

Collingwood Medical Centre

Quality report

Newgate Lane
Fareham
PO141AS

Date of inspection visit:
15 May 2019

Date of publication:
10 July 2019

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

Ratings

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

Chief Inspector's Summary

We carried out an announced comprehensive inspection of Collingwood Medical Centre on 26 September 2018. The practice was rated as inadequate overall, with a rating of inadequate for the key questions of safe, effective and well-led. Caring and responsive were rated as good.

We carried out this announced follow up inspection on 15 May 2019. This report covers our findings in relation to the recommendations made and any additional findings made during the inspection.

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

[Collingwood Medical Centre, Fareham, September 2018](#)

At this second inspection, the practice is rated as good overall.

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 Director Healthcare in his role as the Defence Authority for healthcare and medical operational capability.

At this inspection we found:

- The majority of the workload for Collingwood Medical Centre is musculoskeletal and mental health. The delivery of care to meet this need was responsive and effective.
- A small proportion of the practice workload (less than 10% of activity) involved chronic disease management and this had improved since our previous inspection.
- High risk drugs management had been reviewed and safe processes were now in place and being followed.
- The practice had systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them.
- Management and identification of vulnerable patients had improved and staff understood their role in this.
- The practice fostered an ethos of patient centred care.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- A review of inconsistent clinical coding was underway and there was evidence that the medical centre was better able to review the effectiveness and appropriateness of the care it provided.

However, there was still work to do. The practice had taken steps to assure itself that care and treatment was delivered according to evidence-based guidelines.

- Patients found the appointment system easy to use. Physiotherapy target access indicators were not always met, although access was superior to equivalent NHS services. Waits to see an aviation qualified clinician had reduced since our last inspection.
- The programme of quality improvement work had been widened to achieve improved outcomes for patients.
- Communication across the practice had improved, although there was still scope to hold a joint clinical meeting to ensure that key messages and learning reached all clinicians.

We saw one area of notable practice:

Medics had completed a blood sample bottle labelling audit which resulted in the medical centre enquiring about a sample bottle label printing process in DMICP. The labels were subsequently provided by the local hospital trust. This resulted in a 'purple ASER' and has been recognised by DPHC as a notable practice for wider sharing.

The Chief Inspector recommends:

- Improving Access to Psychological Therapies (IAPT) was not available to patients at Collingwood Medical Centre as funding had not been secured. We have noted that IAPT is made available to patients in some regions, but not all and we have fed this finding back to DMSR (Defence Medical Service Regulator) and DPHC (Defence Primary Healthcare). IAPT services provide evidence based treatments for people with anxiety and depression and can be especially helpful for patients whilst they are waiting to be seen by DCMH staff.
- Consider ways to increase clinical contact time and so improve access to care within the PCRf.
- Code all patients who were also carers so that extra support or healthcare can be offered as required.

Dr Rosie Benneyworth BM BS BMedSci MRCP
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 second CQC inspector, a GP specialist adviser, a practice nurse specialist adviser, a practice manager adviser, a medicines team inspector and a PCRf adviser.

Background to Collingwood Medical Centre

Collingwood Medical Centre is located in Fareham near Portsmouth. The treatment facility offers care only to forces personnel. Dependants and children must register at an NHS practice. At the time of inspection, the patient list was approximately 2200. The practice holds an out of hours clinic once a month for Reservists.

In addition to routine GP services, the treatment facility offers physiotherapy services and travel advice. The medical centre does not provide minor surgery. Family planning advice is available, with referral onwards to NHS community services. Maternity and midwifery services are provided by NHS practices and community teams.

At the time of our inspection, the facility had a Principal Medical Officer (PMO is a lead GP), a Deputy Principal Medical Officer (DPMO) and four civilian GPs, two practice nurses, a locum pharmacy technician who worked in the practice dispensary and nine medics (the work of a military medic has greater scope than that of a health care assistant found in NHS GP practices). The facility was led by a military practice manager, supported by a deputy and a number of administrative staff. The facility was also attached to a primary care rehabilitation service (PCRF) which provided physiotherapy and exercise rehabilitation. The PCRF was led by a band 7 physiotherapist and employed a further three physiotherapists and two exercise rehabilitation instructors. A Regional Clinical Director assumes overall accountability for quality of care at the Medical Centre and we interviewed them as part of this inspection.

Are services safe?

