Kineton Medical Centre

Quality report

Kineton Marlborough Barracks
Temple Herdewyke
Warwickshire
CV47 2UL

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30 April 2019

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

Ratings

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

Chief Inspector's Summary

This practice is rated as inadequate overall

The key questions are rated as:

Are services safe? – inadequate
Are services effective? – inadequate
Are services caring? – requires improvement
Are services responsive? – requires improvement
Are services well-led? – inadequate

We carried out this comprehensive inspection of Kineton Medical Centre on 30 April 2019. For reasons of availability, the rehabilitation element of the inspection was undertaken on 1 May 2019. Defence Medical Services (DMS) are not registered with the CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014 and are not required to be. Consequently, DMS services are not subject to inspection by the CQC and the CQC has no powers of enforcement. This inspection is one of a programme of inspections that the CQC will complete at the invitation of the Surgeon General in his role as the Defence Authority for healthcare and medical operational capability.

At this inspection we found:

- Systems were in place to safeguard and support patients who were vulnerable.
- The arrangements for managing medicines stock needed improving.
- High risk medicines were being appropriately managed. Shared care agreements were in place for patients who needed them.
- A system for managing incidents and significant events was in place and all staff were familiar with how to report a significant event.
- Duty of candour principles had not been consistently adhered to.
- Staffing levels at the practice were not sufficient to meet the needs of the patient population at all times.
- Processes to manage risk were inadequate, including those related to health and safety, information management systems and monitoring/search systems to ensure patients were recalled in a timely way for reviews, screening, vaccinations and occupational medicals.
- Processes to promote effective staffing were undeveloped, including access to mandated training and training relevant to the needs of the population, such as managing thermal injuries. Clinical supervision and peer review were not consistent or effective across all staff groups.
- Medical cover was in place on weekdays between the times when the practice closed and NHS 111 commenced providing medical cover.
- Staff understood the Mental Capacity Act (2005) and how it applied in the context of the service they provided.
- Staff respected the privacy, dignity and confidentiality of patients.

- The governance of the practice was underdeveloped, including quality improvement activity. There were insufficient GP hours to provide effective clinical leadership. The practice was not sufficiently supported by the regional team.

The Chief Inspector recommends:

- A review of all patient records to ensure patients are recalled in a timely way for reviews, screening, vaccinations and occupational medicals.
- A comprehensive whole-system governance review of the service that takes account of:
    - the sufficiency of current provision of GP services and staffing levels;
    - contract monitoring arrangements;
    - arrangements for clinical leadership;
    - quality improvement activity, including clinical audit;
    - arrangements for regular and effective communication with the chain of command;
    - peer review for clinicians, including review of clinical records;
    - systems to support effective staffing, including training, supervision, appraisal and peer review;
    - medicines management;
    - support from the regional team
- A programme of relevant and targeted clinical improvement work should be developed to improve patient outcomes and care.

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

Our inspection team

The inspection was led by a CQC inspector and included a GP, practice manager, practice nurse and physiotherapist specialist advisors. A GP specialist advisor and CQC inspector shadowed on this inspection.

Background to Kineton Medical Centre

Kineton Medical Centre provides routine primary health care and occupational health to a small patient population of 200 service personnel. The patient population comprises three military units and a security unit.

Medical cover is provided through a contract with an NHS primary care practice, located three miles away. Three NHS GPs provide 10.5 hours of medical care each week with one of the GPs identified as the clinical lead. A primary care rehabilitation facility (PCRF) is based at the practice.

The practice is open 08:00 to 16:30 Monday to Thursday and on Fridays from 08:00 to 13:00.

Patients have access to a GP at the practice during the following times:
Monday 08:00 to 09:30

Tuesday 08:00 to 09:30
Wednesday 08:00 to 09:30
Thursday 08:00 to 12:30
Friday 08:00 to 09:30

Outside of these times patients can attend the local NHS primary care practice and access NHS 111 from 18:30.

