

# Brawdy Medical Centre

## Quality report

Cawdor Barracks  
Brawdy  
Haverfordwest  
Pembrokeshire  
SA62 6NN

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28/02/2019

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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	Requires improvement 
Are services safe?	Requires improvement 
Are services effective?	Requires improvement 
Are services caring?	Good 
Are services responsive to people's needs?	Good 
Are services well-led?	Requires improvement 

# Chief Inspector's Summary

## **This practice is rated as Requires Improvement overall**

The key questions are rated as:

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

We carried out this announced follow up comprehensive inspection on 28 February 2019. This report covers our findings in relation to the recommendations made and any additional improvements made since our last inspection.

The previous inspection took place on 22 March 2018 and the practice was rated inadequate overall. A copy of the report from that comprehensive inspection can be found at:

[https://www.cqc.org.uk/sites/default/files/20180628\\_brawdy\\_medical\\_centre.pdf](https://www.cqc.org.uk/sites/default/files/20180628_brawdy_medical_centre.pdf)

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:**

- Contracts for clinical services had been revised and contract monitoring arrangements strengthened, which meant clinical service provision was consistent and sustainable.
- Uncertainty about the leadership and management of the practice beyond the end of March 2019 meant a risk to the recently revised governance systems effectively embedding.
- Staff felt engaged, supported and valued by management.
- 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.
- Safeguarding systems were effective in ensuring vulnerable patients, including young people were monitored.
- The assessment and management of risks was detailed and recognised as the responsibility of all staff.
- Clinical records were not consistent in terms of the quality of record keeping, including the coding used.
- Clinical staff had not received the full range of training based on patient population need, such as training in thermal injuries.
- The arrangements for managing medicines needed improving, including the monitoring of patients prescribed high risk medicines.

- Staff were aware of current evidence based guidance and worked collaboratively and shared best practice to promote better health outcomes for patients.
- There was evidence to demonstrate quality improvement was starting to embed in practice, including the development of annual programme of clinical audit.
- The practice proactively sought feedback from staff and patients which it acted on. Results from the Defence Medical Service patient survey showed patients were treated with compassion and were involved in their care and decisions about their treatment.
- Information about how to complain was available. Improvements were made to the quality of care as a result of complaints.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

### **The Chief Inspector recommends:**

- Clinical staff have access to and receive training appropriate to meeting the needs of the patient population.
- The arrangements for medicines management are reviewed to ensure they are managed in accordance with operational policy.
- A risk assessment is undertaken and procedure agreed in the event of a medical emergency occurring when staff are treating patients at the gym.
- An action plan is developed in response to the infection prevention and control audit.
- The practice ensures that the privacy and dignity of patients is maintained at all times.
- An in-depth review of clinical records, use of clinical templates and Read coding to ensure consistent recording of clinical decision making and patients' conditions.

**Dr Rosie Benneyworth** BM BS BMedSci MRCGP  
Chief Inspector of Primary Medical Services and Integrated Care

### **Our inspection team**

The inspection was led by a CQC lead inspector and included a GP, practice manager, physiotherapist, practice nurse and pharmacy specialist advisors.

### **Background to Brawdy Medical Centre**

Rurally located and a short distance from the village of Brawdy, the medical centre provides a routine primary care, occupational health and rehabilitation service to a military personnel population of approximately 500, some of whom are subject to operational deployment at any time. In addition to providing a service to three units, the medical centre also oversees the occupational health needs of a small reservist population.

Medical cover is provided under a contractual agreement by a local NHS primary care practice. Three GPs provide this service from 08:30 to 11:30 Monday to Thursday. The medical centre staff team comprises a locum practice manager, two practice nurses, a practice administrator and two physiotherapists.

Although not employed by the medical centre, the practice is supported by two combat medical technicians (referred to as medics) who are attached to the unit. In the army, a medic is a soldier

who has received specialist training in field medicine. It is a unique role in the forces and their role is like that of a health care assistant in NHS GP practices but with a broader scope of practice.

