Waddington Medical Centre

Quality report

Date of inspection visit:
12/02/2019

Lincolnshire
LN5 9NB

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

Ratings

Overall rating for this service	Requires improvement
Are services safe?	Inadequate
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

Waddington Medical Centre is rated as Requires Improvement overall

The key questions are rated as:

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

We carried out an announced comprehensive inspection of Waddington Medical Centre on 12 February 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.

The overall findings from the inspection:

- The practice had some systems in place to minimise risks to patient safety. However, the infrastructure of both the medical centre and the PCRF compromised patient safety overall.
- The arrangements for managing medicines, including emergency medicines was good. However, improvement was needed in the care of patients prescribed high risk medicines.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.
- There was evidence to show good collaborative working and sharing of best practice to promote better health outcomes for patients. Staff were proactive in helping patients to live healthier lives.
- There was evidence to demonstrate quality improvement was embedded in practice, including a programme of clinical audit and quality initiatives used to drive improvements in patient outcomes. This was particularly evident in the PCRF.
- Staff had received mandatory training.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- Information about services and how to complain was available.
- Staff were aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.
- There was a clear leadership structure and an 'open door' policy was encouraged. However, not all staff felt supported, valued and included in the whole practice ethos.

Notable Practice

- The practice has introduced a Patient Experience Tool Champion. They were responsible for distributing 50 surveys per month to patients, collating the responses and putting forward any actions identified so that improvements may be made. We saw several changes had been made including a dedicated results line being implemented for patients to access their test results more promptly.
- Waddington PCRF (Primary Care Rehabilitation Facility) had been the catalyst to introduce a regional forum for PCRFs to share and learn together. At this meeting the participants shared ASERS, lessons learned, evidence based practice and any other pertinent issues. These meetings were minuted for all staff to access and read.
- The 'Fit for Life' twelve-week initiative has been driven by the practice and is fully developed following an audit on obesity. The results show that although there is a high drop out rate of those that remained, 23% of patients had recorded weight loss on course one and 39% on course two.

The Chief Inspector recommends:

- Review the premises and facilities to provide an environment that minimises risks for the patients and staff.
- Review the system for the management of high risk medicines.
- Review the system for the recall of patients with long term conditions to ensure the practice is responsive to those patients ensuring they are fit to deploy.
- Ensure all staff are aware of their roles and responsibilities, including their lead roles.
- Ensure all staff, at every level and within the practice are part of the whole team ethos and their views are listened to, valued and considered.

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

Our inspection team

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

Background to Waddington Medical Centre

Waddington Medical Centre has a patient population of approximately 2585. The practice provides primary healthcare to maintain operational effectiveness and maintain force health protection, by ensuring vaccinations, audiology testing and gradings are up to date and current. The practice does not provide primary health care for families.

In addition to routine primary care services, the practice provides occupational health care to service personnel, including force preparation, diving medicals and aviation medicals. Family planning advice is available. The Primary Care Rehabilitation Facility (PCRF) is based in an alternative building.

The medical centre has seen a large turnaround of staff within the last three months, including three new Medical Officers (MOs), one of which has been deployed, and six new medics. All medics are 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. Eight medics at Waddington were qualified to Level 4 Emergency Medical Technicians which is a higher level qualification.

Although the staffing establishment for the practice is 40.5, at the time of the inspection 10.5 posts were vacant. The staff team on the inspection day comprised a mix of full and part time civilian and military staff and included:

Position	Incumbent
Civilian Medical Officer (also SMO)	1 CMP in post, 1 CMP gapped
Medical Officers	3 in post, 1 deployed
Locum GPs	1 in post
Practice nurses	4 in post (3 x military and 1 x civilian)
Military Practice Manager (RAF Medic)	1 PM in post
Military Warrant Officer (RAF Medic)	1 WO IC in post
SNCO Military (RAF Medic)	2 SNCO in post
Junior Ranks (RAF Medics)	10 in post, 4 gapped
Pharmacy Technician	2 (military and 1 civilian) In post
Administrative staff	1 civilian in post, 3 civilians gapped
Physio	3 (1 military and 2 civilian) in post, 1 x civilian gapped
ERI	2 military in post, 0.5 civilian gapped

A Regional Clinical Director (RCD) assumed overall accountability for quality of care at the practice.

