

Lichfield Medical Centre

Quality report

DMS Whittington
Lichfield,
WS14 9PY

Date of inspection visit:
19 November & 6 December 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?	Good 
Are services effective?	Outstanding 
Are services caring?	Outstanding 
Are services responsive to people's needs?	Outstanding 
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? – Good

Are services effective? – Outstanding

Are services caring? – Outstanding

Are services responsive? – Outstanding

Are services well-led? - Outstanding

We carried out an announced comprehensive inspection of Lichfield Medical Centre on 19 November 2018. For reasons of availability, the Primary Care Rehabilitation Facility (PCRF) of the service was inspected on 6 December. 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, capability and integrity to provide a patient-centred service.
- An inclusive team approach was supported by all staff who valued the opportunities available to them to be part of a service that focused on continuous improvement.
- 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 awareness of current evidence based guidance was at the core of providing effective care. Staff had received training so they were skilled and knowledgeable to deliver care and treatment that met the needs of the patient population.
- 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:

- At all times the practice team was mindful of the potential vulnerability of trainees. A red tab on the patient's uniform indicated they were under 18, which prompted the receptionist to check for any alerts on the patient's record. These young trainees were prioritised ensuring they were seen without delay. The duty doctor and nurses had simultaneous triage slots each day. Trainees were seen initially by the nurse and if needed could see a doctor straight away. This efficient system had been well received by patients and unit commanders as it meant minimal disruption to course attendance for trainees.
- Practice staff noticed an increase in the number of personnel running at lunchtime in hot summer temperatures. They engaged with the station to ensure daily temperatures were displayed at the front gate and provided reminders for personnel to keep well hydrated.
- Aware that the unit physical training instructors (PTI) were not confident with prescribing exercise to pregnant service personnel, the lead physiotherapist provided training to the PTIs and doctors on exercising safely in pregnancy. As a result, one of the doctors produced a risk assessment form for the PTIs to refer pregnant women to the doctor for assessment of fitness to exercise. An audit is planned to look at the impact this has had on the confidence levels of the PTIs.
- If requested by the patient, PCRf staff took a video using the patient's own mobile phone of the patient completing their exercises. This supported patients to check they were doing their exercises correctly outside of the PCRf.
- A 'Mental Wellbeing First Aid Box' was displayed in the waiting area to guide and advise patients who were struggling with emotional or stressful issues. The practice was working with the station padre and welfare team to develop a 'mindfulness programme' to support patients with emotional and mental health needs.

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 pharmacy advisor. The PCRf was inspected by a physiotherapy advisor on the second day of the inspection.

Background to Lichfield Medical Centre

Whittington Barracks is the UK centre for Defence Medical Services (DMS) and supports service personnel on phase 2 training courses. Based in the barracks, Lichfield Medical Centre provides primary and occupational health care to a Tri-Service population. The patient population includes 450 permanent staff and between 300-350 trainees on 14-week training courses. At the time of the inspection there were 735 registered patients; 55 patients were over the age of 50 with 26 patients

aged from 17 to 18. Families and dependants are not treated at the practice and are signposted to local NHS practices.

Lichfield Medical Centre is part of the DMS Whittington Group Practice; a hub and spoke model with Lichfield the hub practice and Birmingham Medical Facility (BMF) the spoke practice. There is one Senior Medical officer (SMO) for the group who has overall responsibility for the governance structure across both practices.

There is a dispensary in the medical centre. Although the Primary Care Rehabilitation Facility (PCRF) is in a separate building, the physiotherapy and rehabilitation team was integrated with the medical centre. The PCRF provided a full service to BMF.

Family planning advice is available with referral available to NHS community services. Maternity and midwifery are provided by NHS practices and community teams.

The practice is open from 08:00 to 17:00 Monday to Thursday (closed Thursday afternoon for staff training and with cover in place), 08:00 to 12:00 on Wednesday and 08:00 to 16:00 on Friday. Arrangement for medical cover is in place weekdays until NHS 111 is available at 18:00. At weekends and public holidays patients are advised to use NHS 111.

