

Leeming Medical Centre

Quality report

Northallerton
North Yorkshire
DL7 9NJ

Date of inspection visit:
28 March 2019

Date of publication:
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	Good 
Are services safe?	Good 
Are services effective?	Good 
Are services caring?	Good 
Are services responsive to people's needs?	Good 
Are services well-led?	Good 

Chief Inspector's Summary

This practice is rated as good overall

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

We carried out an announced comprehensive inspection of Leeming Medical Centre on 28 March 2019. For reasons of availability, the medicines management element of the inspection was undertaken on 20 March 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 medical centre was well-led and leaders demonstrated they had the vision, skill and capability to provide a patient-focused service. The leadership post for the Primary Care Rehabilitation Facility (PCRF) had been vacant since March 2018.
- The practice understood the needs of the patient population and clinical provision was focussed on ensuring patient's needs were met.
- 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.
- The assessment and management of risks was comprehensive.
- Processes were in place to identify and manage vulnerable patients.
- The arrangements for managing medicines were safe. There was an effective approach to the monitoring of patients on high risk medicines.
- Staff were aware of current evidence based guidance. They had received training so they were skilled and knowledgeable to deliver effective care and treatment.
- The practice worked collaboratively and shared best practice to promote better health outcomes for patients.
- There was clear evidence to demonstrate quality improvement was embedded in practice, including an annual programme of clinical audit used to drive improvements in patient outcomes. Quality improvement was less well developed for the PCRF.
- 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.

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

- Staff understood the needs of its population and tailored services in response to those needs. For example, a vasectomy clinic based at the practice had been commissioned through NHS England. Providing this service, including a no scalpel vasectomy (NSV) approach, meant that patients had reduced waiting times for the procedure, a less invasive procedure so shorter operating time and quicker recovery time. The practice had submitted a quality improvement plan (QIP) for this initiative.
- The practice took into account Public Health England guidance on NHS screening for transgender and non-binary patients (collectively referred to as 'trans'). A standard operating procedure had been developed to ensure patients were offered gender appropriate screening. For example, all trans women (male to female) were identified and asked if they would like to be referred for screening.

The Chief Inspector recommends:

- A review of the PCRf to ensure effective leadership is in place.
- Review lone working arrangements to ensure the safety of pharmacy staff at all times.
- Undertake a cleaning audit to establish whether routine deep cleans are required.
- Whilst the coding for mental health conditions is being developed at a broader level, an agreement should be reached by clinicians so consistent Read codes are used for the practice.

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 GP, practice nurse, practice manager, physiotherapist and pharmacist. A CQC inspector shadowed on this inspection.

Background to the Leeming Medical Centre

RAF Leeming, based in North Yorkshire trains, delivers and supports UK and overseas expeditionary air operations. The station is home to a diverse range of squadrons and lodger units including 90 Signals Unit and a mountain rescue team.

Leeming Medical Centre provides primary health care, occupational health care and rehabilitation to the military service population based at RAF Leeming, along with primary health care for their families and dependants. The patient population is approximately 2048. A reservist population of approximately 7500 are supported with occupational health.

A primary care rehabilitation facility (PCRf) is co-located with the medical centre and provides a direct access physiotherapy service for air crew personnel and a self-referral process for all military personnel.

The practice facilitates a range of clinics including: occupational medicals; triage clinic; vaccination clinics; children's immunisations; audiology clinics; well women clinic; over-40 health checks; smoking cessation; health management clinics i.e. diabetes, asthma, hypertension and reservist medicals. Clinics facilitated by visiting clinicians include a pre- and post-natal midwife clinic, a vasectomy clinic and community mental health.

The RAF medics working in the medical centre provide airfield medical cover throughout flying hours and can respond to an airfield emergency when called. A medic is trained to provide medical support and airfield crash cover on various operations and exercises. In a medical centre setting, their role is similar to that of a health care assistant in NHS GP practices but with a broader scope of practice.

The practice is open from 08:00 to 18:30 Monday, Tuesday and Thursday. It is open from 08:00 to 12:00 Wednesday and Friday for routine appointments only. Arrangements are in place on weekdays for access to medical cover when the practice is closed and before NHS 111 is available.

