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 from the provider and patients.

### Ratings

| Overall rating for this service | Good  
|--------------------------------|-------
| Are services safe?             | Good  
| Are services effective?        | Good  

Letter from the Chief Inspector of General Practice

This practice is rated as Good overall

The key questions are rated as:

Are services safe? – Good
Are services effective? – Good

We previously carried out an announced comprehensive inspection of Raleigh Medical Centre (referred to as the ‘practice’ from herein) on 19 February 2018. The practice was rated as good overall, with a rating of requires improvement for the key question of safe. Whilst at the previous inspection the effective domain was rated good overall, some improvement was required with regard to audit.

A copy of the report from that comprehensive inspection can be found at:

http://www.cqc.org.uk/what-we-do/services-we-regulate/defence-medical-services#army

We carried out this follow up inspection on 22 May 2019. This report covers our findings in relation to the recommendations made and any additional improvements made since our last inspection.

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:

- Significant event (ASER) recording was well managed.
- There was evidence to demonstrate quality improvement was embedded in practice, including an annual programme of clinical audit used to drive improvements in patient outcomes.
- There were systems in place to assess and monitor key risks including:
- Ensuring that checks of professional registers for staff were current.
- The safe management of patient safety alerts.
Dr Rosie Benneyworth BM BS BMedSci MRCGP
Chief Inspector of Primary Medical Services and Integrated Care
Our inspection team

Our desk-based inspection was undertaken by a CQC inspector.

Background to Raleigh Medical Centre

Raleigh Medical Centre provides primary care and occupational health to Phase 1 recruits and the unit's permanent members of staff. It also provides care to patients who are stationed at the base for the duration of a short course. An average of 60 new patients (recruits) arrive each week to commence training and join the practice. There is a high turnover of the patient population, which on the day of the inspection was approximately 1,400, made up of 900 recruits and 500 more permanent staff.

In addition to routine GP services, the treatment facility offers physiotherapy and rehabilitation services. Maternity and midwifery services are provided by NHS practices and community teams. Mental Health referrals are made to HMS Drake located approximately 2 miles away.

The practice has a 14 bed overnight observation facility, situated on the upper floor of the practice. This is run by the practice staff who provide 24 hour a day cover.

The practice is open from Monday to Friday, between 07:00 and 18:30. Outside of these times, patients were referred to NHS 111 or local out of hours services. The nearest accident and emergency unit is located at Derriford Hospital which was approximately 22 miles away.

The practice has a dispensary which is open from 07:45 to 15:00 on Mondays, 07:45 to 16:00 on Tuesday and Thursdays and 07:45 to 12:00 on Wednesday and Fridays. The dispensary is closed on a Wednesday and Friday afternoon. Any medicines that are not immediately available within the dispensary can be collected on prescription from Lloyds Pharmacy, who have a contract to dispense medicines for Defence Primary Healthcare (DPHC) sites. Throughout this report, Raleigh Medical Centre will be referred to as 'the practice'.

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

<table>
<thead>
<tr>
<th>Position</th>
<th>Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principal Medical Officer (PMO)</td>
<td>1 in post</td>
</tr>
<tr>
<td>Medical Officers (MO)</td>
<td>1</td>
</tr>
<tr>
<td>Locum GPs</td>
<td>4</td>
</tr>
</tbody>
</table>
Practice nurses | 5  
--- | ---  
Military Practice Manager | 1  
Administrative staff | 4 civilians  
Medics | 7  
Primary Care Rehabilitation Facility (PCRF) | 3 physiotherapists  
 | 2 Exercise Rehabilitation Instructor (ERI) (1 locum)

Why we carried out this inspection

The Care Quality Commission (CQC) carried out this inspection as one of a programme of inspections at the invitation of the Surgeon General in his role as the Defence Authority for healthcare and medical operational capability. Defence Medical Services (DMS) are not required to register with CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. Consequently, DMS services are not subject to inspection by CQC and CQC has no powers of enforcement. However, where CQC finds shortfalls in the quality of services during inspection, we will report them by making a recommendation for action to the Surgeon General’s office.

How we carried out this inspection

To conduct this inspection, we contacted the practice manager in April 2019 and advised that we would be following up our findings of the inspection of February 2018. We reviewed information sent to us by the practice.

As this was a follow-up inspection, we focused on two key questions where improvements were required. We did not speak to patients as part of this review or use CQC comment cards to gather patient views of the service.
Are services safe?

Our findings

Following our previous inspection, we rated the practice as requires improvement for providing safe services. We found gaps in systems and processes to keep patients safe, including systems for managing serious incidents (ASERS) and medicines alerts. In addition, there were gaps in staff checks, including professional register checks.

When we carried out this follow up inspection we found that all the above recommendations had been acted on. Following our review of the evidence provided, the practice is now rated as good for providing safe services.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- Arrangements were in place to monitor the registration status of clinical staff with their regulatory body. All staff had professional indemnity cover.
- All Medicines and Healthcare Products Regulatory Agency (MHRA) 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. There was a designated lead and deputy responsible for this role.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- All staff were familiar with reporting incidents and reporting was actively encouraged at the practice. 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. The ASER system was also used to report good practice and quality improvement initiatives.
- We were provided with several examples of significant events that had been raised demonstrating they were effectively reporting incidents. Changes were made as a result of significant events. For example, the management of blood results and the management of fridge temperatures and maintaining a cold chain for medicines requiring refrigeration.
Are services effective?

Our findings

Following our previous inspection, we rated the practice as good for providing effective services overall. However, some improvement was required with regard to audit. At this inspection we found that improvements had been made and that quality improvement and audit was embedded within the practice ethos and undertaken by all staff.

Monitoring care and treatment

A programme of clinical and non-clinical audit was in place. Clinical audit was driven by population need. The range of audits we looked at referenced best practice, including NICE guidance/quality standards. There was evidence of up to two cycles for some audits. Examples of completed clinical audits we looked at and discussed with staff included antibiotic prescribing. The PCRF had also completed audits, including one on stress fractures.

There was a lead member of staff for overseeing the audit calendar but all practice personnel were encouraged to participate in audit. The audits and recommendations were discussed monthly at the senior management meeting and in individual health professional team meetings. Recommendations were placed on the management action plan and protocols and policies were updated accordingly.

The outcomes of audits are also discussed as a whole practice at the weekly meeting to ensure full distribution within the practice.