeguarding arrangements. For a child with a protection plan in place, a code was also used on the record for adults with parental responsibility. A search of the electronic patient record system (referred to as DMICP) took place each month to inform the register of vulnerable patients.
- Vulnerable children were discussed at the child health meetings held monthly at the practice and included the health visitor for the practice. The practice was represented at the monthly station welfare meetings and the SMO attended Unit Health Committee meetings each month; both these forums were used to discuss the needs of vulnerable service personnel, including those under the age of 18.
- The SMO provided chaperone training for the staff team in September 2018 and the training data base confirmed all relevant staff had received this training. Notices were displayed advising patients that a chaperone was available. In addition, staff had been subject to safety checks to ensure they were suitable to work with young people and vulnerable adults.
- The full range of recruitment records for permanent staff was held centrally. However, the practice 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. The DBS status of visiting clinicians was monitored. Anyone without a current check was suspended from working at the practice. 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 process 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. The PCRf completed separate IPC audits and there was scope for these audits to be undertaken as part of the medical centre IPC audits.
- Environmental cleaning was provided by an external contractor. Cleaning schedules and monitoring arrangements were established. A six-monthly deep clean of the practice was included in the contract. Environment cleaning was monitored every month and a report sent to the contract supervisor.
- 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 March 2018.
- Measures were in place to ensure 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. A simulated evacuation took place in August 2018.
- Equipment was checked and maintained according to manufacturers' instructions. Testing of portable electrical appliances and medical equipment was in-date.

Risks to patients

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

- Staff we spoke with said the practice was sufficiently staffed to ensure patient's needs were met in a timely way. The PCRf had some posts that were vacant and these were covered by locum staff.
- 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. An emergency kit, including a defibrillator, oxygen with adult/child masks and emergency medicines were accessible to staff in a secure area of the practice; all staff knew of its location. A first aid kit and accident book was available. Routine checks were in place to ensure the required kit and medicines were available and in-date.
- The practice provided first response to the airfield for incidents, such as an airplane crash. Shortly before the inspection the practice team had tested the major incident plan as a response exercise. Staff participated in regular training simulation exercises, such as chest pain and anaphylaxis. 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. Information was also provided in the waiting area to support patients with recognising and understanding occupational heat stress and heat injuries.
- A large display on how to recognise and manage sepsis, a life-threatening condition, was in the reception area. It included a brief overview of symptom recognition in both children and adults. The receptionist said that patients had taken photographs of it. Symptom recognition of sepsis for under-5s, 5 to 11 and 12 years and over was displayed in clinical rooms. Face-to-face training was provided for staff in January 2018. Two further on-line training sessions took place that included materials from the Sepsis Trust UK.

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 DMICP showed 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.
- With the aim to become a paperless practice, a system of electronic processing and tasking of clinical correspondence on DMICP (electronic patient record system) had been introduced. The practice scanned non-electronic correspondence received from secondary care services, attaching it to an alert on DMICP and sent it to the clinician. This was monitored closely and an audit was undertaken in July 2018 showed a high rate of success and satisfaction with the new system.
- New patients registering with the practice had a health check completed through a face-to-face appointment. This also meant any lapsed recalls could be identified and addressed.
- The practice recognised that the summarising of patients' records was not up-to-date. Through a successful bid for extra funding the practice secured a member of staff for a fixed period to manage the backlog of summarising. As a result, the backlog had reduced by 40% since August 2018. At the time of the inspection all records had been through scrutinised (first stage of the process) and 68% of the records had been summarised (second stage of process).
- Rigorous processes were in place to ensure care records were of a high and consistent standard. For example, an audit of the notes completed by ERIs was undertaken against a recognised standard in January 2017. The audit was undertaken again in June 2018 and improvement noted. An action plan was developed with a plan to repeat the audit again in 12 months. The SMO undertook an audit of doctors' clinical records in February 2018. A high standard was achieved and actions were discussed at one of the clinical development meetings. Similarly, an audit of nursing records was undertaken in March 2018. Both audits were due to be repeated in 12 months.
- A protocol to support a safe and effective handover of children and vulnerable adults was in place. It was developed in response to the health visitor not being informed when a child moved to another practice due to their parent being posted or a change of circumstances. Before deregistering the patient from DMICP, the GP was required to provide a formal handover to the health visitor and/or the new practice the patient was transferring to. This protocol also applied to service personnel deemed to be vulnerable and due to leave the military and transferring to NHS primary care. A dedicated member of staff managed the patient registration system and produced a report each month for patients seeking to deregister with the practice. We were provided with an example of how a patient under the age of 18 was seamlessly transferred to an NHS practice using this protocol.
- 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. An electronic register of specimens was maintained and regularly checked by the nursing team. All test results were reviewed by the duty doctor and where appropriate tasked to the patient's GP for action. In the absence of the patient's GP, the duty doctor followed up on any action required.

