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

<table>
<thead>
<tr>
<th>Overall rating for this service</th>
<th>Good</th>
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<tbody>
<tr>
<td>Are services safe?</td>
<td>Requires improvement</td>
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<tr>
<td>Are services effective?</td>
<td>Good</td>
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<tr>
<td>Are services caring?</td>
<td>Good</td>
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<tr>
<td>Are services responsive to people’s needs?</td>
<td>Good</td>
</tr>
<tr>
<td>Are services well-led?</td>
<td>Good</td>
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</table>
Chief Inspector’s Summary

This practice is rated as good 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? - Good

We carried out an announced comprehensive inspection of Dartmouth Medical Centre on 15 January 2019. 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, skill and capability to provide a patient-focused service. Communication and cohesive working was highly evident with a strong ethos to continually drive improvements and improve outcomes for patients.
• The practice understood the needs of the patient population and made changes to ensure patient needs were met.
• The practice had systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them. However, some improvement was needed to keep patients and staff fully safe. This included personal safety alarms for staff and ensuring patients could be seen in the waiting room.
• The arrangements for managing medicines were safe. The security of blank prescriptions required improvement.
• The practice was clean throughout. However, assurances were needed to establish that all aspects of the cleaning policy were known and had been adhered to, including a deep clean.
• Infection control and clinical waste were well managed except for the security of the outside clinical waste bin which was not secure.
• Staff were aware of current evidence based guidance. They had received training so they were skilled and knowledgeable to deliver effective care and treatment. However, staff had not received training in the Mental Capacity Act. An induction plan was in place for locum staff but this was not specific to Dartmouth Medical Centre.
• The practice worked collaboratively and shared best practice to promote better health outcomes for patients.
• There was clear evidence to demonstrate quality improvement was embedded in practice, including an annual programme of clinical audit used to drive improvements in patient outcomes.
• The practice proactively sought feedback from staff and patients which it acted on. 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. However, equipment no longer in use should be removed. Access to the building was good although there was no level access directly into the reception area. An access audit as defined in the Equality Act 2010 had not been completed for the premises.

• 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:

• An Exercise Rehabilitation Instructor (ERI) led project investigating the link between injury and the amount of activity in Officer Cadets, utilising watches that track the amount of activity each training unit is completing each day;

• The ERI had an information stand at the monthly staff meetings to raise awareness of various health initiatives, for example the management of back pain.

The Chief Inspector recommends:

• Ensure the cleaning schedule is in line with Defence Primary Healthcare (DPHC) policy.

• Ensure systems for the security of clinical waste.

• Ensure blank prescriptions are kept securely.

• Review the premises and facilities to establish whether improvements can be made to provide an environment that minimises risks for the patients and staff.

• Ensure all staff are trained so they provide effective care, specifically training in the Mental Capacity Act.

• Comprehensive bespoke inductions for locum staff to be provided so that extra resilience is available.

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 comprised specialist advisors including, a GP, a practice nurse, a practice manager and a physiotherapist.

Background to the Dartmouth Medical Centre

Dartmouth Medical Centre provides primary care and occupational health to Phase 1 and Phase 2 Officer Cadets (OCs) and some permanent members of staff. An average of 150 new patients (OCs) arrive three times a year to commence training and join the practice. There is a high turnover of the population at risk (currently it is 650), where 142 are permanent members of staff and the remaining are 69 undergraduates located all over the country, and 440 are trainees.
In addition to routine primary care services, the practice provides occupational health care to service personnel, including force preparation. Family planning advice is available. Maternity and midwifery are provided by NHS practices and community teams. Patients have access to medicines through a community pharmacy located very near to the medical centre. A Primary Care Rehabilitation Facility (PCRF) is located on the premises, with physiotherapy and rehabilitation staff integrated within the medical centre.

The PCRF comprises of two clinical rooms within the main medical facility for the ERI and the physiotherapist. There is a separate rehabilitation gymnasium closely located, but not in the same building, where rehabilitation classes take place. There is access to an on-site swimming pool where hydrotherapy sessions take place.

The practice is open from 07:30 to 16:30 Monday to Thursday and on Friday 07:30 to 13:00. Arrangements are in place on weekdays for access to medical cover when the practice is closed.

