High Wycombe Medical Centre

Quality report

Station Medical Centre
No.3 Site
Walters Ash
High Wycombe
HP14 4UE

Date of inspection visit:
21 March 2019

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4 June 2019

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

Ratings

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

Chief Inspector's Summary

This practice is rated as Requires Improvement overall

The key questions are rated as:

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

We carried out this announced follow up comprehensive inspection on 21 March 2019. For reasons of availability, medicines management was inspected on 25 March 2019. This report covers our findings in relation to the recommendations made and any additional improvements made since our last inspection.

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

https://www.cqc.org.uk/sites/default/files/20180816_raf_high_wycombe.pdf

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

At this inspection we found:

- The practice proactively sought feedback from staff and patients which it acted on. Patient feedback about the practice was positive. Patients were included in decision making about their care, and were treated with dignity and respect.
- The staff team said the practice was well supported by the regional team.
- Due to insufficient staffing levels in 2018, there was a backlog in summarisation, medicals, recalls and audiometry assessments. The practice was aware of this and had a plan in place to address the backlog.
- Staff highlighted that the practice had improved with more structure introduced since the last inspection. Staff said they felt engaged, supported and valued by the leadership team.
- There was an open and transparent approach to safety. An effective system was in place for managing significant events and staff knew how to report and record using this system.
- Safeguarding systems were in place to ensure vulnerable patients were effectively supported.
- Information about services and how to complain was available for patients. Not all patient concerns raised were logged as a complaint.
- Although some improvement was needed, overall the arrangements for managing medicines were safe.

- Clinical waste was not being appropriately transported.
- Staff were aware of current evidence based guidance and worked collaboratively and shared best practice to promote better health outcomes for patients.
- Quality improvement activity was starting to embed in practice, including the development of annual programme of clinical audit.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.
- Although clinical records were well written, there was not a coherent approach to coding.
- Improvements had been made to the telephone system. However, it was not always easy to access the practice by telephone. This was a longstanding issue related to the infrastructure and outside of the control of the practice.

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

- The rehabilitation team had identified a trend of referrals for back pain. Many of the patients had sedentary jobs so the team developed an exercise programme titled 'The Office Gym' and provided a presentation at the station air safety day. It received positive feedback and the plan is for the team to provide exercises in the station magazine. The next stage was to formally audit the impact for patients.

The Chief Inspector recommends:

- The arrangements for medicines management are reviewed to ensure they are managed in accordance with operational policy.
- The approach to recalling patients is revised to ensure all patients with a long term condition are recalled without delay.
- The arrangements for managing complaints are reviewed to ensure the practice is working in accordance with the complaints policy and procedure.
- The practice and regional team continue to work with the station and regional team to resolve the problems with the telephone system.
- A review of the how vulnerable people are managed processes including the introduction of searches and agreed coding.

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

Our inspection team

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

Background to High Wycombe Medical Centre

Located in Walter Ash, Buckinghamshire, RAF High Wycombe Medical Centre is a primary health care service for HQ Air Command. The medical centre provides care only to service personnel. Families and dependants of personnel are signposted to local NHS practices. At the time of

inspection, the patient list was approximately 1673. The majority of patients were male and aged between 25 and 44.

In addition to routine GP services, the practice provides rehabilitation. Occupational health services are also provided for patients and for small number of reservists. Family planning advice is available with referral onwards to NHS community services. Maternity and midwifery services are provided by NHS practices and community teams.

At the time of our inspection the staff team included a recently appointed Senior Medical Officer (SMO), Deputy Senior Medical Officer (DMSO), a recently appointed civilian GP, two practice nurses and a health care assistant (HCA). A practice manager was responsible for the day-to-day running of the service supported by a team of administrators.

Although not co-located, the Primary Care Rehabilitation Service (PCRF) team, comprising a lead physiotherapist, locum physiotherapist and locum exercise rehabilitation instructor (ERI), worked closely with the medical centre. A Regional Clinical Director (RCD) assumed overall accountability for quality of care at the Medical Centre.