Safe and appropriate use of medicines

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

- The SMO was the medicines management lead with the day-to-day management of medicines delegated to a pharmacy technician, who was also the dispensary manager. Procedures were in place for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment minimised risks. There were consistent lines of team communication within the dispensary. Weekly meetings were held to discuss the coming week, workload and expectations of the team.
- A record of dispensary stock was held and expiry dates checked each month. Appropriate arrangements were established for the safety of controlled drugs (CD), including destruction of unused CDs. Medication requiring refrigeration was monitored twice a day to ensure it was stored within the correct temperature range. Prescription pads were securely stored and their use monitored.
- A repeat prescription authorisation form has been developed for the safe management of repeat prescriptions. This meant it was easy and clear for each prescriber to ensure they were aware of potential issues with a prescription.
- Patient Group Directions (PGD) had been developed to allow nurses to administer medicines in line with legislation These were current and signed. The SMO audited the PGDs periodically to ensure that only authorised staff were using them. Three non-medical prescribers worked at the practice and received clinical support from the SMO.
- A register to monitor the prescribing of high-risk medicines was maintained. Monthly searches were undertaken to ensure the register was up-to-date. showed their care was consistently and effectively managed. Shared care agreements were in place and alerts used to identify patients on these medicines. High risk medicines were discussed at the monthly clinical development meetings and we noted DMARDs were discussed at this forum in September 2018.
- The practice had modified the DPHC high risk drug monitoring template. This modified version broke down each medicine into separate tabs thus making it clearer and easier to use for both the prescribers and the dispensary staff.

Track record on safety

The practice had a good safety record.

- A lead for health and safety was identified and they were suitably trained 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 held on the HG workplace and reviewed annually. They included risk assessments for hazardous substances, pregnant workers, operating electrical equipment and lone working.
- Panic alarms were installed in all rooms and were tested regularly. Staff also had been issued with personal alarm to summon assistance in an emergency.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

A whole-team approach in relation to reporting incidents was encouraged at the practice. Staff used the 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. A 'significant event tracker' was maintained on the HG workbook. Staff provided several examples of significant events they had raised demonstrating they were effectively reporting incidents. Significant events were discussed at clinical and practice meetings. A 'lessons identified' log was

maintained on the HG workbook. It included lessons learnt from various sources including incidents reported through ASER.

- The ASER system was also used to report good practice and quality improvement initiatives. For example, the protocol developed by the practice for deregistering children under the age of 18 and vulnerable adults to ensure continuity of care was reported through ASER.
- One of the medics was identified as an ASER representative for junior members of staff and had received training for the role. This role was introduced to enhance the culture of incident reporting amongst junior staff who may not feel confident or able to approach a higher ranked staff member for advice. This process was working well and junior staff were familiar with this lead role.
- The pharmacy technicians were responsible for managing medicine and safety alerts. They checked for alerts twice a day and maintained an electronic register. Alerts were emailed to staff and discussed at the monthly governance meeting.

Are services effective?

Outstanding

We rated the practice as outstanding for providing effective services.

Effective needs assessment, care and treatment

The practice had processes to keep clinicians up to date with current evidence-based practice.