The staff team comprised a mix of full and part time civilian and military staff and included:

- The Principal Medical Officer (PMO).
- One civilian GP (CMP) (one day per week).
- One Advanced Nurse Practitioner (ANP)
- One practice nurse.
- One medic - (A medic is trained to provide medical support and airfield crash 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).
- A physiotherapist and an Exercise Rehabilitation Instructor.
- A newly appointed practice manager was responsible for the running of the practice and a team of two administrators.
- A Regional Clinical Director (RCD) assumed overall accountability for quality of care at the practice.

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<tr>
<th>Are services safe?</th>
<th>Requires improvement</th>
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<td>We rated the practice as requires improvement for providing safe services.</td>
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**Safety systems and processes**

Systems to keep patients safe and safeguarded from abuse were in place. However, there was scope for improvement

- A framework of regularly reviewed safety policies was in place and accessible to staff, including locum staff. Staff received safety information about the practice as part of their induction and refresher training.
- Measures were in place to protect patients from abuse and neglect. The practice had both safeguarding children and vulnerable adult’s policies which had recently been reviewed. They were both displayed in the waiting area. The PMO had recently reviewed and updated the links with local agencies and these were displayed in clinical areas.
• The PMO was the practice safeguarding lead and was trained to level three. The locum CMP was also trained to level three. The practice manager was the deputy and they, along with all other clinical staff were trained to level two.

• The initial registration identified new patients who were vulnerable or subject to formal safeguarding arrangements. Codes were used on the electronic patient record system (referred to as DMICP), and regular searches made to highlight these patients. Vulnerable patients were discussed, with written consent, at the weekly Trainee at Risk Forum (TRAF). Practice staff had developed good relationships with the welfare team. The practice was represented at the monthly station welfare meetings where concerns about vulnerable patients were also discussed.

• All staff had received chaperone training and notices advising patients of the chaperone service were displayed in clinic doors. Staff had been subject to safety checks to ensure they were suitable to work with young people and vulnerable adults. If patients requested access to a female GP, male nurse or male Physiotherapist this could be facilitated via Raleigh or Drake medical centres that were situated approximately an hour away.

• 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, including locum 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). The practice nurse was the IPC lead and was suitably trained for the role. An annual IPC audit had taken place.

• Environmental cleaning was provided by an external contractor. The practice was visibly clean with a dedicated cleaner working within the practice five days a week for six hours a day. Cleaning schedules and monitoring arrangements were established. However, practice staff had not had sight of the cleaning contract so were unsure as to what duties the cleaning contractors should be doing. We noted that no thorough deep clean had been undertaken.

• Systems were in place for the safe management of healthcare waste. Consignment notes were retained at the practice and an annual last waste audit was carried out. We noted that the large container bin that was located outside was not secured and was freestanding due to issues with the practice being a listed building. This had been raised by the practice and was an item on their risk register for attention.

• Measures to ensure the safety of facilities and equipment were managed by the station environmental health technician. Electrical safety checks were completed within the last 12 months. Water safety measures were undertaken each week and checks each month. A fire risk assessment of the building was undertaken annually. Firefighting equipment tests were current. Staff were up-to-date with fire safety training and were aware of the evacuation plan.

• Equipment was checked and maintained according to manufacturers’ instructions. Testing of portable electrical appliances and medical equipment was in-date. We noted there was an item of electrotherapy equipment seen which was considerably out of service date (and not used within defence healthcare anymore); staff reported it had not been used for years and there
were issues with organising its removal. It was signed as ‘not in use’, although it was still within the clinical room.

Risks to patients

There were systems in place to assess, monitor and manage risks to patient safety. However, there was scope for improvement.