The staff team

Position	Numbers
Senior medical officer (SMO)	One full time
Deputy SMO	One full time
Registrar	One
Medical Officers (MO)	One full time
Civilian medical practitioners (CMP)	One part time; one on reserve forces strength
Principal Nursing Officer (PNO)	One full time
Practice nurses	Two full time; one part time
Warrant Officer	One full time
Practice manager	One full time
Deputy practice manager	One full time
Administrative staff	Five full time admin grades; one allocated to administer Fylingdales Medical Centre
Pharmacy technician	Two full time. One line covered by locum due to absence.
PCRF	Two full time physiotherapists and one exercise rehabilitation instructor (ERI). One physiotherapy line covered by locum and ERI line covered by locum due to staffing gaps
Medics	11
Other	Two full time environmental health technicians (air asset); one full time ambulance driver (station asset); part time midwife (NHS asset); part time mental health clinicians; vasectomy clinic (commissioned service)

Are services safe?**Good****We rated the practice as good for providing safe services.****Safety systems and processes**

Systems were established to keep patients safe and safeguarded from abuse.

- A framework of regularly reviewed safety policies was in place and accessible to staff, including locum staff. Staff received safety information about the practice as part of their induction and refresher training.
- Measures were in place to protect patients from abuse and neglect. Adult and child safeguarding policies were in place, including local safeguarding contact details. All staff had received up-to-date safeguarding training at a level appropriate to their role. Clinical staff had completed level 3 training. The Senior Medical Officer (SMO) and Deputy SMO were the safeguarding leads for the practice.
- Regular searches of the electronic patient record system (referred to as DMICP) was undertaken to identify vulnerable patients, with the last search undertaken in March 2019. Codes and alerts were used on to highlight these patients. A register of vulnerable patients was maintained and managed by the practice. The practice was represented at the monthly station welfare meetings where concerns about vulnerable patients were also discussed. The SMO had developed links and was attending local safeguarding meetings with health and social services.
- A register for vulnerable children was in place and reviewed at monthly meetings attended by clinicians and the health visitor. The last meeting was held in March 2019.
- All staff had received chaperone training and notices advising patients of the chaperone service were displayed in clinic rooms. Staff had been subject to safety checks to ensure they were suitable to work with young people and vulnerable adults.
- The full range of recruitment records for permanent staff was held centrally. However, the practice could demonstrate that relevant safety checks had taken place at the point of recruitment, including a Disclosure and Barring Service (DBS) check to ensure staff, including locum staff, were suitable to work with vulnerable adults and young people. DBS checks were renewed every five years.
- Arrangements were in place to monitor the registration status of clinical staff with their regulatory body. All staff had professional indemnity cover. Information was in place to confirm staff had received all the relevant vaccinations required for their role at the practice.
- There was an effective process to manage infection prevention and control (IPC), including a lead for IPC who was appropriately trained for the role. The staff team was up-to-date with IPC training. An annual IPC audit had taken place.
- Environmental cleaning was provided by an external contractor. Cleaning schedules and monitoring arrangements were established. A deep clean of the premises was not included in the cleaning contract. It was confirmed by email from the contract management officer and based on a risk assessment and the cleaning schedule that a deep clean was not required. The practice had identified the absence of deep cleaning on the risk register. A specific cleaning audit had not been undertaken which would indicate if a deep clean was required. We identified no concerns with the cleanliness of the premises.
- Systems were in place for the safe management of healthcare waste. Consignment notes were retained at the practice and an annual waste audit was carried out in March 2019.

Risks to patients

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

- Staff we spoke with said staffing levels and skill mix was adequate to meet the needs of the patients. The exception to this was the Primary Care Rehabilitation Facility (PCRF). The military physiotherapy post was not filled and the Exercise Rehabilitation Instructor (ERI) post was vacant from the day after the inspection. Staff gaps were managed through the use of locums. The practice was in the process of developing a specific induction pack for locum staff.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures, including staff trained in basic life support and intermediate life support. An emergency kit, including a defibrillator, oxygen with 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. Daily checks were in place to ensure the required kit and medicines were available and in-date.
- The practice provided emergency cover for the airfield with the medics providing 24-hour emergency airfield cover. Medics had completed the emergency care provider course. A duty doctor was also available should the medics require assistance.
- Staff were up-to-date with the required training for medical emergencies. They participated in regular training simulation exercises for emergency situations, including scenarios to promote the recognition and management of sepsis. A sepsis protocol was displayed in each of the clinical rooms. Training was available in climatic injuries.

