Corsham Medical Centre

Quality report

Westwells Road
Corsham
Wiltshire
SN13 9NR

Date of inspection visit:
16 May 2019

Date of publication:
10 July 2019

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

Ratings

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

Chief Inspector's Summary

This practice is rated as good overall.

The key questions are rated as:

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

We carried out an announced comprehensive inspection at Corsham Medical Centre on 16 May 2019. Defence Medical Services (DMS) are not registered with the Care Quality Commission (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 had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice improved their processes.
- The practice demonstrated an ethos of patient centred care.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Effective systems were in place for chronic disease management, including a recall system which ensured that patients' conditions were reviewed in a timely way. However, the recall system for health checks on patients aged over 40 required strengthening.
- Clinical record keeping was detailed and clear and would be easy for a locum clinician to follow. The practice was delivering care and treatment according to evidence-based guidelines.
- Patients found the appointment system easy to use and could access care when they needed it. However, there was a backlog of appointments to see the physiotherapist.
- A programme of quality improvement work was in place and was starting to deliver better outcomes for patients. However, there was scope for improved communication of outcomes, most notably to the practice nurse.
- Staff had developed strong links with military bases located nearby and the practice made good use of National Health Service (NHS) knowledge and resources.

We saw two areas of notable practice:

- The practice had supported families of military personnel despite them not being registered patients. For example, the practice had engaged with the family welfare team and health visitors, signposting family members of military personnel to support even though not registered at the practice.

- A GP had supported a Ghurkha family having identified a soldier who was vulnerable. The practice contacted a Lama Guru who confirmed they could help the individual and the GP then persuaded the soldier to make contact. The GP followed up by contacting the Lama Guru to gain confirmation that contact had been made.
- The practice had no direct links with the out-of-hours services through Defence Medical Information Capability Programme (DMICP) so high-risk patients were registered at Box Surgery to allow an electronic interface; for example, for palliative patients.

The Chief Inspector recommends:

- Consider how the delivery of care to meet the musculoskeletal (MSK) needs of patients can be improved to reduce waiting times and reviewed to ensure safe and effective care is being delivered.
- Extend the governance arrangements to fully incorporate the PCRF (Primary Care Rehabilitation Facility).
- Ensure all staff have access to the ASER system.

Dr Rosie Benneyworth 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 and a CQC inspection manager. The team included a GP specialist adviser, a practice nurse specialist adviser, a practice manager adviser and a PCRF adviser.

Background to Corsham Medical Centre

Corsham Medical Treatment Facility (MTF) is located in Wiltshire near Bath. The MTF is part of Ministry of Defence (MOD) Corsham, communication base. Facilities management is contracted to an external contractor, Interserve. Healthcare services are incorporated into the contract and the medical provision is sub-contracted to an NHS provider, Box Surgery. The surgery have had an association with providing medical services to the base since 1948. The treatment facility offers care to forces personnel. Dependants and children are registered with nearby NHS practices. At the time of inspection, the patient list was approximately 430.

Occupational health, travel health and physiotherapy services are provided on site. Family planning advice is available, with referral onwards to NHS community services. Maternity and midwifery services are provided by NHS practices and community teams. Medicals offered include diving, commissioning and Fitness for Leadership course.

The Centre is manned by contracted staff from Box Surgery and Interserve. There are 15 posts outlined in the table below:

Position	Numbers
SMO	1 civilian GP (part-time)

DSMO	1 civilian GP (part-time)
Part Time Civilian GP	3 civilian GPs (part-time)
Practice Manager	1 practice manager
Nurse	1 civilian nurse (part-time)
Administrative support	2 medical administrators (Interserve staff)
PCRF staff	2 physiotherapists (providing a combined three sessions weekly) 1 exercise rehabilitation instructor (ERI) (one session a week, employed through the DPHC temporary healthcare workers contract)
Contracted staff	1 medical administrator (part-time) 2 domestic ESS contracted staff

Are services safe? — Good

We rated the practice as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep patients safe and safeguarded from abuse.

