

Windsor Victoria Medical Centre

Quality report

Sheet Street
Windsor
Berkshire
SL4 1HF

Date of inspection visit:
3 April 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	Outstanding 
Are services safe?	Outstanding 
Are services effective?	Good 
Are services caring?	Good 
Are services responsive to people's needs?	Good 
Are services well-led?	Outstanding 

Chief Inspector's Summary

This practice is rated as outstanding overall

The key questions are rated as:

Are services safe? – Outstanding

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Outstanding

We carried out an announced comprehensive inspection of Windsor Victoria Medical Centre on 3 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, capability and integrity to provide a service that constantly sought ways to develop and improve.
- An inclusive team approach was supported by all staff who valued the opportunities available to them to be part of a patient-focused service.
- 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, well embedded and recognised as the responsibility of all staff.
- The arrangements for managing medicines, including obtaining, prescribing, recording, handling, storing, security and disposal minimised risks to patient safety.
- Staff awareness of current evidence-based guidance was at the core of providing effective care. Staff had received training so they were skilled and knowledgeable to deliver care and treatment that met the needs of the patient population.
- 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 an annual programme of clinical audit 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:

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. Examples include:

- Development of the Health and Healthcare Compendium and a Unit Health Committee spreadsheet.
- Development of the templates and protocols including, sepsis, medication review, Tri- service boarding/grading protocol and template, antimalarial DMICP protocol and the Medic Issuing Protocol.
- The implementation of a supporting carers protocol to work through, this had been shared with Windsor Combermere practice who also used it.
- The practice utilised broader defence resources for example in its use of the 'Purple Pack'. They recognise they are a key stakeholder in holistic support and utilise information available to ensure their patients receive the support, care and advice they need.

Dr Rosie Benneyworth BM BS BMedSci MRCP
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, a practice nurse, a practice manager, a pharmacy technician and a physiotherapist.

Background to the Windsor Victoria Medical Centre

The Medical Centre at Victoria Barracks offers primary healthcare and occupational health to military personnel. The regular patient population is currently 440. The primary focus is to provide primary healthcare to maintain operational effectiveness, force health protection and cater for the health needs of personnel transitioning to civilian employment or retirement.

The main population comes from 1 Coldstream Guards, the second supported population is the personnel from Combermere Barracks. The facility does not provide Primary Health Care for families or civilian Ministry of Defence (MOD) employees.

In addition to routine primary care services, the practice provides occupational health care to service personnel, including force preparation. 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 located near to the medical centre. A Primary Care Rehabilitation Facility (PCRF) is located on the premises, with physiotherapy and rehabilitation staff integrated within the medical centre.

The PCRf is within the main medical facility and is used by the ERI and physiotherapist. There is a separate rehabilitation gymnasium closely located, but not in the same building, where rehabilitation classes take place.

The practice is open from 07:30 to 16:30 Monday to Thursday and on Friday 07:30 to 13:00. 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:

Position	Incumbent
Regimental Medical Officer (RMO)	1 in post
Medical Officers (MO)	1
Locum GPs	Nil
Practice nurses	1 military (deployed), 1x civilian (shared with Combermere Medical Centre)
Military Practice Manager	1 in post
Med Sergeant	1 in post
Administrative staff	1 civilian in post
Medics	4 in post, 3 deployed.
PCRf	1 civilian physiotherapist (shared with Combermere Medical Centre) 1 civilian Exercise Rehabilitation Instructor (ERI)

Are services safe? Outstanding

We rated the practice as outstanding 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 RMO was the practice safeguarding lead and was trained to level 3 in both children and adult safeguarding. The practice nurse was trained to level 2 and was working towards level 3 in line with new intercollegiate guidance. 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 those 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 two patients deemed to be vulnerable and they confirmed they were being effectively supported and monitored by the practice. The RMO 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 which was 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.
- There was an effective process to manage infection prevention and control (IPC). The practice nurse was the IPC lead and was suitably trained for the role. An annual IPC audit had taken place in March 2019 and an action plan developed following this.
- 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.
- Measures to ensure the safety of facilities and equipment were managed by the station environmental health technician. Electrical safety checks were completed within the last 12 months. Water safety measures were undertaken each week and checks each month. 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.
- 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 were 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 to the clinician.
- External referrals were booked by the RMO 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).
- A process was in place for the management of specimens, including the transport of specimens to the local NHS practice for collection.