The practice is open from 08:00 to 18:30 Monday to Friday. Arrangements are in place on weekdays for access to medical cover when the practice closed and before NHS 111 is available. A medic from the practice covered the airfield 24 hours a day. There was also Medical Officer on call for any aviation medical issues. This was in place 365 days a year.

Are services safe? | Inadequate

We rated the practice as inadequate for providing safe services.

Safety systems and processes

The practice had systems to keep patients safe and safeguarded from abuse, but there was scope to improve them.

- A framework of safety policies was in place and were regularly reviewed and accessible to staff, including temporary staff. Staff received safety information about the practice they were working in and as part of their induction and during refresher training.
- Measures were in place to protect patients from abuse and neglect. Adult and child safeguarding policies were available and took account of local arrangements. A safeguarding lead and deputy were identified for the practice. They both had received level 3 training relevant for the role, and all staff were up-to-date with safeguarding training at a level appropriate to their role. Staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. The chaperone policy and notices were displayed advising patients of the service.
- A female GP visited the practice once a week and would see patients who had requested to see them. Patients could also see a female GP at Cranwell Medical Centre which was located 12 miles away. A female nurse was always available.
- Measures were in place to highlight and monitor vulnerable patients, including the use of Read codes and application of alerts on electronic patient records. A central register of vulnerable patients was maintained. We looked at the register and noted all patients had alerts on their records.
- The full range of recruitment records for permanent staff was held centrally. The deputy practice manager could demonstrate that relevant safety checks had taken place including a DBS check to ensure staff were suitable to work with vulnerable adults and young people. DBS checks were renewed every five years. They also monitored each clinical member of staff's registration status with their regulatory body. All staff had professional indemnity cover. Information was in place to confirm staff had received the relevant vaccinations required for their role at the practice.
- Systems were in place to ensure equipment was safe. Electrical safety checks were undertaken in accordance with policy. Fire safety including a fire risk assessment, fire plan, firefighting equipment tests and fire drills were all in-date. Portable appliance and clinical equipment checks were up-to-date and records maintained.
- The practice was clean and tidy throughout. The civilian practice nurse was the infection prevention and control (IPC) clinical lead. There was an IPC protocol and staff had received up to date training. Annual IPC audits were undertaken, the last being in January 2019, and we saw evidence that the practice was 93% compliant with actions taken to address any improvements when possible. The main issue of non-compliance was carpet in clinical areas and the practice having no sluice. Urine specimens were disposed of in sealed urine pots then into the healthcare waste bins. The cleaners used the bath and shower head to fill the cleaning buckets, which were on wheels, and then emptied dirty water back into the bath to dispose of. The bathroom was only used for this purpose. A request had been made for impermeable wipe clean flooring to be fitted, this was hoped to be done in March 2019.

Risks to patients

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

- The medical centre was an ageing structure, not fit for purpose. There were insufficient consulting rooms and the building did not provide sufficient clinical capacity to meet the growing demands. Plans for a new build incorporating the PCRF were approved in July 2008, but no works had started. In the meantime, funding had been secured to make internal changes with works expected

to start in May 2019. Works will include, a new reception area (shared with the dental centre) together with a larger waiting room, one additional consulting room and accessible toilet. The medical centre continues to submit requests for improvements for example for carpets to be removed and replaced with vinyl flooring, and to improve the interior decorating as the paintwork is of a poor standard.

- The PCRF was relocated in an old building once used as a gym in May 2010. In November 2011 the Care Quality Commission (CQC) inspected the facility and said, “patient privacy and dignity was compromised in the current facility used for physiotherapy assessment and treatment. (In June 2017, the Military Band Leaders would walk through the gym areas during working hours to access their offices. In October 2017, this practice was changed to provide two separate entrances to the building. Under a local agreement, the Band Leaders are not allowed to enter the main hall during normal working hours). The CQC also said ‘The current use of this facility also posed an infection control risk’. This issue was actioned with a storeroom being made into a clinical room. There remains, however, an infection control risk in the separate carpeted treatment room (which also had no sink).
- There was only one sink in the PCRF facility with hot water, this was located in the treatment room. It was found to be blocked in January 2019 with brown water overflowing, an ASER was raised. Because this was the only sink and no other handwashing facilities were available within the PCRF, the department was closed for five days. This affected the care of 50 patients. The PCRF has not been given priority for urgent action as the building is not listed as a medical facility; simply an old gym and offices. There were no patient’s toilets or showering facilities within the PCRF.
- The PCRF space was shared with the Military Band and therefore space was limited. The band used the open space in the PCRF for marching and this had over time damaged the flooring. Therefore, the PCRF had to introduce a ‘no bare foot’ policy which is not ideal in a rehabilitation setting.
- In the PCRF there was one clinical room with four plinths to accommodate seven clinicians. Within this room there were only two IT terminals. Other rooms within the PCRF area were carpeted.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. Airfield incidents and crashes were proactively practised for, the last being a table top exercise in October 2018.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Staff had guidance available to identify and manage patients with severe infections, such as sepsis. However, training on sepsis had yet to be delivered but was on the training plan.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. There was a documented approach to the management of test results. A recent audit conducted showed the system was safe and effective.
- 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. To mitigate this, reception staff checked the waiting room every 15 to 20 minutes. New works scheduled for Spring this year to improve the waiting area would resolve any observation issues.

