This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information given to us by the practice and patient feedback about the service.

### Ratings

<table>
<thead>
<tr>
<th>Overall rating for this service</th>
<th>Outstanding ⭐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are services safe?</td>
<td>Good ⚫</td>
</tr>
<tr>
<td>Are services effective?</td>
<td>Good ⚫</td>
</tr>
<tr>
<td>Are services caring?</td>
<td>Good ⚫</td>
</tr>
<tr>
<td>Are services responsive to people’s needs?</td>
<td>Outstanding ⭐</td>
</tr>
<tr>
<td>Are services well-led?</td>
<td>Outstanding ⭐</td>
</tr>
</tbody>
</table>

Windsor Combermere Medical Centre Quality Report 02/04/2019
Chief Inspector’s Summary

This practice is rated as outstanding overall

The key questions are rated as:

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

We carried out an announced comprehensive inspection of Windsor Combermere Medical Centre on 2 April 2019. Defence Medical Services (DMS) are not registered with the CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014 and are not required to be. Consequently, DMS services are not subject to inspection by the CQC and the CQC has no powers of enforcement. This inspection is one of a programme of inspections that the CQC will complete at the invitation of the Surgeon General in his role as the Defence Authority for healthcare and medical operational capability.

At this inspection we found:

- The practice was well-led and leaders demonstrated they had the vision, skill and capability to provide a patient-focused service. Effective communication and cohesive working were evident with a strong ethos to continually improve outcomes for patients.
- The practice understood the needs of the patient population and made changes to ensure patient needs were met.
- The practice had systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them.
- The arrangements for managing medicines were safe. Repeat prescribing could be improved.
- Infection control and clinical waste were well managed, and the practice was clean throughout.
- Staff were aware of current evidence-based guidance. They had received training, so they were skilled and knowledgeable to deliver effective care and treatment. An induction plan was in place for all staff and this was bespoke to the practice.
- The practice worked collaboratively and shared best practice to promote better health outcomes for patients.
- There was substantial evidence to demonstrate quality improvement was embedded in practice, including a comprehensive programme of clinical audit and quality initiatives used to drive improvements in patient outcomes.
- The practice proactively sought feedback from staff and patients which it acted on. Feedback showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
• Facilities and equipment at the practice were sufficient to treat patients and meet their needs.
• Staff were aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

We identified the following notable practice, which had a positive impact on patient experience:

• The practice had a proactive approach to continual improvement and particularly mental health. Their approaches showed upstream thinking building resilience into responsive well led care.
• We saw a document in the waiting room called the "Purple Pack". This was information for patients who had experienced a bereavement and contained lots of valuable information that would be helpful for patients requiring support.

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

Our inspection team

Our inspection team was led by a CQC lead inspector. The team comprised specialist advisors including, a second CQC inspector (shadowing) a GP, a practice nurse, a practice manager, a pharmacy technician and a physiotherapist.

Background to the Windsor Combermere Medical Centre

The Medical Centre at Combermere Barracks offers primary healthcare and occupational health to military personnel. The regular patient population is currently 494. The main focus is to provide primary healthcare to maintain operational effectiveness and maintain force health protection.

The majority of the population comes from The Household Cavalry Regiment (HCR). The second supported population is the Band of the Household Cavalry who perform at State Ceremonial events across the country, often on horseback. The third key population is that of the Household Cavalry Mounted Regiment’s (HCMR) Training Wing. Household Cavalry soldiers, fresh out of training begin their service life learning to ride at Combermere before moving on. The practice also offers appointments for reservists. The facility does not provide primary health care for families or civilian Ministry of Defence employees.

Family planning advice is available. Maternity and midwifery are provided by NHS practices and community teams. Patients have access to medicines through a community pharmacy. A Primary Care Rehabilitation Facility (PCRF) is located on the premises, with physiotherapy staff integrated within the medical centre.

The PCRF comprises of one clinical room within the main medical facility, used by the physiotherapist.

