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 from our ongoing monitoring of data about services, and information given to us from the provider, patients, the public and other organisations.

### Ratings

<table>
<thead>
<tr>
<th>Overall rating for this service</th>
<th>Inadequate</th>
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<tbody>
<tr>
<td>Are services safe?</td>
<td>Inadequate</td>
</tr>
<tr>
<td>Are services effective?</td>
<td>Inadequate</td>
</tr>
<tr>
<td>Are services caring?</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Are services responsive to people’s needs?</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Are services well-led?</td>
<td>Inadequate</td>
</tr>
</tbody>
</table>
Bulford Medical Centre is rated as inadequate overall

The key questions are rated as:

- Are services safe? – Inadequate
- Are services effective? – Inadequate
- Are services caring? – Requires Improvement
- Are services responsive? – Requires Improvement
- Are services well-led? – Inadequate

We carried out an announced comprehensive inspection of Bulford Medical Centre on 12 March 2019.

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

The overall findings from the inspection:

- Although there was an open and transparent approach to safety, systems to manage risk were not being accurately used, such as the process for managing test results, complete oversight of safety alerts and ensuring all patients could be seen in the pharmacy waiting room.
- The arrangements for managing medicines, needed review: The management of Controlled Drugs (CDs) did not conform to Defence Primary Healthcare (DPHC) policy and high-risk medicines prescribed in secondary care were not recorded on the patients notes by the practice.
- The practice fostered an ethos of patient centred care.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Communication across the practice was regular but fragmented. As a result, staff did not always receive key messages. In addition, opportunities for staff to contribute to the development of the practice and share innovative ideas was limited.
- The management of long-term conditions required improvement.
- Quality improvement activity was under developed, particularly clinical audit based on the measurement of clinical outcomes.
- Staff had received mandatory training but the management of this required improvement.
- Staff were proactive in helping patients to live healthier lives.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- Information about services and how to complain was available.
- Staff were aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.
• Leadership within the practice was inconsistent and required strengthening including support from the regional team.

Notable Practice

• The practice had introduced a ‘Downtime Pack’ for use when there was a DMICP failure so that urgent patient consultations could continue with least disruption.

The Chief Inspector recommends:

• Ensure the premises and facilities provides an environment that minimises risks for the patients and promotes privacy.
• A review of formal governance arrangements including systems for monitoring risks, quality improvement processes, complaints clinical effectiveness and medicines management.
• Widen peer review of medical records to ensure that national best practice guidance is adhered to.
• Implement an effective system for the recall of patients with long term conditions.
• Ensure all locum staff have permissions access the significant event reporting system (referred to as ASER) and to access Sharepoint, the platform used for storing documents and hosting work in progress.
• Develop a more thorough and formal way of discussing and recording relevant and current evidence-based guidance and standards and ensure all staff have access to this.
• Develop a system whereby patient feedback is used to make improvements.
• Establish staff responsibilities to ensure there is resilience within the staffing structure and all staff have ownership of their own roles. This includes management of the training programme.
• Develop and support the team so that it is cohesive in its approach to patient care.

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

Our inspection team

The team that inspected Bulford Medical Centre included a CQC lead inspector and specialist advisors including a GP, a practice manager and a nurse. The pharmacy inspector visited on 7 March prior to the inspection day.

Background to Bulford Medical Centre

Bulford Medical Centre is located approximately 10 miles north of Salisbury and has a patient population of approximately 4000. The practice provides primary healthcare to maintain operational effectiveness and maintain force health protection, by ensuring vaccinations, audiology testing and gradings are up to date and current. The practice also provides primary health care for approximately 900 dependants of service personnel.

A dispensary is based in the medical centre. Additional services/clinics provided include: over 40 health checks; immunisations; travel advice; ear syringing; smoking cessation; sexual health promotion; chronic disease management; well woman; well man and weight management.
The practice is open from 08:00 to 16:30 Monday, Tuesday and Thursday, Wednesday 08:00 to 12:30 and on a Friday 08:00 to 16:00. Telephone medical advice is available after these times and before 18:30 when patients can contact NHS 111.