- The practice had safety policies including adult and child safeguarding policies which were reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. Policies were regularly reviewed and were accessible to all staff, including locums. They outlined clearly who to go to for further guidance.
- There was a system to highlight vulnerable patients on records and a risk register of vulnerable patients. Staff were alerted to a vulnerable patient by automated alerts from the electronic clinical operating system and there was a lead GP to coordinate the care.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. We noted examples where staff had gone the extra mile to protect vulnerable patients.
- Most staff had received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. GPs were waiting for a course to be made available to complete level 3 adult safeguarding training.

- Staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. DBS checks were undertaken where required.
- There was an effective system to manage infection prevention and control (IPC). The nominated lead had received bespoke training. A comprehensive IPC audit had been undertaken and an action plan was in the process of being formulated.
- There were systems for safely managing healthcare waste, an audit had been undertaken in April 2019 and no issues had arisen.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed. There was an effective approach to managing staff absences and for responding to epidemics, sickness, holidays and busy periods.
- There was an effective induction system for temporary medical centre staff tailored to their role.
- The practice was equipped to deal with medical emergencies and permanent staff were suitably trained in emergency procedures. Informal training on sepsis had recently been delivered to administration staff. The nurse told us that she had been reading up on the management of thermal injuries.
- Staff understood their responsibilities to manage emergencies on the premises and had appropriate equipment and medicines that were regularly checked.

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.
- There was some peer review of clinical notes, although there was scope to ensure that notes made by PCRF staff were periodically audited.
- There was a system in place to manage hospital letters and this showed who had read and actioned the letters for each patient.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. There was a documented approach to the management of test results.
- There was an effective system in place to govern referrals. Appointment letters were handed to the patient after the consultation via ERS (electronic referral system). The Practice had

developed referral letter spreadsheets for routine referrals and urgent referrals which we noted to be up to date.

- Sample testing results were processed daily and tracked. Any abnormal results were followed up appropriately.

Safe and appropriate use of medicines

The practice had systems in place for appropriate and safe handling of medicines.

- The systems for managing and storing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice had carried out an appropriate risk assessment to identify medicines that it should stock. The practice kept prescription stationery securely and monitored its use.
- Written procedures were in place and reviewed regularly to ensure safe practice. The SMO was the named lead for medicines management.
- Staff had access to British National Formulary (BNF) and prescribing formulary. Staff prescribed, administered and supplied medicines to patients in line with legal requirements and current national guidance.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. For example, patients who took disease-modifying anti-rheumatic drugs (DMARDs) had shared care protocols uploaded into their notes and we saw that recall dates had been set for blood testing.
- The practice did not routinely hold stock of controlled drugs (CDs). Appropriate steps were taken when handing out any items that included CDs.
- Prescriptions were signed before medicines were dispensed and handed out to patients.
- An effective repeat prescription system was in place and followed by staff.

Track record on safety

The practice had a good safety record.

- The practice manager was the health and safety lead and had received health and safety training specific to the role. There were comprehensive risk assessments in relation to safety issues. All practice staff received formal health and safety training.
- Patients in the waiting area could be observed by practice staff and highlight any potential risk if someone suddenly becomes unwell.
- There was a fixed alarm system in the Medical Centre and the PCRF.
- The practice confirmed that there were occasions when patients' records were unavailable due to system failure. However, staff stated that this was seldom for more than a few hours at a time. In the event of the system being down for a prolonged period of time, only urgent patients were seen and paper notes would be taken and later scanned on the electronic clinical system. These contingency steps were detailed in the business continuity plan.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system and policy for recording and acting on significant events and incidents. Staff had received training in using the system and understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. However, most recent significant events were administrative, suggesting there was scope to widen learning across the clinical team. A trend of information governance errors had been identified and remedial action taken to minimise the risk of repeat.
- There was a system for receiving and acting on safety alerts. The practice learned from patient and medicine safety alerts. For example, in 2018, the practice had carried out a simulation for a collapsed patient following a Central Alerting System (CAS) alert.
- Staff had access to the significant event reporting system and understood how to use it. However, the locum exercise rehabilitation instructor (ERI) had not been given access.

