

Brecon Medical Centre

Quality report

Dering Lines
Brecon
Powys
LD3 7RA

Date of inspection visit:
7 February 2019

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

Ratings

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

Chief Inspector's Summary

This practice is rated as requires improvement overall

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Requires improvement

Are services caring? – Requires improvement

Are services responsive? – Good

Are services well-led? - Requires improvement

We carried out an announced comprehensive inspection of Brecon Medical Centre on 7 February 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 understood the needs of the patient population and made changes to ensure patient needs were met.
- Although there was an open and transparent approach to safety, systems to manage risk were not being accurately used, such as the risk register and significant event management process.
- There was under reporting of significant events and we found incidents that should have been reported as a significant event and had not.
- The arrangements for managing medicines needed improving, including the 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.
- Supportive processes for staff needed improving, particularly in relation to induction and training.
- Staff worked to best practice to promote better health outcomes for patients.
- Quality improvement activity was under developed, particularly clinical audit based on the measurement of clinical 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 to patients.
- 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.

- The practice manager was new to primary care and a key leader of the service but had not been provided with sufficient training to effectively manage systems used to manage risks at the practice.
- The regional team had not effectively communicated the plans regarding the restructure of the service to the practice staff.

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

- The PCRf team was working closely with the Infantry Battle School providing training and briefings on maximising recovery post endurance events, advising students and delivering training on flexibility for injury prevention. An external review had commended this work.
- The PCRf were engaged in a quality improvement programme exploring the effectiveness of structured yoga-based rehabilitation classes. The programme started in October 2018, was reviewed in December 2018 and was due a further review in March 2019.

The Chief Inspector recommends:

- A review of formal governance arrangements including systems for monitoring risks, quality improvement processes, clinical effectiveness and medicines management, including the management of high risk medicines.
- A review of processes to promote effective staffing, including role specific training, induction, peer review and supervision arrangements.
- Complete an access audit as defined in the Equality Act 2010.

Dr Rosie Benneworth 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 manager, physiotherapist and pharmacist.

Background to the Brecon Medical Centre

Brecon Medical Centre provides a primary health care, occupational health & rehabilitation service to a military service population (mainly army) of 419 permanent patients and a transient population of 600; ranging in age from 15 to 54 and predominantly male. The patient population is drawn from a range of units over a wide geographic area. The main unit is the Infantry Battle School. The practice does not provide primary health care for families or civilian Ministry of Defence employees.

A dispensary (due to be decommissioned in March 2019) and Primary Care Rehabilitation Facility (PCRf) are based in the medical centre. Additional services/clinics provided include: over 40 health checks; enhanced primary health care mental health support; Immunisations; travel advice; ear syringing; smoking cessation; sexual health promotion; chronic disease management; removal of stitches/dressings; well woman; and weight management.

The practice is open from 08:00 to 16:30 Monday to Friday. Telephone medical advice is available from 16:30 to 18:00 when patients can contact NHS 111. Patients can access NHS 111 at the weekends and public holidays.

The practice has a staffing establishment of 15. At the time of the inspection four posts were vacant, including an administrative post and three nursing posts (one nurse deployed). Recruitment was underway for a part-time Civilian Medical Practitioner (CMP). The current staff team included a Senior Medical Officer (SMO), part-time CMP, matron, practice manager, administrator, two practice nurses, a pharmacy technician and two physiotherapists. A Regional Clinical Director (RCD) assumed overall accountability for quality of care at the practice.

Are services safe?

Inadequate

We rated the practice as inadequate for providing safe services.

Safety systems and processes

Systems to keep patients safe and safeguarded from abuse were in place. Improvement was needed to strengthen some of these systems.