The medical centre is open from 08:00 to 17:30 Monday to Thursday and is closed on a Friday. The arrangements for access to medical care outside of opening hours are outlined in the practice leaflet and directs patients to contact NHS 111. Medical cover is provided by the NHS practice when the practice is closed and before NHS 111 commences.

<b>Are services safe?</b>	<b>Requires improvement</b>
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**We rated the practice as requires improvement for providing safe services.**

Following our previous inspection, we rated the practice as inadequate for providing safe services. We found gaps in processes to keep patients safe including: systems for managing significant events; patient safety alerts; clinical record keeping; safeguarding of vulnerable patients; infection prevention and control (IPC); management of specimens; staff recruitment and medicines management, including high risk medicines.

At this inspection we found the recommendations we made had mostly been actioned. Some further action was required in relation to medicines management. The practice is now rated as requires improvement for providing safe services.

### **Safety systems and processes**

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

- A framework of regularly reviewed safety policies was in place and accessible to staff, including locum staff. Staff received safety information about the practice as part of their induction and refresher training.
- Measures were in place to protect patients from abuse and neglect. Adult and child safeguarding policies were available to all staff. All staff had received up-to-date safeguarding training appropriate to their role and knew how to identify and report concerns. The senior GP was the safeguarding lead and one of the practice nurses was the deputy. Both had completed level 3 training.
- Coding and alerts were used on the electronic patient record system (referred to as DMICP) to identify patients who were vulnerable. A register of vulnerable patients was also maintained.
- We spoke with the welfare officer for the camp who described improved integration between the practice and unit. Chaired by the Chain of Command, Unit Health Committee (UHC) meetings were held at the medical centre each month and a GP attended. The welfare team used a vulnerable risk management (VRM) tool that provided a pathway to support patients assessed as vulnerable and/or at risk. All patients supported through VRM were reviewed at the UHC a minimum of every 28 days.
- Staff who acted as chaperones were trained for the role and had been subject to safety checks to ensure they were suitable to work with young people and vulnerable adults. Notices were displayed advising patients that a chaperone was available.
- The full range of recruitment records for permanent staff and staff providing a service under contract was held centrally. The practice manager could demonstrate relevant safety checks had taken place at the point of recruitment, including a Disclosure and Barring Service (DBS) check to ensure staff were suitable to work with vulnerable adults and young people. DBS checks were renewed every five years. The DBS check for one of the medics had expired and

they were not seeing patients while it was being renewed. The GPs were on the performers list for Wales and had DBS checks undertaken as part of that process. The performers list is a process that provides an extra layer of reassurance for the public that NHS GPs are suitably qualified, have up to date training and have passed other relevant safety checks to ensure they can provide a service to vulnerable people. However, Defence Primary Health Care (DPHC) were in the process of undertaking its own DBS checks for the GPs.

- 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 system to manage infection prevention and control (IPC). The practice nurse was the lead for IPC and had completed appropriate training for the role. All staff currently working at the practice had received IPC training. Although an IPC audit had been completed, an action plan had not been developed to address the areas that needed improving. Arrangements were in place for environmental cleaning one hour in the morning and an hour in the afternoon. A recent restructure of the schedule meant the clinical high-risk areas were being more effectively cleaned. Deep cleans were undertaken twice a year. An environmental cleaning audit had been undertaken.
- Clinical waste was stored appropriately. Usually it was stored outside but had been moved indoors temporarily to a spare room while awaiting the bin lock to be fixed. An annual waste audit had been completed and consignment notes maintained.
- The practice ensured that facilities were safe. Electrical safety checks were completed as required and water safety checks were undertaken regularly. A legionella risk assessment had been carried out for the camp and the medical centre had access to the certificate. Fire safety management including regular checks were carried out, including the testing of firefighting equipment. Staff were up-to-date with fire safety training. Arrangements were in place for the monitoring and maintenance of equipment. Testing of portable electrical appliances and medical equipment was in-date.

## **Risks to patients**

There were systems to assess, monitor and manage risks to patient safety. However, some improvement was needed.