The practice is open from 07:30 to 16:30 Monday to Thursday and on Friday 07:30 to 12:30. Arrangements are in place on weekdays for access to medical cover when the practice is closed.
The staff team comprised a mix of full and part time civilian and military staff and included:

<table>
<thead>
<tr>
<th>Position</th>
<th>Incumbent</th>
</tr>
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<tbody>
<tr>
<td>SMO</td>
<td>1 in post</td>
</tr>
<tr>
<td>Medical Officers (MO)</td>
<td>1</td>
</tr>
<tr>
<td>Locum GPs</td>
<td>Nil</td>
</tr>
<tr>
<td>Practice nurses</td>
<td>1 military, 1x civilian (shared with Victoria Medical Centre)</td>
</tr>
<tr>
<td>Military Practice Manager</td>
<td>1 in post</td>
</tr>
<tr>
<td>Administrative staff</td>
<td>1 civilian in post</td>
</tr>
<tr>
<td>Medics</td>
<td>2 in post, 4 deployed.</td>
</tr>
<tr>
<td>PCRF</td>
<td>1 Civilian physiotherapist (shared with Victoria Medical Centre).</td>
</tr>
</tbody>
</table>

**Are services safe?**  
**Good**

**We rated the practice as good for providing safe services.**

**Safety systems and processes**

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

A framework of regularly reviewed safety policies was in place and accessible to staff, including locum staff. Staff received safety information about the practice as part of their induction and refresher training.

- Measures were in place to protect patients from abuse and neglect. The practice had both safeguarding children and vulnerable adult’s policies.
- The SMO was the practice safeguarding lead and was trained to level 3. All other staff were trained to the appropriate level.
- The practice had effective and well managed systems in place to maintain an accurate and up to date register of patient’s subject to safeguarding arrangements, and patients assessed to be ‘at risk’. Codes were used carefully on the electronic patient record system to identify patients who were vulnerable, including patients with low mood or subject to formal safeguarding.
arrangements. A search of the electronic patient record system (referred to as DMICP) took place weekly to inform the register of vulnerable patients. Appointments were prioritised for vulnerable patients including those under the age of 18. We looked at the records for four patients deemed to be vulnerable and they confirmed they were being effectively supported and monitored by the practice.

- From the examples provided, it was evident the practice proactively minimised risks to their patients by providing and/or sourcing relevant support from external stakeholders. For example, the SMO met with the Multi Agency Safeguarding Hub (MASH) when appropriate to do so or if there were concerns about a patient or their family.

- All staff had received chaperone training and notices advising patients of the chaperone service were displayed. Staff had been subject to safety checks to ensure they were suitable to work with young people and vulnerable adults. If patients requested access to a female GP, this could be facilitated via Pirbright Medical Centre, situated approximately 17 miles away.

- The full range of recruitment records for permanent staff was held centrally. However, the practice could demonstrate that relevant safety checks had taken place at the point of recruitment, including a Disclosure and Barring Service (DBS) check to ensure staff, including locum staff, were suitable to work with vulnerable adults and young people. DBS checks were renewed every five years.

- Arrangements were in place to monitor the registration status of clinical staff with their regulatory body. All staff had professional indemnity cover. Information was in place to confirm staff had received all the relevant vaccinations required for their role at the practice.

- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice had an infection control policy and the lead staff member had received infection control training. The last infection control audit was undertaken in February 2019. We also saw a hand washing audit and re-audit had been completed.

- Systems were in place for the safe management of healthcare waste. Consignment notes were retained at the practice and an annual last waste audit was carried out.

- The practice manager was the lead for health and safety. Measures to ensure the safety of facilities and equipment were in place. Electrical and gas safety checks were up-to-date. Water safety measures were regularly carried out with legionella inspection. A fire risk assessment of the building was undertaken annually. Firefighting equipment tests were current. Staff were up-to-date with fire safety training and were aware of the evacuation plan. We saw a hazard register was in place but not a comprehensive risk assessment of the building. The practice manager acknowledged this and agreed to get this completed as soon as possible. We received evidence following the inspection that this had been completed.

- Equipment was checked and maintained according to manufacturers’ instructions. Testing of portable electrical appliances and medical equipment was in-date.

**Risks to patients**

There were systems in place to assess, monitor and manage risks to patient safety.

- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. An emergency kit, including a defibrillator, oxygen with adult masks and emergency medicines were accessible to staff in a secure area of the practice; all staff knew of its location. A first aid kit and accident book was available. Routine checks were in place to ensure the required kit and medicines were available and in-date.
Staff were up-to-date with the required training for medical emergencies. They participated in regular training simulation exercises for emergency situations. The recognition and management of sepsis had been discussed as a team. They also used a specifically designed template for sepsis to ensure the correct treatment plan for the patient.