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way. We saw the PCRF had undertaken a notes audit which showed good compliance overall.
- Summarisation of records was 85% completed on the patient electronic record system (referred to as DMICP) and were flagged for the nurse and/or doctor to review.

Safe and appropriate use of medicines

The arrangements for managing medicines and vaccines were well managed. This included obtaining, recording and handling of medicines. However, some areas needed to be improved.

- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use. All staff who administered vaccines had received the immunisation training as well as the mandatory anaphylaxis training.
- Controlled drugs (CDs) were kept on the premises and were safely stored.
- The practice used a competency log for dispensing. This enhanced medics training and promoted safe practice.
- Repeat prescriptions were accepted in person, via email, fax or post. Repeat medicines were processed within 48 hours.
- All prescription pads were stored in the dispensary which was locked at all times and entry was restricted. All forms were booked out of the bound register and signed out by individual prescribers.
- The management of high risk medicines was inconsistent. There were two different registers in place for monitoring, one which was controlled by the pharmacy staff and the other by the medicines lead. There was a new register that was in its infancy having only being in place for the past two weeks. We saw monthly searches had taken place by pharmacy staff, however none of the staff were sure of whose responsibility this was to maintain, despite there being a named medicines lead.
- We saw the records for two patients who were prescribed high risk medicines, neither had shared care agreements in place. The practice told us they were pursuing this. We did see these patients were regularly monitored with blood tests undertaken at the required times.
- There had been no quarterly reports made by the regional team and no internal audit of anti-biotic prescribing. However, we did see an audit undertaken by one of the nursing staff in March 2018 which showed good compliance in using Penicillin for tonsillitis. This was due for re-audit in March 2019 but we noted this was not on the audit calendar. The last regional pharmacy visit was in March 2018 and no issues had been found.
- All Medicines and Healthcare Products Regulatory Agency (MHRA) safety notices and alerts were correctly logged on a spreadsheet with hyperlinks to the relevant webpage for the alert or safety notice. Only those alerts considered to be relevant were sent to the clinical staff.
- PGDs (Patient Group Directions) were in use to allow non-prescribing staff to carry out vaccinations in a safe way. PGDs were appropriately managed as staff had received training and authorisation by the SMO had been recorded. All had completed their relevant vaccine administration training.
- Out of hours, secondary care prescriptions and amendments to current therapy as directed by secondary care were receipted and scanned onto the system. A message was sent to the referring

doctor to action anything that was necessary. In the absence of the referring doctor, the duty doctor was tasked to action any medication changes.

Track record on safety

The practice had a good safety record.

- The practice manager was the lead for health and safety and had completed training relevant for the role. Risk assessments pertinent to the practice were in place including patient handling, needle stick injury, lifting and handling and lone working. A water test for Legionella had been completed. The PCRF had a specific risk assessment for the safe use of needle acupuncture.
- There was an alarm system in the practice and staff had individual alarms to summon assistance in the event of an emergency.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong. However, improvement was needed to ensure learning was shared.

- Staff used the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events, incidents and near misses. Staff had the initial electronic access to the system, including locum staff. However, one Medical Officer (MO) was new in post and did not yet have full access. We discussed this and the practice agreed to arrange this as soon as possible. Staff provided several examples of significant events they had raised demonstrating there was a culture of effectively reporting incidents. For example, a cytology sample went missing so a receipt book was introduced by duty driver. A recent audit showed no more samples had been unaccounted for and gone missing.
- ASERs were a standing agenda item at the weekly practice meeting and were also included in weekly clinical meetings, where pertinent, these were minuted. We saw evidence that showed the practice had raised 26 significant events from August 2018 to date.
- A root cause analysis and comparison of incident types had been conducted by the Warrant Officer.