- The practice team was fully staffed and appeared appropriate for the patient numbers. The practice minimised the need for locum staff by observing Dartmouth Medical Centre block leave periods and other planned absences were covered by Raleigh or Drake Medical centres. Regional Head Quarters supported requests for locum staff for longer absences.
- To minimise risks associated with continuity, an induction process was in place for all staff to ensure they were familiar with systems and ways of working in Defence Primary Health Care (DPHC). The practice had an induction pack which covered mandatory and role specific induction for all clinical and administrative staff and locums. However, it was generic and was not specific to the practice which would be particularly useful for locum staff.
- 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 masks and emergency medicines were accessible to staff in a secure area of the practice; all staff knew of its location. A first aid kit and accident book was available. Routine checks were in place to ensure the required kit and medicines were available and in-date.
- The layout of the practice meant not all patients in the waiting area could be observed by reception staff. This was particularly important in the event of a medical emergency. This had been entered on to the practice risk register and following the inspection we received confirmation that a resolution to this was being pursued with some urgency.
- Staff were up-to-date with the required training for medical emergencies. They participated in regular training simulation exercises for emergency situations. The recognition and management of heat and cold injuries had been discussed as a team.

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. A process was established for scrutiny and summarising of patients’ records. There was no significant backlog of clinical records requiring summarisation.
- Staff described occasional loss of connectivity with DMICP but said this did not have a significant impact on patient care. If this happened, the business resilience plan was followed and urgent appointments only were offered.
- A dedicated member of the administrative team was responsible for the management of referrals, including internal referrals and those to external secondary care services. A referral tracker was in place that included a coloured system to identify if the status of a referral needed to be checked. Urgent referrals were followed up after two weeks.
- 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.
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, one area needed improvement.

- The PMO was the lead for medicines management within the practice. 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. Repeat prescriptions were accepted in person and were reviewed regularly with the patients. Repeat medicines were processed within 48 hours.
- 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 not kept on the premises.
- All prescription pads were stored in the printers in clinician’s rooms during the day and were securely locked away at night. However, they were left insecurely during breaks (lunchtime) as there were no locks on any of the doors. The PMO agreed that this could be easily resolved and arrangements would be made to keep them safe at all times. All forms were booked out of the bound register and signed out by individual prescribers.
- High risk medicines were managed effectively. We saw one patient who was prescribed these and there were managed entirely by the secondary care.
- 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. There was a designated lead and deputy responsible for this role.
- 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 PMO had been recorded. All had completed their relevant vaccine administration training.
- PSDs (Patient Specific Directions) were only used by the nurse prescriber and were appropriately managed.
- Out of hours, 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 CMP (Civilian Medical Practitioner) or the ANP was tasked to action any medication changes. There was a clear policy in place that reflected this process and staff were aware of it.

Track record on safety

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

- The practice manager was the lead for health and safety but had only been in post two days. They were planning to apply for formal training. Safety processes for the practice were monitored and reviewed, which provided a clear, accurate and current picture that led to safety improvements. Risk assessments pertinent to the practice in place, including those for hazardous substances, operating electrical equipment and lone working.
• There was no alarm system in the practice and staff did not have individual alarms to summon assistance in the event of an emergency. This was recorded on the practice risk register and alarms were being sought.

**Lessons learned and improvements made**

The practice learned and made improvements when things went wrong.

• 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 the initial electronic access to the system, including locum staff. However, the practice manager was new in post and did not yet have full access and the ANP also did not have full access as expected they would. We discussed this and the practice agreed to arrange this as soon as possible. It was also entered on the risk register in the interim.

• Staff provided several examples of significant events they had raised demonstrating there was a culture of effectively reporting incidents. ASERs were a standing agenda item at the weekly practice meeting and these were minuted. We saw evidence that showed the practice had raised 10 significant events from December 2017 to December 2018. A root cause analysis and comparison of incident types has been conducted to identify underlying issues and bring out any key lessons. For example, the process for blood results management was reviewed following two ASERs being raised, which led to a more robust procedure for the management of results.

<table>
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<th>Are services effective?</th>
<th>Good</th>
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<td><strong>We rated the practice as good for providing effective services.</strong></td>
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**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 weekly clinical meetings open to attendance by all clinicians. For example, the NICE updates for Primary Care from November 2018 were discussed at the December meeting.

Both the physiotherapist and the ERI attended the Regional Rehabilitation Unit meetings to discuss evidence based guidance, to share good practice and receive updates.

The PCRF had all the equipment and space it needed to deliver a safe and effective service.