Good

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. As the practice supports seven different operational units, the commitment to attend all unit health committees and health and welfare meetings was significant and so not always possible. However, there were arrangements in place to ensure that welfare concerns were shared both by and with the medical centre in order to safeguard patients who are permanent staff.
- 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, including locums. They outlined clearly who to go to for further guidance.
- At our last inspection, some clinical staff we spoke with were unaware of the system which had been recently implemented to highlight vulnerable patients in clinical records and clinical staff could not point us to a risk register of vulnerable patients. At this inspection all clinical staff we spoke with could demonstrate to us how to use an alert in DMICP (the patient electronic record system). We looked at four alerts on patient records and noted that confidential information was visible on the screen which all practice staff with access to records would be able to see. The practice rectified this following our feedback.
- The practice worked with other agencies to support patients who are trainees and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. Since our last inspection, the arrangements in place to protect patients who are permanent staff had been clarified. Practice staff attended as many meetings with welfare teams and Chain of Command as they could to discuss the needs of this population group. If Chain of Command had concerns about any individual, they knew that they could contact the practice quickly by telephone to discuss their concerns with a clinician. The practice liaised with local NHS Accident and Emergency departments to facilitate protection plans when required. There was a military clinical presence within the local A&E department.
- 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 Disclosure and Barring Service (DBS) check.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. DBS checks were undertaken where required. The anomalies found at our last inspection had been addressed. (DBS checks

identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

- 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. There was no sign to state where oxygen was being stored. However, the practice have put this in place and sent us photographic evidence post inspection.

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.
- There was an induction system in place for temporary staff and this had been tailored to their role.
- Clinicians adhered to military guidance around sickness periods for personnel. They communicated effectively with 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.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.
- When there were changes to services or staff, the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

- At our previous inspection we identified that staff did not always have the information they needed to deliver safe care and treatment to patients because individual care records were not always written and managed in a way that kept patients safe. Read coding errors meant that the medical centre could not easily search for cohorts of patients to ensure best delivery of care. Since September 2018, the practice had worked hard to review clinical notes and address Read coding errors. The practice acknowledged that there was still work to be done, but we noted that the direction of travel was positive.
- The system to manage hospital letters was effective. Hospital letters were scanned and tasked to a clinician for their review. The system to manage pathology results was effective.
- There was no backlog in electronic summarising at the practice. Summarising was undertaken by medics who passed on information to clinicians about patients with a long term condition or who are currently downgraded. The notes of new patients without obvious pre-existing conditions were summarised by medics and a Read code applied to show that this had been done. Since our last inspection there had been oversight of this process by a clinician.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. There was a documented approach to the management of test results. Medics had completed a blood sample bottle labelling audit which resulted in the medical centre enquiring about a sample bottle label printing process in DMICP. The labels

were subsequently provided by the local hospital trust. This resulted in a 'purple ASER' and has been recognised by DPHC as a notable practice for wider sharing.

- Referrals and hospital appointments were managed well by the administrative team and patients were well supported to obtain the most timely access to secondary care. A standard referral template letter was in use by clinicians and an audit had been done to ensure that referrals were being written in the most effective way.
- Access to clinical records in DMICP was sometimes delayed due to connection issues at Collingwood Medical Centre and staff told us that there was a time lag, specifically on medication pages. However, staff did not report any significant periods where they had had no access to the system and they told us that patient safety had therefore not been compromised.

