

Odiham Medical Centre

Quality report

Hook
Hampshire
RG29 1QT

Date of inspection visit:
04 December 2018

Date of publication:
6 February 2019

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 from our ongoing monitoring of data about services, and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Chief Inspector's Summary

Odiham Medical Centre is rated as Requires Improvement overall

The key questions are rated as:

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

We carried out an announced comprehensive inspection of Odiham Medical Centre on 4 December 2018.

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

The overall findings from the inspection:

- There was an open and transparent approach to safety. All staff knew how to raise and report an incident. We saw some inconsistencies with the management of significant events with no clear indication that a root cause analysis had been completed and actions identified to address what had occurred, or actions put in place to reduce the likelihood of re-occurrence.
- The practice had some systems in place to minimise risks to patient safety. However, areas of governance and staff management required review to ensure the effectiveness of these systems. For example, systems in relation to: infection control including the management of sharps bins; and safety of staff and patients throughout the building.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it. Access to physiotherapy appointments was good.
- The practice proactively sought feedback from staff and patients which it acted on. Results from the Defence Medical Services (DMS) patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- There was a clear strong leadership structure and staff felt engaged, supported and valued by management.
- Staff were aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

- The practice had a governance system in place and all staff understood their role and responsibilities in the structure.

Notable Practice

- The practice participated in a monthly aviation medicine dial-in; this was a telephone conference held by aviation trained GPs and the flight safety team and included international military medical centres. All the doctors (including locums who were aviation trained) had protected clinic time to dial-in. This was an opportunity for clinicians to update on air safety incidents related to aviation medicine, and any aviation medicine updates such as changes in policy.

The Chief Inspector recommends:

- Review the premises and facilities to establish whether improvements can be made to provide an environment that minimises risks for the patients and staff.
- Standardise use of Read coding to facilitate accurate clinical searches and so deliver a reliable system for reviewing vulnerable patients including those who are carers.
- Review the system for recall of patients with long term conditions.
- Ensure all staff are practised and trained so they provide effective care, specifically how to respond to a major and/or security incident.
- A review of formal governance arrangements including systems for assessing and monitoring risks should be embedded and understood by all staff. This should include management of infection control and some aspect of medicines management.

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

Our inspection team

The team that inspected Odiham Medical Centre included a CQC lead inspector and a team of specialist advisors including a GP, a practice manager, a nurse, a physiotherapist and a medicines team inspector.

Background to Odiham Medical Practice

Odiham Medical Centre is a helicopter flying station. There are approximately 1640 patients all of which are military service personnel predominantly aged between 18 and 55. In addition to routine GP services, the practice provides a range of other services including, immunisations, sexual health, smoking cessation, cervical cytology, over 40's health screen and chronic disease management. The Primary Care Rehabilitation Facility (PCRF) is located nearby and the dispensary is located in the building, however, the dispensary is temporarily closed. Maternity services are provided by NHS practices and community teams.

The practice is open on Monday, Tuesday, Thursday and Friday 08:00 to 17:00, and from 17:00 to 18:30 for urgent cases only. The practice opens on a Wednesday 08:00 to 12:00 and is closed in the afternoon for meetings and staff training, but access to a GP for urgent cases is available. There are no extended hours clinics, although if a patient was unable to attend in core hours this would be made available on an ad hoc basis. There is a duty medic within the practice for out of hours airfield cover only. There is also an aviation medical doctor on call and response time is within two hours between

18:30 hours and 08:00 hours. At weekends and on bank holidays, patients are diverted by a telephone message to NHS 111 services.

The practice team comprises a mix of military and civilian staff. The core team includes four military GPs, one full time equivalent (FTE) civilian GP, three military nurses, a pharmacy technician, three physiotherapists, and one Exercise Rehabilitation Instructor (ERI). The practice is managed on a day-to-day basis by a full-time practice manager and a Warrant Officer supported by 14 medics, (the work of a military medic is similar to that of a health care assistant in NHS GP practices but with a broader scope of practice).

Are services safe?	Requires improvement
---------------------------	-----------------------------

We rated the practice as requires improvement for providing safe services.

