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.

<table>
<thead>
<tr>
<th>Ratings</th>
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<tbody>
<tr>
<td><strong>Overall rating for this service</strong></td>
<td><strong>Good</strong></td>
</tr>
<tr>
<td>Are services safe?</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Are services effective?</td>
<td><strong>Good</strong></td>
</tr>
<tr>
<td>Are services caring?</td>
<td><strong>Good</strong></td>
</tr>
<tr>
<td>Are services responsive to people’s needs?</td>
<td><strong>Good</strong></td>
</tr>
<tr>
<td>Are services well-led?</td>
<td><strong>Good</strong></td>
</tr>
</tbody>
</table>
This practice is rated as Good overall

The key questions are rated as:

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

We carried out this announced follow up comprehensive inspection on 16 April 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 9 March 2018 and the practice was rated requires improvement overall. A copy of the report from that comprehensive inspection can be found at:


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

At this inspection we found:

• The practice was well-led and leaders demonstrated they had the vision, skill and capability to provide a patient-focused service.
• The practice understood the needs of the patient population and made changes to ensure patient 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 health and safety risk assessments needed updating and an access audit completed in accordance with the Equality Act 2010.
• The approach to the monitoring of patients on high risk medicines needed strengthening.
• 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.
• Quality improvement was embedded in practice, including a 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.

• Staff were aware of the requirements of the duty of candour.

The Chief Inspector recommends:

• A review of the management of high risk medicines to ensure they are monitored in accordance with operational policy.

• Ensure the premises used to deliver care and treatment is subject to an environmental risk assessment, an access audit as defined by the Equality Act 2010, is fit for purpose and properly maintained.

• Up-dating the health and safety risk assessments for the practice.

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

Our inspection team

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

Background to Chester Medical Centre

Chester Medical Centre is located approximately two miles from the city of Chester and provides a primary health care and occupational health service to a regular tri-service military population of approximately 630 patients. It also provides an occupational health service to a reservist population of 3000. The practice does not provide a service to the dependants and families of service military personnel who are directed to local NHS services.

There is no dispensary at the practice and medicines are outsourced to a local pharmacy. A Primary Care Rehabilitation Facility (PCRF) is co-located with the medical centre.

The medical centre is open from 08:00 to 16:30 Monday to Thursday, closing each day for lunch 12:30 to 13:30. On Friday the opening hours are 08:00 to 12:30. Outside these hours, access to a medical cover is provided by Valley Medical Centre. From 18:30 midweek and when the practice is closed at weekends and public holidays, patients are diverted by a telephone message to NHS 111 services.

The staff team

<table>
<thead>
<tr>
<th>Position</th>
<th>Numbers</th>
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<tbody>
<tr>
<td>Regimental Medical Officer</td>
<td>One (deployed at the time of inspection)</td>
</tr>
<tr>
<td>Civilian Senior Medical Officer</td>
<td>One (locum and acting up for the RMO)</td>
</tr>
<tr>
<td>Civilian medical practitioner</td>
<td>Two (locums)</td>
</tr>
<tr>
<td>Practice nurses</td>
<td>Two – one civilian; one military (deployed at the time of inspection)</td>
</tr>
<tr>
<td>Practice manager</td>
<td>One military</td>
</tr>
<tr>
<td>Administrative staff</td>
<td>Two</td>
</tr>
</tbody>
</table>
Are services safe? | Requires improvement
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We rated the practice as requires improvement for providing safe services.

Following our previous inspection, we rated the practice as requires improvement for providing safe services. We found gaps in processes to keep patients safe including: systems for managing significant events; patient information; chaperoning; infection prevention and control (IPC) and the management of high risk medicines.

At this inspection we found the recommendations we made had mostly been actioned. Further improvement was required in relation to the management of high risk medicines. The practice continues to be rated as requires improvement for providing safe services.

Safety systems and processes

Systems were in place 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 available to all staff and a standard operating procedure (SOP) had been developed. All staff had received up-to-date safeguarding training appropriate to their role and knew how to identify and report concerns. Staff were aware of who the safeguarding lead and deputy were for the practice. Both had completed level 3 training.