- Clinical staff assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. NICE (National Institute for Health and Care Excellence) and other practice guidance was a standing agenda item at monthly clinical development meetings open to attendance by all clinicians. For example, the clinical development meeting minutes from September 2018 indicated that individual clinicians provided presentations on the following NICE guidance: generalised anxiety disorder, colorectal cancer and meningitis in the under 16s. Other standing agenda items at the meeting included clinical policy updates, clinical audit, medicines management including high risk medicines and aviation medicine. The lead physiotherapist represented the PCRf at these meetings
- The PCRf held a clinical governance meeting which included feedback back to the team on relevant matters emerging from the clinical development meetings. We noted that best practice guidance outcome measures and audit agenda were items at the September 2018 meeting. The lead physiotherapist attended the regional 'Injuries in training working group' that monitored injury statistics and worked to an action matrix for injury prevention. A GP and the lead physiotherapist attended the 'Injuries in training steering group'.

Monitoring care and treatment

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 two patients, their last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For five patients, their last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.
- There were 59 patients recorded as having high blood pressure. Fifty-three patients had a record for their blood pressure taken in the past nine months. Forty-five patients had a blood pressure reading of 150/90 or less.
- There were 44 patients with a diagnosis of asthma. Forty patients had an asthma review in the preceding 12 months which included an assessment of asthma control using the three Royal College of Physicians questions. A consistent asthma review template was used by all clinicians.

The nursing team was responsible for chronic disease management. They managed the chronic disease register and carried out regular searches, recalling patients when appropriate. We looked at a selection of patient records and were assured that clinicians were consistent in how patients were reviewed. For example, clinicians consistently used the same asthma review template.

The practice had developed and introduced a specific range of codes for disease monitoring based on population need. Where applicable a code was added to a patient's clinical record. This ensured a straight forward approach to searching the system to identify specific patients. For example, there were codes for patients referred for a colonoscopy, gout monitoring, thyroid disease monitoring and cardiac disease monitoring. Importantly, there were two codes specific to mental health; 'psychiatric monitoring' and 'mental health review follow up'. Because of the organisational-wide variance in how mental health Read coding is applied, the SMO showed how these two codes were effectively used to search for and thus monitor patients with mental health needs.

We did a search using the code 'psychiatric monitoring' and this identified three patients, the same number that was identified on the QOF mental health register. The SMO said patients were referred to the Department of Community Mental Health (DCMH) at about six weeks if no improvement was seen. Using this coding system, alongside the protocol for transferring vulnerable patients, meant when patients moved to another practice they were highly likely to experience a seamless transfer of care.

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 95% of patients compared to 93% regionally and 85.5% for DPHC nationally. Audiometric assessments were appropriately recorded in accordance with the Hearing Conservation Programme.

Two members of staff were identified as the lead for audit. A comprehensive programme of clinical and non-clinical audit was outlined in a spreadsheet that all staff had access to. It identified the auditor, initial or repeat audit, date the audit was presented to the team, recommendations and review date. A link was included to the completed audit. We noted that a wide range of staff participated in audit and staff told us they were encouraged to do so.

Clinical auditing took account of population need and referenced best practice, including NICE guidance/quality standards. Examples of audit included, contraception, minor surgery, cytology, QRISK assessments for patients at risk of developing cardiovascular disease, hypertension, asthma, depression and antibiotic prescribing audit had been undertaken. Clinical audit was a standing agenda item at the clinical development meetings where clinicians presented their audits. For example, at the September 2018 meeting the annual antibiotic audit was presented, along with the aircrew logbook audit and the secondary coronary heart disease audit.

The PCRf had a separate audit plan for 2018. Some of the intended clinical audits had been deferred due to staffing gaps. Audits that had been undertaken included core class audit, acupuncture audit and lower back pain audit.

Effective staffing

A culture of continuous learning and development was promoted at the practice. The practice sought innovative ways to deliver training and share information.

