

# Bickleigh Medical Centre

## Quality report

Plymouth  
Devon  
PL6 7AJ

Date of inspection visit:  
4 July 2019

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24 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?

Good 

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**

We carried out an announced comprehensive inspection of Bickleigh Medical Centre on 4 July 2019.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

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

## **At this inspection we found:**

- The practice was well-led and leaders demonstrated they had the vision, passion and integrity to provide a patient-focused service that constantly sought ways to develop and improve.
- An inclusive whole-team approach was supported by all staff who valued the opportunities available to them to be part of a patient-centred service.
- There was an open and transparent approach to safety. An effective system was in place for managing significant events and staff knew how to report and record using this system. However, this system was under utilised.
- The assessment and management of risks was good and recognised as the responsibility of all staff. The major incident plan required updating.
- The arrangements for managing medicines, including obtaining, prescribing, recording, handling, storing, security and disposal minimised risks to patient safety.
- Staff were aware of current evidence-based guidance. They had received training so they were skilled and knowledgeable to deliver effective care and treatment.
- The practice worked collaboratively and shared best practice to promote better health outcomes for patients.
- There was evidence to demonstrate that quality improvement was embedded in practice, with an annual programme of clinical audit in place to drive improvements in patient outcomes moving forward.

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- The practice proactively sought feedback from staff and patients which it acted on. Feedback showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.
  - Information about services and how to complain was available.
  - People's individual needs and preferences were central to the planning and delivery of tailored services. The services were flexible, provided choice and ensured continuity of care.
  - Facilities and equipment at the practice were sufficient to treat patients and meet their needs.
  - Staff were aware of the requirements of the duty of candour.

**We saw one areas of notable practice:**

The physiotherapist had set up a specific staged rehabilitation programme utilising research evidence to assign patients to a progressive scheme for return to their activities. This included patient information material, with clear pictures and instructions that have been specifically and individually created for the unit's patient population. This had been shared with other units who have similar patient populations.

**The Chief Inspector recommends:**

- Ensure significant event reporting is comprehensive and that the systems already in place are used to support any identified actions and this is shared with all staff to prevent reoccurrence.
- Update the major incident plan.
- Update Standard Operating Procedures to reflect local practices.
- Support the practice manager by ensuring access to practice management training.
- Diagnose and improve the Information Technology (IT) access.

**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 inspector. The team included a GP specialist adviser, a practice nurse specialist adviser, a practice manager adviser, a medicines team inspector and a Primary Care Rehabilitation Facility (PCRF) adviser.

## Background to Medical Centre

Bickleigh Medical Centre provides the full range of primary and intermediate health care for all entitled service personnel from all three services, and occupational care to entitled reservists across the South West region.

There are no registered dependants and currently a very small population of under 18-year olds. The majority of the population at risk are aged between 18 and 55 with the average age of patients being 27 years old. There is a high turnover of the patient population, which on the day of the inspection was approximately 600.

In addition to routine GP services, the treatment facility offers physiotherapy and rehabilitation services. Family planning advice is available within the practice and maternity and midwifery services are provided by NHS practices and community teams. Mental Health referrals are made to Drake Medical Centre.

The Primary Care Rehabilitation Facility (PCRF) comprises of one clinical room within the main medical facility, for the physiotherapist. There is a separate rehabilitation gymnasium closely located, but not in the same building, where rehabilitation classes take place.

The practice is open on Monday, Tuesday and Thursday 08:30 to 16:30 hours, Wednesday and Friday 08:30 to 12:30 hours for walk-in and pre-booked patients. Outside of these times a senior medic is on call for emergencies 16:30 to 18:30. After this patients are referred to local out of hours' services/Emergency Department.

The Centre has a mix of military and civilian staff. The current establishment and staffing gaps are outlined in the table below:

Position	Numbers
<b>Civilian Medical Officer (also SMO)</b>	1 CMP (Civilian Medical Practitioner) in post.
<b>Senior Medical Officers (SMO)</b>	1 Unit MO (Medical Officer) non-Defence Primary Healthcare (DPHC). Currently deployed.
<b>Practice nurses</b>	1 military nurse, 1 day per week.
<b>Military Practice Manager</b>	1 day per week.
Administrative staff	1 in post.
Medics	1 in post.