The staff team

Position	Numbers
Two NHS GPs, one with responsibility for clinical leadership	Six hours cover each week between the two GPs
CMPs	Two covering a total of 4.5 hours per week
Practice nurse (Band 6)	One full time (no nurse available at the time of inspection)
Practice manager	One full time
Administrative staff	One full time
PCRF	One part time physiotherapist 15 hours per week with an additional seven hours overtime
Other	Community psychiatric nurse based at the practice two days per week

Are services safe? | Inadequate

We rated the practice as inadequate for providing safe services.

Safety systems and processes

Systems were in place to keep patients safe and safeguarded from abuse.

- A framework of regularly reviewed safety policies was in place and accessible to all staff working at the practice. Staff received safety information about the practice as part of their induction and refresher training.
- Measures were in place to protect patients from abuse and neglect. Adult and child safeguarding policies were available to all staff. All staff had received up-to-date safeguarding training appropriate to their role and knew how to identify and report concerns. Staff were aware of who the safeguarding lead and deputy were for the practice. Both had completed level 3 training. The lead GP was the deputy safeguarding lead and had assumed the lead role while the practice nurse was absent from the service.
- The practice manager emailed the local safeguarding team should any contact be required in relation to the families of service personnel.
- Coding and alerts were used on the electronic patient record system (referred to as DMICP) to identify patients who were vulnerable. The practice manager developed a vulnerable patient register when they took up post at the practice recently. The lead GP discussed patients who were vulnerable with the chain of command if it was appropriate to do so.
- Staff who acted as chaperones were trained for the role and had been subject to safety checks to ensure they were suitable to work with young people and vulnerable adults. All staff had

received chaperone training and notices were displayed advising patients that a chaperone was available.

- The full range of recruitment records for permanent and locum staff were held centrally. The practice manager could demonstrate relevant safety checks had taken place at the point of recruitment, including a Disclosure and Barring Service (DBS) check to ensure staff were suitable to work with vulnerable adults and young people. DBS checks were renewed every five years. The GPs were on the performers list and had DBS checks undertaken as part of that process. The performers list is a process that provides an extra layer of reassurance for the public that NHS GPs are suitably qualified, have up to date training and have passed other relevant safety checks to ensure they can provide a service to vulnerable people.
- A role specific induction was being developed. For example, a specific induction was being put together in the event that a locum nurse would be recruited.
- Arrangements were in place to monitor the registration status of clinical staff with their regulatory body. All staff had professional indemnity cover.
- The practice nurse was identified as the lead for infection prevention and control (IPC). In their absence, the practice manager had taken on the role temporarily. An IPC audit had been completed by the regional nurse a week prior to the inspection but the report of this audit had not been processed. The practice manager was unaware if previous IPC audits had been undertaken. We supported the practice manager with accessing the electronic repositories (Moss and Meridio) where previous audits were likely to be held but we were unable to locate any IPC audits.
- The practice had a dedicated external contractor cleaner who worked to a cleaning schedule. The cleaning manager carried out monthly audits; audits over the last three months identified no concerns. A deep clean was carried out in September 2018.
- Clinical waste was stored in locked yellow bins but these were not secured to prevent them being moved. The practice manager provided us with the consignment notes for 2019. They were unaware of where the consignment notes prior to this year were stored. Clinical waste was removed twice weekly with sharp waste removed monthly. Waste medicines were returned to the supplying pharmacy.

Risks to patients

Processes to assess and manage risks to patient safety were not adequate.

- The practice nurse was absent from the service for an undefined time period at the time of the inspection. The regional nurse was providing some clinical support while the regional team was in the process of sourcing alternative nursing input, including the option of a locum nurse. With no nurse and the GP provision of 10.5 hours per week, clinical availability was limited. Patients had the option of seeing a GP or nurse at the NHS practice located approximately three miles away. The limited time available from the GPs to see patients had been added to the risk register.
- The physiotherapist had a contract for 15 hours per week with ongoing weekly overtime of seven hours. They did not have the support of an exercise rehabilitation instructor (ERI) or unit physical instructors. They had raised business cases for a review of their hours and for an ERI but had not received a response.
- A locum specific induction pack was being developed to orientate and support locum staff with practice working systems.