- All staff received a comprehensive generic and role-specific induction. The PCRf induction process was very thorough and would benefit from being shared widely with other PCRfs. An audit of the staff induction process was undertaken in October 2017 to ensure it remained effective.
- Mandated training was monitored and we noted the staff team were in-date for all required training. Practice delivered training was recorded and monitored through the HG workbook. Appropriate training, checks and support were in place, such as for the advanced nurse prescribers and doctors undertaking specialist medicals.
- Staff said they were supported to develop the skills, knowledge and gain experience to carry out their roles with confidence. For example, receptionists received a comprehensive information reference booklet to support them in their role. It included how to respond to phone calls, the arrangements for booking various appointments, different types of health checks and medicals and the working hours of the doctors.
- A detailed training needs analysis (TNA) was carried out in 2018 across the practice with questionnaires tailored to departments/teams. Action plans were developed to address training gaps. For example, doctors identified a training need in relation to their role in the management of an airfield incident. As a result, they were issued with a folder listing the actions they need to take in the event of such an incident. Because staff identified health care governance as a training need, each month the practice held a training session on a health care governance subject. This initiative was identified as a quality improvement project (QIP).
- All staff had an identified workplace supervisor and had access to one-to-one meetings, mentoring 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.
- Innovative social media platforms were used to provide training and updates, such as Instagram, Padlet Forums and Skype. For example, SMO used the Padlet application, an on-line virtual bulletin board, to share information on various topics with the team, such as the sepsis toolkit and NICE guidance. The SMO also used the application to seek the views of staff on ways to improve patient care.
- The practice accommodated a wide-range of trainees and had processes in place to ensure they were well supported. Trainees included physiotherapists, nurses, GPs, medics and

pharmacy technicians. A student on placement within the PCRf was very complimentary about how well the staff had made them feel part of the team.

- 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.

- 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 were 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. An electronic referral system was used for patients to book appointments internally and with secondary care services. Before leaving the practice, patients booked their appointment with a dedicated team responsible for managing referrals. The practice carried out a patient survey to seek feedback on the referral system. The feedback was all positive.
- 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. A GP referral audit was undertaken in April 2018 and showed that GPs were appropriately referring in accordance with practice protocol. Some issues with coding was identified and action was planned to address this.
- The practice had developed good working relationships both internally and with health and social care organisations. The doctors and PCRf staff held meetings on a regular basis to discuss and monitor patients under the care of PCRf. The SMO and lead physiotherapist attended the Unit Health Committee (UHC) meetings held monthly for each squadron. These meetings reviewed the needs of patients who were medically downgraded and those who were vulnerable. The practice also worked closely with the Regional Rehabilitation Unit (RRU) and the DCMH. The practice had good links with the local midwifery service, health visiting team, local safeguarding boards and the University of Lincoln. The SMO was a member of the Local Medical Committee so kept up-to-date local NHS activity.

Helping patients to live healthier lives

Staff were proactive and sought options to support patients to live healthier lives.

- 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 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. Information was available to patients about external services that provide support and counselling for a variety of issues, such as anxiety and depression.
- Health promotion information was included in the quarterly patient newsletter and on the patient Facebook page. The practice also provided support with health fairs held on the station each year. The PCRf provided musculoskeletal and injury prevention workshops for patients.

- An analysis of the reasons why service personnel were downgraded (restricted duties) had been undertaken to inform the health promotion programme. Based on the outcome, this led to the PCRf and nurse facilitating a programme of four healthy lifestyle clinics were throughout August 2018 covering four distinct topics. Despite low attendance at the clinics (attendance of one to seven patients at each clinic), patient feedback indicated the sessions were informative and valuable. Patients also made comments about other topics they would like to see included. Further clinics were on-hold until staffing resources at the PCRf increased.
- 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:

- 98.5% of patients were recorded as being up to date with vaccination against diphtheria compared to 96% regionally and 95% for DPHC nationally.
- 98.5% of patients were recorded as being up to date with vaccination against polio compared to 96% regionally and 94.5% for DPHC nationally.
- 91% of patients were recorded as being up to date with vaccination against hepatitis B compared to 80% regionally and 77% for DPHC nationally.
- 93% of patients were recorded as being up to date with vaccination against hepatitis A, compared to 93% regionally and 91% nationally.
- 98.5% of patients were recorded as being up to date with vaccination against tetanus, compared to 96% regionally and 95% for DPHC nationally.