Although the staffing establishment for the practice is 17.6 whole time equivalents (WTE), at the time of our inspection the WTE was 16.6. The team comprised a mix of full and part time civilian and military staff including:

- A Senior Medical Officer (SMO), one civilian GP and a locum GP three day per week;
- Four practice nurses, including a locum nurse
- Two physiotherapists and an Exercise Rehabilitation Instructor (ERI);
- A pharmacy technician
- A practice manager was responsible for the running of the practice supported by a deputy practice manager and team of five administrators. Some of the administrative team were medics. A medic is trained to provide medical support and emergency cover 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.

Are services safe?	Good
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We rated the practice as good for providing safe services.

Safety systems and processes

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

- A framework of regularly reviewed safety policies was in place and accessible to staff, who 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. One of the GPs was the safeguarding lead and the SMO was the deputy; both had completed level 3 training. Adult and child safeguarding policies were available to all staff. All staff had received up-to-date safeguarding training at a level appropriate to their role; the nurses and physiotherapist had level 3 training. The contact details for safeguarding leads and regional leads was available in

clinical areas. Business size cards were available to all staff that provided both internal and external safeguarding contacts, and electronic links to local safeguarding polices.

- A procedure was in place to guide staff with the administrative management of vulnerable patients. Codes were used on the electronic patient record system to identify patients who were vulnerable or subject to formal safeguarding arrangements. A search of the electronic patient record system (referred to as DMICP) took place weekly to inform the register of vulnerable patients. Appointments were prioritised for vulnerable patients including those under the age of 18. We looked at the records for two patients deemed to be vulnerable and they confirmed they were being effectively supported and monitored by the practice.
- Vulnerable patients were discussed at the multi-disciplinary weekly Trainee Board meetings at the practice and at the monthly Unit Health Committee (UHC) meetings, attended by the welfare team, Chain of Command and the SMO. Vulnerable risk meetings could be arranged if there was an urgent need.
- The SMO had provided chaperone training for the staff team 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 outcome of the offer of a chaperone was recorded in the patient's clinical record.
- 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. 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 each month and the results discussed at the monthly health care governance meetings.
- 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. The contract manager carried out spot checks to ensure the cleaning was happening in line with the contract. Systems were in place for the safe management of healthcare waste. Consignment notes were retained at the practice.
- 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 barracks fire officer was responsible for fire safety at the practice and carried out an annual risk assessment of the building annually. Firefighting equipment tests were all in-date. Staff were up-to-date with fire safety training and were aware of the evacuation plan.
- Equipment was checked and maintained according to manufacturers' instructions. The maintenance of equipment at the PCRF was managed through two contracts. The lead physiotherapist was looking into how this could be better managed. 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. Systems were in place to ensure effective planning for staff leave. There was one point of contact for managing leave and absences. With being part of a group practice, the medical centre had a bigger pool of staff to draw from. In the absence of a female GP, the practice could access the female GP at BMF.
- The deputy practice manager had the responsibility for locum and temporary staff. Since taking up post recently, they had reviewed the induction and mandatory training programme 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. Two anaphylaxis kits were available in the nurse's clinical rooms. Emergency medical equipment was not held in the PCRf and the arrangement in place was to call 999.
- Staff were familiar with how to manage patients presenting with a potential thermal related injury or condition. They provided an example of this and it had been presented at a clinical meeting as a case review. The case review showed there had been learning as to how a thermal condition could be better managed should a patient present with this again. We noted that one of the nurses presented an article on heat stress at the May 2018 clinical meeting, which led to action being taken by the practice including the securing of an ice machine.
- Staff had received training about the symptoms of sepsis and how to respond. Guidance on sepsis was available to the receptionist. Staff used the DMICP sepsis trigger and template for patients presenting with the symptoms of infection. A sepsis protocol based on national guidance was kept in all clinical rooms.