Are services safe?	**Requires improvement**

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

Following our previous inspection, we rated the practice as inadequate for providing safe services. We found gaps in processes to keep patients safe including: infection prevention and control (IPC); management of specimens; staff recruitment and medicines management, including high risk medicines.

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

Safety systems and processes

Systems were established to keep patients safe and safeguarded from abuse. There was scope to improve these systems.

- A framework of regularly reviewed safety policies was in place and accessible to staff, including locum staff. Staff received safety information about the practice as part of their induction and refresher training.
- Measures were in place to protect patients from abuse and neglect. Adult and child safeguarding policies were available to all staff. All staff had received up-to-date safeguarding training appropriate to their role and knew how to identify and report concerns. The Senior Medical Officer (SMO) and Deputy Senior Medical Officer (DSMO) were the safeguarding leads; both had completed level 3 training. There were no patients under the age of 18 registered at the time of this inspection.
- Coding and alerts were used on the electronic patient record system (referred to as DMICP) to identify patients who were vulnerable. Clinicians coded patients as vulnerable based on their clinical judgement. A register of vulnerable patients was held on DMICP and it was last updated on 11 March 2019. Searches using the code to identify a vulnerable patient were not routinely being carried out. The DSMO attended the station welfare meetings where vulnerable patients were discussed. Any vulnerable patients identified by the welfare team were added to

the practice register. Minutes confirmed that vulnerable patients were discussed as a standing agenda item at the monthly clinical meetings.

- Staff who acted as chaperones had been subject to safety checks to ensure they were suitable to work with young people and vulnerable adults. Training had been provided 18 months ago and further training had been arranged for April 2019. Notices were displayed advising patients that a chaperone was available.
- The full range of recruitment records for permanent staff and staff providing a service under contract was held centrally. The practice manager could demonstrate relevant safety checks had taken place at the point of recruitment, including a Disclosure and Barring Service (DBS) check to ensure staff were suitable to work with vulnerable adults and young people. DBS checks were renewed every five years. The DBS check for the practice manager had expired and an application was in process.
- 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 IPC lead nurse was deployed so the deputy IPC was overseeing IPC activity. Both had completed appropriate training for the role. All staff working at the practice had received IPC training. Effective arrangements were in place for environmental cleaning of the medical centre. Cleaning of the PCRF was inconsistent. The practice manager was aware of and managing this. A deep clean was undertaken in December 2018.
- Clinical waste was stored appropriately. However, the physiotherapist was inappropriately transporting clinical waste, including sharps boxes, from the PCRF to the medical centre for disposal. Consignment notes were maintained but an annual waste audit had not been completed.
- The practice ensured that facilities were safe. Electrical safety checks were completed as required and water safety checks were undertaken regularly. A legionella risk assessment had been carried out for the station and the medical centre had access to the plan. Fire safety management including regular checks were carried out, including the testing of firefighting equipment. Staff were up-to-date with fire safety training. Arrangements were in place for the monitoring and maintenance of equipment. Testing of portable electrical appliances and medical equipment was in-date.

Risks to patients

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

- Since the last inspection and until January 2019, the practice had not been sufficiently staffed, particularly in relation to clinical staff. All the doctors were new with the SMO taking up post in January 2019. A health care assistant (HCA) had also been appointed recently. Specific induction packs were in place to orientate and support locum staff with practice working systems. The only locum staff at the time of the inspection were working in the PCRF.
- Clinical staff were up-to-date with training to manage medical emergencies. Administrative staff received basic life support training.
- Clinical staff were familiar with signs and symptoms of sepsis, including using the DMICP sepsis template. Although sepsis displays and information was available, specific training in sepsis had not been provided for administrative staff. The practice had recognised this need and sepsis had been added to the training programme. The SMO had received training in

thermal injuries and had discussed the recognition and management of thermal injuries with the staff team.

- The patient waiting area could be observed from reception to ensure the safety of patients.