- The practice was equipped to deal with medical emergencies. In the absence of the practice nurse, the emergency medicines and equipment were checked daily by the practice manager. Not all staff were not up-to-date with training to manage medical emergencies. The training records showed that just two staff were in-date for basic life support training. Not all staff had received training in sepsis and thermal injuries.
- The waiting area could not be observed by staff and the practice manager had secured CCTV. A request had been sent to the Support Unit for it to be installed.

Information to deliver safe care and treatment

Information processes to support staff with providing patients with safe care needed strengthening.

- The new guidance on registering and deregistering patients (DPHC standard operating procedure GN28) had not been implemented. Beyond new service personnel registering with the practice on arriving and being invited to attend for a new patient registration medical, there was no formal scrutiny and summarisation of medical records taking place. A search showed that 184 out of 200 currently registered patients had not been summarised.
- Staff described occasional freezes or lost connectivity with DMICP. The patient appointment list was printed so in the event of no access to DMICP, the list was used and consultation notes scanned onto DMICP at a later point.
- A process of peer review of clinical records was in place for the GPs and was undertaken annually. The physiotherapist's clinical note keeping was subject to a review by the Regional Rehabilitation Unit (RRU) in September 2018. In addition, there was not a process in place to monitor the quality of the nurse's record keeping until the regional nurse carried out a formal records review in April 2019.
- Patients could have an appointment at the NHS GP practice if out-of-hours or if no GP was available. There was no process in place to monitor the numbers of patients attending this practice. Furthermore, there was no protocol or process in place for the transfer of NHS consultation records to Kineton Medical Centre so they could be included in the patient's DMICP record.
- There was an effective system in place for the management of referrals and the administrator oversaw the process. Two referral registers were in operation; one for referrals by a GP to external agencies and one for referrals made by the physio internally. Urgent referrals were highlighted on the registers in red. The registers were monitored weekly, including assurance that the referral had been received. In addition, a check was made to confirm whether the patient attended the appointment. The physiotherapist also kept and maintained their own register of referrals.
- In response to concerns about the management of specimens, the practice reviewed and revised the system, including liaison with Lablinks. Failsafe measures were introduced; barcodes to monitor the receipt of test results, revision of the specimen log to include recording if any action was required and the development of a dedicated pathology link register for GPs to complete. In addition, a standard operating procedure had been implemented and a protocol developed for the transportation of specimens from the medical centre to the NHS practice. A tracking system was maintained and a monthly search carried out to monitor the throughput of samples.

Safe and appropriate use of medicines

The management of medicines needed improving.

- The lead GP was responsible for medicines management at the practice. All prescriptions and dispensing were outsourced to a local pharmacy. Medicines, including vaccines, medical gases and emergency medicines were stored securely.
- Although we found medicines were in-date, there was no stock management system in place so the practice was unable to clearly account for the input and output of medicines. Medicines requiring refrigeration were monitored twice a day to ensure they were stored within the correct temperature range. Blank prescriptions were securely stored and their use monitored. Patient Group Directions (PGD) had been developed to allow the nurse to administer medicines in line with legislation These were up-to-date and signed by the SMO.
- A list of high-risk medicines (HRM) was identified for the practice. A register to monitor the prescribing of HRM had been set up this year and searches of patients prescribed HRM were carried out in March and April 2019.
- We reviewed the clinical records for the three patients identified on the HRM register and noted they were being monitored appropriately and coding consistent. A shared care agreement was in place for the patients who required this. Patients on HRM were also discussed at the integrated practice and clinical meetings.

Track record on safety

Health and safety processes were undeveloped.

- The practice manager was the lead for health and safety. A safety, health, environmental and fire risk assessment (referred to as a SHEF assessment) had been completed but not signed off. Risk assessments pertinent to the practice, including risk assessments for products hazardous to health were not available and the practice manager was unable to confirm if they were in place.
- The Support Unit was responsible for electrical, gas and water safety checks. The practice manager tried unsuccessfully to secure information to confirm these safety checks had been completed, including evidence to support that a legionella risk assessment had been undertaken. The absence of evidence to confirm water safety checks were taking place had been added to the risk register.
- Fire safety management arrangements included regular checks and testing of firefighting equipment. Staff were up-to-date with fire safety training and had participated in an evacuation exercise in April 2019. Arrangements were in place for the monitoring and maintenance of equipment. Testing of portable electrical appliances and medical equipment was in-date.
- A risk assessment and policy were in place to support the physiotherapist with the safe delivery of acupuncture. Staff had access to personal alarms to summon assistance in the event of an emergency.