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.
- Effective systems were in place for the management of electronic and hardcopy correspondence. For example, non-electronic correspondence received from secondary care services was scanned onto DMICP and sent it to the clinician.
- A dedicated member of the administrative team was responsible for managing and monitoring the status of referrals. They had developed an electronic referral form, which was completed by the doctor and presented by the patient to the administrative team. An appointment was booked before the patient left the practice. A referrals register was in place and the status of referrals was checked each morning.
- A process was established for scrutiny and summarising of patients' records. There were no backlogs with summarisation.
- One of the nursing team was identified as the lead for test result (known as Lablinks). A process was in place for the management of specimens, including the transport of specimens to the laboratory and the use of Lablinks to manage test results. A protocol was available to guide staff in the event of a system failure. The nursing team monitored results and forwarded

them to the GP for action. X-rays received by post were scanned to DMICP and assigned to the GP.

Safe and appropriate use of medicines

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

- One of the GPs was the medicines management lead with the day-to-day management of medicines delegated to the pharmacy technician. Procedures in place for the safe management and storage of medicines, including vaccines, medical gases, emergency medicines and equipment minimised risks. The regional team regularly audited the management of medicines and we noted all the actions following the last audit in April 2018 had been met.
- A record of dispensary stock was held and expiry dates routinely checked. 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.
- Appropriate arrangements were established for the safety of controlled drugs (CD), including the destruction of unused CDs. An audit was conducted by the regional pharmacist with the most recent one undertaken for January to March 2018. Systems were established to monitor any potential misuse.
- A process was in place for monitoring any prescribing by secondary care or out-of-hours services. Information received was scanned to DMICP and tasked to the patient's doctor. A weekly audit was undertaken to check scanning of such information was appropriately taking place. Repeat prescriptions were agreed in writing or in person. A maximum of six repeat prescriptions were permitted and then the patient's care was reviewed.
- Patient Group Directions (PGD) had been developed to allow nurses to administer medicines in line with legislation. These were current and signed by the SMO. Nurses received competency checks from the regional pharmacist and these were refreshed every three years.
- A register to monitor the prescribing of high-risk medicines was maintained. Routine searches were undertaken to ensure the register was up-to-date. Coding was used to identify patients taking high risk medicines. A review of patient's records showed their care was consistently and effectively managed. Shared care agreements were in place and alerts used to identify patients on these medicines.

Track record on safety

The practice had a good safety record.

- The practice manager and deputy practice manager were the leads for health and safety 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 were in place and reviewed annually. They included risk assessments for hazardous substances, pregnant workers and operating electrical equipment. A lone working risk assessment was particularly relevant for the PCRf as it was in a separate building to the medical centre. Measures were in place to minimise the risks associated with lone working.
- Panic alarms were installed in clinical rooms and were tested regularly. They were not available in all areas of the building and a request had been submitted for this. 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.

- All staff were familiar with reporting incidents and reporting was actively 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. Three staff were trained to carry out root-cause analysis of incidents. The ASER system was also used to report good practice and quality improvement initiatives.
- Significant events were closed by the practice manager once they had been actioned and any changes made. We noted that one had been open for over six months. The practice manager explained that it was linked to a complaint which had been passed to the regional team. The event would remain open until all actions had been completed at regional level.
- Staff provided several examples of significant events they had raised demonstrating they were effectively reporting incidents. Changes were made as a result of significant events. For example, a patient did not receive the results of her mammogram. As a result, an audit was undertaken and a protocol developed. Significant events were discussed at clinical and practice meetings.
- The pharmacy technician was responsible for managing medicine and safety alerts. They checked for alerts regularly and maintained an electronic register. Alerts were emailed to staff and discussed at the monthly clinical meetings. The pharmacy technician provided two examples of appropriate action taken in response to alerts.