**Monitoring care and treatment**

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

- There were two patients were on the diabetic register. Both patients had a last measured total cholesterol of 5mmol/l or less which is an indicator of positive cholesterol control. One of these patients had a last blood pressure reading of 150/90 or less, the other patients care was being completely undertaken by secondary care services.

- There were nine patients recorded as having high blood pressure. Seven patients had a record for their blood pressure taken in the past nine months. Nine of these patients had a blood pressure reading of 150/90 or less.

- There were five patients with a diagnosis of asthma. All had received an asthma review in the preceding 12 months which included an assessment of asthma control using the three Royal College of Physicians questions.

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

We looked at a range of patient records and were assured that the care of patients with a mental illness and/or depressive symptoms were being effectively and safely managed.

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). Audiometric assessments for Phase One trainees were in date for 93% of patients.

Audit was evident in the practice and seen as the responsibility of all staff. A programme of audit was in place. There was a dedicated audit template used for consistency which identified the auditor, initial or repeat audit, date the audit was presented to the team and review timeframe.

Where appropriate, audit referenced organisational and/or national best practice. Examples of audits undertaken included: appointment waiting times; antibiotic prescribing; results handling; long term conditions, and PCRF treatment processes. We saw an audit had been undertaken by another clinician from another practice regarding anti-biotic prescribing. The results showed a good baseline of compliance with a small amount of work needed to further improve. A re-audit was scheduled for six months’ time. We noted that no minor operations audit had yet been undertaken. This had been planned for on the audit calendar but had not yet been completed due to the very low numbers of operations being carried out.

Effective staffing

Continuous learning and development was promoted at the practice.

- Mandated training was monitored and the staff team was in-date for all required training except for training in the Mental Capacity Act. Following the inspection, we saw that this had been added to the risk register for action. Competency checks were undertaken where appropriate. Role-specific training was encouraged, such as additional training for the IPC lead.

- The Regional Rehabilitation Unit (RRU) undertook advisory visits to the PCRF to support the physiotherapist and ERI. Written feedback was seen.
All staff had an identified workplace supervisor and had access to one-to-one meetings, mentoring and support for revalidation. Clinical staff were given protected time for professional development. We saw that clinicians had protected time for peer review. The PMO and ANP regularly gave teaching sessions based on case reviews with all clinical staff.

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 clinical records we reviewed showed appropriate staff, including those in different teams, services and organisations were involved in assessing, planning and delivering care and treatment.

- The practice had developed good working relationships both internally and with health and social care organisations. The clinicians and PCRF staff held meetings on a regular basis to discuss and monitor patients under the care of PCRF. The notes seen on the electronic clinical system were not always appropriately Read-coded, the staff present at the meetings were not always listed, and the actions / outcomes of each review were not clearly assigned. It was suggested by staff a reason for this may be that there were a large number of patients to review within the time allocated for the MDT session.

- The PMO and physiotherapist attended the Unit Health Committee (UHC) meetings held each month. These meetings reviewed the needs of patients who were medically downgraded and those who were vulnerable.

- The PMO had visited the local NHS practice with a view to establish links and relationships.

Helping patients to live healthier lives

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

- Clinical records showed that staff encouraged and supported patients to be involved in monitoring and managing their health. Staff also discussed changes to care or treatment with patients as necessary.

- The practice supported national priorities and initiatives to improve the population’s health including, stop smoking campaigns and tackling obesity. A health promotion display board was available to patients and it was refreshed based on the annual health promotion calendar. At the time of the inspection it provided information about how to manage flu symptoms.

- We saw posters, displayed throughout PCRF and the rehabilitation gym with clear advice on exercises and progressions.

- We saw two nurses had received additional training in sexual health. Information was available for patients requiring sexual health advice, including sign-posting to other services and a very informative, yet discreet, information board located in the corridor.

- Patients had access to appropriate health assessments and checks. Routine searches were undertaken for patients eligible for bowel and breast screening and appropriate action taken if patients met the criteria.
It is important that military personnel have sufficient immunity against the risk of contracting certain diseases. The World Health Organisation sets a target of 95% for vaccination against diphtheria, tetanus, pertussis and polio and measles, mumps and rubella.