Are services effective?	Requires Improvement

We rated the practice 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.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from National Institute for Health and Care Excellence (NICE) and used this information to deliver care and treatment that met patients' needs. We saw evidence which showed there were processes in place to review updates, discuss these with clinical colleagues to ensure evidence-based best practice was updated in line with amendments.
- A regional PCRF forum was started by the PCRF at Waddington. At this meeting the participants share ASERS, lessons learned, evidence based practice and any other pertinent issues. These meetings were minuted for all staff to access and read.

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

Monitoring care and treatment

The practice had a chronic disease management plan in place. The documented lead for this was the SMO. However, it was clear through discussion that this was managed and led by the practice nurses. Some improvement was needed to ensure personnel with long term conditions had been reviewed and were fit to deploy.

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

The practice was unable to provide this information on the day of the inspection as the IT system used was not working. We received this information the following week.

- There were 20 patients on the diabetic register. DMICP records for these patients showed that cholesterol levels had been measured for 10 patients within the past six months and 10 were 5mmol/l or less. For 17 patients, their last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.
- There were 86 patients recorded as having high blood pressure. Seventy-five had a record for their blood pressure taken in the past nine months. Fifty-five patients had a blood pressure reading of 150/90 or less.
- There were 44 patients with a diagnosis of asthma. Thirty-five patients had an asthma review in the preceding 12 months which included an assessment of asthma control using the three Royal College of Physicians questions. The remainder were overdue as they had not attended their appointment, the recall system was fully embedded with monthly searches taking place.
- Eight patients had been treated with new depressive symptoms between December 2018 and February 2019 (56 Days). Eight had a review between 10 and 56 days after diagnosis, we were assured their care was being effectively and safely managed, often in conjunction with other relevant stakeholders such as the welfare team and the Department of Community Mental Health (DCMH).

Information from the practices 'clinical data base 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:

- 87% of patients had an audiometric assessment within the last two years.

There was evidence that clinical audit was taking place within the medical centre. We noted that this was predominantly undertaken by the practice nurses and administration with no recent audit activity undertaken by the SMO or MOs', this was mainly due to the inconsistency of staff due to

deployment and new staff new in post. Audit activity was recorded and monitored by the practice nurse who was the audit lead, through the healthcare governance (HCG) workbook, a system that brings together a comprehensive range of governance activities, including the risk register, significant events, patient safety alerts, Caldicott log, building fault log, quality improvement and audit. An audit calendar was in place that identified the audits to take place going forward. Clinical audits undertaken for the practice included: a diabetic audit, cervical cytology audits, prescribing audits, and high-risk medicines, some of these were second cycle audits. A minor operations audit was scheduled to be undertaken within the audit year.

The PCRF showed it valued audit and we evidenced many examples where patient care had been improved as a direct result. For example, an audit was undertaken as group therapy sessions were poorly attended so the team implemented Individual Programme (IP) sessions. These sessions were supervised by an ERI, with a view to assisting exercise, competency, confidence, general advice and education. This audit began in November 2016 over a two-year cycle and following positive outcomes these sessions were formally implemented as effective use of ERI expertise from January 2018. The results showed an improved rate of discharge form the PCRF and a reduction in The Regional Rehabilitation Unit (RRU) referrals.

An audit on obesity was first undertaken in January 2017 by the PCRF. We saw evidence that showed this was on its third cycle with the last audit being undertaken in January 2019. The outcome was the design of the 'Fit for Life' initiative. This was a 12-week programme to help motivate military personnel to lose weight. The results showed some positive examples but with high drop out rates. This work continues.

Effective staffing

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

- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, two nurses were trained in sexual health and all permanent physiotherapists had received aircrew training.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- Staff had access to one-to-one meetings, appraisal, coaching and mentoring, clinical supervision and support for revalidation. Clinical staff were given protected time for professional development and evaluation of their clinical work.
- The practice collaborated with RAF Scampton staff who attended training sessions including practical sessions with the fire section, this promoted team cohesion. Medical Centre staff had also participated in major incident training at RAF Scampton to further advance training skills. The practice operated (staff permitting) staff rotation of medics to Scampton to broaden trade knowledge and skillsets which was well received.
- A clinic map had been developed to support receptionists in their role. It included arrangements for booking various appointments, different types of health checks and medicals, whilst also including the specialities of the doctors. Patients received effective and accurate information with appropriate appointments.