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 the monthly clinical meetings open to attendance by all clinicians.
- Clinicians routinely presented a NICE or other practice guideline at the meeting and the team reviewed clinical practice accordingly. For example, a presentation on the NICE Familial Breast Cancer guidance led to the setting up of a search to identify patients with a higher risk due to a family history of breast cancer. Following a presentation of the guidance on sore throat assessment and Lyme disease, it was identified that the Centor Score was more appropriate to the population than FeverPain Score. This led to the practice requesting a system update to include a Centor Score template on DMICP.
- Other standing agenda items at the clinical meetings included Quality and Outcomes Framework (QOF) management, clinical audit, medicines management, clinical risk register and the sharing of journal articles.
- Peer review/case discussion was also a standing item. For example, a case was discussed that involved screening for the human immunodeficiency virus (HIV) and the team agreed with the screening decisions taken by the clinician. The management of two patients referred to cardiology were discussed, suggesting that investigations were indicated beyond just an ECG (traces electrical activity of the heart).

- Nursing staff had regular meetings and notes of these meetings indicated that processes and systems to support good quality clinical care were discussed, such as Lablinks, clinical coding, screening and nurse clinics. PCRF staff and SMO met each week to discuss the progress of patients referred with musculoskeletal injuries.

Monitoring care and treatment

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

The SMO and a practice nurse were the leads for the management of chronic conditions and was the deputy. In addition, each of the doctors had a range of QOF conditions they were responsible for monitoring. Chronic disease registers were maintained for each condition and regular searches undertaken, recalling patients when appropriate. Relevant clinicians attended the monthly chronic disease meetings.

We looked at a selection of patient records and were assured that clinicians were consistent in how patients with chronic conditions were reviewed. For example, clinicians consistently used the same asthma review template.

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

- There were five patients on the diabetic register. For three patients, their last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For all five patients, their last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control. Four patients were being managed by secondary care services.
- There were 19 patients recorded as having high blood pressure. All patients had a record for their blood pressure taken in the past nine months. One newly diagnosed patient had a blood pressure reading of 150/90 or more.
- There were 13 patients with a diagnosis of asthma. All had an asthma review in the preceding 12 months which included an assessment of asthma control using the three Royal College of Physicians questions.
- Because of the potential vulnerability of the trainee population, the practice was keen to identify any mental health concerns at the earliest opportunity and act promptly. We identified that 66 patients were being treated for a depressive disorder. Records showed these patients were being effectively managed and supported. Fifty-five referrals had been made to the Department of Community Mental Health (DCMH) in the last 12 months, representing 6% of the overall patient population compared with 4% across the defence medical services. The SMO highlighted this increased number was likely related to the vulnerability of Phase 2 army trainees.
- The SMO conducted a mental health and wellbeing audit of trainees 'on hold'. This means that Phase 1 trainees arrive at Whittington Barracks waiting to start a Phase 2 course. Sometimes the wait can be up to 12 months and during that time the trainees have no role or occupation. At the time of inspection approximately 60 trainees were 'on hold'. The audit showed 31% of this patient group had a depressive disorder and 21% were experiencing

anxiety. Feedback was given to the station commander and welfare committee. Changes to the training programme were being considered.

- The practice maintained a register for patients who were outside of QOF but had enhanced risk i.e. transgender patients.

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 91% of patients. The assessments were appropriately recorded in accordance with the Hearing Conservation Programme. Only one audiometry booth was working so this had created delays with waiting times for audiometry assessments. The practice had reported this and it was identified on the practice risk register.

A quality improvement lead was identified for the practice. A register was maintained and detailed the improvements made based on information from various sources, including significant events, audit and patient feedback.

Audit was clearly embedded in practice and seen as the responsibility of all staff. An extensive programme of clinical and non-clinical audit was in place. The audit register 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.

Clinical audit was driven by population need. The range of audits we looked at referenced best practice, including NICE guidance/quality standards. Examples of audit included: mammogram; cytology; contraception; chlamydia; gout; shared care; depression and validated suicide risk assessment; minor operations; consent; QOF; high risk drugs; ankle injuries; asthma and results handling.

Prescribing audits included: Depo Provera (contraceptive injection) use in under 18s; the prescribing of antibiotics for acute cough; the prescribing of diazepam (a controlled medicine that can be addictive) for back pain/spasm and an audit of controlled drugs prescribed for more than three months.