Information to deliver safe care and treatment

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

- Although the new DMICP template for patient registration included a section on summarisation, staff were not currently using this, rather using an alternative summarising template instead. Summarising was carried out by the doctors and nurses. There were 133 records awaiting summarisation which the clinical team were working through. The backlog in summarisation was due to consistent low staffing levels until January/February this year. A plan was in place to address this backlog. After the inspection the SMO advised us that A new summarisation standard operating procedure had been introduced to support both nurses and doctors with summarisation. As a result, the number of records awaiting summarisation had significantly reduced since the inspection despite low staffing levels.
- Staff described the occasional loss of connectivity with DMICP as frustrating because it limited access to the patient's record. All outages were reported and how to respond was outlined in the business continuity plan. If DMICP was unavailable then only urgent patients were seen.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. Internal referrals were managed by the doctors using the DMICP internal tracking document. External referrals were arranged through the NHS e-Referral Service (eRS), including urgent referrals. Individual doctors were responsible for checking the status of the internal referrals they made, and the referrals clerk was responsible for checking the status of the eRS referrals made by the practice.
- A lead and deputy were identified for the management of specimens and results. A process was in place including the transport of specimens to the laboratory and the use of Lablinks to manage test results. Results were recorded and forwarded to the doctor for review and action.

Safe and appropriate use of medicines

At the last inspection the practice failed to ensure safe management of medicines. Improvements had been made at this inspection.

- The DSMO was the medicines management lead for the practice. The practice had improved the management of high risk medicines. A local standard operating procedure (SOP) had been prepared. There was a register in place and relevant alerts had been placed on the medical record to inform clinicians.
- The management of medical devices still required review. The test strips and calibration solution for blood glucose monitoring were incorrect. This meant we could not be assured patients test results were correct.
- Prescription stationery was now stored securely however the accounting was not robust and audits had not been completed. This was highlighted during the inspection and the practice manager was reviewing this.
- Patient Group Directions (PGD) had been adopted by the practice to allow nurses to administer medicines in line with legislation. The nurses had completed the required training and authorisation sheets had been signed by the SMO. Most PGD items were stored correctly. We

found a medicine without a pre-printed label (referred to as over-labelled) and medicines without appropriate address labels. This was highlighted during the inspection.

- The fridge temperatures were recorded regularly. There was ambiguity about a deviation in storage and the practice had identified some medicines to be outside of their product license, however they were being managed appropriately.
- Medical emergency medicines were in date. Although, the expiry date monitoring was efficient storage was not in line with DPHC policy and replacement items had not been stored in a timely manner.
- The outsourcing procedure with the local pharmacy had improved. The log for prescriptions faxed to the pharmacy was being completed. Patients were contacted by email or telephone to remind them to collect medication. There was a member of staff responsible for this task and additional staff members were being trained to ensure continuous service.

Track record on safety

Improvements were needed in relation to safety.

- The practice manager was the lead for health and safety. Risk assessments pertinent to the practice were in place including risk assessments for acupuncture, needle stick injury and for products hazardous to health.
- All clinical rooms had alarms for staff to summon assistance in the event of an emergency. Some of these were not positioned in a way that staff could access them easily. The panic alarms were not working and staff had identified this the week prior to our inspection. It had been reported to maintenance.
- The PCRF staff coordinated their work to minimise lone working. The PCRF alarm system was connected to the guardroom.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff had electronic access to the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events, incidents and near misses. One member of the administrative team was awaiting access. The practice manager completed the process and carried out any investigations required. Significant events were a standing agenda item at the practice meetings. Patient centred significant events were a standing agenda item at the clinical meetings. Although staff told us lessons learned were discussed at the meetings, we were unable to determine if any follow up took place to ensure action agreed was completed.
- A recent pre-inspection by the regional team suggested the practice was under reporting significant events. We noted that eight were reported in 2018 and just one was reported by the PCRF. Five significant events had been reported in 2019 with three of these since the pre-inspection. This showed the practice had acted on the feedback from the pre-inspection review.
- The practice manager checked the system twice a day for medical alerts. Relevant alerts were circulated to staff via email and also discussed at the practice meetings. Although a register was in place to log referrals received, it was not up-to-date.