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

### **Safety systems and processes**

- The practice had systems to keep both adults and patients under 18 years of age safe and safeguarded from abuse. The practice had safety policies including safeguarding policies for adults and under 18s 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. There are regular (weekly) meetings with the unit welfare team and the executive team.
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required.
- There was an effective system to manage infection prevention and control.
- There were systems for safely managing healthcare waste.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions.

### **Risks to patients**

There was a system 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. The CMP took their leave during unit block leave which reduced the requirement for locum cover. When locum cover was required it was provided by Drake Medical Centre who understood the Standard Operating Procedures and practices within Bickleigh practice.
- There was a role specific induction system in place for new or temporary staff. The practice had also put together desk top instructions covering all areas.
- Clinicians adhered to military guidance around sickness periods for personnel. They communicated effectively with the Chain of Command so that line managers knew which tasks personnel could safely undertake.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. The practice had only had a very small number of heat injuries in the last few years. This is attributed to the Chain of Command taking ownership of the risk and managing it appropriately with restricted activities during periods of extreme temperatures. There were two well equipped treatment rooms of a good size, suitable layout and double door ambulance access. There was a spinal board available.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. All clinical staff and the administrator had completed training in sepsis recognition. There was appropriate use of the sepsis template and there were notices in all of the clinical rooms to serve as an aide memoire for staff. We also saw guidance at the reception desk to help staff when dealing with patients presenting as acutely unwell.

## **Information to deliver safe care and treatment**

- The system to manage hospital appointments was effective and patients were well supported to obtain the most timely access to secondary care. Hospital letters were scanned and tasked to a clinician for their review. The system to manage pathology results was failsafe.
- There was no backlog in electronic summarising at the practice. New patients were required to attend an appointment with the nurse within a week of being based at Bickleigh. At that appointment a full medical history was taken and records checked and updated.
- The patient electronic record system (referred to as DMICP) suffered from frequent and prolonged network outages which appeared undiagnosed and unresolved. This was mitigated by an adequate supply of laptops which could access a secure Wi-Fi network and deliver safe care. However, there was no printer supplied with the laptops which would be safe practice instead of relying on hand written documents (for example the printing of prescriptions).
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. This included good links with the local general hospital, the sexual health clinic and the tissue viability nurses, all located in nearby Plymouth. The physiotherapist had clear and strong working relationships with the two-unit Exercise and Rehabilitation Instructors (ERIs) in the gym; and the wider medical team; and evidence was seen of joint meetings with other multi-disciplinary team (MDT) staff with clear actions recorded on DMICP.

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

The arrangements for managing medicines and vaccines were good. This included arrangements for obtaining, recording and handling of medicines.

- All dispensing was outsourced to Drake Medical Centre. Routine prescriptions were dispensed within 24 hours and more urgent ones were available the same day. There was also a contract with a local pharmacy in place to dispense any medicines that Drake Medical Centre did not have in stock.
- Standard Operating Procedures (SOPs) were in place but these would benefit from being adapted to reflect local policies. For example, access to the prescription cupboard.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use. All staff who administered vaccines had received the immunisation training as well as the mandatory anaphylaxis training.
- All prescription pads were stored securely at all times and entry was restricted.
- There were searches for some of the 'high risk medicines' but these were not being run on a regular basis, a reflection of low numbers of patients and a close knowledge of the patients by the CMP. We checked the records for two patients prescribed a high-risk medicine and appropriate monitoring of their health was taking place. Shared care agreements with secondary care services were in place for all patients. We saw two recent prescribing audits, one reviewing prescribing in urinary tract infections and another looking at prescribing of a particular pain killer in Primary care.
- All Medicines and Healthcare Products Regulatory Agency (MHRA) safety notices and alerts were received into the practice by email and correctly logged on a spreadsheet. Only those alerts considered to be relevant were sent to the clinical staff. A table top instruction was also evident to ensure all staff were aware of the process to be followed. We discussed that this

process would be more robust if designated staff logged into the MHRA website themselves to check alerts as an added safety measure.