- The Senior Medical Officer (SMO) had made links with the local safeguarding board. The practice had advised local NHS primary care practices of the safeguarding leads should any contact be required in relation to the families of service personnel.

- Coding and alerts were used on the electronic patient record system (referred to as DMICP) to identify patients who were vulnerable. Routine system searches were undertaken to identify and monitor vulnerable patients including those subject to safeguarding arrangements. Patients identified as vulnerable were reviewed at the regular unit health committee (UHC) meetings, which included the SMO, chain of command and welfare team.

- Staff who acted as chaperones were trained for the role and had been subject to safety checks to ensure they were suitable to work with young people and vulnerable adults. An SOP regarding chaperoning had been developed specific to the practice. Notices were displayed advising patients that a chaperone was available.

- The full range of recruitment records for permanent and locum staff were 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.
• 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.

• A lead and deputy were identified for IPC and had appropriate knowledge and experience for the role. The lead was due to leave the service and the incoming lead had applied for further training (link course) in IPC. All staff had received IPC training.

• It was identified at the previous inspection that the building, fixtures and fittings did not fully support compliance with IPC requirements. The IPC lead for the Defence Primary Health Care (DPHC) audited IPC arrangements and the premises in March 2019 and identified areas of concern. These included no sluice facilities, sinks not compliant with recommended standards, inappropriate and/or damaged flooring, fixtures and fittings. The practice had developed a management action plan (MAP) as a result of recommendations made. It was evident the actions were being addressed and statements of need had been submitted for work to the infrastructure.

• Supported by an SOP and cleaning schedule, arrangements were in place for environmental cleaning. A deep clean was undertaken in March 2019. The practice nurse carried out a weekly walk-around to monitor the standard of the cleaning.

• Clinical waste was stored appropriately. An annual waste audit was completed in August 2018. A clinical waste register was maintained, and consignment notes retained.

• The practice manager was the lead for risk management and a practice specific SOP in relation to risk management had been developed. Electrical and gas safety checks were completed as required and water safety checks were undertaken regularly. A legionella risk assessment had been carried out in February 2019. Fire safety management arrangements included regular checks and testing of firefighting equipment. Staff were up-to-date with fire safety training and had participated in an evacuation exercise in June 2018. 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.

• Staff confirmed the practice and Primary Care Rehabilitation Facility (PCRF) had enough suitably skilled clinician time to meet the needs of the patient population. Specific induction packs were in place to orientate and support locum staff with practice working systems. The PCRF locum induction pack was in the process of being revised.

• The practice was equipped to deal with medical emergencies and records were maintained of the status of staff training in emergency procedures. The recommended emergency medicines and equipment were available and in-date; records confirmed they were checked monthly.

• Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. The staff team received sepsis training in June 2018. Information on sepsis screening and management was available in clinical areas. A trainee medic facilitated a presentation on thermal injuries for the team last year. A heat injury protocol was developed in March 2019.

• The waiting area could not be observed by staff and the practice manager had submitted a statement of need for CCTV to be installed.
Information to deliver safe care and treatment

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

- A practice specific SOP for new patient registration had been developed that took into account the new DPHC guidance for patient registration and deregistration. It incorporated a summarisation template on DMICP. The template prompted staff to summarise the patient’s notes when the patient was having their initial health check. Summarisation was up-to-date. A new patient registration audit was undertaken in April 2019.

- Staff described occasional freezes or lost connectivity with DMICP. Responding to DMICP outages was outlined in the business continuity plan. The patient appointment list was printed each morning so in the event of no access to DMICP, the list was used, and consultation notes scanned onto DMICP at a later point.

- The exercise rehabilitation instructor (ERI) working at the main gym did not have WIFI so was unable to access DMICP. The practice had a workaround for this to ensure access to current patient information. WIFI had recently been installed and a business case submitted for a laptop to be made available for DMICP access in the gym.

- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. These included an SOP for managing incoming postal correspondence and an SOP for referral management. Both internal and external referrals were made by the doctors and were tracked by the administrative team.

- Peer review of clinical records was established at the practice for all staff providing clinical care. We had access to the clinical records audit for 2018 which showed standards of record keeping by doctors had improved since 2017.

- A practice specific SOP was in place for the management of samples. A tracking system was maintained and a monthly search carried out to monitor the throughput of samples.

Safe and appropriate use of medicines

Although improvements to the management of high medicines had been made further improvement was needed.

- The Band 6 practice nurse was the lead for medicines management at the practice. All prescriptions and dispensing were outsourced to a local pharmacy. Procedures were in place for the safe management and storage of medicines, including vaccines, medical gases, emergency medicines and equipment minimised risks.

- A record of dispensary stock was held and expiry dates routinely checked. 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. Patient Group Directions (PGD) had been developed to allow nurses to administer medicines in line with legislation. These were up-to-date and signed by the SMO.

- Although controlled drugs (CD) were not stored at practice, a CD cabinet was available and an SOP regarding access to the cabinet was in place. Arrangements were established to monitor the prescribing of CDs on a quarterly basis. Repeat prescriptions were agreed in writing or in person. Prescribing audits were undertaken quarterly by the regional pharmacist and included the prescribing of antibiotics.

- A register to monitor the prescribing of high-risk medicines (HRM) was not in place at the previous inspection. At this inspection two registers were in operation; one specifically for patients prescribed medicines for inflammatory arthritis (referred to as DMARDs). There was
not a clear list identifying what medicines were deemed high risk for the practice. The registers were reviewed in April 2019. Six patients were identified as prescribed an HRM. Some medicines identified as an HRM were not required to be categorised as such.

- We reviewed the clinical records for four patients on the HRM registers. Although patients were being monitored appropriately, we found coding was not consistent and shared care agreements were either not in place or incomplete for some patients. The regional pharmacist carried out a medicines audit in February 2019 and the audit had not identified these concerns we found with HRM.

**Track record on safety**

The practice had a good safety record.

- The practice manager was the lead for health and safety. Risk assessments pertinent to the practice were in place including risk assessments for needle stick injury and for products hazardous to health. These were due to be reviewed as they were dated 2016. The ERI was working from a room in the main gym. A health and safety risk assessment of the room had not been undertaken.

- Staff had access to personal alarms to summon assistance in the event of an emergency. This included the ERI who worked from the unit gym. The ERI worked alone and a lone working risk assessment had been completed.

**Lessons learned and improvements made**

The practice learned and made improvements when things went wrong.

- An SOP was established for the management of significant events, which were processed through an electronic organisational-wide system (referred to as ASER). The system was also used to report incidents, near misses and examples of good practice. All staff had access to the system so could report concerns they identified. Staff provided several examples of significant events demonstrating they were effectively reporting incidents. Significant events were a standing agenda item at the monthly practice meetings. An ASER register and log of lessons learnt from significant events was maintained.

- An SOP was in place for the management of medical alerts. Both the practice manager and practice nurse were responsible for checking for any new alerts or updates. Relevant alerts were circulated to staff via email, added to a register and discussed at the practice meetings.

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<table>
<thead>
<tr>
<th>Are services effective?</th>
<th>Good</th>
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<tbody>
<tr>
<td><strong>We rated the practice as requires improvement for providing effective services.</strong></td>
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</tr>
<tr>
<td>Following our previous inspection, we rated the practice as requires improvement for providing effective services. This was because processes for monitoring patient care and treatment were undeveloped including those in relation to quality improvement, data to effectively manage long term conditions and the effectiveness of staff.</td>
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</tr>
<tr>
<td>At this inspection we found the recommendations we made had been actioned. The practice is now rated as good for providing effective services.</td>
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**Effective needs assessment, care and treatment**

The practice assessed needs and delivered care in accordance with relevant and current evidence based guidance and standards.
• Processes were established to ensure clinical staff were kept up-to-date with 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. Staff described how updates on NICE and medicines management were outlined in a newsletter circulated to staff by the DPHC each month.