- A framework of regularly reviewed safety policies was established 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, including information local contact numbers were available to staff. Staff were aware of who the two safeguarding leads were in the practice that they could approach for advice. Staff had received up-to-date safeguarding training at a level appropriate to their role. All clinical staff had completed level 3 training. The administrator’s safeguarding training expired in November 2018.
- Processes were not in place to identify patients who were vulnerable or subject to formal safeguarding arrangements, such as the use of coding on the electronic patient record system (referred to as DMICP). We were advised that the absence of alerts/coding was historical and related to the preference of previous staff. This had not changed even though there had been a change of staff in November 2019. Staff were unable to explain the decision-making process as to which patients should be coded. We found that not all patients who were potentially vulnerable had been coded. The practice was represented at the monthly Unit Health Committee (UHC) meetings and welfare meetings where the needs of vulnerable patients were discussed to ensure they were being adequately supported.
- All staff who acted as chaperones had received appropriate training. They 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. The practice held some basic information and 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.
- We checked the system to monitor the registration status of clinical staff with their regulatory body and confirmed clinical staff were appropriately registered. 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.
- Arrangements were in place to manage infection prevention and control (IPC). The nurse with the lead for IPC was suitably trained for the role. The IPC lead was undertaking a course and at the time of inspection was on placement at another practice for six weeks. They were also subject to deployment if required. A deputy IPC lead had been identified to cover when they

were absent from the practice. They had not received any additional training for this lead role. The IPC lead said they could be contacted by telephone for IPC advice while on placement and would continue to undertake IPC audits for the practice. The last IPC audit was undertaken in November 2018

- Environmental cleaning was provided by an external contractor. Cleaning schedules and monitoring arrangements were established. Cleaning staff had received IPC training. A deep clean of the practice was included in the contract.
- Systems were in place for the safe management of healthcare waste. Consignment notes were retained at the practice and an annual waste pre-acceptance audit was undertaken. The last audit was carried out in October 2018.
- Measures to ensure the safety of facilities and equipment were in place. Electrical and gas safety checks were up-to-date. Water safety measures were regularly carried out with a legionella inspection undertaken in January 2019. 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.
- Arrangements were in place for the monitoring of equipment. We found the blood pressure monitor in the emergency grab bag had been missed at the annual equipment check in November 2018 and we highlighted this to staff at the time of inspection. Testing of portable electrical appliances and medical equipment was in-date.

Risks to patients

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

- Despite staffing gaps, staff said they were meeting the needs of patients. Interviews for a part time CMP were due to take place the day after the inspection and a business case had been put forward to recruit another administrator. The practice was in the process of revising operational activity to address the gaps in system management left by a restructure of the medical centre, including the closure of the ward facility. For example, the ward nurses undertook system searches and summarisation of patient records at night. One of the nurses had transferred to primary care as part of the restructure. The practice had not used locum doctors or nurses for some time.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. A first aid kit and accident book were available. Staff were up-to-date with the required training for medical emergencies. Simulation training exercises for emergency situations had recently been introduced.
- The SMO was the regional lead for climatic injuries and had provided the staff team with training in the management of thermal injuries. We noted a significant event had been raised in August 2018 for a patient admitted to hospital with heat exhaustion. Staff told us they had discussed national guidance on managing sepsis as a team and, without staff awareness, a sepsis scenario was instigated to check if staff responded appropriately (they did).

Information to deliver safe care and treatment

Information needed to deliver safe care and treatment to patients needed improvement.

- The practice was following the new Defence Primary Healthcare (DPHC) guidance for patient registration and deregistration, which included a template on DMICP. The template prompted staff to summarise the patient's notes when the patient was having their initial health check. Staff highlighted that if the patient opted out of the health check then summarisation may not

be effectively completed. They planned to feed this back to the DPHC as this new system was in the early stages of use. A system search showed 99% of patients' notes had been summarised.

- Staff described regular 'freezing' or loss of connectivity with DMICP but said this did not have a significant impact on patient care. When it happened, staff could use laptops at WIFI docking stations or revert to hardcopy records to be uploaded to patient records at a later point.
- A draft standard operating procedure (SoP) for the management of referrals had been developed in December 2018 that took into account both internal and external referrals. Internal referrals were sent electronically. Due to NHS connectivity issues, external referrals were sent by post. We noted two significant events were raised in 2018 in response to two paper copy referrals being mislaid in the system. A referral tracker was in place that included an 'anticipation date', which prompted staff to start following up on the referral. Urgent referrals were followed up after two weeks. An audit of referrals had not taken place.
- A process was in place for the management of specimens, including the transport of specimens to the laboratory, the use of Lablinks and the tasking process on DMICP to manage test results. The nursing team checked daily for results and forwarded them to the GP for action. A workaround system was in place should Lablinks fail.

Safe and appropriate use of medicines

The practice had systems to support the safe handling of medicines. Improvement was needed to strengthen some of these systems.