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. Arrangements were in place for peer review of clinical records and any issues identified were discussed at the clinical team meeting.
- A process was established for scrutiny and summarising of patients' records. Civilian records were managed by a dedicated family's administrator and summarisation of records was up-to-date. Eighty-six percent of service personnel records had been summarised at the time of the inspection. Monthly searches were undertaken to identify new patients joining the practice.
- Staff described occasional loss of connectivity with DMICP, meaning clinics could be delayed. If this happened, the business resilience plan was followed and only emergency patients were treated.
- External referrals were booked by the doctor and patient through the NHS e-Referral Service (eRS), including urgent referrals. The administrator responsible for monitoring the eRS referrals checked the status of these each day. 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). Doctors were responsible for monitoring the referrals they made to the DCMH. 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 and the use of Pathlinks to manage test results. A log was

maintained of specimens with the throughput and status of specimens managed by the practice nurses. Results were forwarded to the GP for action if required.

Safe and appropriate use of medicines

The practice had reliable systems for the appropriate and safe handling of medicines.

- The deputy SMO was the medicines management lead with the day-to-day management of medicines delegated to a pharmacy technician. Safe procedures were in place for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment.
- Dispensary stock and medicines contained in the doctor's bag was checked each month. Appropriate arrangements were established for the safety of controlled drugs (CD), including destruction of unused CDs. Medication requiring refrigeration was monitored twice a day to ensure it was stored within the correct temperature range. Prescription pads were securely stored and their use monitored.
- The risk associated with the management of single person dispensing had been minimised. The dispensary was well laid out with a separate checking bench and a clear process to reduce the risk of errors.
- Patient Group Directions (PGD) had been developed to allow nurses to administer medicines in line with legislation. These were current and signed. A recent audit showed a 98% compliance with the PGD protocol. Repeat prescriptions were safely managed with no repeats issued after six months until the patient was reviewed by the doctor.
- A register to monitor the prescribing of high-risk medicines was maintained. Monthly searches were undertaken to ensure the register was up-to-date. We noted that shared care agreements were in place and alerts used to identify patients on these medicines.

Track record on safety

The practice had a good safety record.

- Measures to ensure the safety of facilities and equipment were in place. The practice manager was the lead for risk and the deputy practice manager the lead for health and safety. Electrical and water safety were up-to-date. 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.
- Safety processes for the practice were monitored and reviewed, which provided a clear, accurate and current picture that led to safety improvements. Risk assessments pertinent to the practice were in place, including those for hazardous substances, operating electrical equipment and lone working.
- A process was in place for checking equipment. However, the cardiovascular equipment was out of date for servicing since November 2018 but was still in use for patients. It had been raised as a significant event following an external inspection by the Regional Rehabilitation Unit (RRU) in March 2019 and added to an issues log. A servicing date had been agreed. Testing of portable electrical appliances and medical equipment was in-date.
- An alarm system was in place to summon support in the event of an emergency. This was not available in the dispensary. The pharmacy technician sometimes worked alone which posed a risk to their safety. We discussed this with the practice manager who agreed to explore options to improve the safety of the pharmacy technician.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff used the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events, incidents and near misses. All staff had electronic access to the system, including locum staff. Staff provided several examples of significant events they had raised demonstrating there was a culture of effectively reporting incidents. A weekly ASER meeting was held to review significant events and undertake a root cause analysis. Staff were emailed with any actions identified.
- The ASER system was also used to report good practice and quality improvement initiatives.
- The pharmacy technician was responsible for managing medicine and safety alerts. The system was checked for alerts twice a day and any alerts logged on the register. Alerts were emailed to staff with a read receipt. They were also discussed at the team meetings.

Are services effective?

Good

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.