• NICE guidance was discussed at the weekly clinical meetings, monthly health governance and monthly joint practice meetings with Valley Medical Centre. The practice also held weekly ‘ghost clinics’; case-based discussions between clinicians.

• The PCRF team referenced best practice guidelines in their treatment of patients, such as the Defence Rehabilitation website. The physiotherapist referred to the Cochrane Reviews (systematic reviews of primary research in health care) to ensure the PCRF team was working in accordance with current evidence-based practice. Examples of Cochrane Reviews referenced by the physiotherapist included those for acupuncture and the treatment of pain.

**Monitoring care and treatment**

Processes were in place to monitor that patients were treated and cared for in a timely way and based on need.

• The SMO and practice nurse were the leads for chronic disease management. Regular searches were undertaken to monitor patients diagnosed with a chronic condition and to ensure patients were recalled in a timely way.

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

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

• There were nine patients recorded as having high blood pressure. Eight had a record for their blood pressure taken in the past nine months and five had a blood pressure reading of 150/90 or less. Four patients had blood pressure outside of this range and were being effectively managed.

• There were 10 patients with a diagnosis of asthma and nine had an asthma review in the preceding 12 months which included an assessment of asthma control using the three Royal College of Physicians questions. The remaining patient had recently joined the practice.

• There was one patient 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 their last blood pressure reading of 150/90 or less.

• A search of the referrals showed that two patients had been referred to the Department of Community Mental Health (DCMH).

• We looked at a selection of clinical records for patients with a chronic condition and patients being treated for depression. The quality of the record keeping was good with the patient pathway clearly evident; templates were regularly used, such as the asthma review template. Read coding was consistent as it had been agreed for the practice and had been reviewed this year.
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 81% of patients. A unit has recently returned from a training exercise which meant 135 patients were awaiting an audiometric system within the next six months. Audiometric assessments were appropriately recorded in accordance with the Hearing Conservation Programme.

One of the ways the practice engaged in quality improvement activity was through clinical audit to measure the effectiveness of care. Audit was based on population need and examples included a first cycle depression audit in April 2019, a third cycle asthma audit in January 2019, a second cycle gout audit in July 2018 and a first cycle hypertension audit in February 2019. Each audit included discussion points and action. They were shared and discussed with the team at clinical meetings and/or the weekly team training sessions. The PCRF had developed an audit programme and three audits were planned for 2019.

**Effective staffing**

Continuous learning and development was promoted at the practice.

- A generic and role-specific induction was provided for new staff taking up post. Mandated training was monitored by the practice manager who reminded staff when their training was due to be renewed. Generally, the staff team was in-date for required training. Competency checks were undertaken where appropriate. Role-specific training was encouraged. For example, the practice manager had completed specific training relevant to the role. Locum staff had access to the same training available to permanent staff.

- Staff had access to one-to-one meetings, appraisal, mentoring and support for revalidation. Weekly training sessions and regional events provided staff with protected time for professional development and evaluation of their clinical work. Peer review was achieved through case discussion, record reviews and clinical supervision.

**Coordinating care and treatment**

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

- The SMO, physiotherapist and ERI attended the UHC meetings, a forum for unit commanders, the welfare team and clinicians to discuss patient’s needs, including occupational health updates.

- 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 practice had good links with local health and social service teams. Clinicians worked closely with the Regional Rehabilitation Unit (RRU) and the DCMH and had links with the local midwifery service and podiatry team. In response to patient need, the practice had an agreement in place for direct access to the local scanning service.

- Patients due to the leave the military were identified at the UHC meetings and they received a resettlement brief from the welfare team on matters such as housing options. They also received a pre-release and final medical. The patient was provided with a summary of their
Helping patients to live healthier lives

The practice was consistent and proactive in supporting patients to live healthier lives. Based on population characteristics and need, this involved a focus on injury prevention and healthy lifestyle.