Lessons learned and improvements made

Processes to learn from and make improvements when things go wrong needed to be strengthened.

- Significant events were managed through an electronic organisational-wide system (referred to as ASER). The system was also used to report incidents, near misses and examples of good practice. All staff had access to the system so could report concerns they identified. There had been no established forum to discuss significant events and lessons learnt until health governance meetings were set up this year.

- The practice manager carried out daily checks for any new alerts or updates. All alerts were logged and those relevant to the practice were circulated to staff via email. There was no recorded evidence of the action taken in response to alerts.

Are services effective?	Inadequate

We rated the practice as inadequate for providing effective services.

Effective needs assessment, care and treatment

The practice assessed needs and delivered care in accordance with relevant and current evidence based guidance and standards.

- Processes were established to ensure clinical staff were kept up-to-date with evidence based guidance and standards, including guidance from the National Institute for Health and Care Excellence (NICE). The practice received the DPHC newsletter that included NICE and medicines management updates. Although not evident from the minutes, staff said NICE guidance was discussed at the practice meetings.
- The physiotherapist referenced best practice guidelines in their treatment of patients, such as the Defence Rehabilitation website. With no access to an ERI or unit physical instructors, the physiotherapist was facilitating rehabilitation classes herself twice a week on a four week rolling programme.

Monitoring care and treatment

Data collected for the Quality and Outcomes Framework (QOF) was not being consistently used to monitor health 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 nurse was the lead for long term conditions (LTC) management and maintained a chronic disease patient register. In the absence of the practice nurse, we carried out our own searches of DMICP and determined the following patient outcomes:
    - Eight patients were recorded as having high blood pressure. All had a record for their blood pressure taken in the past nine months and five had a blood pressure reading of 150/90 or less.
    - Three patients were recorded as having diabetes. Two had a last measured total cholesterol of 5mmol/l or less which is an indicator of positive cholesterol control. Two had a last blood pressure reading of 150/90 or less which is an indicator of positive blood pressure control.
    - Six patients had a diagnosis of asthma and all had an asthma review in the preceding 12 months which included an assessment of asthma control using the three Royal College of Physicians questions.
- We identified concerns in relation to consistency which could likely impact the validity of QOF data produced from DMICP. Some searches were incorrectly set up. For example, depending on how we searched, the numbers of patients with an LTC varied slightly. Searches were not

always reliable due to inaccurate Read coding. As an example, a patient was coded as having 'hay fever with asthma' despite not having a formal diagnosis of asthma.

- There was not a clearly defined system for recalling patients with LTCs and it was being undertaken on an ad hoc basis. For example, searches for patients with hypertension and patients with asthma were carried out in January 2016 and repeated in March 2019. Given the small number of patients with LTC, we were able to review the majority of the clinical records. A consistent approach, such as the DMICP asthma template was not being used for reviews. For example, some patients had their asthma reviewed in ways other than through recall, such as through the Joint Medical Employment Standard (JMES); this is a medical to inform the chain of command of the employability and deployability of service personnel.
- We discussed with the doctor the management of patients with a mental health need and were assured that patients were well managed and receiving care appropriate to their needs. We confirmed this through a review of clinical records. Clinicians were mindful of the impact the occupational role could have on the mental health of patients and ensured any concerns or disclosures were discussed as a multi-disciplinary team. Clinicians had a good knowledge of where to signpost patients to for additional support, such as welfare.
- GPs adopted the Read codes used by the Department of Community Mental Health (DCMH) and referred patients to the DCMH in accordance with policy. A community psychiatric nurse (CPN) spent two days per week at the practice. The lead GP did not have capacity to attend the Unit Health Committee (UHC) meetings so had discussions with the chain of command about any patients who were vulnerable due to their mental health.
- 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). A risk was identified at the practice meeting on 25 April 2019 that over 50% of the patient population would shortly be out-of-date for audiometric assessments. Current figures showed that the practice had succeeded in reducing this figure; our search showed 83% of patients had received an audiometry assessment with 33 patients waiting to be recalled. The clinical records we looked at showed audiometric assessments were appropriately recorded in accordance with the Hearing Conservation Programme.
- Quality improvement activity was very limited at the practice, including clinical audit activity to measure the effectiveness of care. Two first cycle clinical audits were completed in 2019; minor surgery and clinical record keeping. We were not provided with evidence of clinical audits before 2019. A prescribing audit was undertaken at regional level for the timeframe January to March 2018.
- The physiotherapist collated musculoskeletal health questionnaire scores for all patients and analysed the data. Furthermore, in 2017/18 the physiotherapist led on a quality improvement project (QIP) to successfully reduce injury rates by 50%. This involved setting up rehabilitation classes and education for the unit regarding suitable physical training. The physiotherapist undertook this QIP despite working part time and with no access to an exercise rehabilitation instructor or qualified unit physical training instructors (referred to as RAPTCI). They have been unable to maintain this impressive level of improvement due to a lack of unit assets.