**Information to deliver safe care and treatment**

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

- Individual care records were written and managed in a way that kept patients safe. The care records we looked at on DMICP showed information needed to deliver safe care and treatment was available to relevant staff in an accessible way. Staff described occasional loss of connectivity with DMICP but said this did not have a significant impact on patient care.
- Effective systems were in place for the management of electronic and hardcopy correspondence. For example, non-electronic correspondence received from secondary care services was scanned onto DMICP and sent it to the clinician.
- External referrals were booked by the SMO through the NHS e-Referral Service (eRS), including urgent referrals. The administrator responsible for monitoring the eRS referrals checked the status of these each week. We were advised that individual clinicians were responsible for monitoring internal referrals, such as those to the Department of Community Mental Health (DCMH) and Regional Rehabilitation Unit (RRU). The physiotherapist checked the status of referrals to the RRU as part of the caseload review each week.
- A process was in place for the management of specimens, including the transport of specimens to the laboratory. This process included booking the patient a follow up appointment, a week later, to ensure they obtained their results.

**Safe and appropriate use of medicines**

The arrangements for managing medicines and vaccines were well managed. This included arrangements for obtaining, recording and handling of medicines.

- The SMO was the lead for medicines management within the practice. All dispensing was outsourced to the contracted community pharmacy. Repeat prescriptions were accepted in person and were reviewed regularly with the patients.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use. All staff who administered vaccines had received the immunisation training as well as the mandatory anaphylaxis training. Controlled drugs (CDs) were not kept on the premises.
- There were systems in place for the management of high-risk medicines. There were currently no patients who were prescribed these.
- Out of hours and amendments to current treatment, 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, there was a clear policy in place that reflected this process and staff were aware of it.
- The regional pharmacist and the practice worked well together. The regional pharmacist sent through monthly prescribing data which enabled the practice to then run searches and subsequent audits into prescribing habits. For example, we saw how the use of a brand name cough medicine had been prescribed instead of a generic one; the practice searched through
the consultations of those patients prescribed cough medicine and found the same Medical Officer (MO) had issued it each time. The SMO then provided training to the individual on the NICE guidance around prescribing for a cough.

**Track record on safety**

The practice had a good safety record.

- The practice manager was responsible for managing medicine and safety alerts. They received the alerts and then passed these on to two sergeants who carried out searches. A spreadsheet clearly showed, the date of the alert, the details and who had seen it and any actions taken.
- There was an individual alarm in every room throughout the practice to summon assistance in the event of an emergency.

**Lessons learned and improvements made**

- All staff were familiar with reporting incidents and reporting was actively encouraged at the practice. Staff used the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events, incidents and near misses. All staff had electronic access to the system. ASER system was also used to report good practice and quality improvement initiatives.
- Staff provided several examples of significant events they had raised demonstrating they were effectively reporting incidents. Changes were made as a result of significant events. For example, a new patient to the practice who had previously been diagnosed with a cancer had not had their diagnosis and care discussed or been handed over by the previous unit. This was raised as an ASER, shared with the previous practice clinicians and improvements made to their handover processes. All significant events were discussed at practice meetings.

<table>
<thead>
<tr>
<th>Are services effective?</th>
<th>Good</th>
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**We rated the practice as good for providing effective services.**

**Effective needs assessment, care and treatment**

The practice had processes to keep clinicians up to date with current evidence-based practice.

Clinical staff assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. NICE (National Institute for Health and Care Excellence) and other practice guidance was a standing agenda item at the weekly clinical meetings open to attendance by all clinicians. For example, the NICE update discussed at the March practice meeting was about wound care. The guidance was attached within the practice minutes.

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

**Monitoring care and treatment**

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

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

- There were two patients on the diabetic register. Both patients had a last measured total cholesterol of 5mmol/l or less which is an indicator of positive cholesterol control. Both patients had a last blood pressure reading of 150/90 or less.
- There were three patients recorded as having high blood pressure. All three patients had a record for their blood pressure taken in the past nine months. All three patients had a blood pressure reading of 150/90 or less.
- There were no patients with a diagnosis of asthma.