Are services effective?	**Requires improvement**

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

Following our previous inspection, we rated the practice as inadequate for providing effective services because processes for monitoring patient care and treatment were not consistent. There were gaps in the provision of effective services including: clinical meetings; inconsistent follow up of patients with long term conditions (LTC); consistency of Read coding; quality improvement activity; staff training; vaccinations activity and screening for national programmes.

At this inspection we found some of the recommendations we made had been actioned or there was an action plan. However, the recall of patients with long term conditions (LTC) and consistency with coding had not been effectively addressed. The practice is rated as requires improvement for providing effective services.

Effective needs assessment, care and treatment

- The practice assessed needs and delivered care based on population need and in accordance with relevant and current evidence based guidance and standards. For example, the PCRF identified a trend of referrals for back pain. Many of the patients had sedentary jobs so the PCRF developed an exercise programme titled 'The Office Gym' and provided a presentation at the station air safety day. It received good feedback and the plan is for the PCRF to provide exercises to be included in the station magazine. The next stage is to formally audit the impact for patients.
- Clinical staff were aware of evidence based guidance and standards, including guidance from the National Institute for Health and Care Excellence (NICE). Staff referred to this information to deliver care and treatment to meet patients' needs. They described how updates on NICE and medicines management were outlined in a newsletter circulated to clinical staff by the DPHC each month. NICE guidance was a standing agenda item at the monthly clinical meetings. For example, antenatal care for uncomplicated pregnancies was discussed at the meeting in February 2019.
- The physiotherapists referred to best practice guidelines in their treatment of patients, such as the Defence Rehabilitation website.

Monitoring care and treatment

A lead and deputy were identified for chronic disease management and they carried out monthly searches to monitor patients diagnosed with a chronic condition.

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 following patient outcome data shows that recall figures were low. Pathways to manage conditions were still being developed and the chronic disease register was in in its infancy. Staff explained this was due to inconsistent clinical leadership and low clinical staffing levels until February 2019. A plan was in place to address the backlog of recalls.

- There were 85 patients recorded as having high blood pressure. Fifty-six had a record for their blood pressure taken in the past nine months and 52 had a blood pressure reading of 150/90 or less.

- There were 22 patients with a diagnosis of asthma. Thirteen had an asthma review in the preceding 12 months which included an assessment of asthma control using the three Royal College of Physicians questions.
- There were 12 patients were on the diabetic register. Eight patients had a last measured total cholesterol of 5mmol/l or less which is an indicator of positive cholesterol control. Seven patients had a last blood pressure reading of 150/90 or less.

Due to low staffing levels, there was a significant backlog of approximately 800 medicals. The SMO said these were mainly routine occupational health medicals (low risk surveillance medicals). We discussed the risk for patients and were advised that the risk was if a patient was posted to a flying station or was scheduled to be deployed. In these instances, aviation medicals could be undertaken on a need basis.

Supported by the Regional Clinical Director, a plan was in place to address the backlog as funding had been agreed for a short term increase in clinical resources, including a fixed term appointment of a locum doctor and healthcare assistant. A recent policy change indicated a large number of these medicals are no longer required i.e. groundcrew medicals at age 30 and 35 and aircrew medicals for those in non-flying posts. The SMO suggested this change will likely reduce the backlog significantly.

Information from the Force Protection Dashboard, which uses statistics and data collected from military primary health care facilities, was also used to gauge performance. Service personnel may encounter damaging noise sources throughout their career. It is therefore important that service personnel undertake an audiometric hearing assessment on a regular basis (every two years). Staff acknowledged that there was also a backlog with audiometric assessments. Audiometric assessments were in date for 62% of patients. Audiometric assessments were being addressed as part of the plan to reduce the backlog of medicals.

We looked at a selection of clinical records for patients with mental health needs. Although we saw examples of good quality record keeping, Read coding was not consistent so there was a risk to the reliability and validity of searches. There was no agreed practice protocol about what Read codes clinicians working at the practice should use.