- Staff confirmed the practice and PCRf had an enough suitably skilled clinician time to meet the needs of the patient population. For example, one of the GPs was trained in sports medicine. Specific induction packs were in place to orientate and support locum staff with practice working systems.
- The practice was equipped to deal with medical emergencies and records were maintained of the status of staff training in emergency procedures. The physiotherapists were out of date with anaphylaxis training. It was acknowledged in the practice meeting minutes from 14 February 2019 that outstanding anaphylaxis training would be delivered in-house by a suitably qualified clinician. Emergency medicines and equipment were in place and records confirmed they were checked monthly. The blood glucose monitor on the emergency trolley was the incorrect one for multiple patient monitoring. The correct ones were available but not in use.
- The physiotherapists regularly worked from the gym that was not co-located with the medical centre. A risk assessment had not been undertaken and plan developed to outline how a medical emergency would be managed.

- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. The GP provided two examples of medical emergencies that had occurred and the responses taken were appropriate. GPs had received sepsis training through their general training schedule. Although they had not received formal training in thermal injuries, the GP we spoke with had treated patients for heat stroke. The remainder of the staff team had not received specific training in sepsis or thermal injuries. A cold injury display was located in the patient waiting room
- Since the last inspection CCTV had been installed so the waiting area could be monitored to ensure patients safety.

### **Information to deliver safe care and treatment**

Staff had the information they needed to deliver safe care and treatment to patients.

- The practice was following the new Department of Primary Healthcare (DPHC) guidance for patient registration and deregistration, which incorporated a summarisation template on DMICP. The template prompted staff to summarise the patient's notes when the patient was having their initial health check.
- Staff described losing connectivity with DMICP as frustrating because it limited access to the patient's record; important for consultation and proposing a treatment plan. How to respond to DMICP outages was outlined in the business continuity plan. If patients were seen at the NHS practice then their clinical notes were handwritten (referred to as an FMed5) and given to the patient to take to Brawdy Medical Centre. The FMed5 was then scanned onto their DMICP record.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. The GPs typed their own referrals and passed them to the administrator for processing. A comprehensive referral register was maintained and the administrator and practice nurse monitored the progress of referrals.
- Since the last inspection a pathway had been developed for specimen handling and transportation of samples. Military transport was now used to transport samples in a specific transport box. Although a process was in place for immediate action in response to abnormal results, this was not illustrated in the pathway. The practice nurse said they would update the pathway to reflect this. The specimen fridge was stored in the dispensary and required labelling to identify its purpose and prevent medicines being inadvertently stored in it.

### **Safe and appropriate use of medicines**

Although improvements to the management of medicines had been made further improvement was needed.

- The Band 6 practice nurse was the lead for medicines management at the practice. All prescriptions and dispensing was outsourced to a local pharmacy. The outsourcing process was carried out by the administrator.
- The process for managing medicine stocks was not in accordance with DPHC policy as entries were incorrectly coded on DMICP. All vaccines were date checked prior to entry into the system. There were no named members of staff to deal with ordering and managing the receipts of vaccines. The lock on the fridge was broken and the room the fridge was kept in could not be locked as it held the medical emergency kit. This meant vaccines were not held securely.