A notice board in the waiting area provided detailed information for service personnel about the different vaccinations they were required to have.

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

The practice had developed a quick reference health advice booklet for service personnel on operational tours. It provided information on diseases such as malaria, managing extreme climate changes, diet and fluids, avoiding insect bites and sexual health.

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 staff team received training regarding the Mental Capacity Act (2005) in August 2018.
- The practice monitored the process for seeking consent appropriately.

Are services caring?	Good
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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 quarter two 2018 Patient Experience Survey (420 respondents) showed that majority of patients would recommend the practice to family and friends. The 38 CQC comment cards completed prior to the inspection were very complimentary about the caring attitude of staff.
- The practice provided patients with a quarterly newsletter. We looked at the Autumn 2018 issue and noted it provided information on clinics, child health, Stoptober and medicines. The practice also had a patient Facebook page for sharing information.
- The practice had an information network available to all members of the service community, known as HIVE. This provided a range of information to patients who had relocated to the base and surrounding area. Information included what was available from the local unit and from civilian facilities, including healthcare facilities.

Involvement in decisions about care and treatment

Staff supported patients to be involved in decisions about their care.

- Interpretation services were available for patients who did not have English as a first language. Notices were displayed in clinical areas and in reception informing patients this service was available. Resources had been developed to meet the needs of minority groups. For example, the practice leaflet and posters were available in Arabic.
- The Patient Experience Survey showed all but seven of the 420 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, including the use of alerts, codes and regular searches. Patients were asked at registration whether they had caring responsibilities. A carer's information board was available in the reception area. It included information about local and national support networks, including those for young carers.

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 a private room to discuss their needs.
- The practice could facilitate patients who wished to see a GP of a specific gender.
- A policy had been developed titled: "Staff as patients' policy: respecting patients and clinicians". It was developed following a discussion about the impact of staff registering as

patients at the practice, which explored matters such as confidentiality, conflict of interest and downgrading. Staff of the practice seeking to register as a patient were required to sign confirming they had read the policy.

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

Services were 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.
- Breast feeding and baby changing facilities were available and children had access to a play area in the waiting room.
- An access audit as defined in the Equality Act 2010 had been completed for the premises and reasonable adjustments had been made to accommodate patients. Patient services were on ground floor level. The practice had a dedicated parking space for patients with a disability. Disabled parking and WC facilities were available.
- Because pork gelatine is used in some vaccines i.e. shingles, MMR, the practice had sourced alternatives for the population of non-meat eaters and for those who did not eat pork for religious or cultural reasons.

Timely access to care and treatment

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 two to three days. Specific appointment slots were available for vulnerable groups, such as cadets, carers and school aged children. Double appointments at either the request of the clinician or patient could be made. Non-attendance at appointments were monitored and displayed in the patient waiting area. In September 2018 26 patients failed to attend their appointment.
- Home visits and telephone consultations were available. Additional clinics could be accommodated and opening hours extended to accommodate operational need, such as short notice deployment. Waiting times for specialist medicals were approximately two weeks, including diving and aviation medicals. A direct access nurse service (DANS) was available and this was targeted at cadets.
- At the time of the inspection the next available routine physiotherapy appointment was in two working days. This was displayed on the PCRf door. Despite being under resourced, the waiting time for an ERI was six working days. An annual waiting time audit (August 2018) for the PCRf showed patients were being seen with well under the target of 10 working days.
- A direct access physiotherapist service (DAPS) was in place that included inclusion/exclusion criteria for self-referral. Changes had been made to the DAPS criteria for cadets to incorporate specific training injuries. An audit was undertaken to determine if performance targets were being met following the introduction of the DAPS for permanent staff. Some recommendations were made but overall DAPS was perceived as a highly effective way of triaging patients.
- Arrangements were in place for patients to access primary care when the practice was closed, including emergency care. The Patient Experience Survey showed that 411 respondents out of 420 had received their appointment at a time that suited them.