The SMO advised us that recent referrals/cases were discussed at the end of clinical meetings. Peer review was in the process of being formally developed and the practice was looking at introducing peer review clinics. Rehabilitation staff new to the service had their clinical records reviewed after two weeks in post.

Quality improvement had improved but was in the very early stages of development, particularly clinical audit with most audits process-based or using system searches, and on their first cycle. An audit lead was identified and an audit programme in place. The searches and clinical audits undertaken included: direct access physiotherapy (second cycle), NICE guidance and mental health referrals, adult immunisation, cytology and PCRF non-attendance reduction audit.

Effective staffing

A generic induction and role specific induction packs had been developed. The practice manager regularly monitored that staff were up-to-date with mandated training; figures showed it was almost at 100%.

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

and support for revalidation. The practice was closed on Wednesday afternoons to facilitate training, meetings and continuing professional development.

Coordinating care and treatment

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

- The clinical records we looked at showed appropriate staff, including those in different teams, services and organisations were involved in assessing, planning and delivering care and treatment.
- The GPs had good links with local health and social service teams due to their work in NHS primary care. The practice worked closely with the Regional Rehabilitation Unit (RRU) and the DCMH, and had links with the local midwifery service and health visiting team. They referred patients to an alternative medical centre for specialised medicals they did not provide, such as diving medicals.
- Patients due to the leave the military had a release medical. Staff said they would signpost patients to the welfare team for support. The welfare had information about a wide-range of support and resource for personnel due to leave.
- The practice was represented by the physiotherapist and a doctor at the quarterly station health and wellbeing meetings.

Helping patients to live healthier lives

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

- The health care assistant was the health promotion lead. Health promotion displays were available for patients and were based on population need and national campaigns. Health fairs were held on the station and the practice participated in these.
- The DSMO was the sexual health lead. Clinicians were aware of who they could refer and/or signpost patients to.
- The practice had introduced searches for patients who are eligible for national screenings programmes. The bowel and aortic aneurysm searches were yet to be undertaken. Breast screening identified 23 eligible patients.

It is important that military personnel have sufficient immunity against the risk of contracting certain diseases. The World Health Organisation sets a target of 95% for vaccination against diphtheria, tetanus, pertussis and polio and measles, mumps and rubella. The following illustrates the current 2018 vaccination data for patients using the practice:

- 90% of patients were recorded as being up to date with vaccination against diphtheria.
- 96% of patients were recorded as being up to date with vaccination against hepatitis B.
- 98% of patients were recorded as being up to date with vaccination against hepatitis A.
- 100% of patients were recorded as being up to date with vaccination against typhoid.

Searches of the system were undertaken each month and a list populated by the practice nurses who then recalled the patients for their vaccinations.

Consent to care and treatment

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

- Clinicians supported patients to make decisions. They understood the requirements of legislation and guidance when considering consent and decision making. They were also familiar with the key principles of the Mental Capacity Act and how it could apply to their population group.
- The practice monitored the process for seeking consent was appropriate.

Are services caring?	Good

We rated the practice as good for caring.

Kindness, respect and compassion

- Throughout the inspection staff were courteous and respectful to patients arriving for their appointments.
- Results from the October to December 2018 patient experience survey indicated that patients were treated with dignity and respect. The 31 CQC comment cards completed prior to the inspection were very all complimentary about the caring attitude of staff. We also spoke with two patients who described a positive experience of using the practice.
- The practice had an information network available to all members of the service community, known as HIVE, which provided a range of information to patients who had relocated to the base and surrounding area. Information included what was available from the local unit and from civilian facilities, including healthcare facilities.

Involvement in decisions about care and treatment

- Staff supported patients to be involved in decisions about their care. In relation to physiotherapy and rehabilitation, expectations were discussed with each patient to ensure bespoke goals and a treatment plan was identified for the patient.
- Interpretation services were available for patients who did not have English as a first language. Information was available informing patients of this service.
- The patient survey indicated respondents felt involved in decisions about their care. Feedback on the CQC patient feedback cards highlighted that patients received information about their treatment to support them with making informed treatment and care.
- The practice proactively identified patients who had caring responsibilities, even if that was an indirect caring role. A carer's register was held on DMICP and was last updated in March 2019. There were seven carers identified. Their needs were discussed at the welfare meetings.