- The fridge temperature was monitored to ensure vaccines were stored within the correct temperature range. During closures, vaccines were appropriately transported to the pharmacy the practice had outsourcing arrangements with. However, there was no formal agreement in place with the pharmacy. A number of out-of-date medical items were identified in the dispensary, treatment room and in the doctor's room. A medicines risk management audit had been carried out by the regional team. It had failed to identify the out-of-date items we found.
- Although a process was in place to monitor prescriptions issued for controlled drugs (CD), no formal process was established to monitor the prescribing of CDs. CDs were not held on the premises and just one accountable drug (AD) was in stock. It was stored in a locked and sealed trolley and recorded in the CD register. AD checks were not taking place in accordance with DPHC policy i.e. checks by two people and an external check.
- Prescriptions were held in the CD cupboard. However, access to the keys for this cupboard was not controlled as the keys were not being signed in and out. Repeat prescriptions were requested in person by the patient, transcribed onto a telephone message note and passed to the GP. This was contrary to DPHC procedure on repeat prescribing which requires all requests for repeat prescriptions to be recorded by the patient.
- A tracker system was in place to monitor patients prescribed medicines by other services, such as secondary care and out-of-hours. From this, the GP added the prescription to the patient's record. All patients discharged from secondary care were reviewed by the GP. Patients prescribed medicines for long-term conditions had an annual medicines review. If there were any concerns then the reviews were carried out more frequently. Measures were in place to ensure repeat prescribing was managed in a safe way.
- Patient Group Directions (PGD) had been adopted by the practice to allow nurses to administer medicines in line with legislation These were current and signed. The practice nurse had completed the necessary training in accordance with DPHC policy and had been signed off by the GP to work with PGDs. The exclusions for certain PGDs was not documented. A PGD audit had not been undertaken but a vaccination audit had been completed in December 2018 and showed compliance.
- Whilst a register of patients on high risk medicines was in place, it was not accurate. We noted a patient on a medicine for a gastric disorder was not on the register. There was no indication from the clinical records how often the patient should have their blood tested while taking this medicine. We noted another patient on the register did not have a shared care agreement in place. The practice had followed this up with secondary care on 27 February 2019. An audit of high risk medicines was scheduled on the audit calendar for April 2019.
- Uncollected prescriptions were destroyed but not recorded in DMICP. A prescription for antibiotics from the end of January 2019 had not been collected and there was no record to indicate this had been followed up with the patient.
- Searches had been undertaken for women of child bearing age prescribed Valproate (medicine used to treat bipolar disorder, migraine and other disorders).

### **Track record on safety**

The practice had a good safety record.

- A medic was the lead for health and safety. We highlighted at the previous inspection that medics attached to the unit were not ideal for lead roles as they were subject to both planned and unplanned absences based on the requirement of their unit. Shortly after the inspection,

the practice manager confirmed that all lead roles now included a deputy who was a civilian member of staff.

- Risk assessments pertinent to the practice were in place including risk assessments for acupuncture, needle stick injury and for products hazardous to health.
- All clinical rooms had alarms for staff to summon assistance in the event of an emergency. The PCRf team carried personal alarms. There was no lone working in the building

### **Lessons learned and improvements made**

The practice learned and made improvements when things went wrong.

- All staff had electronic access to the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events, incidents and near misses. The practice manager completed the process and carried out any investigations required. Staff provided several examples of significant events demonstrating they were effectively reporting incidents. Significant events were a standing agenda item at the weekly practice meetings.
- The practice manager checked the system twice a day for medical alerts. Relevant alerts were circulated to staff via email and also discussed at the practice meetings.

<b>Are services effective?</b>	<b>Requires improvement</b>
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**We rated the practice as requires improvement for providing effective services.**

Following our previous inspection, we rated the practice as inadequate for providing effective services because processes for monitoring patient care and treatment were not consistent. There was minimal evidence of quality improvement activity, including clinical audit. In addition, there were gaps in training and knowledge, and the clinical skills of the medics were underutilised.

At this inspection we found the recommendations we made had been actioned or there was an action plan. The practice is now rated as requires improvement 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. Clinical staff were aware of evidence based guidance and standards, including guidance from the National Institute for Health and Care Excellence (NICE). Staff referred to this information to deliver care and treatment to meet patients' needs. They described how updates on NICE and medicines management were outlined in a newsletter circulated to clinical staff by the DPHC each month. NICE guidance was a standing agenda item at the weekly practice meetings.

Because the practice was small with limited availability of the GPs, practice and health governance meetings were integrated. We noted that quality improvement, audit and clinical governance were standing agenda items at the meetings. Staff said that the meetings had supported with team cohesiveness, communication, shared learning and coordination of care. The physiotherapists referred to best practice guidelines in their treatment of patients, such as the Defence and Directory rehabilitation website.

### **Monitoring care and treatment**

The band 6 practice nurse was the lead for chronic disease management and they carried out monthly searches to monitor patients diagnosed with a chronic condition and ensure patients were recalled in a timely way.