The staff team comprised a mix of full and part time civilian and military staff and included:

<table>
<thead>
<tr>
<th>Position</th>
<th>Incumbent</th>
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</thead>
<tbody>
<tr>
<td>Civilian Medical Officer (also SMO)</td>
<td>1 Civilian staff in post</td>
</tr>
<tr>
<td>Regimental Medical Officers (RMO)</td>
<td>2 in post, 1 deployed, 1 vacant</td>
</tr>
<tr>
<td>Locum GPs</td>
<td>2 in post</td>
</tr>
<tr>
<td>Practice nurses</td>
<td>4 (2 military and 2 civilian) 2 vacant</td>
</tr>
<tr>
<td>Military Practice Manager</td>
<td>In post</td>
</tr>
<tr>
<td>Pharmacy Technician</td>
<td>In post</td>
</tr>
<tr>
<td>Administrative staff</td>
<td>5 in post</td>
</tr>
<tr>
<td>Medics</td>
<td>6 in post</td>
</tr>
<tr>
<td>Health Care Assistant</td>
<td>1 vacant</td>
</tr>
</tbody>
</table>

- 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

The practice had systems to keep patients safe and safeguarded from abuse but improvement was needed.

- A framework of safety policies was in place and were regularly reviewed and accessible to permanent staff. We saw that locum staff did not have permissions to log into Sharepoint which is the platform used for storing documents and hosting work in progress. It is designed to allow the easy sharing of information across the Military of Defence (MOD).
- All staff received safety information about the practice and as part of their induction and during refresher training.
- Measures were in place to protect patients from abuse and neglect. Adult and child safeguarding policies were available and took account of local arrangements. A safeguarding lead and deputy
were identified for the practice. All staff were up-to-date with safeguarding training at a level appropriate to their role. Staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. The chaperone policy and notices were displayed advising patients of the service.

- Measures were in place to highlight and monitor vulnerable patients, including the use of Read codes and application of alerts on electronic patient records. A central register of vulnerable patients was maintained. We looked at the register and noted all patients had alerts on their records.

- The full range of recruitment records for permanent staff was held centrally. The practice manager could demonstrate that relevant safety checks had taken place including a DBS check to ensure staff were suitable to work with vulnerable adults and young people. DBS checks were renewed every five years. They also monitored each clinical member of staff’s registration status with their regulatory body. All staff had professional indemnity cover. Information was in place to confirm staff had received the relevant vaccinations required for their role at the practice.

- Systems were in place to ensure equipment was safe. Electrical safety checks were undertaken in accordance with policy. Fire safety including a fire risk assessment, fire plan, firefighting equipment tests and fire drills were all up-to-date. Portable appliance and clinical equipment checks were up-to-date, and records maintained.

- The practice was clean and tidy throughout. The Acting Senior Nurse was the infection prevention and control (IPC) clinical lead. There was an IPC protocol and staff had received up to date training. Annual IPC audits were undertaken, the last being in March 2019, and we saw evidence that the practice was 94% compliant with actions taken to address any improvements when possible. The main issue of non-compliance was the management of sharps bins, this had been discussed and actioned with staff to improve processes.

**Risks to patients**

There was scope to improve some elements of the system to assess, monitor and manage risks to patient safety.

- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Staff had guidance available to identify and manage patients with severe infections, such as sepsis. We were given an example of a recent incident whereby a young child was identified by the initial triage staff as having signs of sepsis triggering early intervention.

- The layout of the practice meant not all patients in the dispensary waiting area could be observed by reception staff. This was particularly important in the event of a medical emergency.

- 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. We looked at the procedures used by the duty GP to ensure test results were reviewed daily. We noted that results were only audited quarterly by choosing 20 results at random to check they had been received back into the practice, which was the DPHC mandated audit. DPHC policy also states that the practice must provide audit showing three consecutive months of 100% compliance, we did not see this in place. There was no practice led failsafe system in place to ensure that all test results were received back.

