

# Halton Medical Centre

## Quality report

Halton  
Aylesbury  
Buckinghamshire  
HP22 5PG

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

We carried out an announced comprehensive inspection of Halton Medical Centre on 9 May 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, passion and integrity to provide a patient-focused service that constantly sought ways to develop and improve.
- An inclusive whole-team approach was supported by all staff who valued the opportunities available to them to be part of a patient-centred 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. There was an effective approach to the monitoring of patients on high risk medicines.
- Staff were aware of current evidence-based guidance. They had received training so they were skilled and knowledgeable to deliver effective care and treatment.
- The practice worked collaboratively and shared best practice to promote better health outcomes for patients.
- There was 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.

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

- The mental health and wellbeing of recruits underpinned the assessment process of all clinicians. Staff were mindful that recruits were young, vulnerable and may be away from home for the first time. If recruits presented at a nurses' clinic with low mood or mental health concerns they were referred to the duty doctor. Furthermore, any patients with past mental health concerns identified through the notes summarisation process were highlighted to the duty doctor. The primary care rehabilitation facility (PCRF) team completed an audit (referred to as the Orebro-McTeague audit) on recruits to identify mental health issues linked to pain. As a result, the PCRF team instigated training with recruits and identified further follow-up for patients with mental health concerns. Rather than issue repeat prescriptions of anti-depressants, patients were reviewed each month with all doctors using the code 'depression interim review'.
- An audit identified that Read codes and review templates were not consistently used by all clinicians. This resulted in the development of a Read coding and blood pressure monitoring protocol, and a quick reference guide for the monitoring of each chronic disease. This was having a positive impact as a peer review of doctors' clinical records showed consistency with the use of Read codes and review templates.
- A pattern of pelvic stress injuries (PSI) in recruits had led to the setting up of injury steering group meetings between the station executive, doctors and the PCRF team. To reduce this trend, marching methods were changed. The management of PSI was auditing from March 2017 to March 2018 using the current PSI management guideline. Recommendations were made for clinicians to ensure adherence to the guidance on sick leave and down grading timeframes.
- A healthy eating working group was established based on concerns about the diet of recruits. Quarterly station meetings were held involving the lead physiotherapist, clinicians from the practice, the dental practice, catering team and representatives from the station executive. Changes had been made including chip-free days, the station shop ceasing to sell high energy drinks and a review of the catering/nutritional training for recruits.
- The practice proactively identified patients who were carers. An information leaflet had been developed for staff to support them with how to identify a patient with a caring role, including the specific Read codes to use to identify carers. A carers' information board was displayed in the waiting area. All local carer's groups were advertised on the board, including groups for young carers. The practice leaflet for patients also included information about carers including links to national organisations.

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

## Our inspection team

Our inspection team was led by a CQC lead inspector. The team comprised specialist advisors including a GP, practice nurse, practice manager, physiotherapist and pharmacist.

## Background to the Halton Medical Centre

Halton Medical Centre provides a primary care service to a patient population of 2149 comprising service personnel, families and dependents. Registered patients include 69% service personnel, of which 42% are recruits. Civilians comprise 31%. The medical centre also provides occupational health care and a rehabilitation service for service personnel.

The operational focus for the medical centre is to support phase 1, 2 and 3 training and to ensure Recruit Training Squadron (RTS) students are fully fit to pass out of recruit training and commence their specific trade training. There are 20 intakes per year of 80 to 120 recruits per intake and at any one time there are five intakes going through the training programme. In 2018, 2000 recruits graduated and 5000 completed specialist training. For permanent members of staff, the focus is on maintaining readiness for deployment and fitness to attend further training.

The medical centre is a dispensing practice with a full time pharmacy technician in post. A primary care rehabilitation facility (PCRF) is located within the building and provides a variety of rehabilitation services for service personnel only. A ward facility is available in the medical centre and this is due for a planned closure on 31 May 2019.

The medical centre is open from 07:00 to 18:30 hours. Emergency cover is provided and patients can access out of hours cover through the NHS 111.