The practice nurse was identified as the lead for chronic disease management and managed the chronic disease register. They carried out regular searches, recalling patients when appropriate. We looked at a range of patient records and were assured that the care of patients with a mental illness and/or depressive symptoms were being effectively and safely managed.

Service personnel may encounter damaging noise sources throughout their career. It is therefore important that service personnel undertake an audiometric hearing assessment on a regular basis (every two years). Audiometric assessments were in date for 93% of patients.

Audit was embedded in practice and seen as the responsibility of all staff. An extensive programme of clinical and non-clinical audit was in place. The audit register identified the auditor, initial or repeat audit, date the audit was presented to the team, recommendations and review date.

Clinical audit was driven by population need. The range of audits we looked at referenced best practice, including NICE guidance/quality standards. Examples of audit included: PGDs, cytology; anti-biotic prescribing, over 40’s screening; and results handling.

Audit was a standing agenda item at the clinical meetings where clinicians routinely presented the audits they had undertaken. All audits led to practice being reviewed and changes made if necessary. We saw many examples of this;

- An audit was raised following a complaint regarding a lost specimen. As a result of the complaint, a full investigation took place and an ASER was raised. It was established that the delay and loss of the specimen occurred because of hospital error. The SMO visited the hospital to meet with staff and discuss how he error occurred. Following this, further work was undertaken improving the template used by the practice to emulate the one used by the hospital to ensure consistency of recording. An audit was undertaken in January 2019 that showed the process undertaken by the practice was robust, but that the receipt of results still required improvement. Recommendations were identified, such as giving the patient a follow up appointment to ensure they received their test results. We saw this in practice on the day of the inspection and we were told this was working well. A re-audit was due in three months.
- An audit was undertaken due to the escalation of physiotherapy Key Performance Indicators (KPIs). Over a three-month period, it was found that the waiting time had gone from 8 to 15 days to see a physiotherapist. This was thought to be partly due to the adaptation and increase in training (weight carrying as part of the new Physical Employment Standards). Discussion
took place and a recommendation put in place to provide an additional triage service for those patients who presented with an acute musculoskeletal (MSK) injury. Early indications show that this system has slightly improved the physiotherapy waiting times; We saw during a three-month period that:

- Forty triage appointment slots were made available
- Thirty slots were used
- Six slots were inappropriate (chronic or non MSK)
- Eight were only seen on one occasion with advice and exercises issued.
- Sixteen initial triage assessments led to further treatment

In summary the audit showed that 16 of 30 patients needed an ongoing physiotherapy appointment, and the remaining 14 were either given immediate advice or treatment or the referral was not appropriate. This triage system has eased the pressure on physiotherapy waiting times.

**Effective staffing**

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

- All staff received a comprehensive generic and role-specific induction.
- Mandated training was monitored, and the staff team were in-date for all required training. Staff had received appropriate training for their role. For example, in the management of sexually transmitted infections.
- A bespoke induction process was in place for all staff to ensure they were familiar with systems and ways of working in Defence Primary Health Care (DPHC) and specifically at Windsor Combermere.
- Training was scheduled each week for an afternoon. Topics were selected based on staff need and sought to support staff with their continuing professional development (CPD). In addition, competency checks and role specific CPD was supported by the practice, such as for nurses to specialise in long term conditions. Staff told us they had an identified workplace supervisor and regular supervision sessions. Records indicated that staff appraisals were up-to-date.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

**Continuous learning and development was promoted at the practice.**

- All staff had an identified workplace supervisor and had access to one-to-one meetings, mentoring and support for revalidation. Clinical staff were given protected time for professional development. We saw that clinicians had protected time for peer review.
- There was a formalised memorandum of understanding with Pirbright for providing senior physiotherapy support to the PCRF. This was undertaken to allow for support with staffing challenges and improve patient care. Pirbright had a longstanding connection with the Combermere PCRF in terms of oversight of training, support and governance. This policy formalised the previously informal support.
- We saw evidence that all medics providing triage were trained and well supported to do so. This included treatment and medicine issuing protocols.