Effective staffing

Processes to ensure staff had the skills, training and support to deliver effective care and treatment were not adequate.

- The induction process was under review as it was last updated in 2015. The regional team had provided a generic induction pack for all staff and an induction pack for locum staff. The practice manager was the most recently inducted member of staff and we established that the induction was not sufficient.
- Staff training had not been effectively monitored until the practice manager took up post. The database showed a large number of gaps in mandatory training. The practice manager was trying to establish if staff had completed the training and it had just not been recorded. This included contacting the NHS primary care practice to determine the mandatory training GPs had completed and whether it met the requirements of the DPHC. The practice manager had plans to timetable protected time for staff training each month.
- The practice manager had completed the DMS official practice management course. There was no evidence of any other formal training to support the practice manager in their role. The support from regional headquarters was not sufficient given the development needs of the service that we identified.
- Due to absence of the nurse, the practice manager (a combat medical technician by trade) was undertaking clinical tasks such as audiometric assessments and dressing changes. The practice manager was not up-to-date with clinical training and competency checks. Although this was identified on the risk register, we highlighted to the regional manager that there was a risk to patient care with the practice manager continuing to practice clinically.
- The GPs received peer review, supervision and appraisal through their NHS practice. All GPs were suitably trained in occupational health to effectively meet the needs of the patient population.
- For clinicians working as lone professionals, support was not adequate. The practice nurse was supervised remotely from Lichfield Medical Centre and attended the clinical meetings at Lichfield. There had been no process of peer review, including a review of clinical records for the nurse until a review shortly before this inspection. The physiotherapist received remote support and supervision from Lichfield which involved a remote appraisal once a year. The physiotherapist kept up-to-date by attending regional in-service training on a quarterly basis at the regional rehabilitation unit (RRU).

Coordinating care and treatment

Systems to inform the chain of command of employability and deployability of service personnel were not reliable.

- The practice manager and practice nurse attended the unit health committee (UHC) meetings, a forum for unit commanders, the welfare team and clinicians to discuss patients' needs, including occupational health updates. Due to limited working hours, the lead GP and physiotherapist did not have capacity to attend the meeting. They either met with or spoke with the chain of command to provide updates on individual patient's needs.
- The needs of patients who were downgraded in terms of deployability were discussed at the UHC meetings. We noted that searches to monitor the numbers of downgraded patients were not being regularly carried out. For example, a search for patients classified as MLD (medically limited deployable) was undertaken in April 2016 and next repeated in January 2019.
- We determined that 12 out of 200 patients were out-of-date for their medical health occupational health reviews. All except one had been recalled and had an appointment booked. There was no identified recall system in place for occupational health medicals.

- The clinical records we looked at showed appropriate staff, including those in different teams, services and organisations were involved in assessing, planning and delivering care and treatment.
- Through the networks established by the GPs from the NHS primary care practice, there were good links with local health and social service teams. Clinicians worked closely with the RRU and the DCMH and had links with the local midwifery service and podiatry team.
- Patients due to leave the military received a pre-release and final medical. Due to conflicting views from staff, it was unclear whether a summary and authorisation form for the next GP to access the patient's records was being completed. There was no signposting to support services for patients leaving.