Safe and appropriate use of medicines

- There was an appropriate system in place for the safe handling of medicines:
- The systems for managing and storing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice had carried out an appropriate risk assessment to identify medicines that it should stock. The practice kept prescription stationery securely and monitored its use. The storage issues that we identified at the previous inspection had been addressed, including safe storage of medicines in doctors' bags. The medical centre had received an exemption certificate from the local Police Constabulary Controlled Drug Liaison Officer which stated that storage of controlled drugs was exempt from the requirements set down by The Misuse of Drugs Act 1973 (safe custody regulations).
- There was a named GP responsible for the dispensary.
- Access to the dispensary was restricted to authorised staff only. As on our first inspection, there was no lock on the vaccines fridge. However, the room was lockable and the practice have confirmed that the lock was used at night and that an accountable staff member carried a key during the working day.
- Written standard operating procedures (SOPs) were in place to support safe dispensing practice. There was a system for staff to record that they had read and understood them. Since the first inspection, the locum pharmacy technician had read the SOPs in their entirety and signed the proforma to confirm this.
- An antibiotic prescribing audit update had been undertaken since the last inspection to ensure that prescribing practice was in line with local guidelines. We saw recent input from a regional pharmacist in terms of prescribing and dispensing support and oversight, in addition to audit work around prescribing for patients with long-term conditions. The practice had started a programme of peer review of prescribing.
- The practice had worked hard to improve monitoring of patients' health and to ensure medicines were being used safely and followed up appropriately. A register of patients taking high risk drugs had been established and alerts were now in place in DMICP records. Staff we spoke with were now aware of the Defence Primary Health Care (DPHC) DMARDs policy. Patients who took DMARDs (disease-modifying anti rheumatic drugs) had shared care protocols uploaded into their notes and we saw evidence of recall dates being set for blood testing.
- Since the last inspection, the medical centre had conducted searches to ensure that patients currently using an ACE inhibitor (angiotensin converting enzyme inhibitors are medicines used to treat high blood pressure, scleroderma and migraines amongst other conditions) or ARBs (angiotensin receptor blockers are used to manage high blood pressure, treat heart failure and reduce risk of stroke) had had their renal function checked in the last 12 months.

- Prescriptions were signed before medicines were dispensed and handed out to patients.
- The management of repeat prescriptions had been reviewed to ensure that patients taking high risk drugs had the relevant monitoring checks before their repeat prescription was issued.
- 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 PMO had been recorded. Authorisation for PSDs was now in line with DPHC PSD policy and there was evidence to show that the prescriber had carried out the required clinical checks.

Track record on safety

- The practice had a good safety record, although staff at the medical centre were open about the risk of injury associated with HMS Collingwood hosting the Field Gun Race on site.
- The practice manager was the lead for health and safety and had completed training relevant for the role. 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.
- Staff had been issued with new personal alarms since our last inspection and these were now loud enough to attract attention. However, this was not the case for any staff who were lone working in the rehabilitation gym. We were told that the Exercise Rehabilitation Instructor did work alone at times. A risk assessment had been undertaken to mitigate concerns as far as possible, given the location of the gym. A statement of need has been submitted for a new built in alarm system to be installed throughout the medical centre.
- Since our last inspection, the major incident plan to guide a response in the event of multiple casualties had been reviewed. It was noted that HMS Collingwood hosts the Field Gun Race which involves personnel pushing a heavy field gun at pace and the presence of public observers. There has been a history of casualties both during training and on the day of the event. The responsibility for provision of medical cover was shared across all attending units with The Field Gun Officer holding the lead. Shared medical cover arrangements for the Field Gun Race had been agreed and were to be provided with support from an external provider. Collingwood Medical Centre were clear that their role is to provide basic first aid to military personnel.

Lessons learned and improvements made

- There was a system for delivering learning and making improvements when things go wrong.
- There was a system and policy for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so. At our previous inspection we identified that the locum pharmacy technician, a member of the reception team and a locum GP did not have a login for the ASER system and so could not report incidents. This had been rectified. An ASER tracker was introduced following inspection feedback.
- There were systems for reviewing and investigating when things went wrong. There was evidence that the practice learned and shared lessons, identified themes and took action to improve safety in the practice. Staff we spoke with could recall the learning from some recent significant events and we saw that a whole practice meeting had been established to ensure that all staff were party to discussions. Staff had recently received training around the use of the ASER system.
- Since our previous inspection, a system for receiving and acting on patient safety alerts had been established. CAS (Central Alerting System) alerts were now routinely forwarded to

clinicians for their review and action. A tracker had been implemented to show when DMICP searches had been conducted in accordance with specific drug recalls. Staff were unable to show us evidence of these searches within DMICP on the day of the inspection, although they have since provided evidence to us post inspection.

- Patients who we previously identified as taking contra-indicated medicines had been reviewed to ensure that prescribing practice was safe.

Are services effective?

Good

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. At our last inspection we saw instances where these were not being followed to deliver care and treatment that met patients' needs, specifically the management of DMARDs. At this second inspection, work was ongoing to ensure that best practice guidelines were being followed. Clinical meetings had been held, including a joint meeting between HMS Collingwood, Southwick Park and HMS Sultan and minutes contained a record of discussion of best practice guidance. Our review of patient notes showed that these discussions were leading to improvements in clinical practice. Peer review between GPs had been extended and peer review of prescribing practice had commenced.

- The Defence Primary Health Care (DPHC) Team produced a newsletter that was circulated to clinicians providing further information and a summary of relevant safety updates. Staff we spoke with could refer to this and gave examples of updates they had acted on and discussed within the practice.