- Peer review was embedded in practice. A process was established for staff to undertake regular peer review of each other's recorded clinical consultations with patients. A new peer review document supported the process and ensured consistency in approach. Good practice was shared with the whole practice.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

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

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

- This included care and risk assessments, care plans, medical records and investigation and test results.
- Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital.
- Records showed that all appropriate staff, including those in different teams, services and organisations were involved in assessing, planning and delivering care and treatment appropriate to the needs of each individual patient.
- Clinical meetings to discuss patients were held each week between the physiotherapists and clinicians. Aircrew patients who self-referred to the PCRF were discussed every week. PCRF staff referred patients to other clinics if it was deemed appropriate to their rehabilitation, such as smoking cessation.
- The RRU had run one ultrasound clinic at the PCRF to see patients jointly and as an education session for PCRF staff.

Supporting patients to live healthier lives

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

- Records showed, and patient feedback confirmed, that staff encouraged and supported patients to be involved in monitoring and managing their health. Staff also discussed changes to care or treatment with patients as necessary.
- The practice supported national priorities and initiatives to improve the population's health including, stop smoking campaigns.
- Patients had access to appropriate health assessments and checks. Routine searches were undertaken to identify for patients eligible for bowel and breast screening.
- The medical centre and the PCRF were involved in the delivery of the 'Fit for Life' initiative, which supports weight loss through exercise and education to address lifestyle issues. This had been driven by the medical centre and was fully developed.

It is important that military personnel have sufficient immunity against the risk of contracting certain diseases. The World Health Organisation sets a target of 95% for vaccination against diphtheria,

tetanus, pertussis and polio and measles, mumps and rubella. The following illustrates the current 2018 vaccination data for the practice patient population

- 94.38% of patients were recorded as being up to date with vaccination against diphtheria.
- 94.38% of patients were recorded as being up to date with vaccination against polio.
- 96.62% of patients were recorded as being up to date with vaccination against hepatitis B.
- 98.35% of patients were recorded as being up to date with vaccination against hepatitis A.
- 94.38% of patients were recorded as being up to date with vaccination against tetanus.
- 98.31% of patients were recorded as being up to date with vaccination against yellow fever.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.
- We saw written consent was obtained from patients, prior to treatment, by the PCRF staff before then scanned it onto the clinical system.

Are services caring?	Good

We rated the practice as good for caring.

Kindness, respect and compassion

- We received 35 CQC comment cards completed prior to the inspection. All feedback in relation to how patients were treated by staff was positive. A theme identified overall was that patients felt respected and well cared for, with all staff showing kindness and respect. The five patients we spoke with echoed this view.
- During our inspection we observed that members of staff were courteous and helpful to patients and treated them with dignity and respect.
- Results from the January Patient Experience Survey showed 98% of patients said they would recommend the practice to friends and family.
- A practice Medical Officer (MO) was recognised and awarded by the station for the support and compassion they demonstrated for a patient diagnosed with a terminal illness. The MO ensured processes had been put in place to ensure that the patient had access to full medical support and pastoral care 24 hours a day to help with the difficult decisions that a family must make when faced with a terminal illness. The MO conducted numerous home and hospice visits which was outside the normal radius of 5 miles for home visits and kept in regular contact with the patient and family. The patient and family were also provided with additional contact details should they require support outside of normal working hours.
- The Practice recognised the importance of assigning a named doctor where feasible for patients facing terminal illnesses, this provided patients with continuity of care and also built upon

relationships particularly when families were involved but were not registered at the practice. Care/welfare packages were discussed at weekly clinical meetings to ensure all clinicians and PCRF input (if applicable) were fully aware of the care package in the event that the assigned doctor was unavailable.