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 recorded as having high blood pressure. Both had a record for their blood pressure taken in the past nine months and both had a blood pressure reading of 150/90 or less.
- There were five patients with a diagnosis of asthma and four 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 remaining patient had recently left the practice.
- There were no patients with a diagnosis of diabetes.
- A search of the referrals showed that two patients had been referred to the Department of Community Mental Health (DCMH). We were advised that a plan was in place for the community psychiatric nurse based at the DCMH to attend the UHC meetings each month.
- We looked at the clinical records for 12 patients, including those with a chronic condition and patients being treated for depression. Although we saw examples of good quality record keeping, Read coding was not consistent and standard review templates were not always used. For example, a patient was coded as eligible for repeat prescriptions when it was not the case. Instead of using templates, reviews were written freehand style. This meant another GP taking over care may find it difficult to effectively track the patient's care based on the clinical records. We noted a patient was prescribed an anti-depressant with no reason for this recorded and no record of whether the patient was offered mental health support. We found no evidence in the records we looked at that chronic disease medication review templates had been used.
- A process of quarterly clinical peer review had been introduced for records maintained by nurses, GPs and medics. We looked at the peer review of the nurse's clinical records undertaken in December 2018. Undertaken by the regional nurse, the review followed a clearly defined structure that addressed coding, medical history, detail, medication and consent. Points of good practice and areas for improvement were identified. The findings of peer review were presented at the practice meeting. The PCRf reviewed clinical notes annually and this was last undertaken in October 2018. The practice was unable to provide us with a copy of the peer review of GP records.

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 75% of patients. There was no comparable regional or national data. Audiometric assessments were appropriately recorded in accordance with the Hearing Conservation Programme.

Quality improvement was very limited at the previous inspection, in particular clinical audit. An audit programme capturing data system searches, mandated audits and clinical audit based on the measurement of outcomes had been developed for 2018/19. It was still in the early stages and most audits were on their first cycle. The audit programme did not show all the stages for each audit, notably the implementation of change to improve outcomes. It also did not integrate the audit activity taking place at the PCRf. Examples of audits that had taken place included cytology, asthma, management of vaccinations and sampling. A quality improvement project in relation to results handling had been undertaken by the practice nurse in February 2019. This led to a change in practice in relation to ensuring improved communication with secondary care requests for blood samples.

The NHS practice had an external audit for antibiotic prescribing. Based on the findings, the GPs had reviewed their antibiotic prescribing, applying the lessons learnt also to Brawdy Medical Centre.

### **Effective staffing**

In addition, the GPs had received internal occupational health training specifically in relation to the assessment and management of downgraded personnel. They were also being supported with downgrading by the regional occupational health nurse. The GPs were not included in invitations to regional training within the military. Access to this training may have supported them with training in thermal injuries and other clinical areas particular to the patient population. The GPs were required to keep up to date with training and appraisal in order to remain on the performers list.

A generic induction and role specific induction packs were in place. We noted that one had been thoroughly completed for a recently recruited member of staff. The practice manager had a system in place and checked each month that staff were up-to-date with mandated training. The staff team had not been in post long enough for an appraisal. A record of the NHS appraisal completed by the GPs was included in the checks.

Records of skills, qualifications and training were maintained for all staff. Staff were encouraged and given opportunities to develop. Staff had access to one-to-one meetings, appraisal, mentoring and support for revalidation.

Nursing staff were given protected time for professional development and evaluation of their clinical work. Peer review was achieved through case discussion, record reviews and clinical supervision.

At the last inspection we identified that the clinical skills of the medics were not being used effectively. They were undertaking an administrative role due to staff shortages and suitable clinicians not being available to provide mentoring and competency assessments. This was still the case due to further change of staff last summer and the locum practice manager only taking up post in October 2018. With a practice manager in post, it was perceived that the medics role would focus more on clinical matters.

### **Coordinating care and treatment**

Staff worked together and with unit commanders and other health care professionals to deliver effective care and treatment.

- At the last inspection there was no clinician representation at the Unit Health Committee (UHC) meetings, a forum for unit commanders and clinicians to discuss patient's needs, including

occupational health updates. The medics were not attending the meetings either. Staff advised us that the meetings were now held at the medical centre and a GP always attended, along with the physiotherapist, a medic, nurse and the practice manager. The welfare officer said the meetings were more integrated and purposeful with full team engagement. The medics carried out searches for downgraded patients and the needs of these patients were reviewed at the UHC meetings.