Monitoring care and treatment

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

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

- There were five patients on the diabetic register. We reviewed the treatment and care offered to all these patients and found that current NICE guidance had been followed. For four of these diabetic patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For one diabetic patient, the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control. All diabetic patients had been referred to clinics and study days run by the local hospital.
- There were 41 patients recorded as having high blood pressure and 37 patients had a record for their blood pressure taken in the past nine months. Six of these patients had a blood pressure reading of 150/90 or more. We reviewed the treatment and care offered to four hypertensive patients and found that improvements had been made in line with national guidelines. At our last inspection we had found that some hypertensive patients who were prescribed medication to manage their condition had not been appropriately recalled. We also noted Read coding errors. The DPMO (Deputy Principal Medical Officer) had undertaken work

to address the risks and improve care for these patients. He confirmed that the Read coding work was ongoing and that he was in the early stages of establishing a 'long-term conditions working group'.

- There were 17 patients with a diagnosis of asthma. Following our initial inspection, the DPMO had worked to improve the recording and Read coding around asthmatic care. All patients had had an asthma review in the preceding 12 months which included an assessment of asthma control using the three RCP (Royal College of Physicians) questions. Staff had agreed to use a consistent template to record asthma reviews (one which prompted decision making around immunisations). We looked at care records for four asthmatic patients and noted that care was in line with national clinical guidelines.
- At our previous inspection, due to the number of different Read codes in use, the practice could not easily provide information about patients with a new diagnosis of depression. A civilian medical practitioner (CMP) came into post in January 2019 and had taken on the lead for mental health. She had undertaken an audit of all 70 patients with a mental health diagnosis. She identified three patients with a new diagnosis who had not been reviewed within the NICE guidance timeline and these were discussed at the clinical meeting for shared learning. Clinicians referred patients who needed input from the department of community mental health (DCMH) to Portsmouth and staff confirmed that patients were generally seen promptly. Air traffic control personnel had to be referred to Brize Norton DCMH and waiting times for these patients to be seen was longer. In the interim, clinicians were able to provide cognitive behaviour therapy, online mindfulness courses and signpost patients to the 'big white wall' and 'mood gym'. Staff confirmed that in the region where Collingwood sits, Improving Access to Psychological Therapies (IAPT) was not available to patients as funding had not been secured. IAPT services provide evidence based treatments for people with anxiety and depression and can be especially helpful for patients whilst they are waiting to be seen by DCMH staff. We have noted that IAPT is made available to patients in some regions, but not all and we have fed this finding back to DMSR (Defence Medical Service Regulator) and DPHC (Department of Primary Healthcare).
- Data showed that instance of audiometric hearing assessment was below target. Service personnel may encounter damaging noise sources throughout their career. It is therefore important that service personnel undertake an audiometric hearing assessment on a regular basis (every two years). Data from May 2019 showed that 70% of patients' audiometric assessments were in date (within the last two years). DPHC do not have comparative local or national data. Staff confirmed that they had had difficulty attaining the audio requirement due to patients being deployed. We saw that additional clinics had been arranged to address the backlog.
- The medical centre had undertaken additional quality improvement work, including clinical audit, and there were signs that this was beginning to deliver improved outcomes for 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 and commenced since our last inspection, including audits of diabetic, hypertensive and asthmatic patients, patients with a mental health diagnosis and also blood samples and antibiotic prescribing. These clinical audits were relevant to the practice population and we saw evidence that they had triggered improvements in outcomes for patients. Some audit work was entering its second cycle.

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. At our last inspection we noted some gaps in training for practice staff, but training had either been delivered or booked by the time of this second inspection.
- 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 strong regional peer network which facilitated extended learning and sharing of best practice.
- The locum pharmacy technician was registered with the General Pharmaceutical Council. They had completed mandatory training, including use of DMICP. The locum agency provided formalised competence assessment for the locum pharmacy technician.