- Staff assessed patient's 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, at one of the meetings in March 2019 guidance on the antibiotic treatment for urinary infections was discussed. Clinicians were also reminded at the meeting to use the feverPAIN score when considering antibiotics for acute sore throat.
- The clinical meetings were also used to review patient care. For example, patients on high risk medicines and those with shared care agreements were discussed at a clinical meeting in February 2019. Patients on long term sick were reviewed at meetings in February and March 2019 to ensure they were being recalled appropriately.
- PCRF staff referred to the Defence Rehabilitation website for best practice guidance. They took a holistic approach when assessing patients and took the needs of the patient into account when developing specific goals with the patient.

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:

- Nine 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. Nine patients had a last blood pressure reading of 150/90 or less.
- Eleven patients were recorded as having high blood pressure. All had a blood pressure recorded of 150/90 or less.
- Forty-five patients had a diagnosis of asthma. Twenty-four of these 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. We discussed the remaining patients and were satisfied that they were being recalled in accordance with policy. For example, nine patients had not responded, two failed to attend for their appointment and two had appointments booked.

The deputy SMO and Principal Nursing Officer (PNO) were the leads for chronic disease management. They carried out regular searches, recalling patients when appropriate. Searches of the system were undertaken monthly to identify patients requiring follow up. We noted from minutes that the case management of patients with chronic conditions was discussed at the clinical meetings.

We looked at a selection of patient records and were assured that clinicians were consistent in how patients were reviewed. For example, clinicians used the same asthma review template. Read coding was appropriately and consistently applied to patients with chronic conditions. We looked at a range of patient records and were assured that the care of patients with a mental illness and/or depressive symptoms was being effectively and safely managed, often in conjunction with the Department of Community Mental Health (DCMH). Although record keeping was of good quality, Read coding was not consistent which could weaken the reliability and validity of searches. There was not an agreed practice protocol confirming which Read codes for mental health/physiological conditions clinicians should use. This was acknowledged at a clinical meeting in March 2019, highlighting that the mental health service was currently looking into how to 'narrow down' the Read codes used.

The practice provided a no scalpel (NSV) vasectomy clinic, commissioned through NHS England. The clinic was operating on the day of the inspection so we spoke with the specialist doctor who provided this service. They demonstrated that the practice was closely monitored to ensure an effective and safe service taking into account consent, IPC, clinical waste disposal, a process of audit and patient follow up.

Information from the Force Protection Dashboard, which uses statistics and data collected from military primary health care facilities, was also used to gauge performance. Service personnel may encounter damaging noise sources throughout their career. It is therefore important that service personnel undertake an audiometric hearing assessment on a regular basis (every two years). Audiometric assessments were in date for 90.4% of patients.

- The medics were responsible for ensuring that downgraded patients were reviewed every six months. The outcome of these medical assessments were discussed with the doctor and other relevant teams, such as the welfare team and medical board department.
- Quality improvement, including clinical audit, was clearly embedded in practice and seen as the responsibility of all staff. A programme of audit was in place that took account of population need. We could see that best practice based clinical audit cycles were undertaken with appropriate actions for improvement identified.

- Minutes illustrated that clinical audits were discussed at the clinical meetings, including any action and/or changes to practice required. For example, an audit of hospital letters resulted in the action to peer review the quality and accuracy of coding information from hospital letters. A diabetes audit, annual prescribing audit and a hypertension audit were also discussed in detail at recent clinical meetings. Due to ongoing low staffing levels, audit was limited to a notes audit and Direct Access Physiotherapy Service (DAPS) for the PCRf.

Effective staffing

Continuous learning and development was promoted for staff. The database was reviewed each month and discussed at practice meetings to ensure staff were up-to-date with training and development.

A generic and role-specific induction was in place for new staff to the practice.

Mandated training was monitored and the staff team was in-date for all required training. A programme of ongoing development training (referred to as trade training) was in place. Staff also completed population need-based role-specific training. For example, all regular doctors had completed Military Aviation Medical Examiner (MAME) training. Competency checks were undertaken where appropriate, such as clinicians ensuring the clinical practice of medics was safe. Clinicians had not yet completed the training to support provision of Step 1 mental health care in primary care. This was in the process of being arranged with the DCMH.