The latest data (December 2018) showed lower rates of vaccinations for some population groups. These groups consisted of

- Military staff teaching the Phase One Officer Cadets
- Army personnel providing security for the college.
- Officer Cadets
- International Cadets who arrive with little information and who are vaccinated against a different schedule to the Royal Navy.
- Medical and dental students currently at university on cadetships that are registered at the medical centre but are located remotely in other location within the country.

Data was difficult to accurately search for due to these differing population groups. The current data showed good levels of Force Protection for the Cadets and permanent staff.

- Cadets (272) were 93% and above for all vaccinations.
- Permanent staff (79) were 93% and above for all vaccinations except for MMR and Typhoid which were lower.

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.

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<th>Are services caring?</th>
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We rated the practice as good for caring.

Kindness, respect and compassion

Staff supported patients in a kind and respectful way.

- Throughout the inspection staff were courteous and respectful to patients arriving for their appointments.
- Results from the September 2018 Patient Experience Survey showed that from the 30 surveys received, 93% said they would recommend the practice to family and friends. We received 23 CQC comment card completed prior to the inspection. We saw that 22 were entirely positive about the attitude of staff.
- The practice had an information network available to all members of the service community, known as HIVE. This provided a range of information to patients who had relocated to the base and surrounding area. Information included what was available from the local unit and from civilian facilities, including healthcare facilities. The practice used the HIVE social media page to communicate with civilian patients.
Involvement in decisions about care and treatment

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

- Interpretation services were available for patients who did not have English as a first language. Notices were displayed in clinical areas and in reception informing patients this service was available. Resources had been developed to meet the communication needs of staff from minority groups and these resources could be made available for patients if needed. For example, staff notices were available in Arabic.

- The Patient Experience Survey showed that 90% of respondents felt involved in decisions about their care. Feedback on the CQC patient feedback cards highlighted that patients received information about their treatment to support them with making informed decisions about their treatment and care.

- The practice proactively identified patients who were also carers. There were processes 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. Four adults were identified as having caring responsibilities. Where appropriate, their needs were discussed, with their consent, at the college welfare meetings each month.

Privacy and dignity

The practice respected patients’ privacy and dignity.

- Curtains were provided in consulting rooms to maintain patients’ privacy and dignity during examinations, investigations and treatments. Clinic room doors were closed during consultations.

- The layout of the reception area and seating, meant that conversations between patients and reception could be overheard. The practice had addressed this by installing a television to minimise conversations being overheard.

- 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 see a GP of a specific gender.

Are services responsive to people’s needs?  | Good

We rated the practice as good for providing responsive services.

Responding to and meeting people’s needs

Services were organised and reviewed to meet patient needs and preferences where possible.

- An access audit as defined in the Equality Act 2010 had not been completed for the premises. The practice did have an accessible toilet and access to parts of the facility were available via a side entrance. The practice manager has identified that a ramp was required to access the reception area but this was yet not included in the risk register.

- The practice has recently reviewed opening times to see urgent cases from 07:30 prior to the start of training at 08:00, they had also introduced urgent care clinics in the afternoon. The practice had an arrangement in place with another base for cover between the hours of 16:30 and 18:30 and for out of hours cover for new intake students who were restricted to the college
and did not have transport; Opening times and contact numbers were clearly displayed outside the facility and in the patient leaflet available in the waiting room.

**Timely access to care and treatment**
Patients’ needs were met in a timely way.

- Patients with an emergency need were seen that day and the waiting time for a routine appointment was one to two days. Double appointments at either the request of the clinician or patient could be made.
- The practice leaflet identified that home visits were not routinely provided but may be undertaken in exceptional circumstances the discretion of the PMO. We saw the policy was displayed in the patient waiting area.
- Patients accessed physiotherapy via the GP as a direct access physiotherapist service (DAPS) was not yet in place.
- We talked with one patient on the day who said their wait for physiotherapy was an issue we saw another written comment in the PCRF patient satisfaction survey which mirrored this. On inspection day, despite liaison with RHQ, we were unable to obtain the PCRF dashboard, which reports the KPI’s including the access to physiotherapy waiting times, over time. A real-time sample of the DMICP diary on the inspection day showed the next available new patient appointment within five working days.