Involvement in decisions about care and treatment

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

- An interpretation service was available for patients who did not have English as a first language and all staff we spoke with were aware of how to access it.
- The Patient Experience Survey showed from 50 patients asked, 98% felt involved in decisions about their care. Feedback from the CQC patient feedback cards supported this positive outcome.
- Patient information leaflets and notices were available in the patient waiting area advising patients how to access a number of organisations. We saw that information that was age appropriate and relevant to the patient demographic was prominently displayed and accessible.
- 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. Twenty-nine patients were identified as having caring responsibilities. Where appropriate, their needs were discussed, with their consent, at the welfare meetings each month.

Privacy and dignity

The practice did all it could to respect the privacy and dignity of patients. However, some improvement was needed.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Whilst consultation and treatment room doors were closed during consultations some directly opened into the waiting room and conversations taking place in these rooms could be overheard. Staff had done what they could to mitigate this by having a television on in the waiting area.
- Within the PCRF there was limited space with one clinical room for four plinths. This accommodated seven clinicians. Within this room there were only two IT terminals.
- Reception staff at the medical centre knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- There was no accessible toilet within the practice. Staff had tried to correct this by using a larger toilet and signposted it for disabled patients. However, access would still have been difficult for anyone self-propelling in a wheelchair.

Are services responsive to people's needs? | Good

We rated the practice as good for providing responsive services.

Responding to and meeting people's needs

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

- A clinician from the Department of Community Mental Health (DCMH) undertook a clinic once a week.
- There were longer appointments available for patients who required more time.
- The practice operated an all-day 'walk in 'clinic run solely by medics who triaged and assessed patients prior to consulting with the Duty Medical Officer if required. This service is held for any patients that require to be seen regardless of urgency.
- The PCRF held a triage clinic three times a week for musculoskeletal injuries (MSK).
- The PCRF held early morning and late evening clinics in response to patient's needs.
- Telephone consultations were available.
- Home visits were available at the discretion of the practice.
- Patients could receive vaccines required for both occupational and travel health at the practice.
- Multi-disciplinary clinics for managing patients with MSK injuries were held.
- The Practice recognised the importance of assigning a named doctor where feasible for patients facing terminal illnesses, this provided patients with continuity of care and also built upon relationships particularly when families were involved and were not registered at the practice. Care/welfare packages were discussed at weekly clinical meetings to ensure all clinicians and PCRF input (if applicable) were fully aware of current plans in the event that the assigned doctor was unavailable.
- An access audit as defined in the Equality Act 2010 had been completed for the medical centre and the PCRF and reasonable adjustments had been made based, where possible, on the patient population need. For example, spaces had been allocated for disabled drivers directly outside the front door of the medical centre and an area had be coned off outside the PCRF. It also identified the need for an accessible toilet which the practice had tried to accommodate.

Timely access to care and treatment

- Details of how patients could access a GP and NHS 111 out of hours service when the practice was closed were available through the station guardroom, station arrivals brief, station routine orders, medical centre out of hours answer phone message, medical centre social media page, practice leaflet and was displayed on the outer doors of the medical centre.
- Details of the NHS 111 out of hours service was also displayed on the outer doors of the medical centre and in the practice leaflet.
- Patients with an urgent need were seen that day and the waiting time for a routine appointment was usually within two days. The most recent patient survey (January 2019) showed that 92% of patients were happy with the time of their appointment and 98% said it was at a convenient location.
- For routine physiotherapy appointments, the waiting time was approximately 3.5 working days. Patients with an urgent need were seen within 48 hours. A direct access physiotherapist service (DAPS) was in place. A recent audit undertaken in January 2019 showed that patients could book, access DAPS and have an initial assessment within the PCRF within eight days. The audit was undertaken over a two-week period and it was recognised that further audit was required to identify trends. Overall, the audit showed that DAPS was an efficient way for patients to access the PCRF but that further work was needed to develop the service to ensure greater access for all.

Listening and learning from concerns and complaints

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

- Information was available and displayed to help patients understand the complaints process.
- The practice worked with the DPHC complaints policy and procedure. The practice manager was the designated responsible person for handling all complaints. We saw the practice leaflet contained information about the complaints process.
- The patient survey undertaken in January 2019 showed of 50 patients asked that 96% of patients said they felt their concerns were listened to.
- A log of both written and verbal complaints was maintained. Waddington Medical Centre had received six complaints since March 2018 of which had been effectively managed with no emerging theme.
- The PCRF kept a log of their own complaints received, then passed them onto the medical centre for action. Seven complaints had been made since October 2017, five of the complaints made were about the infrastructure including the lack of changing facilities, not enough space, no shower facilities, and lack of heating.
- We saw that compliments were collated into a register and shared with all staff. Nineteen were received since October 2018, comments included gratitude for bespoke appointments and the care and kindness given by staff including the care given by the PCRF staff.