## The staff team

Position	Numbers
Senior medical officer (SMO)	Vacant (gapped)
Deputy SMO	1 - acting SMO
Medical Officers (MO)	3
Civilian medical practitioners (CMP)	5 - 2 x full time; 2 x part time; 1 x locum
Principal Nursing Officer (PNO)	1
Practice nurses	9 – 5 x locums; 1 x under training; 3 x full time
Warrant Officer	1
Practice manager	1
Deputy practice manager	1
Administrative staff	5
Pharmacy technician	1 locum
PCRF	6
Medics	12
Other i.e. visiting clinicians	0

## Are services safe?

**Good**

**We rated the practice as good for providing safe services.**

## Safety systems and processes

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

- A framework of regularly reviewed safety policies was in place and accessible to staff, including locum staff. Staff received safety information about the practice as part of their induction and refresher training.
- Measures were in place to protect patients from abuse and neglect, including adult and child safeguarding policies and local safeguarding contact details. All staff had received up-to-date safeguarding training at a level appropriate to their role. All clinical staff had completed level 3 training in adult and child safeguarding. The Senior Medical Officer (SMO) and a civilian medical practitioner (CMP) were the safeguarding leads for the practice.
- A vulnerable patients register was held on the electronic patient record system (referred to as DMICP) and was reviewed at the monthly practice meetings. Children who were identified as vulnerable were reviewed with the health visitor who visited the practice each month. Appropriate codes and alerts were used on to highlight vulnerable patients.
- All staff had received chaperone training and notices advising patients of the chaperone service were displayed in clinic rooms. Staff had been subject to safety checks to ensure they were suitable to work with young people and vulnerable adults.
- The full range of recruitment records for permanent staff was held centrally. However, the practice could demonstrate that relevant safety checks had taken place at the point of recruitment, including a Disclosure and Barring Service (DBS) check to ensure staff, including locum staff, were suitable to work with vulnerable adults and young people. DBS checks were renewed every five years.
- Arrangements were in place to monitor the registration status of clinical staff with their regulatory body. All staff had professional indemnity cover. Information was in place to confirm staff had received all the relevant vaccinations required for their role at the practice.
- There was an effective process to manage infection prevention and control (IPC), including a lead for IPC who was appropriately trained for the role. The staff team was up-to-date with IPC training. An annual IPC audit had taken place.
- Arrangements were in place for the safe provision of acupuncture by the PCRf team.
- Environmental cleaning was provided by an external contractor. Cleaning schedules and monitoring arrangements were established. A deep clean of the premises took place in August 2018. We identified no concerns with the cleanliness of the premises.
- Systems were in place for the safe management of healthcare waste. Consignment notes were retained at the practice and an annual waste audit was carried out in November 2018.

## **Risks to patients**

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

- Staff we spoke with said staffing levels and skill mix was adequate to meet the needs of the patients. There was a mix of military, ex-military, civilian and five locum staff. All locum staff had received a comprehensive induction to familiarise them with systems in the practice.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures, including staff trained in basic life support and intermediate life support. An emergency kit, including a defibrillator, oxygen with masks and emergency medicines were accessible to staff in a secure area of the practice; all staff knew of its location. A first aid kit and accident book was available. Daily checks were in place to ensure the required kit and medicines were available and in-date.

- Staff were up-to-date with the required training for medical emergencies. They participated in regular training relevant to emergency situations. For example, basic life support was held in November 2018 and again in April 2019, stress fracture training was held in February 2019 and trauma training was planned for May 2019. Staff received sepsis training in May 2019 they were also aware of how to manage patients with a climatic injury.