**Information to deliver safe care and treatment**

Information needed to deliver safe care and treatment to patients required improvement.
Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.

Summarisation of records was completed on the patient electronic record system (referred to as DMICP) and were flagged for the nurse and/or doctor to review. However, no notes audit had been completed since 2015.

Staff described regular ‘freezing’ or loss of connectivity with DMICP and said this did have a significant impact on patient care. Only urgent patients were seen, and all routine appointments had to be re-booked. The practice was proactive in their approach to this and had put together a ‘downtime pack’ which included paper copies of all documentation needed for a patient consultation.

External referrals were solely undertaken by the GPs. A referral book was in place that included anonymised details and dates, which prompted administration staff to start following up on the referral. Urgent referrals were followed up after two weeks.

**Safe and appropriate use of medicines**

The arrangements for managing medicines and vaccines were well managed. This included obtaining, recording and handling of medicines. However, there was scope for improvement.

- The pharmacy carried out regular medicines audits, for example, an audit of a strong painkiller (Tramadol) as they saw an increased trend in prescribing. The SMO also conducted some data collection and the issuing protocols were audited twice yearly to ensure safe prescribing. The regional pharmacist conducted a pharmacy risk audit twice yearly (last completed on 21/02/2019).

- All medicines safety notices and alerts were correctly logged on a spreadsheet with hyperlinks to the relevant webpage for the alert or safety notice. Only those alerts considered to be relevant were sent to the clinical staff. The pharmacy technician checked twice daily and forwarded any relevant medicine alerts to staff at the practice by e-mail and by form of a weekly newsletter. This newsletter was compiled by the pharmacy technician and was a really good source of information. It contained information on alerts, National Institute for Clinical Excellence (NICE) guidance, and medicines information.

- The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care. This was managed by the practice manager who sent on any alerts that were relevant to others. However, alerts were not logged, and no record was kept as to any checks or actions needed.

- PGDs (Patient Group Directions) were in use to allow non-prescribing staff to carry out vaccinations in a safe way. PGDs were appropriately managed as staff had received training and authorisation by the SMO had been recorded. All had completed their relevant vaccine administration training.

- A high-risk medicines list was in place and alerts were used to identify patients prescribed these medicines. A register was maintained and searches undertaken to ensure the register was up-to-date. We checked the records for six patients prescribed a high-risk drug and appropriate monitoring of their health was taking place. Shared care agreements with secondary care services were in place for all patients. Medicines issued in secondary care were not currently added to the patients’ medication record. This was discussed with SMO who was unaware of the policy to add medications to DMICP but agreed to do so from then on.
- Vaccines were kept in a central location. We saw a recent significant event (ASER) had been raised regarding a workman removing the plug from socket resulting in complete fridge failure and loss of stock. The fridge and its contents were quarantined appropriately, and all paperwork submitted to region as per policy. We saw that special plugs were on order for the fridges to be plugged into that could be remotely monitored to ensure compliance.

- 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. The stock checking procedure for CD’s held should be checked quarterly by the Commanding Officer of the unit (though they usually delegated this task to another officer of the unit). However, the area manager for Regional Headquarters undertook this task, which was not in accordance with Defence Primary Healthcare (DPHC) policy.

- Out of hours, secondary care prescriptions and amendments to current therapy as directed by secondary care were receipted and scanned onto the system. A message was sent to the referring doctor to action anything that was necessary. In the absence of the referring doctor, the duty doctor was tasked to action any medication changes.

### Track record on safety

- The practice manager was the lead for health and safety and had completed training relevant for the role. Risk assessments pertinent to the practice were in place including patient handling, needle stick injury, lifting and handling and lone working. A water test for Legionella had been completed.

- There was an alarm system in place to summon assistance in the event of an emergency.

### Lessons learned and improvements made

The practice learned and made improvements when things went wrong. However, improvement was needed to ensure learning was shared.