- Since Easter 2018 access to hydrotherapy had ceased due to limited funding for lifeguard cover. A business case had been submitted for this service to continue. The area manager confirmed that this had been agreed.

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 Warrant Officer was the designated responsible person who handled all complaints and the practice manager deputised in their absence. A record of complaints was maintained, including verbal complaints. The complaints register indicated 17 complaints have been made in the last 12 months. They had been managed and resolved to the satisfaction of the complainants.
- All complaints were discussed at the practice meetings and lessons identified. Changes to practice were made if feasible and used to improve the patient experience. For example, training on autism was organised in response to a complaint from a parent. Communication/interpersonal skills awareness was also provided in response to a patient complaint.
- A suggestion box, forms and pens were located in the waiting area for patients to leave feedback. A token system with emoji faces was in place for children to give feedback on the service.

Are services well-led?	Outstanding
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We rated the practice as outstanding for providing a well-led service.

Leadership capacity and capability

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

On the day of inspection, we saw a practice that was well led. The leaders not only demonstrated managerial experience, capacity and capability, it was clear they had vision, passion and integrity, with a focus on continuous service development. The whole-team approach was supported by all staff who valued the opportunities available to them to be part of a forward-thinking service.

Staff said they had confidence in the managers, who demonstrated a collaborative approach to leading the practice and had the ability to inspire and motivate staff.

The practice received the DPHC award for the most outstanding contributor to Defence Primary Healthcare in 2018.

Vision and strategy

- The practice worked to the DPHC mission statement of:
 “DPHC will deliver a unified, safe, efficient and accountable primary healthcare and dental care services for entitled personnel to maximise their health and to deliver personnel medically fit for operations.”
- The mission statement for the practice was:

“To provide safe, innovative, high quality, patient-centred healthcare, in a supportive and just culture, with universal responsibility for governance.”

- The vision for the practice was developed using the Padlet forum on a day when staff were unable to get to work to adverse weather conditions. The shared vision agreed was:

“Quality healthcare to support the development of tomorrow’s leaders.”

- The vision specific to the PCRf:

“A PCRf to be proud of; quality, innovation and proactivity.”

Throughout the inspection it was clear staff were committed to providing and developing a service that embraced the mission and vision.

Culture

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

- A whole-team ethos was promoted. All staff had an equal voice, regardless of rank or grade.
- Staff we spoke with described a leadership style that encouraged and valued everyone’s view about how to develop 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 needs population and tailored the service to meet those needs. For example, the healthy lifestyle clinics resulting from an analysis of the reasons for downgrading of service personnel.
- Openness, honesty and transparency were demonstrated when things went wrong. A no-blame culture was evident; complaints and incidents were seen as opportunities to improve the service.
- 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.
- Leaders clearly demonstrated that the needs and welfare of staff were priority. Staff were encouraged and supported to be the best they could be through training and developing their skills. This was demonstrated through the comprehensive training analysis undertaken and resulting action.
- There was a strong emphasis on the safety and well-being of all staff. Supervision and appraisal was in place for all staff. A welfare development plan was established for military staff to ensure they had protected time for occupational requirements and activity. A staff bonus scheme was in place with a moderation panel used to ensure parity of rewards.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training.

Governance arrangements

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

- There was a clear staffing structure in place 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 HG workbook, a system that brings together a comprehensive range of governance activities, including the risk register, significant events tracker, lessons learnt log, training register, policies, meetings, quality improvement and audit. All staff had access to the workbook which provided links to meeting minutes, policies and other information.
- A detailed staff handbook on how to prepare for the CQC inspection had been developed by the practice. It provided staff with guidance on the domains, how to prepare, expectations on the day.
- A practice development plan was in place that had a strong emphasis on developing staff including their understanding of governance. For example, and in response to the training analysis, a development area in relationship to health care governance had been met through a series of health governance training sessions.
- An effective range of communication streams were used at the practice. A schedule of regular practice and department meetings were well established. For example, practice meetings, clinical governance meetings and management meetings were held each month. Social media platforms, such as Instagram, WhatsApp, Padlet Forums and Skype were routinely used to share information and updates.
- Audit was a routine method used to measure the effectiveness and success of clinical and administrative practice. A comprehensive audit programme was established with clear evidence of action taken to change practice and improve the service for patients. The PCRf monitored its audits separately and there was scope to develop a whole-system approach to audit.