### **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. A structured approach was in place for peer review of doctors' records that took account of coding, assessment, investigations, prescribing and the clarity of the patient pathway. The most recent peer review was undertaken in January 2019. The PCRf team also peer reviewed clinical records every six months. The most recent peer review took place in November 2018. Trends were noted in terms of missing information. This has since been rectified with a notable improvement in record keeping. Peer review to this standard was not in place for nurses.
- A process involving both doctors and nurses was established for scrutiny and summarising of patients' records. At the time of inspection, 15 sets of clinical records were awaiting summarisation. A first cycle summarisation audit was undertaken in June 2018 and a re-audit planned for June 2019.
- Staff described occasional loss of connectivity with DMICP, meaning clinics could be delayed. If this happened, the business resilience plan was followed and only emergency patients were treated.
- Referrals to other departments and external health care services, including urgent referrals, were managed by a dedicated member of the administrative team. Patients booked appointments through the NHS e-Referral service (e-RS) with the administrator. If an appointment was not available then the administrator followed it up on behalf of the patient. The physiotherapists monitored the referrals they made to the Regional Rehabilitation Unit (RRU) and other services. They acknowledged referrals could be more efficiently monitored if it was integrated with the wider referral tracking system for the practice.
- A clear process was established for the management of specimens and test results. Doctors checked the system twice a day for results. The duty nurse cross referenced the specimen log with DMICP and, if results were not received in a timely way, then it was followed up. An audit showed 100% compliance with the criteria for specimen and test result management.

### **Safe and appropriate use of medicines**

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

- One of the CMPs was the lead for medicines management with the day-to-day management of medicines delegated to a pharmacy technician. Safe procedures were in place for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment.
- Dispensary stock and medicines contained in the doctor's bag was checked each month. Appropriate arrangements were established for the safety of controlled drugs (CD), including destruction of unused CDs. Medication requiring refrigeration was monitored twice a day to

ensure it was stored within the correct temperature range. Prescription pads were securely stored and their use monitored.

- Patient Group Directions (PGD) had been developed to allow appropriately trained nurses to administer medicines in line with legislation. The PGDs were current and signed. An audit completed by medicines lead in April 2019 showed PGDs were appropriately used.
- Repeat prescriptions were safely managed through an online request system and group mailbox. No repeat prescriptions were issued after six months until the patient was reviewed by the doctor. A process was in place to update DMICP if changes to a patient's medication was made by secondary care or an out-of-hours service.
- The lead for medicines management monitored the use of high risk medicines (HRM). A register of HRM used at the practice was held on DMICP and all doctors had access to this. Alerts, coding, diary dates and monthly searches were used to identify and manage patients on HRM. Shared care agreements were in place for the patients that required them.

### **Track record on safety**

The practice had a good safety record.

- Measures to ensure the safety of facilities and equipment were in place. The practice manager and environmental health technician were the leads for risk and for health and safety. Electrical and water safety were up-to-date. A fire risk assessment of the building was undertaken annually. Firefighting equipment tests were current. Staff were up-to-date with fire safety training and were aware of the evacuation plan. Poor lighting outside the medical centre had been identified as a safety concern and this was being addressed by the practice.
- Safety processes for the practice were monitored and reviewed, which provided a clear, accurate and current picture that led to safety improvements. Risk assessments pertinent to the practice were in place, including those for hazardous substances, operating electrical equipment and lone working. They were last updated in October 2018. Equipment checks, including the testing of portable electrical appliances was in-date.
- A lone working policy was in place, particularly for PCRf staff working alone in the gym. An alarm system was available in clinical areas to summon support in the event of an emergency. Staff also carried personal panic alarms.

### **Lessons learned and improvements made**

The practice learned and made improvements when things went wrong.

- Staff used the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events, incidents and near misses. All staff had electronic access to the system, including locum staff. Staff provided several varied examples of significant events confirming there was a culture of effectively reporting incidents. Significant events were discussed at the practice meetings, health care governance meetings and management meetings if needed. The ASER system was also used to report good practice and quality improvement initiatives.
- A significant event register and lessons learned log was maintained on the health governance workbook. Improvements were made as a result of investigations into significant events. For example, equipment maintenance had lapsed for the PCRf equipment. The system for monitoring this had been changed to prevent this issue reoccurring again.
- A significant event raised in relation to the vaccination clinic identified that administrative errors were being made due to insufficient nurses to meet the volume and demand of the clinics. The

protocol was changed to ensure four nurses were available for each clinic and since then no further errors have been reported. This change in practice was reported as a quality improvement project (QIP).

- The pharmacy technician was responsible for managing medicine and safety alerts. The system was checked for alerts twice a day and any alerts logged on the register. Alerts were emailed to staff with a read receipt. They were also discussed at the practice meetings.

<b>Are services effective?</b>	<b>Outstanding</b>
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**We rated the practice as outstanding 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.