Safety systems and processes

The practice had systems to keep patients safe and safeguarded from abuse. However, there was some scope for improvement

- A framework of safety policies was in place and were regularly reviewed and accessible to staff, including temporary staff. Staff received safety information about the practice they were working in as part of their induction and during refresher training.
- Measures were in place to protect patients from abuse and neglect. Adult and child safeguarding policies were available and took account of local arrangements. A safeguarding lead and deputy were identified for the practice. They both had received level 3 training relevant for the role, and all staff were up-to-date with safeguarding training at a level appropriate to their role. Staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. The chaperone policy and notices were displayed advising patients of the service.
- Measures were in place to highlight and monitor vulnerable patients, including the use of Read codes and application of alerts on electronic patient records. A central register of vulnerable patients was maintained. We looked at the register and noted all patients had alerts on their records. However, this was a generic code highlighting that the patient had been discussed at a multi-disciplinary meeting and not that they were vulnerable or a carer. We discussed this with the Senior Medical Officer (SMO) and they agreed to re-consider this. The SMO attended welfare meetings and this forum was used to discuss and monitor the needs of vulnerable patients.
- The full range of recruitment records for permanent staff was held centrally. The practice manager could demonstrate that relevant safety checks had taken place including a DBS check to ensure staff were suitable to work with vulnerable adults and young people. DBS checks were renewed every five years. They also monitored each clinical member of staff's registration status with their regulatory body. All staff had professional indemnity cover. Information was in place to confirm staff had received the relevant vaccinations required for their role at the practice.
- The practice was clean and tidy throughout with exception of the emergency room which needed cleaning properly throughout. The Senior Non- Commissioned Practice Nurse was the infection prevention and control (IPC) clinical lead. There was an IPC protocol and staff had received up to date training. Annual IPC audits were undertaken, the last being in June 2018, and we saw evidence that action was taken to address any improvements identified as a result. The PCRf undertook their own IPC audits. Arrangements were in place for the safe management of healthcare and systems for safely managing healthcare waste. However, we noted that sharps bins were not managed appropriately with some not being dated or closed properly.

- Systems were in place to ensure facilities and equipment were safe. Electrical safety checks were undertaken in accordance with policy. Fire safety including a fire risk assessment, fire plan, firefighting equipment tests and fire drills were all in-date. Portable appliance and clinical equipment checks were up-to-date and records maintained.

Risks to patients

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

- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. For example, they had received medical emergency training in the last 12 months in dealing with chest pain and major sports injuries. Airfield incidents and crashes were proactively practised for, the last being in November 2018. It was noted that the PCRf staff had not been involved in the station wide emergency scenarios although they had seen the major incident policy.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Staff, including reception staff, had guidance available to identify and manage patients with severe infections, such as sepsis.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. There was a documented approach to the management of test results.
- The layout of the practice meant not all patients in two of the waiting areas could be observed by reception staff. This was particularly important in the event of a medical emergency.

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 saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- Summarisation of records was 95% completed on the patient electronic record system (referred to as DMICP) and were flagged for the nurse and/or doctor to review.

Safe and appropriate use of medicines

The arrangements for managing medicines and vaccines were well managed. This included arrangements for obtaining, recording and handling of medicines. However, some areas were needing improvement.

- The SMO was the lead for medicines management within the practice. The role of dispensing was delegated to a registered pharmacy technician when they were in post. The pharmacy technician was currently on sick leave and all dispensing was outsourced to the contracted community pharmacy. Another member of staff dealt with the administration of the prescriptions that were sent to the community pharmacy. There was no dispensing of prescriptions from the dispensary.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use. All staff who administered vaccines had received the immunisation training as well as the mandatory anaphylaxis training.