Privacy and dignity

- Clinic room doors were closed during consultations. Clinical curtains were available when patients were being examined.
- The waiting room was separate from the reception so conversations between patients and reception could not be easily overheard. A confidentiality card was available at reception for patients to indicate to the receptionist if they wished to speak with someone privately. If patients wished to discuss sensitive issues or appeared distressed at reception they could be offered a private room to discuss their needs.

- Patients had the choice of seeing a male or female doctor. The PCRF only had male staff so if a patient specifically requested to be seen by a female then they could be referred to the PCRF at Halton, a 15 minute drive from the practice.

Are services responsive to people's needs?	Requires improvement

Following our previous inspection, we rated the practice as requires improvement for providing responsive services. This was due to a large numbers of patient concerns raised about restrictive telephone access to the service and a direct access physiotherapy service not in place.

At this inspection we found the recommendations had been partially addressed. We also identified a deficit with the complaints process so the practice remains rated as requires improvement.

Responding to and meeting people's needs

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

- Staff understood the needs of its population and tailored services in response to those needs. For example, clinics were organised around the occupational health needs of service personnel.
- Patient feedback at the last inspection indicated a theme of dissatisfaction and frustration with the answering of telephones. Patients frequently received the answerphone. The area manager and SMO had done as much as they could to address the matter, such as additional administrative staff and direct lines to staff/teams. However, the practice had no control over the telephone system and answerphone message as this was an inherent issue with the infrastructure for the last 20 years. The practice could not change the message and if the phone lines were in use there was an automatic direction to the answerphone.
- Although patient feedback at this inspection showed improvement with telephone access, we did not find this was the case. The practice manager had consistently raised this concern with the station since the last inspection. Investigations were ongoing regarding the possibility of introducing a complete new phone system.
- Overall the CQC feedback comment cards completed prior to the inspection highlighted that it was easy to secure an appointment.
- An access audit as defined in the Equality Act 2010 had been recently completed for the premises. It identified some areas where further reasonable adjustments could be made to accommodate patients with access needs.

Timely access to care and treatment

Patients' needs were met in a timely way.

- Patients with an emergency need were seen on the same day by a clinician. The waiting time for a routine GP appointment was one to two weeks. The waiting time to see a nurse was usually within three days. Urgent patients were seen by the physiotherapist within 48 hours and routine appointment requests were met within 10 working days (usually within three days). There were four 15 minute DAPS appointment slots available four days per week.
- The Patient Experience Survey showed that all relevant respondents had received their appointment at a time that suited them. Failure to attend appointments was monitored and the numbers of missed appointments was low. This was displayed each month in the waiting room.

- Telephone consultations were available. Home visits could be facilitated in accordance with the SOP, and was managed on a case-by-case basis. A home visit register was in place but no requests had been made for this service.
- Arrangements were in place for patients to access medical care when the medical centre was closed, including the out-of-hours service.

Listening and learning from concerns and complaints

- A process was established to record and manage complaints, including a complaints log. The practice manager was the lead for complaints. Although there were no complaints recorded on the system at the time of the inspection, we found that concerns raised verbally had not been treated as a complaint. For example, a complaint dealt with by the regional team was not logged on the practice complaint register. We found that a clinical complaint had been managed effectively and lessons learnt discussed at the practice meeting. However, it had not been recorded on the complaints log.
- Information was outlined in the patient information leaflet to support patients with understanding the complaints process.

Are services well-led? | Requires improvement

Following our previous inspection, we rated the practice as inadequate for providing well-led services. This was due to inconsistent leadership and underdeveloped governance systems.

At this inspection we found action had been taken to address the concerns identified. However, improvements were still required so the practice is rated as requires improvement for providing well-led services.