Are services effective?	Requires improvement

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

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) best practice guidelines and these were being followed to deliver care and treatment that met patients' needs. A recent addition to the agenda of clinical meetings was discussion around best practice guidance and changes to practice in light of newly issued guidance. However, minutes that recorded discussion were not yet available.
- The Defence Primary Health Care (DPHC) team produced a newsletter that was circulated to clinicians providing further information and a summary of relevant safety updates. Staff we spoke with could refer to this and gave examples of updates they had acted on and discussed within the practice.

Monitoring care and treatment

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

The practice provided the following patient outcomes data to us from their computer system on the day of the inspection:

- There were six patients on the diabetic register. We reviewed the treatment and care offered to these patients and found that current NICE guidance had been followed. For all six of these diabetic patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For all six diabetic patients, the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.

- There were 15 patients recorded as having high blood pressure. We reviewed the treatment and care offered to these patients and found that current NICE guidance had been followed. A total of 12 of these patients had a record for their blood pressure taken in the past nine months and 14 had a last blood pressure reading of 150/90 or less.
- There were nine patients with a diagnosis of asthma. All but one had had an asthma review in the preceding 12 months which included an assessment of asthma control using the three Royal College of Physicians questions. Smoking status had been captured and there was a record of smoking cessation advice having been offered. The patient who had not been reviewed was on deployment and had an appointment booked for their return.
- The practice regularly monitored patients with depression. We reviewed four patients who were signposted to support services that included Improving Access to Psychological Therapies (IAPT) and Department of Community Mental Health (DCMH) based at Tidworth where the wait for a routine appointment was approximately two weeks. The Read coding for patients with depression was an area for improvement and an audit was planned for June 2019 (Read codes enable coding of clinical information which is easily accessible by a computer search). The practice confirmed to us that, as is the case across Defence Medical Services, there were some inaccuracies due to inconsistent Read coding of patients with depression.
- The practice reviewed its antibiotic prescribing annually and so was proactively supporting good antimicrobial stewardship in line with local and national guidance. The last audit was undertaken in December 2018. In addition, a regional prescribing report had led to a review of the prescribing of a specific antibiotic in February 2018. Further audits on antibiotic prescribing were planned for 2019. The practice had been identified as an outlier for the prescribing of a broad-spectrum antibiotic (one which should only be used for specific infections as it encourages resistance). All eight cases were reviewed and deemed appropriate.

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). Data from May 2019 showed:

- 100% of patients had a record of audiometric assessment.
- 81% of patients' audiometric assessments were in date (within the last two years).

There was evidence of quality improvement work including clinical audit and this had led to improved outcomes for some patients:

- An internal quality assurance tool, the Defence Medical Services (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. When we reviewed the CAF, we saw that a number of areas had been highlighted, as requiring further work and the practice had a plan in place to action these issues.
- A programme of clinical audit was in place and second cycles completed or planned allowed continuous improvement to be monitored. However, there was scope to widen learning opportunities through wider discussion of audit outcomes. The PCRF did not have their own audit or quality improvement programme in place.