Coordinating care and treatment

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

- Through the Care and Welfare Steering Group, the practice met with welfare teams and line managers to discuss vulnerable patients who were both trainees and permanent staff. Staff told us that they had forged some strong links with other stakeholders, including the Collingwood Welfare and Education Steering Group, RNRM Welfare service and Collingwood Chaplaincy. There were established links with military clinicians in the local A&E department who prompted protection plans as required. There was no formalised process for a nominated Link worker at DCMH. Primary care clinicians were required to contact DCMH and discuss patients with different named clinicians or a duty CPN.
- PCRf staff fostered close working relationships with Naval line managers to ensure that trainees were appropriately supported to recover. Patients we spoke with highlighted how this supported them to get back into training when the risk of re-injury was reduced.
- The Medical Centre is located within the same building as the PCRf service which provides physiotherapy assessment and treatment. An exercise rehabilitation service is also available for patients, a five-minute walk from the medical centre. Referral into the service is via a primary care clinician. 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.

Helping patients to live healthier lives

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

- Patients at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. The medical centre liaised with Queen Alexandra Hospital and referred diabetic and asthmatic patients to clinics and study days run by the hospital.
- 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.
- The number of women aged 25 to 49 and 50 to 64 whose notes recorded that a cervical smear had been performed in the last three to five years was 148 out of 165 eligible women. This represented an achievement of 94%. The NHS target was 80%.
- There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using public health information posters and they ensured a female sample taker was always available.

The DPMO had undertaken the 'sexually transmitted infection foundation course' training and staff had leaflets around sexual health to give to patients. Patients could access an online sexual health advice system and referrals to a sexual health consultant could be made as required.

It is important that military personnel have sufficient immunity against the risk of contracting certain diseases. The World Health Organisation sets a target of 95% for vaccination against diphtheria, tetanus, pertussis and polio and measles, mumps and rubella. The data below from May 2019 provides vaccination data for patients using this practice:

- 89% of patients were recorded as being up to date with vaccination against diphtheria compared to 86% regionally.
- 89% of patients were recorded as being up to date with vaccination against polio compared to 86% regionally.
- 95% of patients were recorded as being up to date with vaccination against Hepatitis B.
- 95% of patients were recorded as being up to date with vaccination against Hepatitis A, compared to 91% regionally.
- 89% of patients were recorded as being up to date with vaccination against Tetanus, compared to 87% regionally.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance. Verbal consent was recorded in DMICP in a free text box. PCRf staff took written consent for acupuncture procedures.

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

When providing care and treatment for young recruits aged between 16 and 18 years, staff carried out assessments of capacity to consent in line with relevant guidance.

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff explained that they saw patients from a variety of cultural backgrounds and who spoke English as a second language. The medical centre had taken account of patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- We received 40 patient Care Quality Commission comment cards in total. Of these, 35 were positive about the service experienced, four were mixed and one was negative. Patients praised the proactive and supportive approach of the medical centre staff and felt that a good service was being provided. One patient had experienced delays in their care.
- 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 clinicians and staff at the practice demonstrated that they recognised that the trainee personnel they provided care and treatment for, could be making decisions about treatment for the first time. We asked staff for examples of trainees they had seen and they provided a number of examples to demonstrate that they had supported younger people to access the treatment they required in an appropriate way. We spoke with patients who were attending for physiotherapy appointments and they told us that they were well supported to understand their injury, to set realistic personal goals and to commit to their care plan in order to achieve best results in terms of their recovery.
- Interpretation services were available for patients who did not have English as a first language. Staff demonstrated to us that they could access this service and gave examples of when they had used the system.
- 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 March 2019 (64 responses were collated) showed patients felt they were involved in their treatment:
 - 100% of patients who provided a response said GPs involved them in decisions about their care.
 - 98% of patients who responded said that their privacy and dignity were respected.
- The data presented by the practice was not benchmarked against regional and national averages for DMS, or against the previous year's performance.

- Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of organisations. We saw information that was age appropriate and relevant to the patient demographic which was prominently displayed and accessible. For example, we saw posters for symptoms that may suggest a sexual health screening appointment would be useful and on the importance of vaccinations, spotting potential signs of sepsis and the significance of health checks for over 40s.
- 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.
- Practice staff told us that they had recently started to identify patients who were also carers, although codes were not yet added to their records in order to make them identifiable and so that extra support or healthcare could be offered as required. One carer had been identified to date. The DPMO had recently started attending a carers' meeting.

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.
- The practice had identified the fact that conversations with receptionists could be overheard by patients in the waiting room, due to the open plan nature of the waiting area. Music and television had been provided to assist with privacy.