Vision and strategy

The practice worked to a clearly defined mission statement of the DPHC:

> "DPHC Mission Statement: 'DPHC will deliver a unified, safe, efficient and accountable primary healthcare and dental care service for entitled personnel to maximise their health and to deliver personnel medically fit for operations."

The mission statement specific to the practice was:

> "To provide a high standard of primary care to our entitled patients by working together as a cohesive multi-disciplinary team in an effective and efficient manner."

The practice had been hampered in effectively meeting its mission and making timely improvements due to inconsistent leadership and staff turnover last year. Most notable was a complete change to the medical team. The SMO and the other two doctors had taken up post in recent months.

Now that the practice was almost fully staffed, staff believed the practice was now in a position to deliver a quality primary health care service in accordance with the vision and mission statement.

Leadership capacity and capability

- On the day of inspection, we saw a practice that was well-led. The SMO, practice manager and DSMO not only demonstrated managerial experience and capability, it was clear they had integrity and were focussed on developing the service. They were honest about the areas of improvement needed, had plans in place to make these improvements and were supported by a forward thinking staff team.

- Staff spoke highly of the leadership, describing how the service was more structured and organised. Significant change had been made to how the administration team operated and staff said this had led to improved and a more efficient service provision for patients.
- It was clear the Regional Clinical Director and area manager were actively engaged with the practice to support development of the service.
- The PCRF had regular annual advisory visit from the Regional Rehabilitation Officer (RRO) and the next was due in May 2019.

Culture

- Staff said they felt respected, supported and valued. The practice meetings provided staff with the opportunity to contribute their views and ideas about how to develop the practice. They said they worked well together and supported each other.
- The practice had systems to ensure compliance with the requirements of the duty of candour, including giving those affected reasonable support, information and a verbal and written apology. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training.

Governance arrangements

Governance arrangements had been developed since the last inspection and were in the process of embedding.

- 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.
- The practice worked to the regional health governance workbook, a system that brings together a comprehensive range of governance activities, including the risk register, significant events tracker, lessons learnt log, training register, policies, meetings, quality improvement and audit. All staff had access to the workbook which provided links to meeting minutes, policies and other information.
- Communication had improved since the last inspection. A meeting structure was in place including practice meetings, management meetings, PCRF meetings and clinical meetings that were attended by all clinicians working in the practice.
- Quality improvement, particularly clinical audit, was still in its infancy. An audit programme was in place and it needed further development to ensure it captured the full cycle of each audit and included audits undertaken by the PCRF. Peer review was in the process of being developed.
- Plans were in place to address the backlog of medicals, summarisation and audiometry assessments.

Managing risks, issues and performance

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

- The practice manager understood the risks to the service and kept them under scrutiny through the risk register. They had oversight of national and local safety alerts and incidents. Not all complaints were being logged on the complaints register.
- Staff were working on the management action plan developed following the pre-inspection service review. We could see that some of the actions had been met.
- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety. We noted that the risk register was not up-to-date. For example, some risks had not been graded.
- A business continuity plan was in place.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- An internal quality assurance tool, the DMS Common Assurance Framework (CAF) was used to monitor safety and performance. The DMS CAF was formally introduced in September 2009 and since that time has been the standard healthcare governance assurance tool utilised by DMS practices to assure the standards of health care delivery within DMS.
- The practice had recently started to use the newly introduced eCAF and it was still in the early stages of development.
- The physiotherapist undertook an annual review of the service in 2018 that looked at areas such as referrals, non-attendance and patient feedback

Engagement with patients, the public, staff and external partners

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

- A patient experience survey was undertaken throughout the year and a comments book was in the patient waiting room. The practice had responded to all comments.
- The patient survey was displayed in the waiting area. A ‘you said, we did’ display had just been started and was displayed for patients.
- The practice had good working relationships with the station commander and welfare officer.

Continuous improvement and innovation

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

- Introduction of a confidentiality card at reception.
- Restructure of administration roles and responsibilities.
- The repeat prescription process had been reviewed and improved following patient feedback.
- The development of an exercise programme, ‘The Office Gym’ for sedentary office based staff.
- Introduction of a practice WhatsApp group.