- Clinicians assessed patient's needs and delivered care and treatment in line with current legislation, standards and guidance, supported by clear clinical pathways and protocols. Through multi-disciplinary meetings, clinicians worked closely together to ensure effective care for patients. For example, the nursing team, doctors and the PCRf team took a holistic approach to assessment to ensure the most appropriate treatment and care pathway for individual patients.
- NICE (National Institute for Health and Care Excellence), published practice guidance, research and case studies were topics for discussion at the two weekly clinical meetings open to attendance by all clinicians. For example, the NICE update on the management of adults with diarrhoea was discussed in March 2019 and a physiotherapist presented a screening tool for patients experiencing back pain at a meeting in April 2019. The PCRf team referred to the Defence Rehabilitation website for best practice guidance. For example, there was clear evidence the PCRf followed the guidance for shoulder injuries.

### **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.

A clinician lead was identified for each long-term condition and they were responsible for carrying out quarterly searches and recalling patients when appropriate.

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

- There were nine patients on the diabetic register. For four patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. The remaining five patients were receiving appropriate treatment and care, including scheduled reviews by the diabetic nurse and/or doctor every three months as a minimum. For seven patients, the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.

- There were 28 patients recorded as having high blood pressure. Twenty three patients had a record for their blood pressure taken in the past nine months. Twenty patients had a blood pressure reading of 150/90 or less. Clinical records for the remaining five patients showed the nursing team took a pro-active approach with encouraging patients to attend the practice for a review. Recall letters were sent to the patients each month. Those who failed to respond received a letter from the doctor. Continued non-response was discussed with unit commanders if appropriate. Staff highlighted that patients who were not captured through the recall process would have a blood pressure check as part of their occupational medical.
- There were 39 patients with a diagnosis of asthma. All patients had an asthma review in the preceding 12 months which included an assessment of asthma control using the three Royal College of Physicians questions.

Monitoring the mental health and wellbeing of recruits underpinned the assessment process of all clinicians. Staff were mindful that recruits were young, vulnerable and may be away from home for the first time. Nurses advised us that any recruits presenting with low mood and/or concerns about their mental health were referred to the duty doctor. In addition, the duty doctor was advised if nurses identified any past mental health concerns through the process of notes summarisation. The PCRf team completed an audit (referred to as the Orebro-McTeague audit) on recruits to identify mental health issues linked to pain. As a result, the PCRf team instigated training with the recruits and identified further follow-up for mental health concerns.

We looked at a range of patient records and were assured that the care of patients with a mental illness and/or depressive symptoms was being effectively and safely managed, often in conjunction with the Department of Community Mental Health (DCMH). The practice did not issue repeat prescriptions of anti-depressants. Patients were reviewed each month and all doctors used the code 'depression interim review', which meant the reliability of searches was maximised.

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 93% of patients.

Quality improvement, including clinical audit, was clearly embedded in practice and seen as the responsibility of all staff. The lead physiotherapist was the lead for audit and oversaw a comprehensive annual audit. We looked in detail at a range of audits including repeat audits. They included antibiotic prescribing for sore throat, pelvic stress fractures, hypothyroid audit, PGD audit and a hypertension audit. They were systematic in approach and referenced best practice, including NICE guidance/quality standards. Minutes illustrated that quality improvement and audit were discussed at the health care governance meetings.

The outcome from the findings of audit were followed up. For example, the hypertension audit identified that the same Read codes and review templates were not consistently used by all clinicians. This resulted in the practice developing a Read coding and blood pressure monitoring protocol. Furthermore, in November 2018 a quick reference guide for the monitoring of each chronic disease was developed. It indicated the codes to be used, frequency/timeframes for review, DMICP template to be used and what should happen at each nurse and doctor review, including a review of lifestyle behaviours if appropriate. This was having a positive impact as a peer review of doctors' clinical records in January 2019 showed consistency with the use of Read

codes and review templates. Our review of clinical records also confirmed this level of consistency making it easy to track the patient's pathway.