Audit was a standing agenda item at the clinical meetings where clinicians routinely presented the audits they had undertaken. All audits led to practice being reviewed and changes made if necessary. For example, an audit on raised platelet count in over 40s resulted in nurses starting monthly searches to ensure no patients were missed. A Gabapentin and Pregabalin (medicines used mainly to treat neuropathic pain) audit led to doctors being reminded to issue smaller doses when these medicines were first prescribed. The asthma audit identified that DMICP did not support the 'gold standard' for asthma management and this was addressed with the DMICP administrative team.

Effective staffing

A culture of continuous learning and development was promoted at the practice.

- The deputy practice manager was the lead for induction and had recently reviewed the induction package. All staff received a comprehensive generic and role-specific induction. We

spoke with a recently recruited member of staff who confirmed the thoroughness of their induction.

- Mandated training was monitored and the staff team were in-date for all required training. Staff had received appropriate training for their role. For example, all nurses were trained in the management of sexually transmitted infections. All doctors were trained to undertake diving medicals and the SMO had completed the aviation medical course.
- Training was scheduled each week for one hour and could involve on-line training, in-house training or an external speaker. Topics were selected based on staff need and sought to support staff with their continuing professional development (CPD). In addition, competency checks and role specific CPD was supported by the practice, such as for doctors to continue to undertake aviation and diving medicals. Staff told us they had an identified workplace supervisor and regular supervision sessions. Records indicated that staff appraisals were up-to-date.
- Peer review was embedded in practice. A process was established for staff to undertake regular peer review of each other's recorded clinical consultations with patients. A peer review document supported the process and ensured consistency in approach. Ten consultations were selected at random for the clinician being reviewed. If appropriate actions were identified and feedback given by the reviewer. In October 2018, the three doctors carried out a peer review using this process and it was scheduled to be presented at the next clinical meeting.
- PCRF staff attended regional meetings and participated in regional in-service training facilitated by the Regional Rehabilitation unit (RRU).
- 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 patients and other health care professionals to deliver effective care and treatment.

- New patients had their clinical records checked by a nurse when they first registered. The nurses also summarised the record based on a standard summarising checklist. A new patient screen was carried out for all registrants.
- 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.
- The practice had good working relationships with other units and departments. The SMO and lead physiotherapist attended weekly Trainee Management Board meetings, which were led by the Chair of the Defence College of Education. Patients who were receiving specialist care, unable to undertake training and not fit for the field army were discussed. Unit Health Committee (UHC) meetings were held monthly and were attended by the SMO. 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), the DCMH and other military healthcare professionals. A Community Psychiatric nurse visited the practice on a regular basis.

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.
- There was a designated lead member of staff for health promotion. Three health promotion display boards were available and these were refreshed each month based on a 12-month schedule that took account of the population and national campaigns, such as Stoptober and no smoking day. For example, a display regarding Norovirus had been coordinated following an outbreak of diarrhoea and vomiting. We noted a men's health board was displayed.
- PCRf staff took a whole-person approach when considering the injury, health, wellbeing and barriers to recovery. For example, they took appropriate opportunities to discuss smoking cessation and alcohol intake, and signpost patients to other services.
- Practice staff noticed an increase in the number of personnel running at lunchtime in hot summer temperatures. They engaged with the station to ensure daily temperatures were displayed at the front gate and provided reminders for personnel to keep well hydrated.
- Aware that the unit physical training instructors (PTI) were not confident with prescribing exercise to pregnant service personnel, the lead physiotherapist provided training to the PTIs and doctors on exercising safely in pregnancy. As a result, one of the doctors produced a risk assessment form for the PTIs to refer pregnant women to the doctor for assessment of fitness to exercise. An audit is planned to look at the impact this has had on the confidence levels of the PTIs.
- Given the age of the patient population, sexual health was a high priority for the practice. One of the doctors was the lead for sexual health and nurses provided sexual health advice. Sexual health contact numbers and referral pathways were available in all clinical rooms. Sexual health information was available in the waiting area for patients. The C-Card condom distribution system was in operation and trainees received a briefing on sexual health. Patients were referred on to specialist services as appropriate, such as for persistent non-specific urethritis.
- The PCRf were involved in identifying and signposting patients to the DoFit programme which was delivered by PTIs. The DoFit programme addresses lifestyle issues through education, weight management and exercise.
- The practice was involved with the station padre and welfare team with the development of a 'mindfulness programme' to support patients with emotional and mental health needs.
- Patients had access to appropriate health assessments and checks. Monthly searches were undertaken for patients eligible for bowel and breast screening and appropriate action taken if patients met the criteria. The practice had arranged bowel screening for patients not possible through NHS.