- PGDs (Patient Group Directions) and PSDs (Patient Specific 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 CMP had been recorded. All had completed their relevant vaccine administration training.

### **Track record on safety**

The practice manager was the lead for health and safety. However, they had not completed training relevant for the role as the course they had been enrolled on had been cancelled, this was hoped to be re scheduled. Risk assessments were in place including needle stick injury, lifting and handling, legionella management and lone working. The PCRf had a specific risk assessment for the safe use of needle acupuncture.

- There were alarms within the building and staff also carried personal alarms.

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

- There was an electronic organisational-wide system (referred to as ASER) for recording and acting on significant events, incidents and near misses. All staff knew how to raise and report an incident. We saw only three incidents had had been reported in the past six months. Staff awareness and encouragement to report could be improved upon to ensure learning was identified and shared. We saw an example of a Caldicott breach that should have been reported. ASERS were an agenda item on the fortnightly practice meetings.

<b>Are services effective?</b>	<b>Good</b>
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**We rated the practice as good 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. The CMP attended a meeting at Drake medical centre at least monthly, sometimes more often; where there was a forum to share new guidance and Nice recommendations. There was also a fortnightly governance meeting which preceded the Practice meeting.

### **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.
- We found the care of patients with long term condition was good. For example, those patients with diabetes, hypertension and asthma. The nurse was the lead for chronic disease management and managed the chronic disease register. They carried out regular searches, recalling patients when appropriate. We looked at a selection of patient records and were assured that clinicians were consistent in how patients were reviewed. For example, clinicians used the same asthma review template.

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- We saw that patients that had been treated for new depressive symptoms in the past year had been reviewed 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). Audiometric assessments were in date for 89.5% of 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.
- A programme of clinical audit work had been established but was in its infancy. For example, we saw audits including medicines audits, delays in imaging, infection control, cytology and notes audits. There was evidence of audit activity by the CMP. This was relatively low level, however, there were very low numbers of patients with chronic disease, the bulk of the workload was musculo-skeletal injuries and the physiotherapist was very proactive in developing practices to optimise rehabilitation of these injuries. The practice nurse had been established as the audit lead and an audit calendar was in place showing planned audit work continuing throughout the upcoming year.

### **Effective staffing**

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- 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.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, mentoring, clinical supervision and support for revalidation.
- Nursing staff had established a good peer network which facilitated extended learning and sharing of best practice.
- The ERIs were not DPCH staff instead they belonging to a unit. Despite this we saw that the ERI's were well integrated with the PCRf, including joint physiotherapy and rehabilitation sessions which were recorded within the patient's clinical notes. The ERIs also attend the regional training days at the Regional Rehabilitation Unit in Plymouth, and there was also a regional ERI forum they attended that promoted best practice.

### **Coordinating care and treatment**

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

- The practice met with welfare teams and line managers to discuss vulnerable patients. Staff told us that they had forged some strong links with other stakeholders, including the Royal Marines charities. They also had good access to a private alcohol dependency counsellor who was familiar with the military structure as well as the specific needs of practice population.

- PCRF staff fostered close working relationships, meeting daily with the GP to ensure individual patients were discussed and care planned appropriately to support good recovery.
- The Medical Centre was located within the same building as the PCRF service which provided physiotherapy assessment and treatment. An exercise rehabilitation service was also available for patients, a few minutes' walk from the medical centre. Referral into the service was via a primary care clinician or by direct access by the patient themselves. Patients were able to obtain swift access to the PCRF and strong partnership working arrangements resulted in co-ordinated and person-centred care for patients.
- There were good examples seen of regular meetings arranged between the medical centre staff, the rehabilitation staff and the chain of command.

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

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

- The practice offered basic sexual health advice including the issue of free condoms and referred on to local clinics in the community for more comprehensive services including family planning.
- Medical centre staff attended unit open days and manned stalls to provide health promotion information to personnel.
- 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.
- 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. We saw records that confirmed that 100% of women had received screening or were waiting to be called.

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:

- 97% of patients were recorded as being up to date with vaccination against diphtheria.
- 97% of patients were recorded as being up to date with vaccination against polio.
- 97% of patients were recorded as being up to date with vaccination against Hepatitis B.
- 98% of patients were recorded as being up to date with vaccination against Hepatitis A.
- 97% of patients were recorded as being up to date with vaccination against Tetanus.
- 92% of patients were recorded as being up to date with vaccination against Typhoid.