- The clinical records we looked at showed appropriate staff, including those in different teams, services and organisations were involved in assessing, planning and delivering care and treatment.
- The GPs had good links with local health and social service teams due to their work in NHS primary care. The practice worked closely with the Regional Rehabilitation Unit (RRU) and the DCMH, and had links with the local midwifery service and health visiting team. They also referred patients to St Athan Medical Centre for specialised medicals, such as diving and aviation medicals.
- The welfare officer advised us that patients due to the leave the military were identified at the UHC meetings and they received a resettlement brief from the welfare team on matters such as housing options. They were also signposted to other organisations to support them with the transition.

### **Helping patients to live healthier lives**

Staff were consistent and proactive in helping patients to live healthier lives. Based on population characteristics and need, this involved a focus on injury prevention and healthy lifestyle.

- The Band 6 practice nurse was the health promotion lead. A monthly health promotion plan was in place based on national priorities and initiatives to improve the population's health including, stop smoking campaigns and tackling obesity. The promotion plan also took account of the patient population need. Health promotion displays were available for patients and were regularly refreshed. Health fairs were held on the camp base and the medical centre and PCRFB participated with these.
- The Band 6 practice nurse was the sexual health lead and had a diploma in contraception and sexual health. Clinicians were aware of the 24-hour access service for sexual health advice.
- Routine searches were undertaken for patients eligible for bowel and breast screening and appropriate action taken if patients met the criteria. At the time of the inspection none of the patient population was eligible for screening.

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:

- 88% of patients were recorded as being up to date with vaccination against diphtheria.
- 88% of patients were recorded as being up to date with vaccination against polio.
- 98% of patients were recorded as being up to date with vaccination against hepatitis B.
- 69% of patients were recorded as being up to date with vaccination against hepatitis A.
- 88% of patients were recorded as being up to date with vaccination against tetanus.
- 95% of patient were recorded as being up to date with vaccination against typhoid.

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

### **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. The key principles of the Mental Capacity Act were displayed on each desk.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. The GP provided an appropriate example of when they had assessed a patient's capacity with decision making.
- The practice monitored the process for seeking consent appropriately.

<b>Are services caring?</b>	<b>Good</b>
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**We rated the practice as good for caring.**

### **Kindness, respect and compassion**

- Throughout the inspection staff were courteous and respectful to patients arriving for their appointments.
- Results from the December 2018 patient experience survey (12 respondents) indicated that patients were treated with dignity and respect. The 18 CQC comment cards completed prior to the inspection were very all complimentary about the caring attitude of staff. We also spoke with three patients who described positive experiences of the practice.
- The practice had an information network available to all members of the service community, known as HIVE. Based in Haverfordwest, it 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. In relation to physiotherapy and rehabilitation, expectations were discussed with each patient to ensure bespoke goals and a treatment plan was identified for the patient.
- Interpretation services were available for patients who did not have English as a first language. Information was available informing patients of this service.
- The patient survey indicated 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 had caring responsibilities, even if that was an indirect caring role. If necessary, the practice liaised with the welfare team. One patient was identified as having a caring role.

### **Privacy and dignity**

- Clinic room doors were closed during consultations. Curtains were not provided in consulting rooms. Staff advised they used mobile screens to maintain patients' privacy and dignity during examinations, investigations and treatments. Curtain tracking was due to be fitted.
- The waiting room was separate from the reception so conversations between patients and reception could not be easily overheard. If patients wished to discuss sensitive issues or appeared distressed at reception they could be offered a private room to discuss their needs.
- The three GPs were male so if patients wished to see a female GP then could have an appointment at the NHS practice. The PCRf only had female staff so if a patient specifically requested to be seen by a male then they could be referred to another PCRf.

### **Are services responsive to people's needs?**

**Good**

Following our previous inspection, we rated the practice as requires improvement for providing responsive services. This was due to a restricted service for patients as GPs were not working their contracted hours and restricted times as to when samples could be taken.