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 RMO was the lead for medicines management within the practice. All dispensing was outsourced to the contracted community pharmacy. Another member of staff dealt with the administration of the prescriptions that were sent to the community pharmacy. Repeat prescriptions were accepted in person and were reviewed regularly with the patients and were processed within 48 hours.
- 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. All prescription pads were stored securely.
- High risk medicines were managed effectively. We saw one patient who was prescribed these and they were managed well.
- 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.
- The practice had initiated several new templates used on DMICP to improve safety for patients. These had been shared with a nearby military practice who also had adopted them. These included;

- Medication Review Templates – these helped ensure that appropriate drug monitoring was carried out, facilitating high risk medicine monitoring.
- Antimalarial Protocol – this ensured that the supply of antimalarials was carried out in accordance with policy.
- Medic Issuing Protocols – these provided an efficient and robust process for medics to record the supply of medicines to patients in line with their protocols.
- All Medicines and Healthcare Products Regulatory Agency (MHRA) safety notices and alerts were correctly logged on a spreadsheet with hyperlinks to the relevant webpage for the alert or safety notice. Only those alerts considered to be relevant were sent to the clinical staff. There was a designated lead and deputy responsible for this role. We saw a positive example of how an alert had been managed regarding blood glucose testing strips.
- PGDs (Patient Group Directions) were in use to allow non-prescribing staff to carry out vaccinations in a safe way. PGDs were appropriately managed as staff had received training and authorisation by the RMO had been recorded. All had completed their relevant vaccine administration training.
- Out of hours, and amendments to current therapy as directed by secondary care were receipted and scanned onto the system. A message was sent to the referring doctor to action anything that was necessary.

Track record on safety

The practice had a good safety record.

- The practice manager was the lead for health and safety. 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 in place, including those for hazardous substances, operating electrical equipment and lone working.
- 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

The practice learned and made improvements when things went wrong.

- 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. The ASER system was also used to report good practice and quality improvement initiatives.
- We were provided with several examples of significant events that had been raised demonstrating they were effectively reporting incidents. Changes were made as a result of significant events. For example, an ASER was raised due to blood samples not being delivered by practice staff to the NHS surgery where they were then collected from and taken to the laboratory for testing. We saw that immediate action was taken and steps put in place to prevent this from happening again. The RMO contacted the patients, explained what had happened and apologised. No further incidents had occurred since.

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.

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, we saw NICE updates discussed at the March meeting included updates on blackouts, adult diarrhoea, food allergies and acute coughs. We saw that a two-page visual summary of the recommendations, including tables to support prescribing decisions had been attached to the minutes for all to read. These set out an antimicrobial prescribing strategy for acute cough associated with an upper respiratory tract infection or acute bronchitis in adults, young people and children. It aimed to limit antibiotic use and reduce antibiotic resistance.

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 was one patient were on the diabetic register. They had a last measured total cholesterol of 5mmol/l or less which is an indicator of positive cholesterol control and a last blood pressure reading of 150/90 or less.
- There was one patient recorded as having high blood pressure. They had a record for their blood pressure taken in the past nine months that showed they had a blood pressure reading of 150/90 or less.
- There were three patients with a diagnosis of asthma. All three had received an asthma review in the preceding 12 months which included an assessment of asthma control using the three Royal College of Physicians questions.

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 for 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. 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: yellow fever, anti-biotic prescribing and over 40's screening.