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

There were no invasive procedures carried out at the practice. Minor surgery was carried out by a local military general surgeon, and joint and soft tissue injections were referred to the local RRU. Therefore, there was little requirement to obtain formal written consent. However, when required

staff sought patients' consent for care and treatment in line with legislation and guidance. PCRf staff took written consent for acupuncture procedures. A recent audit highlighted that not all medics were recording when they obtaining consent, actions were put in place and as a result their practice had improved.

Clinical staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Other practice staff had training planned in the basic principles of Mental Health legislation.

When providing care and treatment for young recruits aged under 18 years, staff carried out assessments of capacity to consent in line with relevant guidance.

**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 explained that they rarely saw patients from a variety of cultural backgrounds and who spoke English as a second language. However, the medical centre had taken account of patients' personal, cultural, social and religious needs and had systems in place if it was needed. For example, a translation service.
- 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. There was a notice above reception that explained this.
- We received 23 patient Care Quality Commission comment cards in total, all were complimentary about the care they received.
- The practice had an information network available to all members of the service community, known as HIVE. This provided a range of information to patients who had relocated to the base and surrounding area. Information included what was available from the local unit and from civilian facilities, including healthcare facilities.

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

- 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).
- Results from the practice's Patient Experience Survey in May 2019 (9 responses were collated) 100% of patients said they felt listened to.
- Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of organisations. We saw information that was age appropriate and relevant to the patient demographic which 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 these 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.

## Privacy and dignity

The practice respected patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect. Patients we spoke with confirmed this. We saw all staff interacting with patients in a friendly yet respectful manner.

<b>Are services responsive to people's needs?</b>	<b>Good</b>
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**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, 50% of the patients seen with clinical presentations needed Muscular Skeletal (MSK) intervention. We saw the practice was proactive in ensuring these patients were seen quickly and a treatment plan initiated without delay. The other 50% of patients had occupational health needs. The practice data showed they were managing this well.
- The rehabilitation set-up was well-formed for a relatively small unit; with three levels of rehabilitation available (full-time rehabilitation, part-time rehabilitation (3 sessions a week) and individual-program (IP) access. All the gym equipment and gym space was unit-owned, but there was a timetable to ensure the space was available for the rehabilitation troop. The availability and diversity of gym equipment available for rehabilitation use was good.
- The CMP was qualified to undertake diving medicals and was up to date with his training.
- The practice nurse worked only one day per week at Bickleigh Medical Practice, the rest of their time was spent at nearby Stonehouse Medical Practice. Despite this we saw they were responsive to the needs of the patient' and we were given several examples of when they planned clinics and offered appointments, at Bickleigh, to patients that requested to be seen more urgently. They also were responsive to any female patient that asked for a female clinician (there were only 13 female patients within the practice population).
- The facilities and premises were bespoke and appropriate for the services delivered. An access audit as defined in the Equality Act 2010 was completed for the premises in July 2019. Access was good throughout with level access throughout.
- The medical centre did not routinely offer home visits to its patients. However, there was a policy available to staff and patients around when a home visit might be necessary. This was also highlighted within the practice leaflet.

### Timely access to care and treatment

- Urgent appointments are available on the same day. Routine appointments are also usually available the same day or the next day.
- Outside of routine clinic hours, cover was provided by a medical officer at Drake Medical Centre. From 18:30 hours patients were diverted to the NHS 111 service as appropriate.

- The practice leaflet gave clear directions on local accident and emergency unit access. The nearest accident and emergency department was located at Derriford Hospital.
- The Defence Rehabilitation Headquarters collates a dashboard of information in relation to waiting times for their appointment, however this information was not available to us on the day. Instead we used a real-time check of the DMICP diary and we saw the wait for new patient needing an appointment was one working day. Direct Access Physiotherapy (DAP)- was in place, and the rehabilitation dashboard was unable to provide the percentage of patients who utilise direct access, however the physiotherapists reported the 'majority' of patients do. These are key performance indicators as timely access to physiotherapy and rehabilitation are important for effective patient recovery.
- The PCRf proactively managed DNA (patient who did not attend) rates for their clinics and had achieved above average results with 3% of patient appointments lost to DNAs in June 2019, compared with a PCRf average of 7%.
- We spoke with two patients on the day of our inspection. They both told us that they could secure appointments when they needed them and were confident that they would be seen quickly.