At this inspection we found the recommendations we made had been actioned. The practice is now rated as good for providing responsive services.

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

The practice organised and delivered services to meet patient needs and preferences.

- Staff understood the needs of its population and tailored services in response to those needs. For example, clinics were organised around the occupational health needs of service personnel.
- The CQC feedback comment cards completed prior to the inspection highlighted that it was easy to secure an appointment, in particular a short notice appointment.
- An access audit as defined in the Equality Act 2010 had been completed for the premises in December 2018. It identified that reasonable adjustments needed to be made to accommodate patients with access needs. The audit showed the practice manager had submitted statements of need to the building custodian for adjustments to be made, such as disabled parking, improved lighting and washroom facilities.
- An example of a change made as a result of patient feedback included the provision of a television in the waiting room.
- The PCRf had developed a detailed and objectively measured pathway from the patient's initial presentation to return to full duties. This included appropriate reconditioning sessions (led by unit physical trainers) to facilitate the transition from being injury free to being fully fit for role in order to reduce the risk of re-injury during this period. This pathway was built on a strong working relationship between the unit and PCRf staff, and clear communication of what is required at each stage of the pathway from both the unit and individual.

### **Timely access to care and treatment**

Patients' needs were met in a timely way.

- Patients with an emergency need were seen on the same day by a clinician. The waiting time for a routine GP appointment was one to two days. Patients could be seen by the nurse on the same day of their request. Urgent patients were seen by the physiotherapist within 48 hours and routine appointment requests were met within 10 working days (three days at the time of inspection). The Patient Experience Survey showed that all relevant respondents had received

their appointment at a time that suited them. Failure to attend appointments was monitored and the numbers of missed appointments was low. This was displaced each month in the waiting room.

- Telephone consultations were available. A process for home visits was not in place. This was managed on a case-by-case basis. The GP said there had only been one home visit needed in over 16 years of working at the practice. Arrangements were in place for patients to access the NHS practice when the medical centre was closed, including the out-of-hours service.
- The PCRf had adopted the Direct Access to the Physiotherapy Service (DAPS) directive introduced in February 2018. This was working well and was well managed.

### **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 outlined in the patient information leaflet to support patients with understanding the complaints process.
- The practice manager was the lead for complaints. A process was established to record and manage complaints. There was just one complaint in the system. The GP had responded to the complaint in line with the NHS complaint procedure. The GP was informed that was not correct as the complaint should have been dealt with in accordance with the DPHC process.

<b>Are services well-led?</b>	<b>Requires improvement</b>
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Following our previous inspection, we rated the practice as inadequate for providing well-led services. This was due to ambiguous practice management arrangements and ineffective leadership of the practice. The contractual arrangements with the NHS Medical Centre were unclear and governance structures were underdeveloped.

At this inspection we found action had been taken to address the concerns identified. We have rated the practice as requires improvement for providing well-led services.

### **Vision and strategy**

The practice worked to a clearly defined mission statement of the Defence Primary Health Care (DPHC):

“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.”

Since the last inspection the practice had been supported to make improvements by clinicians from other services and the regional team. Making timely improvements had been hampered by staff turnover last year, notably a complete change to the nursing and administrative team. At the time of this inspection many of the staff were new, including a locum practice manager who took up post in October 2018.

All the staff we spoke with and other stakeholders, such as the welfare officer, were of the opinion that the practice was now in a position to deliver a quality primary health care service in accordance with the DPHC mission statement. They said sustainability was dependent on consistent leadership and management.

## **Leadership capacity and capability**

Up until the locum practice manager took up post in October one of the medics had assumed responsibility for the day-to day management of the practice. This was a risk given that the medic is a unit asset and not employed by the DPHC. Many of the staff expressed concern to us about leadership continuity when the locum practice manager contract ended in March 2019.

We spoke with the Regional Clinical Director (RCD) regarding the temporary nature of the practice manager position. We were assured by the RCD, and provided with evidence to support this verbal assurance, that a practice manager's post had been identified for Brawdy Medical Centre.