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:

- 99.5% of patients were recorded as being up to date with vaccination against diphtheria.
- 99.5% of patients were recorded as being up to date with vaccination against polio.
- 100% of patients were recorded as being up to date with vaccination against hepatitis B.
- 99% of patients were recorded as being up to date with vaccination against hepatitis A.

- 99.5% of patients were recorded as being up to date with vaccination against tetanus.

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?	Outstanding
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We rated the practice as outstanding for caring.

Kindness, respect and compassion

Staff described how 75% of the appointments were for trainees. They were aware that trainees could be vulnerable for many reasons, including their young age and being isolated from family and friends. A red tab on a patient's uniform indicated they were under the age of 18. This prompted the receptionist to check their record for any alerts. The SMO prioritised patients under the age of 18 ensuring they were seen without delay. Reception and administrative staff were also mindful of patients who frequently presented at the practice with low level symptoms and highlighted these patients to the SMO. The receptionist had completed the mental health first aid training.

The 34 CQC comment cards completed prior to the inspection were very complimentary about the caring attitude of staff as were the four patients interviewed on the day of the inspection. Results from the August to September 2018 Patient Experience Survey (49 respondents) showed that 48 patients found the administrative team were helpful and friendly.

Several patient feedback comments indicated that 'staff went the extra mile' and we found evidence to support this. Examples include:

- When the practice became aware the heating was broken in trainee accommodation in cold weather they reported it to the Chain of Command.
- Out-of-hours, a member of staff drove a patient who had no transport to the Department of Community Mental Health for a critical appointment.
- Staff told us about occasions when they collected a patient's medication from the pharmacy and delivered it to their accommodation because the patient was ill and/or had no transport.
- The administrative team told us about an occasion when they looked after a patient's children as the patient had no childcare and needed to attend the practice for a medical.
- The practice arranged for military transport to take a patient from their home off the base to the accident and emergency department 11 miles away. The patient was experiencing acute pain so was unable to drive.
- We were provided with examples of how the practice had continued to coordinate the care of patients at their request despite the patients moving a considerable distance away, even to a different country.

- Provision of a 'virtual practice' for those transitioning out of service.
- Provision of home visits to a housebound patient who lived a 40-minute drive away.
- Transport for patients to secondary care was arranged by the practice. A guardian was provided if the patient was under 18 years old.

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 the waiting area informing patients this service was available.

The Patient Experience Survey showed all 49 respondents felt involved in decisions about their care. Feedback on the CQC patient comment 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. The carer policy was displayed in the waiting area for patients. There were two carers identified at the time of the inspection.

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 meant that conversations between patients and reception could not be easily overheard. An area of the floor was sectioned to support with confidentiality. If patients wished to discuss sensitive issues or appeared distressed at reception they were offered a private room to discuss their needs.

The practice could facilitate patients who wished to have a consultation with a clinician of a specific gender, including patients referred to the PCRf.

Are services responsive to people's needs?	Outstanding
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We rated the practice as outstanding for providing responsive services.

Responding to and meeting people's needs

Services were organised and delivered to meet patient needs and preferences.