- Staff used the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events, incidents and near misses. Permanent staff had the initial electronic access to the system, however, two locum GPs did not. We discussed this, and the practice agreed to arrange this as soon as possible, it was also entered onto the practice risk register. Staff provided several examples of significant events they had raised demonstrating there was a culture of effectively reporting incidents. For example, a patient was given two vaccines that had breached the cold chain temperature necessary to ensure their effectiveness. We saw that appropriate actions had been taken, lessons learnt and shared.

- ASERs were a standing agenda item at the healthcare governance meetings and these were minuted. We saw evidence that showed the practice had raised 25 significant events from March 2018 to date.

<table>
<thead>
<tr>
<th>Are services effective?</th>
<th>Inadequate</th>
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<tr>
<td>We rated the practice as inadequate for providing effective services.</td>
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### Effective needs assessment, care and treatment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) and the Scottish Intercollegiate Guidelines Network (SIGN). The practice also used Practice Based Small Group Learning (PBSGL). NICE guidance was also disseminated via Practice e-mail (primary care update), the pharmacy newsletter

Bulford Medical Centre Quality Report 12 March 2019
and the DPHC newsletter. However, there was no formal meeting which was minuted and showed
there were some processes in place to review updates and discuss these with clinical colleagues to
ensure evidence-based best practice was updated in line with amendments. A ‘journal club’ took
place every month whereby any clinical staff were welcome to attend. These meetings were not
minuted for non-attending staff to refer to. The SMO sent a link to locum staff of any guidance as they
did not have individual access to Sharepoint where they were routinely stored. NICE guidance was
not discussed as an agenda item at any other meeting.

**Monitoring care and treatment**

The documented lead for chronic disease management was the SMO. However, it was clear through
discussion that this was managed and led by the practice nurses. Some improvement was needed to
ensure personnel with long term conditions had been reviewed and were fit to deploy.
There was a chronic disease register in place. This was in its infancy and was not complete. The
recall was by search and, in conjunction with the register, the statistics required improvement.

The practice used data to monitor outcomes for patients. However, the practice was unable to find
and provide us with all the required information on the day of the inspection.

- There were 18 patients on the diabetic register. DMICP records for these patients showed that
  cholesterol levels had been measured for 10 patients within the past six months and 10 were
  5mmol/l or less. For 14 patients, their last blood pressure reading was 150/90 or less which is an
  indicator of positive blood pressure control.

- There were 52 patients recorded as having high blood pressure. All had a record for their blood
  pressure taken in the past nine months. The practice was unable to demonstrate how many of
  these had a blood pressure reading of 150/90 or less.

- There were 64 patients with a diagnosis of asthma. The practice was unable to demonstrate how
  many of these had an asthma review in the preceding 12 months which included an assessment of
  asthma control using the three Royal College of Physicians questions.

- Seventy-one patients had been treated with new depressive symptoms in the past year. All had a
  review between 10 and 56 days after diagnosis, we were assured their care was being effectively
  and safely managed, often in conjunction with other relevant stakeholders such as the welfare
  team and the Department of Community Mental Health (DCMH).

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).
Information given to us on the day showed;

- 68% of patients’ audiometric assessments were in date (within the last two years).

Quality improvement was in the early stages of development for the practice. Some clinical audit work
had been undertaken but when we spoke with staff, it was unclear how the practice approach to this
work had been decided. No lead staff member had been appointed. There was no evidence of
discussion to ensure that clinical audit was relevant to the practice population and would drive
ongoing improvement in outcomes. A significant event had triggered a review of high-risk medicines
(DMARDs) management in January 2019. We saw that this audit identified that change was required
in practice and as a result, Shared Care Agreements (SCA) were to be Read coded moving forward.
On the day of the inspection we ran a search on the clinical system and found that all SCAs were
coded.
The clinical audits completed in 2018/19 included an antibiotics audit, hypertension audit and IPC audit.

Effective staffing
Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment. However, improvement was needed around record ensuring accuracy.