• The practice nurse was the health promotion lead. A monthly health promotion plan was established based on national priorities and initiatives to improve the population’s health. It included stop smoking campaigns and tackling obesity. Health promotion displays were available for patients and were regularly refreshed. Health fairs were held on the camp base and the medical centre and PCRF participated with these.

• The SMO was the sexual health lead. Clinicians were aware of the 24-hour access service for sexual health advice.

• 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 2018 vaccination data for patients using the practice:

• 94% of patients were recorded as being up to date with vaccination against diphtheria.
• 94% of patients were recorded as being up to date with vaccination against polio.
• 88% 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.
• 94% of patients were recorded as being up to date with vaccination against tetanus.
• 71% of patients were recorded as being up to date with vaccination against typhoid.

Regular searches of the system were undertaken by the practice to check for personnel who were due to have vaccinations. This was then forwarded to the unit commander. Regular searches were also undertaken for patients eligible for screening.

Consent to care and treatment

The practice obtained patient 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, including the key principles of the Mental Capacity Act. They supported patients to make decisions. The practice monitored the process for seeking consent appropriately through the process of peer reviewing clinical records.

<table>
<thead>
<tr>
<th>Are services caring?</th>
<th>Good</th>
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<tbody>
<tr>
<td>We rated the practice as good for caring.</td>
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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 April 2018 to March 2019 patient experience survey (156 respondents) 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.

• The practice had an information network available to all members of the service community, known as HIVE. It provided a range of information to patients who had relocated to the base and surrounding area. Information included resources at the unit, civilian services, including healthcare facilities. The practice had requested that information about the medical centre be included on the HIVE website.

• There was no temperature control or ventilation in the gym and the ERI advised us ambient temperatures were variable depending on the weather. The PCRF team were exploring the option of having air conditioning installed to promote the comfort of patients using the gym.

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 decisions about their treatment and care.

• The practice proactively identified patients who had caring responsibilities, even if that was an indirect caring role. Where necessary, the practice liaised with the welfare team. Ten patients were identified on the carer’s register which was updated in April 2019. Patients with a caring responsibility were coded on DMICP to identify them. However, not all had an alert on the system to immediately identify them as a carer. Staff assured us they would review the coding for all carers.

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

• Clinic room doors were closed during consultations. Privacy screening was provided in consulting rooms for when patients were being examined or treated. There was no privacy curtains or screening in the physiotherapy room but only one patient was seen at a time and the door was closed.

• A television was playing in the waiting room to minimise conversations being overheard. If patients wished to discuss sensitive issues or appeared distressed at reception they could be offered a private room to discuss their needs.

• The GPs were male so if patients wished to see a female GP then they could have an appointment at Valley Medical Centre. The PCRF only had male staff so patients specifically requested to be seen by a female could also be referred to the PCRF at Valley Medical Centre.

| Are services responsive to people’s needs? | Good |
We rated the practice as good for providing responsive services.

Responding to and meeting people’s needs
The practice organised and delivered services to meet patient needs and preferences.

- Staff understood the needs of its population and tailored services in response to those needs. For example, bespoke clinics were organised around the occupational health needs of the battalion and clinics for reservists were held at weekends.
- The CQC feedback comment cards completed prior to the inspection highlighted that it was easy to secure an appointment, in particular a short notice appointment.
- An access audit as defined in the Equality Act 2010 had not been completed for the premises. Reasonable adjustments had been made to accommodate patients with access needs. For example, there was wheelchair access, an accessible parking space and an accessible toilet.
- The physiotherapist was the lead for equality and diversity and staff were up-to-date with training in this topic. The practice provided three examples of how the practice had respected the beliefs, values and lifestyle choices when supporting patients with specific 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, including the physiotherapist if a musculoskeletal concern. Patient requesting a routine appointment were usually seen the same or the next day. Specialist medicals were not often requested and would take three days to arrange.
- Both the physiotherapist and ERI were seeing patients within the target of 10 working days. The wait for a referral to the RRU was two to three weeks and for a scan the wait was four to five weeks.
- The patient experience survey showed patients received their appointment at a time that suited them. Failure to attend appointments was monitored and the numbers of missed appointments was low.
- Telephone consultations were available and requests for home visits were managed on a case-by-case basis. A home visit register was in place but no home visits had been requested. Arrangements were in place for patients to access a doctor at Valley medical Centre when the practice was closed and before NHS 111 was available.
- The PCRF had adopted the direct access to the physiotherapy service (DAPS) directive introduced in February 2018. This was working well, particularly the introduction of musculoskeletal triage.