- The clinical audit work undertaken was relevant to the practice population. For example, an asthma audit was undertaken in November 2018 to ensure optimal management of patients with asthma. Clinical audit included medicines management audits; an ACE inhibitors and diuretics audit that led to a safer monitoring system and a diclofenac audit where the prescribing was challenged and an alternative medication found to be more appropriate in two cases.
- We saw an audit had been undertaken on personnel who had been given temporary restricted duties to review if they had been signposted to further education. We saw a notes audits which identified occupational advice was not always Read coded. Second cycles of audit evidenced improvement.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were given opportunities to develop. Recent training completed by a GP included appraisal and revalidation, downgrading and army fitness test.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, mentoring, clinical supervision and support for revalidation. However, although initial planning of how best to support the PCRF had taken place, the professional development and support structure had not yet been fully extended to include the physiotherapist and ERI.
- Nursing staff were appropriately qualified and their competence was assessed regularly. They could demonstrate how they kept up to date. Nursing staff whose role included immunisation had received specific training and could demonstrate how they stayed up to date. Further courses completed by the nurse covered infection prevention control, diabetes and sexual health.
- The practice was resourceful in reaching out to external sources for support. For example, the nursing staff had developed links for professional support with nurses from nearby military medical centres.

Coordinating care and treatment

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

- The practice met regularly with welfare teams and line managers to discuss vulnerable patients and their dependents.
- Coordination of care and treatment for the PCRF could be improved; for example, PCRF staff had not been invited to attend UHC meetings and a referral tracker showed that no referrals had been made to the RRU (Regional Rehabilitation Unit) in 2019. A multidisciplinary team meeting was planned for June 2019 to provide a clinical forum for the GP, physiotherapist and ERI to coordinate the review of patient care.

Helping patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.
- All new patients were asked to complete a proforma on arrival. Notes were scrutinised by administration staff and then reviewed by the nurse and GP. The practice nurse followed up any areas of concern, such as raised blood pressure. However, due to the backlog in scrutinising patient notes, there was a potential risk that practice staff did not have all patient information required.
- The practice offered basic sexual health advice and referred on to local clinics in the community for more comprehensive services including family planning. There was no appointed lead in the practice for sexual health, however the nurse had attended sexual health training.
- The practice nurse was not trained in smoking cessation but had enrolled on a course due to take place in September 2019 (the practice had asked DPHC which service to refer into and in the interim directed patients to a website that supported people in Wiltshire with stopping smoking).
- Patients had access to appropriate health assessments and checks. A monthly search was undertaken for all patients aged 50 to 64 years who were entitled to breast screening. The practice also engaged with all national screening programmes and had a mechanism to ensure that eligible patients were referred into the bowel cancer or abdominal aortic aneurysm (AAA) screening programs.
- The number of women aged 25 to 49 and 50 to 64 whose notes recorded that a cervical smear had been performed in the last three to five years was 41 out of 43 eligible women. This represented an achievement of 95%. The NHS target was 80%. There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using public health information posters and they ensured a female sample taker was always available.
- The practice population included 200 patient aged 40 or above. There was a backlog of health checks so the practice had prioritised the recall for patients aged 50 and above. However, the recall system would benefit from a more structured approach.

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 data below from May 2019 provides vaccination data for patients using this practice:

- 89% of patients were recorded as being up to date with vaccination against diphtheria. No regional or national comparative data was available.
- 89% of patients were recorded as being up to date with vaccination against polio. No regional or national comparative data was available.
- 85% of patients were recorded as being up to date with vaccination against Hepatitis B. No regional or national comparative data was available.
- 93% of patients were recorded as being up to date with vaccination against Hepatitis A. No regional or national comparative data was available.

- 89% of patients were recorded as being up to date with vaccination against Tetanus. No regional or national comparative data was available.
- 95% of patients requiring the typhoid vaccination were recorded as being up to date. No regional or national comparative data was available.

It is common for the Typhoid vaccine to have a lower uptake than other vaccinations. Current guidance state DMS practices should offer the Typhoid vaccination to personnel before deployment and not to routinely vaccinate the whole population.