- The SMO and pharmacy technician were the medicines management leads for the practice. As part of the restructure of the practice, the dispensary was closing by the end of March 2019. This meant a pharmacy technician would no longer be available so roles and responsibilities for medicines management within the practice team would require review to keep patients safe. The practice was implementing new arrangements in response to this change and they were yet to be embedded.
- The dispensary was sometimes accessed by staff in the absence of the pharmacy technician but the access log was not always completed in line with policy. There was a service level agreement with a local pharmacy for patients to obtain prescriptions which meant a longer period for patients to receive their medicines. This service was currently being reviewed to include delivery of prescriptions to the medical centre, improving time to receive treatment. The imminent closure of the dispensary had not been effectively communicated to all patients (through part one orders).
- The arrangements for managing medicines, including emergency medicines and vaccines, did not always minimise risks to patient safety. An emergency kit, including a defibrillator, oxygen with adult/child masks and emergency medicines were accessible to staff in a secure area of the practice; all staff knew of its location. Routine checks were in place to monitor the required kit and medicines were available and in-date. We found there was one item missing from the emergency medicines as it had been ordered on the date it expired. Although systems for the management of blank prescription forms were in place, access was not sufficiently restricted in line with the policy.
- A process was in place to review and circulate to staff national patient safety alerts and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) and the Department of Health Central Alerting System (CAS). A practice nurse and the practice manager received alerts.

- Appropriate arrangements were established for the safety of controlled drugs (CD) and accountable drugs (AD), including the destruction of unused CDs. An audit was conducted by the regional pharmacist which identified inappropriate packing of ADs. We were advised these would be destroyed and this was no longer current practice. The practice had private prescriptions for use out of hours. These were logged in the CD register. We noted there were two prescriptions that were not in the cupboard and could not be accounted for.
- A process was in place for monitoring any prescribing by secondary care and for out-of-hours services. Information received was scanned to DMICP and tasked to the patient's doctor.
- Patient Group Directions (PGD) had been developed to allow nurses to administer medicines in line with legislation. These were current and staff had individual authorisation sheets that were signed by the SMO. The pharmacy technician had completed an audit to look at the use of PGDs in June 2018.
- A register to monitor the prescribing of high risk medicines was maintained and there were two patients on the register. A shared care agreement was only in place for one and it was recorded that the hospital refused to provide an agreement for the other. Our review of patient's records showed that high risk medicines could be managed more effectively. Alerts were not being used to identify patients taking high risk medicines.

Track record on safety

The practice had a good safety record.

- The practice manager was the lead for health and safety but had not yet completed the required training for the role. However, they had 19 years of experience in health and safety management. Safety processes for the practice were monitored and reviewed, including risk assessments pertinent to the practice in place such as those for hazardous substances, operating electrical equipment and lone working.
- Patients could be observed in the waiting area when the receptionist was standing but not sitting. A business case had been submitted for CCTV.
- Personal panic alarms were provided to all staff and were tested regularly. We activated one of the alarms and it was working effectively. The physiotherapists worked alone in the squash courts on the camp and developed a procedure to mitigate the risks to lone working and the action to take in the event of a medical emergency.

Lessons learned and improvements made

The process for learning and making improvements when things went wrong needed strengthening.

- 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 they understood how to report using ASER. However, we found evidence of under reporting. Staff told us about events/incidents which should have been treated as a significant event but had not. For example, a missed referral and issues with DMICP. In addition, the ASER system was not being used to report good practice and quality improvement initiatives. Significant events were discussed as a team at one in four of the weekly practice meetings.

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

Effective needs assessment, care and treatment

- The practice had processes to support clinicians to keep up-to-date with current evidence-based practice so they assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance. Staff were aware of relevant NICE (National Institute for Health and Care Excellence) and other practice guidance. We noted that NICE guidance was not a standing agenda item on any of the meeting minutes and highlighted this to the practice manager who said they would ensure it was included as a topic on the agenda.
- Health care governance meetings followed on from a practice meeting once a month. All staff attended the meetings, including staff from the PCRf. Although the meeting minutes we were given did not clearly illustrate the clinical governance element of the meeting, staff were consistent in their discussions with us that clinical governance meetings were happening. For example, many of the staff told us about how anaphylaxis (severe and potentially life-threatening reaction often triggered by an allergy) was presented at a recent meeting.
- The PCRf team used 'rehab guru' an electronic system to print individual rehabilitation programmes for patients. The team also referred to the Directory and Defence Rehabilitation website for guidance in the management of tendinopathy and lower back pain.