- Controlled drugs (CDs) were kept on the premises and were safely stored. Monthly and quarterly checks were completed on time, however, the quarterly signature only had a single signature. All CDs dispensed must be double checked, but we noted that the second check of CD dispensing was not always occurring. A prescription was noted where a CD was prescribed for patient to be administered within the treatment room. Although the dispensing had been double checked there was no record of who had collected this CD medicine for administration. If this had been collected by a health care professional, there was no record of their registration number nor a signature to state who had collected it.
- Patient medicine returns were recorded, a destruction certificate was completed with issue voucher for each destruction. The practice also accepted out of date CDs for destruction from supply flight first aid kits. However, the returns documentation was not complete with paperwork missing including who and what was returned to the practice dispensary. Without any paperwork there was no audit trail.
- Repeat prescriptions were accepted by telephone or in person and were reviewed regularly with the patients. DPHC guidance states that repeat prescriptions must only be in writing, we discussed this with the practice who agreed this would be done. Repeat medicines were processed within 48 hours.
- All prescription pads were stored in the dispensary which was locked at all times and entry was restricted. All forms were booked out of the bound register and signed out by individual prescribers.
- High risk medicines were managed effectively. We saw 11 patients who were prescribed these and all had shared care agreements in place. We saw these patients were regularly monitored with blood tests undertaken at the required times as per the shared care agreement.
- Oxygen and Nitrous Oxide was available in treatment rooms. The smaller cylinders were free standing and were not stored correctly.
- All Medicines and Healthcare Products Regulatory Agency (MHRA) safety notices and alerts were correctly logged on a spreadsheet with hyperlinks to the relevant webpage for the alert or safety notice. Only those alerts considered to be relevant were sent to the clinical staff.
- PGDs (Patient Group Directions) were in use to allow non-prescribing staff to carry out vaccinations in a safe way. PGDs were appropriately managed as staff had received training and authorisation by the SMO had been recorded. All had completed their relevant vaccine administration training.
- Out of hours, secondary care prescriptions and amendments to current therapy as directed by secondary care were receipted and scanned onto the system. A message was sent to the referring doctor to action anything that was necessary. In the absence of the referring doctor, the duty doctor was tasked to action any medication changes.

Track record on safety

The practice had a good safety record but some improvement was needed.

- The Warrant Officer was the lead for health and safety at each of the locations and had completed training relevant for the role. Risk assessments pertinent to the practice were in place including patient handling, needle stick injury, lifting and handling and lone working. A water test for Legionella had been completed.
- There was no alarm system in the practice and staff did not have individual alarms to summon assistance in the event of an emergency.

Lessons learned and improvements made

The practice reported incidents and were supported to do so. Systems needed improvement to ensure learning and improvement was identified and shared.

There was an electronic organisational-wide system (referred to as ASER) for recording and acting on significant events, incidents and near misses. All staff knew how to raise and report an incident. We saw some inconsistencies with the management of significant events with no clear indication that a root cause analysis had been completed and actions identified to address what had occurred, or actions put in place to reduce the likelihood of re-occurrence. Following the inspection, the practice informed us that these stemmed from legacy ASERs on the system having been submitted in the past and had not been completed in full. They were then unable to identify who had originally submitted them. Prior to closure of legacy ASERs, where there are no DMICP numbers to aid investigation, a generic review was not undertaken to ensure that any points of failure in processes and or protocols were being adhered to. A trend analysis of the legacy ASERs had not been performed.

Are services effective?

Good

We rated the practice as good for providing effective services.

Effective needs assessment, care and treatment

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

- The practice had systems to keep all clinical staff up to date. Clinicians routinely presented a NICE or other practice guideline at weekly clinical meetings and the team reviewed clinical practice accordingly. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. We saw evidence which showed there were processes in place to review updates, discuss these with clinical colleagues to ensure evidence-based best practice was updated in line with amendments. Audits were undertaken stemming from NICE recommendations, for example, for the management of hypertension.
- The practice participated in a monthly aviation medicine dial-in; this was a telephone conference held by aviation trained GPs and the flight safety team and included international military medical centres. All the doctors (including locums who were aviation trained) had protected clinic time to dial-in. This was an opportunity for clinicians to update on air safety incidents related to aviation medicine, and any aviation medicine updates such as changes in policy.

Monitoring care and treatment

The practice had a chronic disease management plan in place managed by the practice nurses. However, there was no structured recall procedure in place for when patients did not respond to recall reminder letters.

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.

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

- There were four patients on the diabetic register. DMICP records for these patients showed that cholesterol levels had been measured for all patients within the past 6 months and 3 were 5mmol/l or less. For three patients, their last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.
- There were 35 patients recorded as having high blood pressure. Thirty-three had a record for their blood pressure taken in the past nine months. Twenty-four patients had a blood pressure reading of 150/90 or less.
- There were 29 patients with a diagnosis of asthma. Twenty-four 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. The remainder were overdue as they had not attended their appointment and the recall system was not fully embedded.
- Thirty-one patients had been treated with new depressive symptoms between 1 April and 27 November 2018 (clinical audit completed 28 November 2018). Of these patients, three were excluded as no follow-up was deemed necessary at the initial consultation and three were new presentations within a few days of the audit. Of the 26 patients remaining, 12 had a review between 10 and 56 days after diagnosis, however the remaining 14 patients were all reviewed within 10 days of initial presentation (100% of new presentations were reviewed within 56 days of presentation; the audit report and chronic disease register reflected this data). We were assured their care was being effectively and safely managed, often in conjunction with other relevant stakeholders such as the welfare team and the Department of Community Mental Health (DCMH).