The PCRF had been impacted by a temporary closure in 2018 that resulted in a backlog of patients in need of treatment. The number of musculoskeletal (MSK) downgrades had been highlighted as a major issue and the five week wait for new and review appointments reported to the Chain of Command (CoC), Interserve, the Regional Clinical Director (RCD) and to DPHC. However, at the time of the inspection there was no clear action plan in place to improve the situation although the practice told us:

- Monthly PCRF multidisciplinary team meetings were scheduled to start in July 2019.
- The DPHC regional physiotherapist clinical lead planned to visit to provide clinical support.
- An audit was planned to review record keeping, complaint sand compliments to better understand the demand on the department.
- The practice planned to use the August 2019 contact review to seek an increase in physiotherapist hours.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

Verbal consent was recorded on the consultation notes.

Are services caring?	Good

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- We received 33 patient Care Quality Commission comment cards in total. Of these, 25 were entirely positive about the service experienced. Eight of the cards were mixed and the negative comments were in relation to the wait times for the PCRF.
- A range of information was available to patients to support their welfare. Information included what was available from the local welfare services in Wiltshire and from civilian facilities,

including healthcare facilities. We saw that additional support was provided to a patient diagnosed with cancer.

Involvement in decisions about care and treatment

- The clinicians and staff at the practice demonstrated that they recognised when people attending the medical centre required extra guidance in making decisions about their care. Staff demonstrated how they gauged the level of understanding of patients, avoided overly technical explanations of diagnoses and treatment and encouraged and empowered young patients to make decisions based on sound guidance and clinical facts.
- Interpretation services were available for patients who did not have English as a first language and staff knew how to access them.
- The Choose and Book service had been implemented and was used to support patient choice as appropriate. (Choose and Book is a national electronic referral service which gives patients the choice of date and time for their first outpatient appointment in a hospital).
- Data received from the patient experience survey (50 questionnaires completed in April 2019) showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example:
    - 82% said that they felt involved in decisions regarding their care. (8% said that this question did not apply to them).
    - 90% said that they would recommend the service to family and friends (6% said that the question did not apply: this is often because military personnel know that their family and friends would not be entitled to register at a military medical centre).

The data presented by the practice was not benchmarked against regional and national averages for DMS, or against the previous year's performance.

- Patient information leaflets and notices were available in the patient waiting area which told 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 acted in a compassionate way toward any patient that had to be discharged on health grounds. We saw that the practice reassured patients and signposted to personnel within the military who could guide them through the exit process and transition to NHS care and other support functions. A GP had supported a Ghurkha family having identified a soldier who was vulnerable. The GP contacted a Lama Guru to discuss the individual and persuaded the soldier to make contact. The GP followed up by contacting the Lama Guru to gain confirmation that contact had been made.
- We noted examples where clinicians were going the extra mile to ensure that a patient's dignity and safety at work were prioritised through ongoing occupational health support and review. GPs had started to establish contacts with other services to ensure that the needs of the patient could be seamlessly met. For example, the practice had supported families of military personnel despite them not being registered patients. We heard examples of where the practice had engaged with the family welfare team and health visitors, signposting family members of military personnel to support even though not registered at the practice.
- Practice staff told us that they proactively identified patients who were also carers and that a code was added to their records in order to make them identifiable so that extra support or

healthcare could be offered as required. Carers were able to attend a dedicated meeting held at Box Surgery.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The layout of the reception area was not ideal but had been adapted to improve confidentiality of conversations at the reception desk. A television provided background noise and seating was a short distance away from the desk.