Helping patients to live healthier lives

Processes to support patients with maintaining a healthy lifestyle were undeveloped.

- The practice nurse was the health promotion lead. A national calendar for health promotion was in place and based on national priorities and initiatives to improve the population's health. Health promotion displays were located in the waiting area and included a stop smoking display, information about antibiotics and skin cancer. The physiotherapist had an information board for patients outside the PCRF. Health promotion fairs were held on the camp base. The physiotherapist was unable to attend due to limited working hours. It was unclear if the practice was represented at these events.
- The lead GP was the sexual health lead. Clinicians referred patients to the walk-in sexual health clinic in Banbury.
- A smoking cessation clinic was previously held at the practice. This was no longer available and staff were unable to explain why it had ceased. Information was available to signpost patients to external alcohol, drug and gambling services.
- DMICP searches to identify patients eligible for a cervical smear and participation in other national screening programmes were not being carried out on a regular basis. For example, a DMICP search for patients due a smear was carried out in 2009 and repeated in 2018. We searched the system and identified 20 patients who met the criteria for cervical screening; they were all in-date for a smear. Our searches identified no patients eligible for any of the other national screening programmes, such as bowel and breast.

It is important that military personnel have sufficient immunity against the risk of contracting certain diseases. The World Health Organisation sets a target of 95% for vaccination against diphtheria, tetanus, pertussis and polio and measles, mumps and rubella.

The following illustrates the current vaccination data for patients using the practice:

- 89% of patients were recorded as being up to date with vaccination against diphtheria.
- 81% of patients were recorded as being up to date with vaccination against polio.
- 52% of patients were recorded as being up to date with vaccination against hepatitis B.
- 87% of patients were recorded as being up to date with vaccination against hepatitis A.
- 81% of patients were recorded as being up to date with vaccination against tetanus.
- 85% of patient were recorded as being up to date with vaccination against typhoid.

It was identified at a practice meeting on 25 April 2019 that vaccinations were not up-to-date for patients and a plan was put in place to recall patients. In the absence of the practice nurse, the

regional nurse had been facilitating vaccination clinics. The above figures show an improvement in the vaccination rates since the practice meeting.

Consent to care and treatment

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

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making, including the key principles of the Mental Capacity Act. They supported patients to make decisions. GPs monitored the process for seeking consent appropriately through the process of peer reviewing clinical records. Consent was taken for minor surgery and this was monitored through a minor surgery audit. The physiotherapist took written consent when treating a patient with acupuncture.

Are services caring?	Requires improvement

We rated the practice as requires improvement for caring.

Kindness, respect and compassion

Staff supported patients in a kind and respectful way.

- Throughout the inspection staff were courteous and respectful to patients arriving for their appointments.
- Results from the January to March 2019 patient experience survey (67 respondents) indicated that patients were treated with dignity and respect. The eight CQC comment cards completed prior to the inspection were all complimentary about the caring attitude of staff.
- The practice had an information network available to all members of the service community, known as HIVE and information about the service was displayed in the waiting area. It provided a range of information to patients who had relocated to the base and surrounding area. Information included resources at the unit, civilian services, including healthcare facilities.

Involvement in decisions about care and treatment

Staff supported patients to be involved in decisions about their care. Processes were underdeveloped to identify and support patients with a caring responsibility.