Staff understood the needs of its population and tailored services in response to those needs. Because of the young population and trainee restrictions on taking telephone calls, text messaging

was successfully used to communicate with patients, including appointment reminders and advice to contact the practice for the outcome of test results.

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. Disabled parking and WC facilities were available. Wheelchairs, including a self-propelling wheelchair was available in the foyer.

Based on patient feedback, a process was put in place where the reception was always staffed so patients did not feel uneasy discussing their health needs within earshot of the whole administration team. This arrangement was working well. The change was communicated to patients as a 'You said....We did' display in the waiting area.

If requested by the patient PCRf staff took a video using the patient's own mobile phone of the patient completing their exercises. This supported patients to check they were doing their exercises correctly outside of the PCRf.

A 'Mental Wellbeing First Aid Box' was displayed in the waiting area to guide and advise patients who were struggling with emotional or stressful issues.

The Patient Participant Group meeting in September 2018 generated a lengthy discussion about lifestyle issues. This led to a further meeting to explore how units could work jointly to look at ways to improve population fitness, weight, alcohol use and mental health.

Timely access to care and treatment

Patients' needs were met in a timely way.

Patients with an urgent need were seen that day and the waiting time for a routine appointment was usually the next day. The practice prioritised early morning appointments for trainees so the impact on their course attendance was minimised. Similarly, the PCRf prioritised appointments to suit the needs of trainees. A direct access nurse service (DANS) was available and this was targeted at trainees. The Patient Experience Survey showed that all 49 could get a routine appointment within 48 hours.

The practice had introduced a system where the duty doctor and nurses had simultaneous triage slots each day. For example, a patient with an urgent need was initially seen by the nurse. If they then needed to see a doctor they could do so seamlessly. This meant disruption to attendance on courses was minimised as patients did not have lengthy waits or need to return at a later point in the day to see a doctor. This system had been well received by patients, unit commanders and staff.

Access to aviation and diving medicals were prompt and timely as doctors were available at the practice to undertake these. Home visits and telephone consultations were available and this was communicated to patients through the practice leaflet.

A notice advised patients what to do if they were waiting longer than 20 minutes was displayed in the waiting area. Non-attendance at appointments was monitored and displayed in the patient waiting area. In October 2018 eight hours of clinical time was wasted due to patients failing to attend their appointment.

For routine physiotherapy appointments, the waiting time was in nine working days. Patients with an urgent need were seen within 48 hours. A direct access physiotherapist service (DAPS) was in place that included inclusion/exclusion criteria for self-referral. DAPS had recently been audited. Access to podiatry was within four to eight weeks. Waiting times to be seen at the Regional Rehabilitation Unit was up to six weeks for non-urgent referrals and within five days for urgent referrals.

Arrangements were in place for patients to access primary care when the practice was closed, including emergency care. The Patient Experience Survey showed that all 49 respondents were satisfied with the location and time of their appointment.

Listening and learning from concerns and complaints

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

Information was available to help patients understand the complaints process. The practice managed complaints in accordance with the DPHC complaints policy and procedure.

The practice manager was the designated responsible person who handled all complaints and the practice manager deputised in their absence. A record of complaints was maintained, including verbal complaints. The complaints register showed two complaints had been made in the last 12 months. One complaint had been managed and resolved to the satisfaction of the complainant and had led to a change in practice. The second complaint was ongoing, linked to a significant event and had been escalated to the regional team.

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.

A suggestion box, forms and pens were located in the waiting area for patients to leave feedback.

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 and capability, it was clear they had vision and integrity, with a focus on continuous service development. The leaders were supported by a staff team who valued being part of a patient-centred service.

The SMO and practice manager had previously demonstrated their leadership acumen at Birmingham Medical Facility (BMF). The BMF was closed in October 2017 due to unsafe practice and risk to patients. The SMO and practice manager from Lichfield Medical Centre revised all systems and processes, and provided support to staff. The BMF re-opened in March 2018 as part of the Whittington Group Practice, based on a hub and spoke model. The BMF was subject to a CQC inspection in June 2018 and was rated as 'Good' overall and for all domains. We acknowledged in the report the organisational change management skills and expertise of the leadership team had been instrumental in driving the improvement at BMF.