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.
- The CMP had recently been identified as the lead for chronic disease management and advised us they were in the process of developing pathways for each of the chronic diseases. One of the practice nurses maintained a chronic disease register and carried out monthly searches, recalling patients when required. Clinical records we looked at showed patients had not been routinely recalled. For example, a patient with asthma, although reviewed in January 2019, had previously been recalled on an ad hoc basis. A formal recall process had recently been introduced.
- We were provided with the following patient outcomes data during the inspection:
 - Ten patients were recorded as having high blood pressure and all had a blood pressure check in the last nine months. Nine of this patient group had blood a pressure reading of 150/90 or less
 - Four patients had a diagnosis of asthma and all had an asthma review in the preceding 12 months which included an assessment of asthma control using the three Royal College of Physicians questions.

- There were no patients with a diagnosis of diabetes. A small number of patients were identified as having low thyroid levels (hypothyroidism). Routine searches were not being undertaken for hypothyroidism.
- The new organisation-wide mental health strategy meant patients were being assessed and treated in primary care if appropriate rather than routinely referred to the Department of Community Mental Health (DCMH). The matron was a registered and validated mental health nurse who provided assessment and care for patients with step 1 (low level) mental health needs. Referrals were made by the doctors. If the matron identified a need then it was discussed with the referring doctor and a decision made about referral onto the DCMH.
- It was not considered whether patients with mental health needs should have a system alert to suggest they were vulnerable. Because of the small patient population, clinicians said they knew which patients were vulnerable. However, not using alerts meant locums and other staff would be unaware if a patient was vulnerable. It could also mean that the clinician was vulnerable if something happened to one of their patients. This issue was compounded by incorrect coding for many patients with a mental health need. Records we looked at showed that patients under the care of the matron were coded as having insomnia even though they presented with symptoms of depression. In addition, there was a lack of consensus on mental health codes to use.
- The wide-range of patient records we looked at confirmed that coding needed to be improved. For example, referrals were not coded and alerts were not used to identify patients prescribed high risk medicines. Clinicians acknowledged that this was an area of weakness that needed to be improved. The SMO had recently provided clinicians with training on the use of coding and searching on DCIMP. A formal process was not established to review the quality of patient records, such as a records audit.
- The PCRf used a musculoskeletal health questionnaire to monitor outcomes for patients. Data was analysed and returned to the Chain of Command. It was also discussed at the Unit Health Committee (UHC) meetings.
- 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 90.6% of patients.
- Quality improvement was in the early stages of development for the practice. There was evidence of data system searches, such as flu vaccine uptake (April 2018) and administrative and mandated audits including IPC, a patient feedback survey and healthcare waste management. However, clinical audit based on the measurement of clinical outcomes was underdeveloped with no evidence of improvement to clinical care. The audit spreadsheet provided no evidence of clinical audit before 2018. The PCRf had undertaken audits in 2017 but the spreadsheet did not fully capture all the audit activity for the PCRf.
- The clinical audits completed in 2018 included a retrospective audit regarding the use of antibiotics for a sore throat, an ankle injury audit and a privacy and dignity audit. The PCRf were engaged in a quality improvement programme (QIP) exploring the effectiveness of structured yoga-based rehabilitation classes. The QIP started in October 2018, was reviewed in December 2018 and was due a further review in March 2019.
- Separate 2019 audit programmes were in place for the PCRf and medical centre. The PCRf completed a Multidisciplinary Injury Assessment (MIAC) referrals audit in January and had a clinical notes audit and third cycle ankle audit scheduled. The medical centre had completed

a nurse's record keeping audit in January. An eye injury audit was in progress. Minor surgery, chaperone and results handling audits were scheduled.

Effective staffing

Continuous learning and development was promoted at the practice.