Are services well-led?	Requires improvement

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

Leadership capacity and capability

We found the management team had the capacity and experience to deliver good quality care but there was scope for improvement.

- Senior management told us there was an ‘Equal Voice’ culture within the medical centre. However, some staff we talked to felt their views were not always listened to and their ideas were not valued by some members of the junior management team. We were told that a staff survey was about to be undertaken to capture the views of all staff.
- There was a comprehensive meetings programme in place and the practice held regular whole team meetings.
- There were clearly allocated responsibilities in the practice with named deputies for cross coverage and resilience in the event of absence from the practice. However, some staff were new in post and it was clear there was confusion as to what their specific role entailed. For example, the medicines management lead.
- Staff were aware of the systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included support training for all staff on communicating with patients about notifiable safety incidents. The leaders encouraged a culture of openness and honesty.

Vision and strategy

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

- The practice worked to the DPHC mission statement of:

  "DPHC will deliver a unified, safe, efficient and accountable primary healthcare and dental care services for entitled personnel to maximise their health and to deliver personnel medically fit for operations." And

  "The aim of SMC RAF Waddington is to provide a high standard of holistic primary care to our entitled patients by working together as a cohesive multi- disciplinary team".

- PCRF Mission Statement

  'To improve the training and operational effectiveness of injured service personnel through provision of high quality targeted rehabilitation, accelerating their return to optimal physical capability and improve preventative injury measures for the wider station'

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

Culture

The practice had a culture of good quality sustainable care.

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

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. There was some scope for improvement.

- There was a clear staffing structure but not all staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas but these needed to be reviewed to ensure the most appropriate person had overall responsibility. For example, the management of long term conditions.
- An understanding of the performance of the practice was maintained. This included, weekly heads of department meetings held on Monday mornings to plan for the week ahead.
- Practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice.

Managing risks, issues and performance

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

- The Warrant Officer understood the risks to the service and kept them under scrutiny through the risk register. However, not all senior management seemed to have a thorough understanding of what was on the risk register and how issues were progressing.
- Processes were in place to manage current and future performance. Performance of clinical staff was demonstrated through peer review, including review of clinical records.
- The Regional Rehabilitation Unit (RRU) undertook advisory visits to the PCRF.
- Plans were in place for major incidents and practice staff were familiar with how to respond to a major and/or security incident.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

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

Engagement with patients, the public, staff and external partners

The practice involved patients and external partners to support sustainable services. However, staff involvement could be improved.

There was one member of staff who was the Patient Experience Tool Champion. Every month 50 surveys were given out, the results collated and actions taken drawn from any emerging themes. These were displayed in the waiting room. For example, concerns were raised within the survey about patients having difficulty in easily getting their tests results. As a direct result of this the practice set up a 'results line' where patients could ring a dedicated number on Monday, Wednesday and Fridays between 1300 and 1400 hours and speak to one of the nurses about their test results. There were also other experienced members of staff who could undertake this task if required.

- Practice and nursing staff attended South Lincolnshire and South West Lincolnshire Clinical Commissioning Groups Practice and user group meetings.
- A representative from the practice attended unit welfare meetings each month.
- The practice actively utilises social media platforms to promote health and provide practice updates to patients.
- Staff had regular meetings and annual appraisals. We saw there was formal integration between the medical centre and the PCRF through meetings and governance issues. However, it was evident through discussion with the PCRF staff that they felt, at times, isolated and not fully part of the medical centre team.
- Staff working within the PCRF had strived for two years to improve the infrastructure by consultation with the regional team and the Station. Significant improvements have been made to protect and improve patient privacy and dignity and delineate the space with the band. Despite varying and numerous attempts to get funding the PCRF infrastructure was affecting staff morale and was the cause of negative patient feedback including complaints.

Continuous improvement and innovation

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

- The introduction of the Patient Survey Champion.
- The audit calendar, particularly the PCRF audit plan and audits carried out have had positive outcomes for patients. The breadth of audits and application to improving clinical care was evident.
- The 'Fit for Life' initiative being fully developed following an obesity audit.