Are services responsive to people's needs?	Good
---	-------------

We rated the practice as good for providing responsive services

Responding to and meeting people's needs

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

- The practice understood the needs of its population and tailored services in response to those needs. For example, the language support requirements for international personnel, proactive support and advice for patients over 40, access to telephone consultations and quick access to physiotherapy and exercise rehabilitation. Furthermore, we saw examples of the medical centre proactively finding ways to meet the health and wellbeing needs of certain patient groups. Yoga and relaxation sessions were being provided for patients experiencing anxiety and pregnant women were all invited to access general advice about exercising during pregnancy and activity adjustments from the PCRf. The practice had written an information leaflet targeted at and circulated to patients over 40 years old. It detailed the importance of reducing risks associated with type 2 diabetes, heart disease, stroke, high blood pressure and dementia through positive lifestyle choices. We saw evidence that the direct engagement with this age group of patients had led to an increase in patients enrolling for health checks. Recently two patients had been diagnosed with type 2 diabetes as a result.
- The facilities and premises were bespoke and appropriate for the services delivered.
- At our previous inspection, the medical centre did not routinely offer home visits to its patients and there was no policy available to staff or patients around when a home visit might

be necessary and appropriate. A policy had been implemented in April 2019 outlining how the needs of vulnerable patients who were unable to attend an appointment should be met. Staff liaised regularly with the local district nursing team to provide nurse visits.

Timely access to care and treatment

- Routine appointments are usually available within two weeks. We checked on the day of our inspection and the next available routine appointment was in five days. Urgent appointments are available on the same day. Access to see an Aviation Medical Officer had improved: patients could be seen daily at 'fresh cases', routine appointments were available within approximately three working days and Annual Aircrew Medicals were currently available within six working days.
- Outside of routine clinic hours, cover was provided by a medic, with back up telephone support provided by a GP. From 18:30 hours, patients were given a mobile number to contact the duty medic who provided overnight cover. The medic provided basic advice and triaged patients, diverting them to the NHS 111 service as appropriate. Line managers of phase two trainees valued the input of duty medics at night if a trainee became ill. However, duty medics were unable to visit patients after hours and so were triaging by telephone only. If the practice closed for an afternoon for training purposes, patients were diverted to a local medical centre. In this way, the practice ensured that patients could directly access a GP between the hours of 08:00 and 18:30, in line with DPHC's arrangement with NHS England.
- The practice leaflet gave clear directions on local accident and emergency unit access. The nearest accident and emergency department was located at Queen Alexandra Hospital.
- The Defence Rehabilitation Headquarters collates a dashboard of information in relation to waiting times and patients who do not attend for their appointment. These are key performance indicators as timely access to physiotherapy and rehabilitation are important for effective patient recovery. Collingwood PCRf was performing slightly below the target for access to physiotherapy. However, we noted that urgent appointments had been made available for patients that needed them.
- For January to March 2019, 68% of new patients (who were trained staff) referred to see a physiotherapist were seen within 10 working days. In addition, 39% of new patients (who were trainees) were seen within the target of three days. DPCH does not currently provide regional or national comparative data. Further review of the key performance indicators showed that data entry errors (which have subsequently been resolved) had contributed to this poor performance. We noted a lack of PCRf administrative support and therefore clinical time was being lost to administration. The PCRf were recruiting to a physiotherapist post and this was impacting access to care. There was no available performance information around access to an ERI as this was no longer requested centrally. Collingwood PCRf plans to adopt a direct access approach, allowing patients to self-refer. Where other PCRfs have adopted this approach, some patients have reported that they have been more inclined to seek support.
- The PCRf proactively managed DNA (patient who did not attend) rates for their clinics and had achieved above average results with 5% of patient appointments lost to DNAs in February 2019, compared with a PCRf average of 7%.
- Results from the practice's patient experience survey (64 responses were received) showed that patient satisfaction levels with access to care was high:
 - 100% agreed that access to routine care and treatment was good
 - 87% agreed that access to out of hours care was good
 - 90% agreed that access to telephone consultation was good

- We spoke with three patients in the waiting room on the day of our inspection. They all told us that they could secure appointments when they needed them and were confident that they would be seen quickly if they had an urgent concern.

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.
- We spoke with three patients who told us that they felt comfortable and knew how to complain if the need arose. They confirmed that military rank would not be a barrier to them raising issues with the practice.
- We reviewed complaints that had been submitted by patients in the past 12 months. We saw that there were processes in place to share learning from complaints. Complaints management was comprehensive.