The SMO continues to be accountable for the overall governance of the group practice. A memorandum of understanding and terms of reference (job description) is in place to support the SMO's role in the group practice model.

Staff told us Lichfield Medical Centre had always been well-led but highlighted that processes had been strengthened and consistency improved since the arrival of the SMO 12 months ago.

Vision and strategy

- The vision for the practice was:

“Always provide evidence-based, safe, holistic and, crucially, patient-centred care to all our PAR [population at risk] at all times”

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.”

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

Culture

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

- Staff described an open and transparent leadership style and said they would feel comfortable raising issues. They said leadership was motivational, meaningful and inclusive. They had opportunities to contribute their views and ideas about how to develop the practice. A suggestion box was available for staff to submit thoughts and views anonymously.
- A whole-team ethos was promoted. All staff had an equal voice, regardless of rank or grade. They said the team worked well together and supported each other.
- The practice clearly demonstrated a patient-centred focus. Staff understood the specific needs population and tailored the service to meet those needs. This was particularly evident in the collective awareness of the vulnerability of the trainee population and the processes that were in place to identify individual risk at the earliest opportunity.
- 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.
- There was a strong emphasis on the safety and well-being of all staff. Supervision and appraisal was in place for all staff. The practice actively promoted equality and diversity. Staff had received equality and diversity training.

Governance arrangements

An effective overarching governance framework was 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 health governance 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.
- An effective range of communication streams were used at the practice. A schedule of regular practice and department meetings was well established. For example, practice meetings, clinical meetings and heads of department meetings were held each month. Administrative staff had a 'team huddle' each morning and nursing staff had a meeting each week.
- Audit was a routine method used to measure the effectiveness and success of clinical practice. A comprehensive population-driven audit programme was established with clear evidence of action taken to change practice and improve the service for patients.

Managing risks, issues and performance

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

- Risk to the service was well recognised, logged on the risk register and kept under scrutiny through regular review. Risks we noted on the day were on the register, such as the hearing booth not working properly
- 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.
- Processes were in place to manage current and future performance. Performance of clinical staff was demonstrated through a structured approach to peer review, including review of clinical records.
- A business continuity plan was in place and plan for major incidents was in place.

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.

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.
- A Patient Participation Group (PPG) had been set up and the first meeting was held in September 2018. Various units/departments had been represented. The minutes and

information on the PPG were displayed in the waiting room. The SMO was in the process of pursuing a Facebook PPG as this would possibly have wider appeal to the younger patient population.

- The practice had good and effective links with internal and external organisations including the welfare department, Regional Rehabilitation Unit (RRU), the DCMH and Defence College of Education.

A staff survey was carried out in October 2018 and the results were positive. A suggestion box was available for staff to submit thoughts and views anonymously.

Continuous improvement and innovation

Continuous improvement was embedded in the culture of the practice that demonstrated a patient-centred approach to developing the service. The practice maintained a detailed quality improvement register which showed learning points, evaluation of impact on practice and subsequent action taken. Sources of improvements were based on the outcome of feedback about the service, complaints, audits, staff suggestions, clinical meeting discussions and significant events.

Some examples of quality improvements made include:

- Development of a standard operating procedure (SOP) for the management of shared care.
- Ensuring that daily temperature readings were advertised at the main gate in the summer to alert runners to the temperature and thus minimise the risk of exertional heat illness.
- Patients presenting with boils were screened for PVL-SA (type of bacteria/poison).
- A laminated treatment of anaphylaxis (serious allergic reaction) held in kit box for quick access in an emergency.
- Condom machines were in the process of being installed in the toilets.

Future developments being considered included:

- Provision of GP Training
- Provision of an educational programme to trainees 'on hold' at the station.
- Further development of lifestyle intervention building on the Dofit programme.
- Further development of the group practice model to include other medical centres.
- Medic lead triage through the provision of a mentoring programme.