All audits led to practice being reviewed and changes made if necessary. We saw examples of this;

- An audit was undertaken to establish how many patients had received a face to face anti-malarial assessment to improve medical readiness of personnel in preparation for deployment. Patients completed questionnaires and data collection was undertaken which showed action needed to be taken. Following this a brief was given by the RMO to the Battalion on preventing Malaria and block bookings were arranged to bring personnel up to date. A further audit was scheduled for May. From the results of the initial audit the practice initiated a new clinical template to ensure compliance with policy.
- The practice does not have access to the ICE system (ordinarily the ICE system links the GP practice directly to laboratories, meaning pathology results can be requested electronically). ASERs had been submitted reflecting episodes of miscommunication with the laboratory leading to delays or sometimes no availability of sample results. We saw an audit had been undertaken to establish where the difficulties were and to initiate improvements. We saw a new system was in place with a new template evident, new directive for staff in the use of DMICP and staff with dedicated roles and responsibilities to ensure the system was failsafe.
- We saw a DMICP consultation and record keeping audit had taken place. It showed that 82% of audited consultations were accurate but with some error found in areas such as the correct template use and no problem title being evident. Further training had been scheduled to train staff further and a re-audit was scheduled.

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 sepsis.
- 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 Victoria.
- 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.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective 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 RMO. 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 practice had developed good working relationships both internally and with health and social care organisations. The clinicians and PCRf staff held meetings on a regular basis to discuss and monitor patients under the care of PCRf.

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. Health promotion material was displayed for patients and it was refreshed based on the annual health promotion calendar. There were television screens throughout the unit that gave information to patients about the services the medical centre provided and health promotional material.
- The unit held a health fair in March 2018. Some examples of the stands included, sexual health, Anthony Nolan, Medical Centre, Police, healthy eating and mental health. This was well attended and a good opportunity to capture data, for example antimalarial questionnaires were completed.
- 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.

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 vaccination data for patients using the practice:

- 88% of patients were recorded as being up to date with vaccination against Diphtheria.
- 90% of patients were recorded as being up to date with vaccination against Hepatitis B.
- 87% 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 Yellow Fever.

The practice had put together a Health and Healthcare Compendium and a Unit Health Committee Spreadsheet. These documents gave an overview of audiometric, vaccination and medical gradings of patients so healthcare could be planned in advance and ensured that risks to health were identified and mitigated, for example regarding climatic injury or work-related stress. Commanders had access to information and resources to facilitate recovery. For example, from musculoskeletal injury. It helped ensure that issues were identified early, empowering individuals and commanders in maximising health. The aim was to help commanders understand and carry out their management of health responsibilities towards their staff in accordance with policy. This represented a responsive, efficient and effective way of working as medical centre staff no longer spent a significant amount of time creating and maintaining spreadsheets with this information.

The RMO introduced a Tri-Service Boarding/Grading DMICP protocol benefiting patients, ensuring they were assessed properly on their fitness to work. Also, an Aide Memoire DMICP Template was

developed which outlined boarding/grading processes in each single service. Within this document there was advice and signposting to relevant policies. The protocol generated documents which included current medical limitations, ensuring that up to date information was used.

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.

Are services caring?	Good
-----------------------------	------

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 38 surveys received, 100% said they would recommend the practice to family and friends. We received 37 CQC comment cards completed prior to the inspection. We saw that all were entirely positive about the 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. 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. Resources had been developed to meet the communication needs of staff from minority groups and these resources could be made available for patients if needed. For example, staff notices were available in Nepalese.
- 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 (with consent), codes and regular searches.
- The DPHC new patient registration questionnaire included a question asking if the patient was a carer. Alongside this, posters were displayed that also encouraged carers to make themselves known to the medical centre and were also displayed electronically on the Battalion's digital information displays throughout base.

- Links to useful internet sites with support for carers were available from the practice SharePoint, the platform used for storing documents and hosting work in progress.
- The practice had implemented a supporting carers protocol to work through, this had been shared with Windsor Combermere practice who also used it. This was used to ensure they provided a holistic approach to carers to ensure their own needs were met and that they were well supported by the practice both physically and emotionally.