Over the years, a pattern of pelvic stress injuries (PSI) in recruits has led to injury steering group meetings between the station executive, doctors and the PCRf team. To reduce this trend marching methods were changed with, for example, the slowest person at the front. The management of PSI was auditing from March 2017 to March 2018 using the current PSI management guideline. Recommendations were made for clinicians to ensure adherence to the guidance on sick leave and down grading timeframes.

### **Effective staffing**

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

A generic and role-specific induction was in place for new staff to the practice. We spoke with a recently inducted member of staff who described a comprehensive and supportive induction.

- A training lead was identified for the practice. Mandated training was monitored and the staff team was in-date for all required training. A comprehensive annual programme of ongoing development training (referred to as trade training) was in place with in-house training sessions held each week. All staff were expected to participate and deliver training.
- Clinicians also completed population need-based role-specific training. For example, the Military Aviation Medical Examiner (MAME) training. Competency checks were undertaken where appropriate, such as clinicians ensuring the clinical practice of medics was safe to practice. Junior medics straight from training worked at the practice and there was a good mentoring programme in place to support them with developing in to the role. A medic is trained to provide medical support and airfield crash cover on various operations and exercises. In a medical centre setting, their role is similar to that of a health care assistant in NHS GP practices but with a broader scope of practice.
- All staff had an identified workplace supervisor and had access to one-to-one meetings, mentoring and support for revalidation. Although locum staff were not entitled to appraisal reports, the Principal Nursing Officer (PNO) implemented an end of contract report to support locum nurses with the Nursing and Midwifery Council (NMC) revalidation process. All staff, including locums, said the practice was encouraging and supportive with continuing professional development.
- The RRU undertook an advisory visit to the PCRf in December 2018 to monitor the performance of and support for Exercise Rehabilitation Instructors (ERI).
- Regional meetings and forums were established for staff to link with professional colleagues in order to share idea and good practice. For example, nurses were facilitated to attend the regional nurse's forum to link with their colleagues.

### **Coordinating care and treatment**

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

- The clinical records we reviewed showed appropriate staff, including those in different teams, services and organisations were involved in assessing, planning and delivering care and treatment.

- The practice had developed good working relationships both internally and with health and social care organisations. For example, monthly meetings were held with the health visitor and the nursing team had developed close links with the out-of-hours district nursing team. The practice also worked with the Royal Air Forces Association (RAFA), a registered charity that provides welfare support to families.
- The RAF Benevolent Fund has been providing a mindfulness programme to support the wellbeing of service personnel. The programme provides a free membership to Headspace (online platform for guided meditation). All the nurses had signed up to the Headspace App.
- The practice was represented at monthly welfare station meetings to discuss the occupational health needs of the units, the needs of patients who were medically downgraded and those who were vulnerable. In addition, the SMO and Warrant Officer attended executive meetings with the chain of command and the padre.
- If needed, clinicians liaised with NHS primary care to ensure a smooth transfer of patients transitioning from the military. The patient received a leaving medical and a summary of their health needs to pass to their new GP. They also referred patients to the welfare team for support with the transition.

### **Helping patients to live healthier lives**

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

- Clinical records showed that staff encouraged and supported patients to be involved in monitoring and managing their health. Staff also discussed changes to care or treatment with patients as necessary.
- A health promotion lead was identified for the practice and they participated in the two weekly station health and wellbeing meetings. The health promotion strategy was underpinned by national priorities and initiatives to improve the population's health including, stop smoking campaigns and tackling obesity. It also took account of the patient population need and seasonal variation impacting health. The practice participated in station health fairs.
- Health promotion displays were available in patient areas. These were dated and refreshed in line with the strategy. At the time of the inspection there was a large display in the patient waiting area outlining the nature of safeguarding and what it meant to patients. Diversity and inclusion were taken into account in the health promotion strategy and leaflets for were available for transgender patients. A variety of mental health booklets were available for patients in the waiting area.
- A healthy eating working group had been instigated by the lead physiotherapist based on: the connection between diet, injury and recovery particularly for recruits who may not have a nutrient rich diet; evidence base suggests obesity is a wider problem for the RAF and a recent audit on body mass index (BMI) and injury rates by the lead physiotherapist suggested injury rates was highest in the lightest group (BMI <19) and the highest (BMI >30). Quarterly station meetings were held involving the lead physiotherapist, Senior Dental Officer, catering and representatives from the station executive, training/education and one of the practice GPs who sits on the armed forces weight management task group. Minutes from the meetings showed a number of changes had been made. For example, catering introduced chip-free days, the station shop stopped selling high energy drinks and review of the approach to the catering/nutritional brief for recruits.
- The nursing team facilitated a two hour health promotion session for recruits in relation to alcohol awareness. They also provided recruits with health education regarding sexual health, smoking, sleep and maintaining mental health wellbeing.