• The upkeep of a training matrix for the practice was undertaken remotely by the regional team. On the day of the inspection we looked at the document which showed many areas of training were overdue and out of date, for example, Basic Life Support and Anaphylaxis training. The following day we were provided with an updated matrix showing staff were in fact in date. However, looking at both documents we saw that training was not concurrently being updated and that there were periods of time in 2018 when training was out date for some months.

• The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, two nurses were trained in sexual health.

• Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.

• The practice was a training organisation supporting GP Registrars.

• A newly developed, role specific induction pack was in place for newly appointed staff. This was up to date and comprehensive.

• Staff had access to one-to-one meetings, appraisal, coaching and mentoring, clinical supervision and support for revalidation. Clinical staff were given protected time for professional development and evaluation of their clinical work.

• Peer review was not evident. The process for staff to undertake regular peer review of each other’s recorded clinical consultations with patients was not taking place. The GP Registrar did however have their notes peer reviewed by the SMO as part of their educational training.

• The approach for supporting and managing staff when their performance was poor was unclear. We saw two complaints within three months that alleged poor staff attitude. We saw no evidence to show this had been addressed. Administrative staff were not line managed by the practice manager, instead they were managed by the Regional Area Manager.

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

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice’s patient record system.

• This included care and risk assessments, care plans and medical records.

• Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients’ needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital.
• Records showed that all appropriate staff, including those in different teams, services and organisations were involved in assessing, planning and delivering care and treatment appropriate to the needs of each individual patient.

Supporting patients to live healthier lives
Staff were consistent and proactive in helping patients to live healthier lives.
• Records showed, and patient feedback confirmed, 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.
• Patients had access to appropriate health assessments and checks. Routine searches were undertaken to identify for patients eligible for bowel and 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. The following illustrates the current 2018 vaccination data for the practice patient population
• 89% of patients were recorded as being up to date with vaccination against diphtheria.
• 88% of patients were recorded as being up to date with vaccination against polio.
• 87% of patients were recorded as being up to date with vaccination against hepatitis B.
• 92% of patients were recorded as being up to date with vaccination against hepatitis A.
• 89% of patients were recorded as being up to date with vaccination against tetanus.
• 94% of patients were recorded as being up to date with vaccination against yellow fever.

There were 33 children under the age of three years four months registered with the practice. There were 32 who had parental consent to vaccination. We found that 100% of these children had received their pre-school vaccinations.

There were 52 children between the ages of three years four months and five years old. We found that 41 had received their pre-school boosters, two were exempt either awaiting notes or being on a ‘catch-up programme’. This meant that 75% of this age range had received their vaccinations. The practice was proactive in their recall and were working with the local healthcare provider to ensure children registered at the practice were invited in at the earliest convenience.

Consent to care and treatment
The practice obtained consent to care and treatment in line with legislation and guidance.
• Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
• Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient’s mental capacity to make a decision.

| Are services caring? | Requires improvement |

Bulford Medical Centre Quality Report 12 March 2019
We rated the practice as requires improvement for caring.

Kindness, respect and compassion

- We received 34 CQC comment cards completed prior to the inspection. All feedback in relation to how patients were treated by staff was positive. A theme identified overall was that patients felt respected and well cared for. The two patients we spoke with echoed this view.
- During our inspection we observed that members of staff were courteous and helpful to patients and treated them with dignity and respect.
- Results from the February 2019 Patient Experience Survey showed 100% of patients said they would recommend the practice to friends and family.

Involvement in decisions about care and treatment

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

- An interpretation service was available for patients who did not have English as a first language. However, this had to be arranged through regional headquarters and could not be done by practice staff. There had been an instance where a translation service had been used to good effect, but this was when there was prior notice given regarding the appointment. This would not be useful for an urgent appointment.
- Patient information leaflets and notices were available in the patient waiting area advising patients how to access a number of organisations. We saw that information that was age appropriate and relevant to the patient demographic was prominently displayed and accessible.
- The practice proactively identified patients who were also carers. There were processes in place to identify patients who had caring responsibilities, including the use of alerts, codes and regular searches. Patients were asked at registration whether they had caring responsibilities.