Are services responsive to people's needs? | Good

We rated the practice as good for providing responsive services

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example, the practice offered weekly dedicated clinics for medicals and longer appointments for patients with more complex conditions.
- An access audit as defined in the Equality Act 2010 had been completed for the premises. All services were provided on the ground floor. There was an accessible toilet in the building. The practice had reported its findings and recommendations to the primary contract holder. The practice had carried out a disability access audit and highlighted no automatic opening door at the main entrance and that the bell on the front door could not be heard by reception staff. The low-level hatch at reception had been blocked by seating and a photocopier. The reception staff told us that they had no current patients who used a wheelchair and they would instruct any patient in need of assistance to request when booking an appointment and they would open the door to hold a conversation with anyone entering in a wheelchair. The audit findings had been reported to the facilities contractor who had advised that special dispensation was granted to the building to allow the doors to be adapted at a time when the centre would be refurbished.
- The practice stated that they would make a home visit in the local area when a patient was too ill to attend the surgery. This was detailed in the practice leaflet and there was a process to ensure that a home visit request would be assessed by a GP to grade the urgency.
- Where military personnel were signed off from work for health reasons, the medical centre ensured that line managers were informed about any downgraded activities for safety reasons. This ensured that Chain of Command had a clear idea of which tasks personnel could safely undertake.

Timely access to care and treatment

- Access to routine appointments was good. A patient who rang in on the day of our inspection could have accessed a same day appointment with a GP or a nurse. Any patient who did not attend (in March 2019 this totalled 14 patients) was contacted by email and any repeat occurrence reported to the practice manager.

- Patients needing to access the PCRF could not self-refer and the wait time was approximately five weeks (the key performance indicator or KPI in DMS is 10 days). However, this compared favourably to the wait times for NHS physiotherapy services locally.
- Outside of routine clinic hours, telephone cover was provided by a GP at Box Surgery. From 18:30 hours, patients were diverted to the NHS 111 service. Patients would be signposted to Box Surgery outside of routine clinics. In this way, the practice ensured that patients could directly access a GP between the hours of 08:00 and 18:30, in line with DPHC's arrangement with NHSE.
- There was clear instruction in the waiting area advising patients of the nearest accident and emergency (A&E department), located at Royal United Hospital Bath. However, this was not included in the practice leaflet.
- Results from the practice's patient experience survey showed that patient satisfaction levels with access to care and treatment were generally high. For example:
    - 90% of patients said that they could access an appointment at a convenient time.
    - 94% of patients said that their appointment was in a convenient location.
    - The majority of comments made in the CQC comments cards were positive. However, mixed reviews in eight of the 33 cards were generally about the long wait time for PCRF appointments.

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.

- Defence Primary Health Care had an established policy and the practice adhered to this.
- The practice manager was the designated responsible person who handled all complaints in the practice. Verbal complaints were recorded and managed through the same process as written complaints
- We saw that information was available to help patients understand the complaints system.
- We reviewed three complaints that had been submitted by patients in the past 12 months. We saw that there were processes in place to share learning from complaints. The theme of complaints was wait time for PCRF appointments. Complaints had not been audited in the past 12 months in accordance with the Common Assessment Framework (CAF). This was because the number of complaints was too low to undertake an audit (the practice manager was aware of the parameters to audit if required).

Are services well-led?	Good

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

Leadership capacity and capability

Leaders were established within their leadership roles and understood the importance of a strong team ethos in the delivery of good primary care. The systems in place supported the delivery of safe and effective care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. It was clear that the practice team enjoyed working together and staff told us that their team ethos was supportive and inclusive.
- The leadership had forged strong links with nearby military medical centres and local NHS services.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values built around the Medical Facility's mission statement, 'We will encourage people to take care of their own health and wellbeing, whilst treating those that become ill with care, compassion and skill.' The practice had a realistic strategy and supporting business plans to achieve their priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The medical centre planned its services to meet the needs of the practice population. For example, there was discussion around the addition of a healthcare assistant to enable the development of the practice nurse.
- The medical centre monitored progress against delivery of the strategy.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. However, not all staff were aware of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They could do this anonymously if they wished, but all staff we spoke with said that they were happy to raise issues directly with manager and leaders. They had confidence that these would be addressed and spoke of a no-blame culture within the practice.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. However, the localised support for the recently appointed ERI was not yet in place although line management support was provided by Lyneham medical centre. Staff annual appraisals had been completed or planned. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff. There were positive relationships between staff and teams.