- The practice produced a quarterly newsletter for patients. The Spring 2019 addition the newsletter provided information about how to manage hay fever. The deputy practice manager managed the patient Facebook page (104 members) and used this platform to share health related information. For example, we noted the page was used to highlight Deaf Awareness Week and Red Cross Week.
- Four clinicians had completed the required training in sexual health. Information was available for patients requiring sexual health advice, including sign-posting to other services. Where appropriate patients were referred to local genitourinary clinic for screening.
- 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. Six patients were eligible for breast screening.

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

- 98% of patients were recorded as being up to date with vaccination against diphtheria.
- 98% of patients were recorded as being up to date with vaccination against polio.
- 94% of patients were recorded as being up to date with vaccination against hepatitis B.
- 99% of patients were recorded as being up to date with vaccination against hepatitis A.
- 98% of patients were recorded as being up to date with vaccination against tetanus.
- 12% of patients were recorded as being up to date with vaccination against typhoid (not mandatory).

The following illustrates the status of childhood immunisations:

- 100% of children were in date at 12 months.
- 97% of children were in date at two years.
- 100% of children were in date at five years.

The medics carried out searches each month to check the status of immunisations.

### **Consent to care and treatment**

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

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. Staff we spoke with were aware of the Mental Capacity Act (2005) and how it could apply to their practice.
- Monitoring the process for seeking consent was undertaken through peer review of clinical records.

<b>Are services caring?</b>	<b>Good</b>
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**We rated the practice as good for caring.**

**Kindness, respect and compassion**

Staff supported patients in a kind and respectful way.

- Throughout the inspection staff were courteous and respectful to patients arriving for their appointments.
- Results and comments from the January/February 2019 Patient Experience Survey (44 respondents) showed patients were happy with how they were treated. The four patients we spoke with and the 41 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 had a detailed information booklet to ensure patients were clear about the facilities available including: contact numbers and opening times; practice boundaries for dependent registration; services provided by the nursing and PCRf teams; access to test results; what to do if service personnel become sick away from their unit; use of a chaperone and referrals to other health care providers.

### **Involvement in decisions about care and treatment**

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

- Interpretation services were available for patients who did not have English as a first language. Although staff said they had not needed to use this service, they were aware of how to access it.
- The Patient Experience Survey showed 95% of patients were involved in decisions about their care (5% did not think this question was applicable to them). 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. An information leaflet had been developed for staff to support them with how to identify a patient with a caring role. It included a definition of a carer and the support that could be provided, such as flexible appointments. The leaflet also indicated the specific Read codes to use to identify carers. A register of carers was maintained.
- A carers' information board was displayed in the waiting area. All local carer's groups were advertised on the board, including groups for young carers. The practice leaflet for patients also included information about carers including links to national organisations. Six patients were identified as having caring responsibilities.

### **Privacy and dignity**

The practice respected patients' privacy and dignity.

- Screening was provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. Clinic room doors were closed during consultations.
- The layout of the reception area and waiting area meant that conversations between patients and reception could not be overheard.
- If patients wished to discuss sensitive issues or appeared distressed at reception, they were offered a private room to discuss their needs. A room was also available if patients wished to

book a secondary care appointment with the referral administrator in private. In addition, a privacy screen had been installed outside the dispensary hatch.

- The practice could facilitate patients who wished to see a GP of a specific gender.