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

- The clinical records we reviewed showed appropriate staff, including those in different teams, services and organisations were involved in assessing, planning and delivering care and treatment.
- The practice had good working relationships with other units and departments. Patients who were receiving specialist care, unable to undertake training and not fit for the field army were discussed. Unit Health Committee (UHC) meetings were held monthly and were attended by the SMO and the physiotherapist. These meetings reviewed the needs of patients who were medically downgraded and those who were vulnerable. The practice also worked closely with the Regional Rehabilitation Unit (RRU), the Department of Community Mental Health (DCMH) and other military healthcare professionals. A community psychiatric nurse visited the practice on a weekly basis.
- The SMO had visited the local NHS hospital with a view to establish links and relationships, and to improve the process for test results and X-ray. We saw evidence that showed the practice sent clear, accurate and up to date information to NHS providers when a patient was discharged. This included referrals to external mental health providers.
- We saw evidence to show that the practice provided NHS care providers with up to date, accurate information for patients leaving the service. Alongside this we saw patients were given advice, support and information to be able to access further support once living a civilian life again.

Helping patients to live healthier lives

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

- Clinicians took a whole-person approach when considering the injury, health, wellbeing and barriers to recovery. For example, they took appropriate opportunities to discuss smoking cessation and alcohol intake, and signpost patients to other services.
- The practice supported national priorities and initiatives to improve the population’s health including, stop smoking campaigns and tackling obesity. A health promotion display board was available to patients and it was refreshed based on the annual health promotion calendar. At the time of the inspection it provided information about how to manage flu symptoms. There were television screens throughout the unit that gave information to patients about the services the medical centre provided and health promotional material.
- We saw posters displayed throughout the PCRF and the rehabilitation gym with clear advice on exercises and progressions.
- Two clinicians had received additional training in sexual health. Information was available for patients requiring sexual health advice, including sign-posting to other services.
- Patients had access to appropriate health assessments and checks. Routine searches were undertaken for patients eligible for bowel and breast screening and appropriate action taken if patients met the criteria.
- Over 40’s checks were provided. A search of patients was undertaken to ascertain who was eligible. Following this, an audit was undertaken in October 2018 to assure the SMO that the correct template was being used, the correct care was being offered and those patients eligible had been invited in. We saw that 22% of those eligible had had an over 40’s check recorded.
Following this, action was taken to seek improvement and a re-audit in March 2019 showed that numbers had increased to 69%. This work was ongoing with further audit planned for six months’ time.

- 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 data below provides vaccination data for patients currently using this practice:

- 97% of patients were recorded as being up to date with vaccination against diphtheria.
- 99% of patients were recorded as being up to date with vaccination against Hepatitis B.
- 96% of patients were recorded as being up to date with vaccination against Hepatitis A.
- 97% of patients were recorded as being up to date with vaccination against Tetanus’

**Consent to care and treatment**

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient’s mental capacity to make a decision.

<table>
<thead>
<tr>
<th>Are services caring?</th>
<th>Good</th>
</tr>
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</table>

**We rated the practice as good for caring.**

**Kindness, respect and compassion**

Staff supported patients in a kind and respectful way.

- Throughout the inspection staff were courteous and respectful to patients arriving for their appointments.
- Results from the March 2019 Patient Experience Survey showed that from the 19 surveys received, 100% said they would recommend the practice to family and friends. We received 34 CQC comment card completed prior to the inspection. We saw that all but one was entirely positive about the care they received.
- The practice had an information network available to all members of the service community, known as HIVE. This provided a range of information to patients who had relocated to the base and surrounding area. Information included what was available from the local unit and from civilian facilities, including healthcare facilities. The practice used the HIVE social media page to communicate with civilian patients
- We saw a document in the waiting room called the “Purple Pack”. This was information for patients who had experienced a bereavement and contained lots of valuable information that would be helpful for patients requiring support.

**Involvement in decisions about care and treatment**

Staff supported patients to be involved in decisions about their care.
• Interpretation services were available for patients who did not have English as a first language. Notices were displayed in clinical areas and in reception informing patients this service was available.

• The practice proactively identified patients who were also carers. There were processes in place to identify patients who had caring responsibilities, including the use of alerts, codes and regular searches. Patients were asked at registration whether they had caring responsibilities. Four adults were identified as having caring responsibilities. Where appropriate, their needs were discussed, with their consent, at welfare meetings each month.

Privacy and dignity
The practice respected patients’ privacy and dignity.