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 sometimes be overheard. The practice had addressed this by 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?

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.
- Patient services were on ground floor level. Access to the building was good although there was no level access directly into the reception area. Signs were in place to direct patients to the back of the building where there was level access. A wheelchair was available.
- 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, we received evidence to show this had been completed and an action plan made including the need for a ramp to be fitted at the front of the building. This request had been submitted to the Chain of Command.
- The practice team had enough staff to provide a good standard of care to its patients. However, the PCRf staffing levels were not sufficient to meet patients need, with waiting times for an initial consultation (routine) being 15 working days. There was one full time physiotherapist covering both Victoria and Combermere Barracks, there was one locum Exercise Rehabilitation Instructor (ERI) in post at Victoria, funded for a three-month period. 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. Patients were also fully able to access the physiotherapy department at Pirbright, 17 miles away if they so wished.
- Smoking clinics and sexual health advice were offered routinely but following feedback from patients at the health fair and a recent patient survey, the practice set up stand-alone clinics for smoking cessation and sexual health at specific times.

Timely access to care and treatment

- Patients' clinical needs were met in a timely way. Appointments were available the same day. Double appointments at either the request of the clinician or patient could be made.

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 were 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. This had been managed effectively and resolved to the satisfaction of the complainants.

Are services well-led?	Outstanding
-------------------------------	--------------------

We rated the practice as good for outstanding 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:
“DPHC will deliver a unified, safe, efficient and accountable primary healthcare and dental care services for entitled personnel to maximise their health and to deliver personnel medically fit for operations.”
- 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

- On the day of inspection, we saw a practice that was well-led. The leaders not only demonstrated managerial experience, capacity and capability, it was clear they had vision, passion and integrity, with a focus on continuous service development. The whole-team approach was supported by all staff who valued the opportunities available to them to be part of a forward-thinking service.
- Staff said they had confidence in the managers, who demonstrated a collaborative approach to leading the practice and had the ability to inspire and motivate staff.

Culture

- The culture at the practice was inclusive and all staff were treated equally. All staff had undertaken Equality and Diversity training.
- Staff described an open and transparent leadership style and said they would feel comfortable raising issues. They felt respected, supported and valued. Both formal and informal opportunities were in place so staff could contribute their views and ideas about how to develop the practice.

- The practice clearly demonstrated a patient-centred focus. Staff understood the specific needs population and tailored the service to meet those needs. For example, the introduction of specific sexual health and smoking cessation clinics.
- Openness, honesty and transparency were demonstrated when things went wrong. A no-blame culture was evident; complaints and incidents were opportunities to improve the service.
- 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, we saw examples of this. 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.

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

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

- Risk to the service was 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.
- Processes were in place to manage current and future performance. Performance of clinical staff was demonstrated through a structured approach to peer review, including review of clinical records.
- A business continuity plan was in place and a plan for major incidents 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 received a Health Governance Assessment Visit (HGAV) from the regional team in February this year. The practice had completed the resulting actions identified in 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 monthly throughout the year. We saw examples where improvements had been made as a direct result of patient feedback, for example initiating a sexual health and smoking cessation clinic.
- 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
- The ERI had initiated their own electronic feedback form capturing fortnightly feedback. For example, following a training or teaching session. Some of the feedback received included positive comments about the equipment and facilities and good individualised care.

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:

- Development of the Health and Healthcare Compendium and a Unit Health Committee spreadsheet.
- Development of the templates and protocols including, sepsis, medication review, Tri- service boarding/grading protocol and template, antimicrobial DMICP protocol and the Medic Issuing Protocol. These had been shared with Windsor Combermere practice who also used them.
- The implementation of a supporting carers protocol to work through, this had been shared with Windsor Combermere practice who also used it. This was used to ensure they provided a holistic approach to carers to ensure their own needs were met and that they were well supported by the practice both physically and emotionally.