- All staff had received a generic induction. Not all staff were in-date for mandated training. Competency checks were undertaken where appropriate.
- Not all staff we spoke with felt sufficiently supported in terms of induction and role specific training. This was evident through staff having limited understanding of governance processes at the practice.
- All staff had an identified workplace supervisor and had access to one-to-one meetings, mentoring and support for revalidation. The matron facilitated group supervision sessions for the nurses. Clinical staff were given protected time for professional development. We received mixed views about how the matron was supervised regarding their work with patients who had a step 1 mental health need. We were advised that the matron received supervision from the DCMH but received no evidence to support this. The matron had requested the DCMH review their case work with patients. The matron kept up-to-date with mental health matters through training and attendance at regional forums.
- Regional meetings and forums were established for staff to link with professional colleagues to share good practice. For example, nurses had opportunities to attend the regional nurse's forum. Peer review was in place for the nursing team provided by the regional nurse. We were unable to confirm if a process of formal peer review was established for doctors.

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. The doctors and PCRf staff held Primary Care Injury management (PIM) every two weeks to discuss the progress of patients under the care of PCRf. We noted that the outcome of the discussion was added to the patient's clinical record.
- The SMO and lead physiotherapist attended the UHC meetings held each month. These meetings reviewed the needs of patients who were medically downgraded and those who were vulnerable.
- The work the PCRf team was undertaking with the Infantry Battle School was recognised during an external governance visit. PCRf input included providing briefings on maximising recovery post endurance event, advising students and delivering training on flexibility for injury prevention.
- The practice also worked closely with the Regional Rehabilitation Unit (RRU) and the DCMH, and had links with the local midwifery service and health visiting team.

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 display board was available to patients and it was refreshed based on the annual health promotion calendar.
- The matron 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.

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:

- 95% of patients were recorded as being up to date with vaccination against diphtheria.
- 89% of patients were recorded as being up to date with vaccination against hepatitis B.
- 95% of patients were recorded as being up to date with vaccination against hepatitis A.
- 91% of patients were recorded as being up to date with vaccination against typhoid.

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. The staff team received training regarding the Mental Capacity Act (2005) in August 2018.
- The practice monitored the process for seeking consent appropriately. Coding in relation to consent was used for all invasive procedures undertaken, including acupuncture.

Are services caring?	Requires improvement
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We rated the practice as requires improvement 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/November 2018 Patient Experience Survey (29 respondents) showed all patients were treated with respect and all would recommend the practice to family and friends. The 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. The practice used the HIVE social media page to communicate with civilian patients

Involvement in decisions about care and treatment

Staff supported patients to be involved in decisions about their care.

- International military students temporarily registered at the practice when on a course at the camp. Interpretation services were available for these 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. A Nepalese translator was available on the camp and the practice leaflet was in the process of being translated to Nepalese. When an interpreter was used then it was recorded in the patient's clinical notes.
- The Patient Experience Survey showed that all 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 were also carers. There were processes in place to identify patients who had caring responsibilities, including the use of alerts and coding. A poster was displayed asking patients to make themselves known if they were carers. Patients were asked at registration whether they had caring responsibilities. No patients were identified as having a caring responsibility at the time of the inspection.

Privacy and dignity

- Curtains were not provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. Staff told us clinic room doors were closed during consultations and mobile screens were available for use. They were reluctant to use the mobile screens because they were old and an infection risk. Staff had recognised this as a concern and a statement of need had been put forward for curtain rails.
- A dental treatment room was located in the medical centre. We observed patients having dental treatment throughout the inspection with the door wide open. We highlighted this to the practice staff at the time of the inspection.
- The layout of the waiting area and seating was near the reception which meant conversations between patients and reception could be overheard. The practice had addressed this through a television was playing in the waiting area to minimise conversations being 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. Only female physiotherapists were available so patients could be referred to an alternative PCRf if that was their wish.

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

Responding to and meeting people's needs

- An access audit as defined in the Equality Act 2010 had not been completed for the premises. The practice had recognised reasonable adjustments needed to be made. For example, a statement of need for automatic opening front doors had been submitted. Accessible WC facilities were available but no pull cord was available in the event of an emergency.
- The PCRf team had increased its use of Rehab Guru to issue professional rehabilitation programmes to patients. This approach meant patients could store and access their programme on Smart phones and tablets.