- 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.
- Two weeks prior to the inspection the RRU undertook an advisory visit to the PCRf to monitor the performance of and support for Exercise Rehabilitation Instructors (ERI). The report was not available at the time of the inspection.
- Regional meetings and forums were established for staff to link with professional colleagues in order to share ideas and good practice. For example, nurses were facilitated to attend the regional nurse's forum to link with their colleagues and share ideas.
- The practice supported trainee primary care doctors and adequate support was available for trainees. A General Practice Education Committee (GPEC) re-accreditation was achieved in 2018.

Coordinating care and treatment

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

- The clinical records we reviewed showed appropriate staff, including those in different teams, services and organisations were involved in assessing, planning and delivering care and treatment.
- The practice had developed good working relationships both internally and with health and social care organisations. For example, the Principle Nursing Officer (PNO) engaged with the local childhood immunisation team, the midwifery team, community IPC team and health visiting team. Clinicians also referred civilian patients to the IAPT (Improving Access to Psychological Therapies) so had made connections with this service. The practice also worked closely with the RRU and DCMH.

- The doctors and PCRf staff held meetings each week to discuss and patients with complex needs and grading reviews. The SMO or deputy SMO attended the monthly station and welfare meetings. These meetings reviewed the needs of patients who were medically downgraded and those who were vulnerable.
- The practice liaised with NHS primary care to ensure a smooth transfer of patients transitioning from the military; doctors directly communicated with the NHS GP if necessary. Doctors encouraged patients with complex needs to request their full medical records so these could be passed to the NHS GP. Doctors provided transitioning patients with a signposting booklet developed by the King's Centre for Military Health Research. This booklet included information on a range of psychosocial community support, including mental health services, employment, education, housing and family support networks. They also referred patients to the welfare team for support with the transition.

Helping patients to live healthier lives

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

- Clinical records showed that staff encouraged and supported patients to be involved in monitoring and managing their health. Staff also discussed changes to care or treatment with patients as necessary.
- The practice supported national priorities and initiatives to improve the population's health including, stop smoking campaigns and tackling obesity. A health promotion lead was identified for the practice. Health promotion displays were available to patients which were regularly refreshed. We noted information was provided on how to stop smoking and sexual health advice. A variety of mental health booklets were available for patients in the waiting area.
- The PNO was identified as the lead for sexual health and they had completed the required training for the role. 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. One patient was eligible for aortic aneurysm screening and 49 for breast screening.

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

- 99% of patients were up to date with vaccination against diphtheria.
- 99% of patients were up to date with vaccination against polio.
- 100% of patients were up to date with vaccination against hepatitis B.
- 95% of patients were up to date with vaccination against hepatitis A.
- 99% of patients were up to date with vaccination against tetanus.
- 94% of patients were up to date with vaccination against typhoid.
- 99% of patients were up to date with vaccination against yellow fever.

The following illustrates the status of childhood immunisations:

- 100% of children were in date with 8, 12 and 16 week immunisations at five months
- 97.1% of children were in date with 8, 12, 16 week and 12 month immunisations at two years
- 95% of children were in date with 8, 12, 16-weeks, 12 month and pre-school immunisations at five years.

Searches were undertaken each month to check the status of immunisations.

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. Staff we spoke with were aware of the Mental Capacity Act (2005) and how it could apply to their practice.
- The practice monitored the process for seeking consent appropriately. Coding in relation to consent was used for all invasive procedures undertaken, including vasectomy.

Are services caring?	Good
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We rated the practice as good for caring.

Kindness, respect and compassion

Staff supported patients in a kind and respectful way.

- Throughout the inspection staff were courteous and respectful to patients arriving for their appointments.
- Results from the October 2018 Patient Experience Survey (30 respondents) showed 87% of patients were treated with dignity and respect and 83% would recommend the practice to family and friends. The three patients we spoke with and the 18 CQC comment cards completed prior to the inspection were very complimentary about the caring attitude of staff.
- The practice had an information network available to all members of the service community, known as HIVE. This provided a range of information to patients who had relocated to the base and surrounding area. Information included what was available from the local unit and from civilian facilities, including healthcare facilities.