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

• The layout of the reception area and seating meant that conversations between patients and reception could be overheard. The practice had addressed this by installing a television to minimise conversations being overheard and marking a demarcation line for people to stand behind when waiting behind another patient.

• If patients wished to discuss sensitive issues or appeared distressed at reception, they were offered a private room to discuss their needs or they could present with a practice confidentiality card which would alert the administrator that the patient wanted to discuss something of a personal nature.

Are services responsive to people’s needs?

Outstanding

We rated the practice as outstanding for providing responsive services.

Responding to and meeting people’s needs
Services were organised and reviewed to meet patient needs and preferences where possible.

• Staff understood the needs of its population and tailored services in response to those needs. For example, the introduction of physiotherapy triage and flexible appointment availability.

• The unit held a health fair in 2018 which was focussed on ‘Resilience & Mental Health’ – primarily as a proactive lifestyle measure, supported by command at all levels, to hopefully reduce mental ill-health both at home and whilst deployed. In preparation for this, the SMO went with other senior members of the Regiment, including the Commanding Officer, Padre and Welfare team, to the Robson Academy of Resilience. This showed the approach to building resilience in personnel from the earliest stages of recruitment, through service life and for operations. The staff spoke in terms of ‘psychological capital’ and ‘putting pennies in the jar early’ – developing a healthy mindset towards resilience as a preventative form of training rather than waiting for personnel to develop symptoms of struggle. The focus was on long-term investment in psychological health, both augmenting physical health and preventing future psychological ill-health.
• The SMO has passed on the techniques to a number of patients, especially those identified as those more vulnerable due to their specific role. Special techniques, mindfulness Apps and researched mind management literature had all been well received and served to de-medicalise stress management. One patient was so empowered by the technique that they were discharged from DCMH feeling much happier and able to cope with their stress. This was discussed with the local DCMH psychiatrist who visited recently and underlined the proactive approach to mental health/fitness. A specific mindfulness session for practice staff was recognised to be useful and this was being added to the educational training plan for the near future.

• A community psychiatric nurse held a clinic at the practice once a week.

• The practice had an accessible toilet and access to the facility was available via a back entrance. Patient services were on ground floor level. A wheelchair was available. Access to the building was good although there was no level access directly into the reception area. At the time of the inspection an access audit as defined in the Equality Act 2010 had not been completed for the premises. Following the inspection this was completed and the need for a ramp was identified. This was planned to be in place by August 2019.

Timely access to care and treatment

• Patients with an emergency need were seen that day and the waiting time for a routine appointment was either available on the same day or the following day. Double appointments at either the request of the clinician or patient could be made.

• Patients accessed physiotherapy via the GP as a direct access physiotherapist service (DAPS) was not yet in place. Physiotherapy waiting times for a first appointment was a concern. This was the subject of an ongoing patient satisfaction survey. The waiting times for physiotherapy were longer than the expected 10 working days (currently fluctuating around 15 working days) despite the strong and patient focussed work ethic of the physio. There was one full time physiotherapist covering both Combermere and Victoria Barracks, there was no Exercise Rehabilitation Instructor (ERI) in post at Combermere. The practice manager had a clear and progressive plan in place. A locum physiotherapist had been recruited (for three months) to assist in reducing waiting times and allowing the physiotherapist some administrative time for mandatory training, caseload review, support to ERI and audits. We discussed the need for the practice to communicate with Regional Headquarters about the provision of an ERI so that patients also had access to ERI services. Patients were fully able to access the physiotherapy department at Pirbright, 17 miles away if they so wished.

Listening and learning from concerns and complaints

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

• Information was available to help patients understand the complaints process. The practice managed complaints in accordance with the DPHC complaints policy and procedure. Both a complaints and compliments log was maintained.

• The practice manager was the designated responsible person who handled all complaints. A record of complaints was maintained, including verbal complaints. One verbal complaint had been received in the last 12 months. We saw this had been logged and had been managed effectively. All complaints were discussed at the practice meetings and lessons identified.
• A suggestion book, forms and pens were located in the waiting area for patients to leave feedback.