Privacy and dignity

The practice did all it could to respect the privacy and dignity of patients. However, some improvement was needed.

- Curtains were provided in consulting rooms to maintain patients’ privacy and dignity during examinations, investigations and treatments.
- The practice waiting room was large and airy. Within the room there was a decorative, transparent partition that patients sat behind so that conversations could not be overheard and patients could be easily seen. However, due to the size of the room and the acoustics, conversations were easily heard. There was a television on the wall that would help reduce this but the practice, despite requesting several times, could not use it as it had no licence to be used. This issue was on the practice risk register.
- Reception staff at the medical centre knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. There was a card available on the reception desk that patients could just give to a staff member without speaking allowing them immediate access to somewhere private.

<table>
<thead>
<tr>
<th>Are services responsive to people’s needs?</th>
<th>Requires improvement</th>
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<tbody>
<tr>
<td>We rated the practice as requires improvement for providing responsive services.</td>
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</tr>
<tr>
<td>Responding to and meeting people’s needs</td>
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</table>
The practice organised and delivered services to meet patients’ needs. It took account of patient needs and preferences.

- There were longer appointments available for patients who required more time.
- The practice operated an urgent system for any patient that needed to be seen more urgently on the day.
- A midwife held a clinic twice weekly.
- Telephone consultations were available.
- An Improved Access Psychological Therapy clinic was held at the practice once a week.
- Home visits were available at the discretion of the practice.
- An access audit as defined in the Equality Act 2010 had been completed for the medical centre. The practice had made reasonable adjustments for patients with disabilities. These included steps free access, and accessible toilet, with hand rails and a call bell and a passenger lift.

**Timely access to care and treatment**

- Details of how patients could access the GP when the practice was closed were available through the base helpline. Details of the NHS 111 out of hours service was also displayed on the outer doors of the medical centre and in the practice leaflet.
- Patients with an urgent need were seen that day and the waiting time for a routine appointment was usually within two days. The most recent patient survey (January 2019) showed that 92% of patients were happy with the time of their appointment and 98% said it was at a convenient location.

**Listening and learning from concerns and complaints**

The practice responded to complaints in a timely way. However, trends were not analysed, nor actions taken to learn from repeated concerns.

- The practice manager was the designated responsible person who handled all complaints in the practice. We saw that information was available to help patients understand the complaints system. The patient survey undertaken in January 2019 showed of 50 patients asked that 96% of patients said they felt their concerns were listened to.
- We reviewed four complaints that had been submitted by patients in the past 12 months. We saw that two submitted in the past three months were regarding poor staff attitudes. These had been dealt with in a timely matter and as per policy, however no trends analysis or actions were taken upon closing.
- We saw that compliments were collated into a register and shared with all staff. Five were received since October 2018, comments included gratitude for the care and kindness given by staff.

<table>
<thead>
<tr>
<th>Are services well-led?</th>
<th>Inadequate</th>
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**We rated the practice as inadequate for providing a well-led service.**

**Leadership capacity and capability**

From evidence gathered throughout the day we saw that the practice was not fully supported by the regional team. Practice management was fragmented between the practice manager and the area
The nursing team had not received any support or been visited by a Regional Nurse Advisor for over 10 months, the Regional Clinical Director told us this this post had been vacant for some time. The nursing team could however get advice by telephone from a nearby base if needed. The practice had not had the benefit of a Healthcare Governance review (HGAV) for eight years.

- The SMO was the lead for the practice, there was a named deputy but they were not currently working. All staff at the medical centre showed a desire to deliver quality care and promote good outcomes for patients. They were beginning to address some areas they had identified as requiring improvement. Some systems required additional work in order to ensure that care for patients was safe and effective. On the day of our inspection we met with a staff team who were open and transparent about the issues they needed to address. They listened to the feedback we gave and offered reassurance that risks and concerns would be addressed as a priority.
- Staff we spoke with told us that they enjoyed coming to work. All staff felt that they could raise concerns if they had them.
- Staff told us that there was a divide between military and civilian staff. Some clinical management was lacking and disjointed with no cross linking of skills (for example military nurses only saw military patients).
- The practice manager lacked autonomy in the overall management of the practice and instead the regional headquarters oversaw many areas which led to some processes not being fully complete.
- Staff were aware of the systems to ensure compliance with the requirements of the duty of candour. (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). This included support training for all staff on communicating with patients about notifiable safety incidents. The leaders encouraged a culture of openness and honesty.