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. Although staff said they had not needed to use this service, they were aware of how to access it.
- The Patient Experience Survey showed that 83% of patients were involved in decisions about their care. Feedback on the CQC patient feedback cards highlighted that patients received information about their treatment to support them with making informed decisions about their treatment and care.
- The practice proactively identified patients who were also carers. There were processes in place to identify patients who had caring responsibilities, including the use of alerts, codes and

regular searches. Patients were asked at registration whether they had caring responsibilities. Four patients were identified as having caring responsibilities.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Screening was 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 waiting area meant that conversations between patients and reception could not be overheard.
- If patients wished to discuss sensitive issues or appeared distressed at reception, they were offered a private room to discuss their needs.
- The practice could facilitate patients who wished to see a GP of a specific gender. The PCRf had no female staff so would refer a patient to another PCRf if they wished to be treated by a female.

Are services responsive to people's needs?

Good

We rated the practice as good for providing responsive services.

Responding to and meeting people's needs

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

- Staff understood the needs of its population and tailored services in response to those needs. For example, a vasectomy clinic based at the practice had been commissioned through NHS England. Providing this service, including a no scalpel vasectomy approach, meant that patients had shorter waiting times for the procedure, a less invasive procedure so shorter operating time and quicker recovery time. The practice had submitted a quality improvement plan (QIP) for this initiative.
- The practice took into account Public Health England guidance on NHS screening for transgender and non-binary patients (collectively referred to as 'trans'). A standard operating procedure had been developed to ensure patients were offered gender appropriate screening. For example, all trans women (male to female) were identified and asked if they would like to be referred for screening.
- Facilities were available for families, including a private room for breast feeding, baby changing facilities and a play area.
- An access audit as defined in the Equality Act 2010 had been completed for the premises. Facilities were in place to accommodate patients with a disability. A lift provided access to the first floor. Disabled parking and accessible WC facilities were available.

Timely access to care and treatment

Patients' needs were met in a timely way.

- Patients with an emergency need could attend the nurse triage clinic in the morning. The nurse then either treated the patient or referred the patient to a doctor, a physiotherapist or a medic. Appointment slots were available to facilitate emergencies. Double appointments at either the request of the clinician or patient could be made.

- There was a two week wait for routine appointments to see a nurse. If a patient was due to deploy then they could be seen earlier. Patients could see a doctor within 48 hours for a routine appointment. The Patient Experience Survey showed that 80% of respondents received an appointment with the doctor within 48 hours.
- Same day appointments were available for children. Clinics were available to facilitate school children.
- One of the squadrons was required to be available for deployment at all times. This meant the practice was organised to provide pre-deployment occupational health care with four hours' notice.
- Because of the large numbers of reservists registered at the practice for occupational health care, a doctor was dedicated to providing a service for this patient group. Depending on need, clinics were organised at short notice, including on Saturday.
- Patients were advised through the practice information leaflet that home visits could be facilitated. Telephone consultations were available with clinicians.
- A DAPS service had been in place for aircrew for the last six years and for station personnel since January 2018. At the time of the inspection access to routine physiotherapy and ERI appointments were within target.
- There was a three month wait for patients referred for a lower limb rehabilitation course. Patients referred to the multi-disciplinary injury assessment clinic (MIAC) and podiatry were seen within three weeks.
- Arrangements were in place for patients to access primary care when the practice was closed, including emergency care.

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. However, the PCRf was not recording compliments.
- The practice manager was the designated responsible person who handled all complaints. A record of complaints was maintained, including verbal complaints. Six complaints were recorded, which had been managed effectively and resolved to the satisfaction of the complainants. There was no emerging trend from the complaints received.
- Any complaints were discussed at the practice meetings and lessons identified. Changes to practice were made if appropriate and used to improve the patient experience.

Are services well-led?	Good
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We rated the practice as good for providing a well-led service.

Vision and strategy

Throughout the inspection it was clear staff were committed to providing and developing a service that embraced the overarching DPHC mission and the mission specific to the practice.

The mission statement for the DPHC mission statement was:

“Provide and commission safe and effective healthcare which meets the needs of the patient and the chain of command”.

The mission statement for Leeming Medical Centre was:

“To deliver air power in support of current and contingent operations globally, while developing commercial activity for defence benefit and enabling our joint supported units to deliver their operational output.”