- The patient survey indicated respondents felt involved in decisions about their care. Feedback on the CQC patient feedback cards highlighted that patients received information about their treatment to support them with making informed decisions about their treatment and care.
- In relation to physiotherapy and rehabilitation, expectations were discussed with each patient to ensure bespoke goals and a treatment plan was identified for the patient.
- An interpretation service was available for patients who did not have English as a first language. Not all staff were aware of this service and there was no information available or displayed informing staff and patients of this service.
- A carers' register was not developed until this year. The first DMICP search for carers was carried out in April 2019 with two patients identified on the register. Staff acknowledged there could be more carers and anticipated the introduction of the new patient registration process would provide the opportunity to identify further carers. No information was displayed advising patients to identify if they had a caring responsibility. We noted from the minutes of the practice meeting in April 2019 that the two carers identified were to be offered the flu vaccine for the next flu season and that an information pack was to be issued to carers.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Clinic room doors were closed during consultations. Privacy screening was provided in consulting rooms for when patients were being examined or treated. There were no privacy curtains or screening in the physiotherapy room but only one patient was seen at a time and the door was closed.
- The waiting area was located away from the reception minimising the risk of conversations being overheard. If patients wished to discuss sensitive issues or appeared distressed at reception they could be offered a private room to discuss their needs.
- Patients had the option of seeing a male or female GP. A female GP from the NHS primary care practice provided the cervical screening service. The physiotherapist was female so patients could be referred to Lichfield PCRF if they wished to see a male.

Are services responsive to people's needs? | Requires improvement

We rated the practice as requires improvement for providing a responsive service.

Responding to and meeting people's needs

The practice organised and delivered services to meet patient needs and preferences.

- Both the patient experience survey and CQC feedback comment cards completed prior to the inspection highlighted that the practice was responsive with securing an appointment and that patients were satisfied their needs were being met.
- The practice manager had started an access audit for the premises as defined in the Equality Act 2010 but was not confident they had the skills to complete the audit. They had sought advice from RHQ. We observed that reasonable adjustments had been made as the medical centre was accessible via automatic doors, wide corridors and doorways.
- The practice manager was the equality and diversity lead. Guidelines, such as trans-gender, had not been accessed but the practice manager had plans to introduce this.

Timely access to care and treatment

Patients had restricted access to appointments.

- With no nurse and the GP provision of 10.5 hours per week, clinical availability was limited. Triage for emergencies (referred to as sick parade) was usually carried out by the practice nurse and, with no nurse available, patients were being seen directly by the GP. Patients had the option of seeing a GP or nurse at the NHS practice located approximately six miles away.
- Telephone consultations were routinely available. Home visits had not been requested and we were advised that they would be managed on a case-by-case basis. There was no standard operating procedure outlining the process to facilitate a home visit.
- The PCRF had adopted the direct access to the physiotherapy (DAP) service directive introduced in February 2018. Seventy-five percent of attendance at the PCRF was through DAP, including telephone consultations. The PCRF was meeting its targets for seeing patients. A new patient would generally be seen within five to 10 working days.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information was outlined in the patient information leaflet to support patients with understanding the complaints process.
- The practice manager was the lead for complaints. A process was established to record and manage complaints. This was communicated to patients through the practice leaflet. The practice received two complaints in the last 12 months and both had been managed effectively.

Are services well-led?	Inadequate

We rated the practice as inadequate for well-led.

Vision and strategy

A vision statement was identified and the practice had some work to do to achieve this.

- The DPHC vision was identified as, 'Safe practice – by design'. The specific vision for Kineton Medical Centre stated, 'Safe, patient-centred care'. Due to gaps in service monitoring, recall processes and staffing resources, the practice was not achieving the DPHC or its own vision at the time of the inspection.
- The PCRF effectively worked to the vision of, 'Education, empowerment, recovery'

Leadership capacity and capability

There was insufficient leadership capacity at the practice.

- GP provision was provided under a Primary Health Care contract with an NHS primary care practice located three miles away. One of the GPs was identified as the lead GP and worked at Kineton Medical Centre six hours a week split over two days. This time was used predominantly to provide patient care. From our interviews with staff, we determined the lead GP had insufficient time to support with effective and consistent clinical leadership at the practice.
- A new practice manager was appointed in December 2018 and had been managing the practice for three months following a period of induction and handover. The practice manager said the handover was inadequate and they relied on their previous two year experience managing a primary care practice.
- Evidence gained during the inspection suggested the practice manager would benefit from an increase in regional support to coordinate and deliver a management action plan for the practice in order to achieve the vision. The input of a military nurse would add to this, particularly with ensuring systems are set up and effectively managed regarding the occupational health needs of the patient population. We understand attempts had been made to assign a military nurse without success.
- The physiotherapist was contracted to work 15 hours per week with an unusual long-term arrangement of seven hours overtime each week. These hours were not sufficient as the physiotherapist did not have the support of an exercise rehabilitation instructor or access to qualified physical training instructors and had no administrative support for the PCRF. In addition, the physiotherapist did not have sufficient time to attend the UHC meetings.