**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. Both a complaints and compliments log was maintained.
- The practice manager was the designated responsible person who handled all complaints and the ERI deputised in their absence. A record of complaints was maintained, including verbal complaints. Three complaints had been received in the last 12 months. They had been managed effectively and resolved to the satisfaction of the complainants.
- Any complaints were discussed at the practice meetings and lessons identified. Changes to practice were made if feasible and used to improve the patient experience. For example, the PMO had conducted a waiting times audit following one of the complaints and intended to re-audit in three months.
- A suggestion box, forms and pens were located in the waiting area for patients to leave feedback.

**Are services well-led?**

| Good |

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

**Vision and strategy**
The practice worked to a clearly defined mission statement and vision including the Defence Primary Health Care (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 mission and vision.

Leadership capacity and capability

- On the day of inspection, the leaders in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate 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.

Culture

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

- Staff told us they felt respected, supported and valued. Staff described an inclusive approach involving all staff supporting each other. 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.
- Openness, honesty and transparency were demonstrated when things went wrong. A no-blame culture was evident; complaints and incidents were 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 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.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.

Governance arrangements

An effective overarching governance framework in place which supported the delivery of good quality care.

- There was a clear staffing structure in place and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. Terms of reference were in place to support job roles. The regional management team worked closely with the practice.
- The practice worked to the 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 communications were used at the practice. A schedule of regular practice and department meetings were well established. This included two staff meetings per week which all staff attended. ASERs, quality improvement initiatives, audit and complaints were all discussed during those meetings to support an inclusive ethos.

- Audit was a routine method used to measure the effectiveness and success of clinical and administrative practice. An audit programme was established with evidence of actions taken to change practice and improve the service for patients.

- There was a comprehensive leads and deputies list displayed around the practice, these roles were documented in respective staff Terms of Reference (TORs) meaning that all staff understood and knew their own responsibilities.

**Managing risks, issues and performance**

There were processes in place for managing risks, issues and performance. There was scope for improvement and this was being addressed.

- Risk to the service were well recognised, logged on the risk register and kept under scrutiny through regular review. The risk register showed the practice had identified the need for personal alarms and CCTV in the patient waiting area. The PNO was addressing these issues with some urgency.

- Processes were in place to monitor national and local safety alerts, incidents, and complaints. A business continuity plan 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 received a Health Governance Assessment Visit (HGAV) from the regional team in 2016. The practice had completed the resulting actions identified in a management action plan (MAP)

**Engagement with patients, the public, staff and external partners**

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

- There were various options in place to encourage patients to provide feedback on the service and contribute to the development of the service. A patient experience survey was undertaken throughout the year.

- The staff team enjoyed regular team days together, the most recent being a clay pigeon shooting day.

- A Patient Participation Group (PPG) had been set up and the first meeting was held at the beginning of December 2018. Six people attended the first meeting. The meeting generated a discussion about communication, appointment access and general discussion about the practice and how improvements could be made.
• There was a suggestions box in the waiting room and from suggestion made a ‘you said we said did’ board was displayed also in the waiting room. In response to feedback from patients there was now a television in the waiting room and the practice had amended their opening time for urgent cases in the mornings. There also had been an audit undertaken about waiting times and this was under review.

• The practice had good and effective links with internal and external organisations including the Regional Rehabilitation Unit (RRU), the Department of Community Mental Health (DCMH) and local NHS primary care providers.

Continuous improvement and innovation

We found numerous examples of that improvements that had been made based on the outcome of feedback about the service, complaints, audits and significant events. These included:

• An ERI-led project investigating the link between injury and the amount of activity in Officer Cadets, utilising watches that track the amount of activity each training unit is completing each day;

• A written proforma to give to unit staff so they know which exercises injured personnel could safely complete;

• The ERI had an information stand at the monthly staff meetings to raise awareness of various health initiatives, for example the management of back pain.

• The practice had developed a document for the patient to give to their line manager to inform them of their downgrade /upgrade following their consultation. It gave good clear instruction as to any restrictions in their work.