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 outlined in the patient information leaflet to support patients with understanding the complaints process.
- The practice manager was the lead for complaints. A process was established to record and manage complaints. This was communicated to patients through the practice leaflet. The practice received two complaints in the last 12 months and both had been managed effectively.
Are services well-led? | Good

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

Following our previous inspection, we rated the practice as requires improvement for providing well-led services. This was due to due to gaps in leadership and systems that needed strengthening.

At this inspection we found action had been taken to address the concerns identified. The practice is now rated as good for providing well-led services.

Vision and strategy

The practice had a mission statement:

“To deliver a unified, safe, efficient and accountable primary healthcare service to maximise health and to deliver personnel medically fit for operations.”

Staff we spoke with throughout the day could identify with this mission statement and knew and understood the values and behaviours required to support it.

Leadership capacity and capability

- One of the GPs who had worked at the practice since 2006 had been acting SMO for the last six months. Recruitment of a permanent SMO was in progress at the time of the inspection. A new practice manager had been appointed recently and they were being supported by the outgoing practice manager.

- Both the SMO and practice manager demonstrated they had the experience and skills to deliver high-quality sustainable care. They clearly understood the practice priorities and demonstrated they had capability and tenacity to drive service change for the benefit of patients. Staff said they were well supported by the regional team, including the PCRF team who were supported by the regional rehabilitation officer.

Culture

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

- Staff told us they felt respected, supported and valued. 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 the leadership team and embedded in practice.

- 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. 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.
Governance arrangements

Governance arrangements had been strengthened since the last inspection.

- 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 to support 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.

- Structured communication systems were in place, including both weekly and monthly practice and clinical meetings. These were well attended by the staff team.

- Quality improvement, particularly clinical audit had been further developed with evidence of repeat clinical audits taking place, and improvements made to practice based on outcomes. The physiotherapist had been in post 10 weeks so the audit programme for the PCRF had just recently been developed. The practice manager maintained a quality improvement project register.

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, which was discussed at the practice meeting. They had oversight of national and local safety alerts, incidents, and complaints.

- There were effective processes to identify, understand, monitor and address current and future risks including risks to patient safety. A business continuity plan was in place and was due for review in April 2019.

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. A domain of the CAF was reviewed at each of the health care governance meeting.

- External practice reviews took place, such as a service review and advisory visit of the PCRF by the RRU in April 2018. The management of medicines was reviewed this year by the regional pharmacist and it did not identify the concerns we found with medicines.

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 suggestion box was in the patient waiting room. A patient participation meeting was organised last year but no...
The practice was looking at alternative ways to encourage patients to provide their views about the service.

- The practice had good working relationships with the unit commanders, the welfare team and external health care providers.

**Continuous improvement and innovation**

The practice was committed to improving services for patients.

Examples of some of the improvements made since the last inspection included:

- Significant improvement to the staff induction process.
- Administrative staff had audited the new patient registration process, which led to improvements with the process.
- Practice correspondence with local NHS primary care practices to ensure a joined up approach to safeguarding.
- Improvements made to the PCRF facilities and equipment, including access to WIFI in the gym.
- Introduction of a traffic light system to grade patients’ musculoskeletal injuries.
- Development and introduction of a reconditioning programme for patients.
- A plan was in place for the community psychiatric nurse based at the DCMH to attend the UHC meetings each month.