Managing risks, issues and performance

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

- Risk to the service were well recognised, logged on the risk register and kept under scrutiny through regular review. 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 monitor national and local safety alerts, incidents, and complaints.
- The dispensary manager had implemented a 4-tier management toolkit. Tasks completed by each member of the staff were added with an option to add further tasks to the tool. All staff could see what needed to be completed and what remained outstanding. This 4-tier management tool ensured the dispensary was accountable for its outputs and showed evidence for all stages of the work it had completed. It also made it easier for the wider staff team to understand how the dispensary worked, how it was managed and the assurance processes used.
- A system was in place to monitor performance target indicators. In particular the system took account of medicals, vaccinations, child health, cytology, summarising and non-attendance rates.
- 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 and the most recent visit took place in July 2018.
- A business continuity plan was in place. The plan for major incidents had recently been revised; a whole station crash and disaster exercise had been undertaken in October 2018.

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 trial the newly introduced eCAF
- The practice received a Health Governance Assessment Visit (HGAV) from the regional team in March 2018 with a positive outcome in terms of performance.

Engagement with patients, the public, staff and external partners

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

- There were various options in place to encourage patients to provide feedback on the service and contribute to the development of the service. A patient experience survey was undertaken throughout the year. The PCRf also conducted its own satisfaction survey.
- A Patient Participation Group (PPG) through a closed Facebook page had been developed and had 138 participants. To encourage participation, the PPG was advertised in the quarterly newsletter and through a leaflet drop in medication bags. The practice had plans to include the newsletter and PPG leaflet with recall letters.
- The practice had good and effective links with internal and external organisations including the Regional Rehabilitation Unit (RRU), the DCMH, local NHS services, social services and academic facilities. As a result of external links, one of the civilian nurses had initiated the first placement for a third year student nurse as part of the management module of the training. This was the first time a military primary care setting had been chosen as a management placement by the university.
- Feedback from staff was sought through a staff survey. In May 2018 staff were encouraged to put ideas forward to improve the service; the outcome of which was displayed as a 'You said: we did' in the staff room. We noted that many of the suggestions had been actioned, such as addressing overcrowding in the car park, more health promotion sessions and using alternative methods to promote the PPG.

Continuous improvement and innovation

Continuous improvement was embedded in the culture of the practice that demonstrated an innovative approach to developing the service for the benefit of the patients. The practice maintained a detailed quality improvement log on the HG workbook which was monitored monthly. We found that improvements were implemented based on the outcome of feedback about the service, complaints, audits and significant events.

Quality improvement projects identified by the practice included:

- The whole-team approach to the development of the practice vision
- The development of the receptionist protocols
- An aircrew logbook flowchart was introduced from an audit outcome that identified logbooks were not being completed in line with policy for aviation medicals. It is a check system for the doctors to ensure all detail is recorded before signing off the logbook.
- The development of coding for disease recall
- Provision of monthly health governance learning topics in response to the training needs analysis

The practice was forward thinking and looking to future developments. These included:

- Preparation for Project Portal; the practice was working closely with internal stakeholders regarding the transfer of all the recruits and training at RAF Halton to RAF Cranwell. The practice was considering the impact and options of an increase in the patient population to approximately 5000.
- Innovative use of technology to enhance training.
- Review options to prompt patient feedback about the dispensary.
- Development of patient-led peer support groups.
- Adoption of new technology to enhance accessibility; one of the staff had put forward a research proposal on a video-based synchronous primary care consultation model
- Pro-active joint ventures to improve health. For example, the practice had been liaising with Station Physical Education Flight (PE'd Flt) to focus on a range of tailored circuits to enhance fitness for service personnel who are downgraded. These will be audited to identify any common themes for downgraded.