Vision and strategy

The practice had a mission statement;

- “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.”

Culture

- On the day of inspection, the leaders told us they prioritised safe, and compassionate care. Everything we saw on the inspection day, and communications with the practice following the inspection, supported this.
- Whilst staff development was encouraged, there processes in place for providing staff with the development they needed was inconsistent, with GPs not undertaking formal peer review and training not being consistently managed

Governance arrangements

- The common assurance framework (CAF), an internal quality assurance tool, was used to monitor safety and performance. The 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. When a CAF assessment is undertaken by Regional Headquarters (RHQ) it is referred to as a Health Governance Assurance Visit (HGAV). The last HGAV was undertaken 2010.
• There was a clear staffing structure. Clinicians had lead roles in key areas but these needed to be reviewed to ensure the most appropriate person had overall responsibility. For example, the management of long-term conditions.

• Clinical audit lacked impact on quality of care and outcomes for patients. There was an absence of clear evidence of action to change practice and improve quality.

• Complaints were not managed effectively enough to ensure learning was identified and actions taken to improve.

• ‘Diary’ meetings for all staff were held on Monday mornings to plan for the week ahead. Head of departments meetings were held on Friday mornings. We saw evidence that practice meetings had been held once every three weeks. We were told that healthcare governance meetings were held monthly but the minutes we reviewed showed there was a three-month gap between the last meetings. Informal journal meetings were held every month, this was an opportunity for clinicians to discuss latest NICE guidance or to present and discuss and interesting or challenging cases. These were not minuted.

Managing risks, issues and performance

There were some processes in place for managing many risks, issues and performance. However, we identified areas where improvement was required.

The SMO oversaw the risk register. This document was sparse and did not contain areas that the practice identified to us as at risk. Some examples the practice stated in its pre-inspection presentation were:

• ‘Not enough equipment. The main treatment room was not equipped.’

• ‘Communication – sometimes key information was not disseminated.’

• ‘Staff do not always feel able to approach leaders with problems.’

• ‘High turnover of GPs.’

• ‘The Population at Risk was due to increase to 6000 in the future.’

There was also a Management Action Plan that the practice had put together that showed areas of improvement required and who was responsible for these. Areas such as updating and implementing protocols were listed within the plan.

• Practice leaders did not record and fully manage national and local safety alerts.

• There was no process established for providing formal peer review for GPs, including review of clinical record keeping and referrals.

• The system for managing laboratory results was not failsafe.

Appropriate and accurate information

• Quality and sustainability were discussed in relevant meetings, but not all staff had sufficient access to information and healthcare governance meetings were not held regularly.

• There were good arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners
The practice involved patients, staff and external partners to support good quality services.

- There was limited evidence to show how quality and operational information was used to ensure and improve performance. Whilst the views of patients were routinely sought in line with DPHC policy, staff could not provide examples of changes this feedback had triggered.

- The practice had good and effective links with internal and external organisations including the Regional Rehabilitation Unit (RRU), the Department of Community Mental Health (DCMH) and local NHS primary care providers.

**Continuous improvement and innovation**

There was some evidence of systems and processes for learning, continuous improvement and innovation.

- The practice had developed and implemented a new bespoke induction programme for all staff.

- Civilian staff provided stability and continuity of care through periods of change in military staffing. However, there was scope to implement more of their ideas for improvement and to extend their involvement through access to formal clinical discussion. They also needed access to Sharepoint.

- The practice had introduced a ‘Downtime Pack’ for use when there was a DMICP failure so that urgent patient consultations could continue with least disruption.