- The practice actively promoted equality and diversity. Staff had received equality and diversity training.

Governance arrangements

The Medical Centre had consolidated and clarified responsibilities, roles and systems of accountability to support good governance and management.

- There was a programme of regular meetings that extended to include all staff. This included a monthly practice meeting, a monthly clinical meeting and a monthly health governance meeting.
- Joint working with the welfare team, SSAFA (The Armed Forces Charity), pastoral support and Chain of Command was interactive and led to co-ordinated person-centred care.
- The PCRF delivered rehabilitation services from a room within the medical centre and a gym located in a separate building. The medical centre had been temporarily closed between February and September 2018 due to manpower constraints. Although alternative rehabilitation services had been offered at an alternative military medical centre (one hour away), the temporary closure created a backlog of patients which, at the time of inspection, were being prioritised. This impacted the governance arrangements for the PCRF: there was no structured programme of quality improvement; there was scope for more formalised clinical supervision and risk management processes had not been fully integrated to include the PCRF. PCRF did attend practice meetings at the medical centre. We fed this back to the regional team who had been in discussion with the leadership team and were due to visit the week after we inspected.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Practice leaders had established a number of policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

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

- There were some effective processes to identify, understand, monitor and address current and future risks including risks to patient safety. Staff told us that they would raise any issue with the practice manger.
- The practice had processes to manage current and future performance.
- Practice leaders had oversight of national and local safety alerts, incidents, and complaints.
- Clinical audit was having a positive impact on quality of care and outcomes for patients. We saw clear evidence of action to change practice to improve quality. Audit findings had generally been shared across the clinical team although there was room for improvement in the communication of outcomes to nursing staff.
- The practice had plans in place and had trained staff for major incidents.

Appropriate and accurate information

The practice worked to ensure that it held appropriate and accurate information.

- An understanding of the performance of the practice was maintained. The practice manager used the Common Assessment Framework (CAF) as an effective governance tool. Practice

meetings were held regularly and were used as an additional governance communication tool. Learning needs were discussed at practice meetings and appropriate training was requested and delivered through this forum. This provided an opportunity for staff to learn about how the performance of the practice could be improved and how each staff member could contribute to those improvements.

- Staff were competent in the use of 'Population Manager' which is a clinical search facility. The information was used to monitor performance and the delivery of quality care, although staff acknowledged common concerns around the accuracy of its outputs. The practice used information from the CAF and Health Governance Assurance Visit (HGAV) to formulate an action plan to address areas of improvement.
- There were robust arrangements at the medical centre in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. The practice had learned lessons from minor information breaches, showed a duty of candour and implemented systems to minimise the risk of reoccurrence.

Engagement with patients, the public, staff and external partners

The practice involved patients, staff and internal partners to influence its services.

- Patients were approached to feed back their views on the way care was delivered to them. We saw that a recent survey had led to improved delivery of care to patients.
- The Medical Facility clearly displayed outcomes from patient feedback in the waiting area.
- The practice was effective in engaging with station commanders, welfare support services, local NHS services, local military services, DPHC and DCMH. There was scope to improve the liaison with PCRF as the number of MSK downgrades had been highlighted as a major issue.
- The practice had no direct links with the out-of-hours services through Defence Medical Information Capability Programme (DMICP) so high-risk patients were registered at Box Surgery as temporary patients to allow an electronic interface; for example, for palliative patients.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement within the practice. New approaches had been adopted to improve on confidentiality breaches, the reception area had been redesigned to promote confidentiality and the practice manager was underway with a project to manage updates for policies and procedures.
- The practice made use of internal and external reviews of incidents and complaints. Learning was used to make improvements.
- The practice planned to bid for extra money in the contract to provide extra physiotherapist time.
- Virtual diabetes clinics had been introduced using a diabetes specialist to review the management of patients with diabetes and support clinicians with advice on treatment.