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<tr>
<th>Are services well-led?</th>
<th>Outstanding</th>
</tr>
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</table>

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

**Vision and strategy**

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

‘Combermere Medical Centre will deliver a unified, safe, efficient and accountable primary healthcare service for entitled personnel to maximise their health and to deliver personnel medically fit for operations’

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

**Leadership capacity and capability**

Despite being a very small practice with limited staff we saw a practice that was well led. The SMO had been attached to the Regiment for 16 years so providing continuity for the patients. They demonstrated they had the experience and skills to deliver high-quality sustainable care. They clearly understood the practice priorities and demonstrated they had capability and tenacity to drive service change for the benefit of patients. We saw evidence of this through communication both internally and externally, through complaints, compliments, significant events and audit.

**Culture**

Staff felt fully engaged within the practice. A culture of teamwork and a strong ethos of patient-centred care was embedded within each staff member. Staff were proud of the practice as a place to work and spoke highly of the culture. Staff at all levels were actively encouraged to speak up and raise concerns, and all policies and procedures positively supported this process.

There was strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and people’s experiences. Staff used information, such as significant events to implement processes in their practice to ensure recurrent events were safeguarded against. The practice was inclusive, and all staff were treated equally.

There was a strong emphasis on the well-being of all staff. Supervision and appraisal was in place for all staff. The practice actively promoted equality and diversity. Staff had received equality and diversity training.

Openness, honesty and transparency were demonstrated when responding to incidents and complaints and we saw evidence of this. Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.

**Governance arrangements**
Governance arrangements were proactively reviewed and reflected best practice. The practice had reviewed how they functioned and ensured staff had the skills and knowledge to ensure those systems worked effectively.

- There was a clear staffing structure in place and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. Terms of reference were in place to support job roles. The regional management team worked closely with the practice.

- The practice worked to the health governance workbook, a system that brings together a comprehensive range of governance activities, including the risk register, significant events tracker, lessons learnt log, training register, policies, meetings, quality improvement and audit. All staff had access to the workbook which provided links to meeting minutes, policies and other information.

- An effective range of communications were used at the practice. A schedule of regular practice meetings was well established. ASERs, quality improvement initiatives, audit and complaints were all discussed during those meetings to support an inclusive ethos.

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

Managing risks, issues and performance

- The SMO understood the risks to the service and kept them under scrutiny through the risk register. For example, we saw the practice had developed their own internal policies and procedures to mitigate risk due to low staffing numbers. Also, a 15-minute triage appointment had been introduced for patients with MSK injuries. This was introduced because it was recognised there was a 15 day wait for an initial appointment to see the physiotherapist and there was ERI provision.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- An internal quality assurance tool, the DMS Common Assurance Framework (CAF) was used to monitor safety and performance. The DMS CAF was formally introduced in September 2009 and since that time has been the standard healthcare governance assurance tool utilised by DMS practices to assure the standards of health care delivery within DMS.

- The practice received a Health Governance Assessment Visit (HGAV) from the regional team in March this year. The practice had completed a management action plan (MAP).

Engagement with patients, the public, staff and external partners

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

- There were various options in place to encourage patients to provide feedback on the service and contribute to the development of the service. A patient experience survey was undertaken throughout the year. We saw there was a token box in the waiting area. This was where a
patient took a token and gave a ‘thumbs up’ or ‘thumbs down’ on a particular issue. For example, this month was satisfaction over physiotherapy waiting times

- A Patient Participation Group (PPG) had been set up and the first meeting was held at the beginning of March 2019; seven people attended. The meeting generated a general discussion about the practice and how improvements could be made. For example, they felt there was not enough information about the services provided by the practice and the wider community. They suggested the best place to put information would be in the accommodation corridors, guardroom and canteen as they would spend time in the evenings looking at them. On the day of the inspection we saw that information about the practice and health promotion were displayed on televisions throughout the base. This had been as a direct result of patient suggestions.

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

Continuous improvement and innovation

Continuous improvement was embedded in the culture of the practice that demonstrated an innovative approach to developing the service for the benefit of the patients. The practice maintained a detailed quality improvement log on the HG workbook which was monitored monthly. We found that improvements were implemented based on the outcome of feedback about the service, complaints, audits and significant events.

Quality improvement projects identified by the practice included:

- Physiotherapy triage.
- Results management.
- Development of a formalised Memorandum of Understanding with Pirbright for providing senior physiotherapy support to the PCRF.

The practice was forward thinking and looking to future developments. These included:

- Mindfulness training for staff.