Leadership capacity and capability

Staff spoke highly of the leadership of the practice. They said leaders were approachable and consistent in how they managed the service. Those responsible for the leadership of the practice demonstrated they had the experience and skills to deliver high-quality sustainable care. They demonstrated they had capability and tenacity to drive service change for the benefit of patients.

However, the departmental leadership of the PCRf was limited. The OC (Officer in Charge) physiotherapy position had been gapped (vacant) since March 2018 and was being covered by a Band 6 locum physiotherapist. The remaining permanent Band 6 physiotherapist was taking on some managerial roles even though no formal management ‘acting up’ arrangements had been agreed. The Band 6 physiotherapist did not have sufficient knowledge and skills to perform all aspects of the PCRf management. The additional managerial roles were having an impact on the physiotherapist’s clinical role.

The SMO was supporting Boulmer Medical Centre as this practice had no consistent medical input. The SMO was managing this well ensuring that the transfer of doctors to Boulmer for clinical sessions was having minimal impact on the service provided to patients at Leeming Medical Centre.

A management and development plan 2019/20 was in place for the practice. It was reviewed by the practice management team on a monthly basis. Although acknowledging that staffing levels were at times stretched, the plan highlighted that clinical care had not been impacted.

Culture

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

- Staff told us they felt respected, supported and valued. Staff described an integrative approach involving all staff supporting each other. Opportunities were in place so staff could contribute to discussions about how to run and develop the practice.
- Staff we spoke with clearly demonstrated a patient-centred focus and they said this ethos was promoted by leaders and embedded in practice.
- The practice had processes 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. A duty of candour register was in place.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.

- The practice actively promoted equality and diversity and provided staff with the relevant training. Staff felt they were treated equally.
- The practice supported staff with maintaining a healthy work life balance and staff were appreciative of the opportunity to participate in flexible working arrangements.

Governance arrangements

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

- There was a clear staffing structure in place and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. Terms of reference were in place to support job roles. The regional management team worked closely with the practice.
- The practice worked to the health governance workbook, a system that brings together a comprehensive range of governance activities, including the risk register, significant events tracker, lessons learnt log, training register, policies, meetings, quality improvement and audit. All staff had access to the workbook which provided links to meeting minutes, policies and other information.
- An effective range of communication streams were used at the practice. A schedule of regular practice, management and clinical meetings were well established.
- Audit was a routine method used to measure the effectiveness and success of clinical and administrative practice. A comprehensive audit programme was established with clear evidence of action taken to change practice and improve the service for patients. Audit was less developed for the PCRf due to staffing and leadership gaps.

Managing risks, issues and performance

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

- Risks to the service were well recognised, logged on the risk register and kept under scrutiny through regular review. There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety. Processes were in place to monitor national and local safety alerts, incidents, and complaints.
- A business continuity plan was in place. The plan for major incidents had recently been tested for the station.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

The Common Assurance Framework (CAF), an organisational-wide internal quality assurance tool, was used to monitor safety and performance. It 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 physiotherapist was unable to locate the CAF for the PCRf.

Engagement with patients, the public, staff and external partners

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

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- 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. A comment book was available in the waiting area. We noted suggestions made by patients and confirmed these had been acted on.
 - The practice had good and effective links with internal and external organisations.
 - Processes were in place for staff to provide feedback on the service.

Continuous improvement and innovation

Seeking to continually improve the service was evident throughout the inspection. We found numerous examples of improvements, including QIPs that had been made based on the outcome of feedback about the service, complaints, audits and significant events. Some of these included:

- A revision of the triage form for the PCRf DAP service in response to patient feedback following the trial operational period.
 - Introduction of flexible working for staff to promote a healthy work life balance and support staff with caring responsibilities.
 - Patients views had been sought about the pharmacy service and these were displayed in the waiting area. They showed 100% satisfaction with the service.
 - The policy on patients deploying to Afghanistan and requiring a hearing conservation programme (HCP) six months before and after deployment was queried given there was no longer regular presence in the country. This led to a policy change which saved both the practice and patients time associated with HCP appointments. The practice submitted this as a QIP.
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