Are services well-led?	Good
-------------------------------	-------------

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

Leadership capacity and capability

Some leaders at the medical centre had been in their current roles for less than a year and were working hard to address some areas they had identified as requiring improvement. The DPMO had been deployed overseas and was due to deploy again soon. Significant work had been undertaken to ensure that care for patients had improved since our last inspection at Collingwood Medical Centre. As at our previous visit, we met with a staff team who were open and transparent about the issues they needed to address. They had listened to the feedback we gave in September and had worked to address the risks and concerns we raised.

Staff we spoke with referred to a 'positive working environment' and told us that they enjoyed coming to work. All staff felt that they could raise concerns if they had them. A practice-wide meeting had been established where all staff could get together to share and learn from key messages.

- The Principal Medical Officer's time was divided across two practices including Collingwood. This was a reduction from the three practices he was previously overseeing. He was well supported by an able management team who had undertaken significant improvement work.
- Leaders were more knowledgeable about issues and priorities relating to the quality of services. As a result, key risks were being addressed.

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 and some key systems had been reviewed to make them more effective:

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Leaders and managers had taken action to address gaps in the performance of the practice, specifically the management of high risk medicines and long term conditions, safeguarding of vulnerable patients, the establishment of a programme of clinical improvement work and the management of Central Alerting System alerts.
- 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. Opportunities for staff to have positive influence on the practice had been extended due to the establishment of a regular practice wide forum.
- 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 Medical Centre was in the process of consolidating and clarifying responsibilities, roles and systems of accountability to support good governance and management and the practice acknowledged that more work was required in some areas.

- Joint working with the welfare team, pastoral support and Chain of Command was in place with a view to safeguarding vulnerable personnel and ensuring co-ordinated person-centred care for these individuals. All staff were now aware of the system in use to identify vulnerable patients and vulnerable patients were discussed at every sub-department meeting and whole practice meeting as required.

- The PCRf delivers rehabilitation services from a building close to the medical centre. The service enables patients to access timely, holistic care. Staff working within the PCRf felt integrated within the medical centre team and we were told that communication and leadership arrangements had improved.
- Shared care protocols were now in place for some patients taking high risk drugs and progress had been made in the effective management of patients with a long-term condition. Where no shared care protocol was held by the medical centre, the date of request was recorded. Where local NHS Trusts classed a drug which required special monitoring as amber, this was recorded as a high risk alert in the patient's care record.
- Practice leaders had established a number of policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.
- A joint clinical meeting had taken place between HMS Collingwood, Southwick Park and HMS Sultan and there were plans to hold this meeting on a termly basis. Weekly clinical meetings were taking place and physiotherapists the CMP and ERI attended these. The practice manager confirmed that the agenda was being modified to include nurses going forward.
- A programme of clinical improvement work was being implemented and was starting to drive improvements in patient outcomes.

Managing risks, issues and performance

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

- Following our initial inspection, practice leaders had improved oversight of national and local safety alerts.
- Clinical audit was starting to have an impact on quality of care and outcomes for patients. We were shown clear evidence of action to change practice and improve quality.

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 number of different meetings were held regularly and we feel that there is still scope to introduce a meeting for all clinicians to attend. A practice wide meeting had been established 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.
- At our previous inspection we identified that information used to monitor performance and the delivery of quality care was not always accurate and useful. Since then, staff had worked to ensure that Read coding for specific patient cohorts was applied more consistently. Where Read coding remained an issue, clinicians had reviewed the care given to individual patients to ensure that it was in line with national guidelines. Staff had agreed to use consistent clinical templates to ensure more standardised delivery of care for patients.
- Since the last inspection, a register of patients taking high risk drugs had been established and all staff were aware of a register of vulnerable patients.
- There were robust arrangements at the medical centre in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. This extended to the PCRf.

Continuous improvement and innovation

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

- We saw examples of the practice focussing on continuous learning and improvement. For example, staff had identified the need to change the blood labelling system following a significant event. In addition, services had been extended to meet patient needs, including the introduction of relaxation classes for patients experiencing anxiety and advice for pregnant women from the PCRFB.
 - Civilian staff provided stability and continuity of care through periods of change in military staffing. Staff contracted in from Interserve were long standing members of the practice team and had devised failsafe and effective systems for managing referrals and hospital appointments. The practice-wide meeting now provided an opportunity for them to put more of their ideas for improvement forward and to extend their involvement in practice issues.
 - The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
 - Nursing staff were part of a supportive interregional network which facilitated clinical supervision and ideas sharing.
-