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:

- 99% of patients had an audiometric assessment within the last two years.

There was evidence that clinical audit was taking place. Audit activity was recorded and monitored by the practice managers through the healthcare governance (HCG) workbook, a system that brings together a comprehensive range of governance activities, including the risk register, significant events, patient safety alerts, Caldicott log, building fault log, quality improvement and audit. An audit calendar was in place that identified the audits to take place going forward. Clinical audits undertaken for the practice included: an asthma audit, hypertension audits, prescribing audits, and high-risk medicines, some of these were second cycle audits.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice could demonstrate how they ensured role-specific training and updating for relevant staff.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the

immunisation programmes, for example by access to on line resources and discussion at practice meetings.

- A comprehensive generic induction pack was in place for newly appointed staff. The induction pack took account of the specific requirements and culture for the practice. Role specific induction packs were also in place. We particularly noted the induction for clinical staff was thorough and competency based to ensure clinical staff were fully skilled in all aspects of military based primary care. As well as permanent military staff two locum GPs were trained in aviation medicine.
- Staff had access to one-to-one meetings, appraisal, coaching and mentoring, clinical supervision and support for revalidation. Clinical staff were given protected time for professional development and evaluation of their clinical work.
- Peer review was embedded in practice. 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. PCRf staff shadowed each other once every month and following this would then feedback to their peers. Good practice was shared with the practice as a whole and with the regional 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.

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital.
- Records showed that all appropriate staff, including those in different teams, services and organisations were involved in assessing, planning and delivering care and treatment appropriate to the needs of each individual patient.
- Clinical meetings to discuss patients were held each month between the physiotherapists and doctors. Patients referred to the PCRf were reviewed every two to four weeks. PCRf staff referred patients to other clinics if it was deemed appropriate to their rehabilitation, such as weight management and smoking cessation.
- The Medical Officers visited the Squadrons to discuss any health issues every month. The SMO attended the SMO attended welfare meetings where the needs of vulnerable patients, including patients with mental health needs were discussed.

Supporting patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- Records showed, and patient feedback confirmed, 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.
- Patients had access to appropriate health assessments and checks. Routine searches were undertaken to identify for patients eligible for bowel and breast screening.
- The PCRF were involved in the delivery of the DoFit programme, which supports weight loss through exercise and education to address lifestyle issues.

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 the practice patient population

- 98 % of patients were recorded as being up to date with vaccination against diphtheria.
- 98 % of patients were recorded as being up to date with vaccination against polio.
- 78% of patients were recorded as being up to date with vaccination against hepatitis B.
- 94% of patients were recorded as being up to date with vaccination against hepatitis A.
- 97 % of patients were recorded as being up to date with vaccination against tetanus.
- 99% of patients were recorded as being up to date with vaccination against yellow fever.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Are services caring?	Good
-----------------------------	-------------

We rated the practice as good for caring.

Kindness, respect and compassion

- We received 36 CQC comment cards completed prior to the inspection. All feedback in relation to how patients were treated by staff was positive. A theme identified overall was that patients felt respected and well cared for, with all staff showing kindness and respect. The two patients we spoke with echoed this view.
- 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.

- All patients admitted to hospital, including those unplanned admissions, were monitored via an admissions board in the administration room and ongoing support offered as needed.

Involvement in decisions about care and treatment

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

- An interpretation service was available for patients who did not have English as a first language and all staff we spoke with were aware of how to access it.
- The Patient Experience Survey showed from 79 patients asked, 86% felt involved in decisions about their care. Feedback from the CQC patient feedback cards supported this positive outcome.
- Patient information leaflets and notices were available in the patient waiting area advising patients how to access a number of organisations. We saw that information that was age appropriate and relevant to the patient demographic was prominently displayed and accessible. We saw a large display which showed patients a map of all areas of deployment, what risks those locations carried and what vaccinations were needed to keep them protected.

Privacy and dignity

The practice respects the privacy and dignity of patients.

- 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 areas meant that conversations between patients and reception could not be easily overheard. A television was on and minimised conversations being overheard. Reception staff said that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

Are services responsive to people's needs?	Good
---	-------------

We rated the practice as good for providing responsive services.