Timely access to care and treatment

- Patients with an emergency need were seen that day and the waiting time for a routine appointment was one to two days. Mostly patients could be seen on the same day. Double appointments at either the request of the clinician or patient could be made. Appointment reminders were sent to patients via text.
- The SMO was trained to undertake diving medicals. Patients requiring aviation medicals were referred to St Athan Medical Centre.
- Same day appointments were usually available for routine physiotherapy appointments. We noted there was one available appointment slot on the day of the inspection and a number were available for the next day. A direct access physiotherapist service (DAPS) was in place for patients registered at the practice. Approximately 50% of all referrals were through DAPS.
- Non-attendance at appointments were monitored and displayed in the patient waiting area.
- Home visits were available and a home visit register had been developed. There had not been any requests for a home visit. Telephone consultations were also available. Arrangements were in place for patients to access primary care when the practice was closed, including emergency care.
- The Patient Experience Survey showed patients received their appointment at a time that suited them.

Listening and learning from concerns and complaints

- Information was available to help patients understand the complaints process. The practice managed complaints in accordance with the DPHC complaints policy and procedure. Both a complaints and compliments log was maintained.
- The practice manager was the designated responsible person who handled all complaints. A system was in place for monitoring complaints. No complaints had been received in the last 12 months.
- A suggestion box, forms and pens were located in the waiting area for patients to leave feedback.

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

Vision and strategy

- The practice worked to the mission statement and vision including that of the Defence Primary Health Care (DPHC):
 - “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.”
- The practice was in the process of a restructure involving the closure of the ward facility by November 2018 and the closure of the dispensary by the end of March 2019. This meant redundancies, a change in job roles and a revision of operational responsibilities. Staff said they had not been consulted effectively or well supported by the regional team regarding the changes.
- An implementation order (change management plan) had been developed in July 2018 by the regional team. The key leaders at the practice confirmed they had not been provided with the implementation order and had not received written confirmation that the ward was closing. We looked at the implementation order; it was brief with no detail as to how the changes would be managed at practice/operation level.

Leadership capacity and capability

- The practice manager was new to the post and new to the role of managing a practice. They had not received the recognised training for this role and that was evident through a limited understanding of the operation of some systems, such as the risk register.

Culture

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

- The impact of the practice restructure was evident on the day of the inspection as we could see staff were feeling a sense of loss and having to readjust to modified roles. However, at practice level staff said they felt respected, supported and valued. They described an integrative approach involving all staff supporting each other. Opportunities were in place so staff could contribute to discussions about how to 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 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 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

The governance framework needed developing to support the delivery of good quality care.

- There was a 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 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.
- There was an integrated approach to the weekly practice meetings with each meeting having a specific focus scheduled three months in advance. We found the minutes did not clearly reflect the focussed area of discussion. For example, healthcare governance was identified as the topic at the meeting on 10 January 2019 yet the minutes did not illustrate this.
- Quality improvement, most notably clinical audit based on the measurement of outcomes was underdeveloped for the practice which meant there was no evidence of improvements made to clinical care. For example, an audit of step 1 mental health provision may have identified the variations and inaccuracies with clinical coding. The audit programme for the practice and PCRF was not integrated.
- Processes to support staff were not always effective or in accordance with operational policy, such as induction and training.

Managing risks, issues and performance

Processes for managing risks needed improving.

- Processes were in place to monitor national and local safety alerts, incidents, and complaints.
- As the practice manager had not received training in risk management, the risk register was not being effectively maintained in terms of the likelihood/impact of risk. In addition, 'retired risks' were not included in the register. Similar applied to the ASER system for managing significant events, such as undertaking a root cause analysis. The practice manager acknowledged risk management in primary health care was new to them and it would benefit risk management in the practice if they received training.
- A business continuity plan was in place. The practice manager acknowledged they lacked confidence in relation to the major incident plan as they had not received training in this area.

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.

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 patient focus group was established.
 - The practice had good and effective links with internal and external organisations including the Regional Rehabilitation Unit (RRU), the DCMH and local NHS primary care providers.

Continuous improvement and innovation

The practice was still going through operational change with the restructure and changes to staff, including recruitment of new staff. Despite the change of staff, the staff team was keen to make improvements to the practice. There were examples of improvements that had been made based on the outcome of feedback about the service, monitoring of the population need and significant events. These included:

- Piloting of yoga-based rehabilitation yoga classes by the PCRf team.
- PCRf input with the Infantry Battle School included the provision of briefings on maximising recovery post endurance event, advising students and delivering training on flexibility for injury prevention.

The practice was also looking to the future. It was in discussions with local NHS services, Brecon Primary Care Practice and Brecon War Memorial Hospital, regarding integrated working practices.