## **Are services responsive to people's needs?**

**Outstanding**

**We rated the practice as outstanding for providing responsive services.**

### **Responding to and meeting people's needs**

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

- Staff understood the needs of its population and tailored services in response to those needs. Appointments slots were available to meet the needs of specific population groups including recruits, carers, school-aged children and school workers. For example, there were set occupational health days throughout the training programme for the phase 1 recruit intakes. Involving vaccinations, tests and health briefings, these were demanding days so the clinics were well structured to ensure they ran effectively. In addition, the practice held a specific emergency access clinic for recruits from 07:00 to 08:50 each day.
- Bank holidays were regular working days for the Recruit Training School (RTS) so the practice changed its working patterns to ensure a nurse and medic were on-call to support recruits who may need medical advice or an admission to the ward.
- The PNO had developed and implemented a vaccination booklet which was issued to two weeks prior to receiving their vaccinations. This was to enable recruits to ask any question prior to vaccination in order to support them with making informed consent in a timely and measured way.
- The practice sought feedback from patients through its patient Facebook page and made changes accordingly. For example, cytology clinic times were changed to facilitate working parents.
- The Patient Experience Survey indicated that 98% of respondents would recommend the practice to family and friends. Some of the comments submitted by patients included: "I would not change anything, I feel well looked after and every decision that is made is in the best interest of my health"; "I'm so very well looked after I wouldn't change one thing" and "They [staff] give you the options to turn things down if you don't want it".
- A welfare and support team (referred to as WASP) was available to support the recruits and welfare staff were trained to provide basic level counselling.
- Facilities were available for families, including a private room for breast feeding, baby changing facilities and a play area. Double appointments at either the request of the clinician or patient could be made.
- A 'staff as patients' policy was in place and staff who were patients of the practice were encouraged to see a CMP rather than a medical officer to promote objectivity.
- An access audit as defined in the Equality Act 2010 was completed for the premises in January 2019. The building was old and did not lend itself to ease of access for patients with a disability. The practice had made as much reasonable adjustment as possible. Clinic rooms were available on the ground floor. Disabled parking and accessible WC facilities were available.

### **Timely access to care and treatment**

Patients' needs were met in a timely way.

- The practice accommodated patients with an emergency need and staff advised us that no patients were turned away and would be seen on the same day. Routine appointments could be accommodated within 48 hours. Same day appointments were available for children. There was a four week wait for medicals.
- Arrangements were in place for patients to access NHS 111 when the practice was closed, including emergency care. However, the duty doctor was available 24 hours seven days a week to respond to the emergency needs of recruits.
- The ward facility was available for admissions (until its planned closure on the 31 May 2019) and the duty doctor and duty nurses were available to support patients requiring an admission.
- Patients were advised through the practice information leaflet that home visits could be facilitated. Telephone consultations were available with clinicians.
- A direct access physiotherapy (DAP) service was in place for permanent staff. Recruits attended sick parade rather than use the DAP service. At the time of the inspection access to routine physiotherapy and ERI appointments were within target.

### **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 displayed in the waiting area, outlined in the practice leaflet and on the Facebook page to help patients understand the complaints process.
- The practice manager was the designated responsible person who handled all complaints. The deputy practice manager took on this role in their absence. The practice managed complaints in accordance with the DPHC complaints policy and procedure. Verbal complaints were not recorded and the practice said they would start to do so. Both a complaints and compliments log were maintained.
- Any complaints were discussed at the clinical and/or practice meetings and lessons identified. Changes to practice were made if appropriate and used to improve the patient experience.

**Are services well-led?**

**Outstanding**

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

### **Leadership capacity and capability**

The leadership team had the experience, skills and drive to deliver high-quality sustainable care.

- 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 with a focus on providing the best possible service for their patients.
- Staff spoke highly of how the practice was led. They said managers demonstrated a collaborative approach to leading the practice and had the ability to motivate staff. The regional management team worked closely with the staff team and the area manager visited the practice each month.
- To plan for consistent and sustainable leadership, staff in deputising leadership roles were given opportunities to develop. For example, the deputy practice manager was booked to attend the practice management course the week after the inspection.

- We inspected on a day that was one of the busiest for practice as a cohort of phase 1 recruits were attending the practice for occupational health, including vaccinations, blood tests and health briefings. The practice managed this and the inspection in a very planned, meticulous and unflustered way.

### **Vision and strategy**

Throughout the inspection it was clear staff were committed to providing and developing a service that embraced the mission and vision.