Culture

Processes to ensure staff were included, valued and supported needed strengthening.

- Not all staff felt respected, supported and valued at both practice and regional level. Staff had ideas and plans to develop the service, including promoting a patient-centred focus, but did not always feel they were listened to. Staff we spoke with said they were comfortable raising

concerns but were not always confident their concerns would be effectively addressed. The support from RHQ was not sufficient given the development needs of the service that we identified. This view was echoed by the staff team throughout the inspection.

- The practice had not always adhered to the requirements of the duty of candour. We noted that patients were not informed, given reasonable support and an apology when their test results were sent to the incorrect location. 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. A duty of candour register was not in place.
- Openness and honesty was demonstrated when the practice responded to patient complaints.

Governance arrangements

Governance arrangements were in the early stages of development.

- There was a staffing structure and staff had allocated roles and responsibilities, including delegated lead roles in specific topic areas. There were insufficient staff numbers to ensure all lead roles were effectively covered, including when staff were absent from the service. Additional roles and responsibilities were not reflected in terms of reference and/or job descriptions.
- The practice manager introduced the health governance workbook this year and it was in the early stages of development at the time of inspection. The workbook brings together a comprehensive range of governance activities, including the risk register, significant events tracker, lessons learnt log, training register, policies, meetings, quality improvement and audit.
- Communication and information sharing systems had recently been strengthened, including the development of structured practice meetings, clinical meetings and multi-disciplinary meetings. These were well attended by the staff team. Clinicians said patient care would benefit from increased multi-disciplinary discussion time.
- Quality improvement activity was underdeveloped, particularly clinical audit. Staff said audits had been lost with a system change. We were provided with no evidence to confirm this was the case. The practice manager had started a quality improvement activity register. There was no indication of quality improvement since 2016 until two items were added to the register in 2019.

Managing risks, issues and performance

Processes for managing risks, issues and performance were undeveloped.

- The practice manager had started to identify, understand, monitor and address current and future risks, including risks to patient safety. However, the risk register was underdeveloped as it had not identified all the risks we found with the service. It also included ‘issues’ which were more appropriate to be included on an issues register, which had not been developed.
- A business continuity plan was in place but had not been reviewed for some years. Staff were unaware of the major incident plan for the camp.
- Performance management was lacking. Peer review and staff supervision processes had not identified the concerns we found with clinical record keeping. In addition, the clinical record keeping audit undertaken in January 2019 was not broad enough to include all clinicians therefore had not identified the issues we found.
- We were advised by the area manager that contract monitoring meetings took place in relation to the GP contract. These meetings were not recorded.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- The internal quality assurance tool, the DMS Common Assurance Framework (CAF) was being 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 domain of the CAF was reviewed at each of the health care governance meeting.
- We were advised that an external assurance visit (referred to as the HGAV) was undertaken in August 2018. A report was not produced and staff were not aware of the findings of the HGAV.
- External practice reviews took place, such as a service review and advisory visit of the PCRF by the RRU in April 2018.

Engagement with patients, the public, staff and external partners

The practice involved patients, staff and external partners to provide feedback on the service.

- A patient experience survey was undertaken throughout the year and a suggestion box was in the patient waiting room. A patient participation meeting was organised last year but no patients turned up. The practice was looking at alternative ways to encourage patients to provide their views about the service. It was clear that the practice acted on patient feedback. For example, condoms were provided and rehabilitation classes were instigated based on patient feedback.
- The practice was not as engaged with the unit commanders as it would have liked. Developing effective relationships may have been hampered by limited participation at UHC meetings.

Continuous improvement and innovation

Examples of improvement made to the service include:

- Resolving the concerns with specimen management through a review and revision of the system
- Strengthening the system to ensure the effective monitoring of referrals.
- Introduced the use of ‘tasks’ on DMICP.

In addition, the physiotherapist had analysed data to support the need to initiate improvements to rehabilitation but was hampered by a of lack of unit level support to enable progress.