Responding to and meeting people's needs

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

- Staff understood the needs of its population and tailored services in response to those needs. For example, the practice offered both telephone appointments and flexible appointment times for those patients who could not attend in core hours.
- An access audit as defined in the Equality Act 2010 had been completed for the premises and reasonable adjustments had been made based on the patient population need. However, the practice had an access ramp in place but the doors adjoining this opened outward making access difficult. A request for this to be changed was made in February 2018 but had not been actioned to date.

Timely access to care and treatment

- The practice was open on Monday, Tuesday, Thursday and Friday 08:00 to 17:00, and from 17:00 to 18:30 for urgent cases only. The practice opens on a Wednesday 08:00 to 12:00 and is closed in the afternoon for meetings and staff training but access to a GP for urgent cases was available.

- Details of how patients could access the GP when the practice was closed were available through the base helpline. Details of the NHS 111 out of hours service was also displayed on the outer doors of the medical centre and in the practice leaflet.
- Patients with an urgent need were seen that day and the waiting time for a routine appointment was usually within two days. The most recent patient survey showed that 83% of patients were happy with the time of their appointment and 90% said it was at a convenient location.
- For routine physiotherapy appointments, the waiting time was in five working days. Patients with an urgent need were seen the same day. A direct access physiotherapist service (DAPS) was in place that included inclusion/exclusion criteria for self-referral.

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 and displayed to help patients understand the complaints process.
- The practice worked with the DPHC complaints policy and procedure. The practice manager was the designated responsible person for handling all complaints. We saw the practice leaflet contained the direct telephone number and email address to contact them if required.
- The patient survey showed that 79% of patients said they felt their concerns were listened to.
- A log of both written and verbal complaints was maintained. Odiham Medical Centre had received six complaints since March 2018 of which had been effectively managed with no emerging theme.

Are services well-led?	Requires improvement
-------------------------------	----------------------

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

Leadership capacity and capability

We found the management team had the capacity, experience, skills and tenacity to deliver high-quality, sustainable care.

- Everything we saw on the inspection day, and communications with the practice following the inspection, supported this.
- There was a clear leadership structure and staff felt supported by management. Staff told us the practice leaders were approachable and always took the time to listen to all members of staff.
- We saw that the staffing structure was structured but also flexible to enable staff to rotate through other posts when there were vacancies. We saw many examples of co-operative working throughout. For example, if a GP was running late another GP would take the next patient.
- The practice held and maintained minutes of a range of multi-disciplinary meetings to monitor vulnerable families and safeguarding concerns.
- There was a comprehensive meetings programme in place and the practice held regular whole team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- The practice was a positive training organisation and had been accredited as a training practice for GPs.

- Staff said they felt respected, valued and supported. All staff were involved in discussions about how to run and develop the practice, and the SMO encouraged all members of staff to identify opportunities to improve the service delivered by the practice.
- There were clearly allocated responsibilities in the practice with named deputies for cross coverage and resilience in the event of absence from the practice.
- Staff were aware of the systems to ensure compliance with the requirements of the duty of candour. (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). This included support training for all staff on communicating with patients about notifiable safety incidents. The leaders encouraged a culture of openness and honesty.

Vision and strategy

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

- The practice worked to the DPHC mission statement 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 practice had a culture of good quality sustainable care.

- Staff stated they felt respected, supported and valued.
- The practice focused on the needs of patients.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas.
- A comprehensive understanding of the performance of the practice was maintained. Practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice.

However, we saw that some areas of governance that required improvement;

- There were insufficient arrangements in place for identifying, recording and managing risks and issues, and for implementing mitigating actions. For example, there were inconsistencies in the oversight of significant event analysis, some aspect of medicines management and IPC.

Managing risks, issues and performance

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

- The practice manager and SMO understood the risks to the service and kept them under scrutiny through the risk register.
- 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.
- Plans were in place for major incidents and practice staff were familiar with how to respond to a major and/or security incident. PCRf staff were familiar with the plans but had not taken part in any emergency scenario training.
- There were no alarms throughout the building, staff did not carry personal alarms.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- There were good arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

- A patient experience survey was undertaken throughout the year and a suggestion box was in the patient waiting room.
- The practice had plans to engage and develop relationships with local health and social care providers.
- The practice, including a representative from the PCRf, attended unit welfare meetings each month.
- Patients through surveys and complaints received. There was no patient participation group.
- Staff through staff meetings, appraisals and one to one monthly discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement and innovation

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking. From minutes of meetings we reviewed, we noted that the leadership of the practice focussed on improving the quality of care for all patients. The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