- The practice worked to the DPHC mission statement of:  
“Safe practice – by design.”
- The mission statement for the practice was:  
“Sustainably deliver and commission safe and effective healthcare which meets the needs of the patient and the chain of command.”

### **Culture**

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

- An inclusive and whole-team approach underpinned the approach of the practice. All staff had an equal voice, regardless of rank or grade. Leaders promoted involvement of staff. For example, all staff were encouraged to deliver the training programme and engage with audit.
- The PCRf was fully integrated with the wider practice, including an integration of governance systems. The lead physiotherapist led the practice on clinical audit, a key example of an inclusive and integrated culture.
- 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 practice was mindful of the vulnerability of young recruits, the injury prevention steering group and the healthy eating working group.
- Openness, honesty and transparency were demonstrated when things went wrong. A no-blame culture was evident; complaints and incidents were seen as 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. 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.
- Leaders clearly demonstrated that the needs and welfare of staff were priority. Staff were encouraged and supported to be the best they could be through training and developing their skills. Supervision and appraisal was in place for all staff.
- The practice actively promoted equality and diversity and staff had received training in this area.

### **Governance arrangements**

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

- There was a clear staffing structure in place and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. Terms of reference were in place to support job roles.
- The practice worked to the health governance (HG) 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. The deputy practice manager had the lead for managing the HG workbook and monitored it each month to ensure it was current.
- An effective range of communication streams were used at the practice. A schedule of regular practice and department meetings were well established. For example, practice meetings, clinical governance meetings and management meetings were held each month.
- Audit was a routine method used to measure the effectiveness and success of clinical and administrative practice. A comprehensive audit programme was established with clear evidence of action taken to change practice and improve the service for patients.

### **Managing risks, issues and performance**

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

- Risk to the service were well recognised, logged on the risk register and kept under scrutiny through regular review. There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety. Processes were in place to monitor national and local safety alerts, incidents, and complaints.
- A system was in place to monitor performance target indicators. In particular the system took account of medicals, vaccinations, child health, cytology, summarising and non-attendance rates.
- Processes were in place to manage current and future performance. Performance of clinical staff was demonstrated through peer review, including review of clinical records.
- A business continuity plan was in place. It had been effectively implemented recently when the medical centre experienced a loss of power.

### **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 PCRf did not have a separate CAF and this was a key example of a whole-systems approach to governance.

### **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 throughout the year. In addition, patients could leave feedback via through the suggestion box. Patients were informed of the response to their feedback through a 'You said we did' notice in
- A Patient Participation Group (PPG) through a closed Facebook page had been developed. The practice used the page to share information with patients and also to petition patient views on proposed developments to the service. The PCRf held quarterly focus groups with phase 1 recruits to seek feedback on the rehabilitation service and how it could be improved.
- Patients were provided with a quarterly practice newsletter that included health education and updates on the service.
- The practice had developed effective relationships with the station executive. The Warrant Officer was the link with the Regional Training Squadron (RTS) and met each month with commanders of the RTS. These meetings led to changes and improved practice, such as revising bank holiday working hours to meet the needs of recruits. The Warrant Officer was currently in discussion with the station executive about the closure of the ward and alternative arrangements for recruits who are sick.
- In addition, good and effective links with internal and external organisations including the welfare team, RRU, the DCMH, local NHS services and social services.

### **Continuous improvement and innovation**

Continuous improvement was embedded in the culture which was one of improving the health and wellbeing of 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 activity we identified included:

- The development of the quick reference guide for chronic disease monitoring, including a consistent approach to the Read codes and review templates used.
- Development of the recruit rehabilitation focus group.
- Clinician focus on the mental health and wellbeing of recruits.
- As a result of a clinical audit, the development of the healthy eating working group. This has led to station-wide changes.
- As a result of audit activity, development of the injury steering group. This led to modifications in training for recruits.
- Development of a vaccination information booklet issued to recruits two weeks ahead of their vaccinations. This supported recruits with making informed decisions about having vaccinations.
- A proactive approach to identifying patients with a caring responsibility.
- Changes made to the organisation of the recruit vaccination clinics as a result of administrative errors. No further errors have occurred since the changes.