From a clinical leadership perspective, staff highlighted that the senior GP had taken more ownership of clinical matters. The GPs were represented at the practice/governance meetings and also the UHC meetings with the chain of command. In addition, the GPs had started to facilitate clinical supervision and informal discussions with the staff team.

The RCD said that the contract with the NHS Medical Centre was under review and that contract monitoring meetings were taking place every six months. The physiotherapy contract had also been revised in October 2018 to ensure the service was sustainable.

## **Culture**

Despite the staff undergoing continual change throughout 2018, they said they felt respected, supported and valued. We had identified a disconnect between the medical centre and the PCRf at the last inspection and this had significantly improved. Given the team was still relatively new, staff suggested that a focus on improving inclusive teamwork would be beneficial.

The regular practice meetings provided staff with the opportunity to contribute their views and ideas about how to develop the practice. They said they worked well together and supported each other.

The practice clearly demonstrated a patient-centred focus. Staff understood the specific occupational needs of patients and tailored the service to meet those needs.

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.

Openness, honesty and transparency were demonstrated when responding to incidents and complaints. Staff knew how to raise concerns but no consistent management line meant there was no formal structure to enable staff to raise concerns.

The practice actively promoted equality and diversity. Staff had received equality and diversity training.

## **Governance arrangements**

Governance arrangements had been developed since the last inspection and were still in the process of embedding due to staff changes and uncertainty about the future leadership of the practice.

- 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. Lead roles were re-defined shortly after the inspection to ensure permanent staff were undertaking these roles. Terms of reference were in place to support job roles. The regional management team was worked closely to support 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.
- Communication had improved since the last inspection. Regular practice/governance meetings were attended by all disciplines/teams within the medical centre and the UHC meetings were well attended.
- Quality improvement, particularly clinical audit, was still in its infancy. An audit programme was in place and it needed further development to ensure it captured the full cycle of each audit and included audits undertaken by the PCRf.

### **Managing risks, issues and performance**

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

- The practice manager understood the risks to the service and kept them under scrutiny through the risk register. They had oversight of national and local safety alerts, incidents, and complaints.
- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety.
- Processes had recently been introduced to manage staff performance. Performance of clinical staff was demonstrated through peer review, including review of clinical records. However, the practice was unable to provide us with a copy of the peer review of the GP records. We found that Read coding and review templates were not consistently used.
- A business continuity plan was in place and was reviewed in October 2018

### **Appropriate and accurate information**

The practice acted on appropriate and accurate information.

- An internal quality assurance tool, the DMS Common Assurance Framework (CAF) was used to monitor safety and performance. The DMS CAF was formally introduced in September 2009 and since that time has been the standard healthcare governance assurance tool utilised by DMS practices to assure the standards of health care delivery within DMS.
- The practice had recently started to use the newly introduced eCAF and it was still in the early stages of development. The PCRf was integrated with the medical centre CAF. The PCRf had an annual advisory visit from the Regional Rehabilitation Officer (RRO) in March 2018 with a positive outcome.

### **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 and feedback book was in the patient waiting room. The feedback book was monitored as we noted staff made a response to suggestions made by patients. For example, a television was placed in the waiting room as a result of patient feedback.
- The practice had good working relationships with the regiment commander and welfare officer. Regular UHC meetings for the regiment were held at the practice.

### **Continuous improvement and innovation**

Despite a turbulent year of staff changes and uncertain leadership, improvements had been made to the practice since the previous inspection. Examples of some of the quality improvements include:

- A PCRFB patient focus group was held in February 2019 to collect patient views about the rehabilitation provided. The focus group was planned and included structured topics for discussion. Based on the feedback, an action plan was developed. The physiotherapists aimed to repeat the process in 6-8 weeks to seek feedback on progress. They recommended that further focus groups be held on topics pertinent to the services delivered by the medical centre and dental centre.
- Introduction of a patient contact/registration card.
- Improved referral tracking.

It was evident the staff had worked hard with the support of regional management to meet the recommendations following the last inspection. We have rated the practice as requires improvement for providing well-led services. This is because the sustainability of the newly revised and implemented governance systems are reliant on consistent leadership and management of the service. At the time of our inspection the locum practice manager's contract was due to cease at the end of March 2019.