### 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.
- We saw that information was available to help patients understand the complaints system.
- There had been no complaints submitted by patients in the past 12 months. We saw that there were processes in place to share learning from complaints.

<b>Are services well-led?</b>	<b>Good</b>
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**We rated the practice as good for providing a well-led service.**

### Leadership capacity and capability

- The practice had not had the benefit of a Healthcare Governance review (HGAV). This was due to the uncertainty in the past 12 months regarding whether Bickleigh would become part of a group practice. Despite this, and being a very small practice with limited staff, we saw a practice that was well led.
- The CMP said they had good support from the regional team and from Drake Medical Centre nearby. The medical centre had regular visits by the area manager.
- There was a stable team in the medical centre. The administrator had been in post for some years, as has the physiotherapist and the CMP, they had daily lunch together and it was clear from their day to day practices that there were no barriers to communication between staff. Whilst most of the medics were not DPHC staff the Royal Marine ethos is such that they displayed high levels of group coherence aimed at doing the best for their fellow Marines.
- The leaders not only demonstrated managerial experience, capacity and capability, it was clear they had vision, passion with a focus on providing the best possible service for their patients.

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They clearly understood the practice priorities and demonstrated they had capability to drive service change for the benefit of patients. The practice manager whilst an experienced leader would benefit from training in practice management to support them in their role.

- There was a comprehensive meetings programme in place and the practice, although very small, held whole team meetings every two weeks.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- All staff were involved in discussions about how to run and develop the practice, and the CMP encouraged all members of staff to identify opportunities to improve the service delivered by the practice.
- The practice was aware of and had 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 clear vision and credible strategy to deliver high quality, sustainable care.

- The practice worked to the DPHC mission statement: 'Safe Practice by Design' and staff told us that they aimed to provide occupationally focussed primary care and high-quality force protection.
- 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.

### **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.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. 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. We noted that medics were well trained and supported to deliver their roles.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training.

- There were positive relationships between staff and teams.

### **Governance arrangements**

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured that:

- There was a clear staffing structure in place and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. Terms of reference were in place to support job roles.
- An understanding of the performance of the practice was maintained. The practice manager used the Common Assessment Framework (eCAF) as an effective governance tool. The practice leaders regularly reviewed this and the management action plan to progress any areas of risk.
- A programme of clinical and internal audit was in its infancy, but the practice recognised the importance of its use for monitoring quality and to make improvements moving forward.
- A comprehensive understanding of the performance of the practice was maintained. The practice nurse monitored achievement against clinical indicators in QOF and reported if there were areas which required focus.

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

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

- The CMP understood the risks to the service and kept them under scrutiny through the risk register. For example, we saw the practice had developed their own internal policies and procedures to mitigate risk due to low staffing numbers. For example, the practice recognised with new staff arriving frequently that they may not be familiar with administration processes and the nuances of the patient population and so developed a step by step guide to common processes for them to refer to.
- Plans were in place for major incidents and staff were familiar with how to respond to a major and/or security incident. However, the plan needed updating.
- Practice leaders had oversight of national and local safety alerts.

### **Appropriate and accurate information**

The practice generally had 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. A practice wide meeting was held every two weeks and had provided a forum for effective discussion and shared learning. Minutes from meetings we reviewed demonstrated that key agenda items had been discussed including safeguarding, NICE guidance and CAS alerts. Meetings were used for forward planning, for example, to ensure that patient needs were met during busy clinic times and periods of staff sickness.

### **Continuous improvement and innovation**

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

- The physiotherapist has set up an innovative specific staged rehabilitation program utilising research evidence to assign patients to a progressive scheme for return to their activities. This includes an abundance of patient information material, with clear pictures and instructions that

have been specifically and individually created for the unit's patient population. This has been shared with unit's who have similar patient populations.