Boulmer Medical Centre

Quality report

Longhoughton
Alnwick
Northumberland
NE66 3JF

Date of inspection visit:
29 May 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 from our ongoing monitoring of data about services, and information given to us from the provider and other organisations.

Ratings

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

Chief Inspector's Summary

We carried out an announced comprehensive inspection of RAF Boulmer Medical Centre on 14 November 2017. The practice was rated as requires improvement overall, with a rating of requires improvement for the key questions of effective, responsive and well-led. Safe was rated as inadequate and caring received a rating of good.

We then carried out an announced focussed follow up inspection on 5 September 2018. The practice had not improved and was rated as inadequate overall, with a rating of inadequate for the key questions of safe, effective and well-led. Responsive was rated as requires improvement.

A copy of the previous inspection reports can be found at:
https://www.cqc.org.uk/what-we-do/services-we-regulate/defence-medical-services

We undertook this announced comprehensive follow up inspection on 29 May 2019. This report covers our findings in relation to the recommendations made and any additional findings during the inspection.

As a result of this inspection the practice is rated as requires improvement overall.

The key questions are rated as:

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

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 follow-up 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:

- There was an open and transparent approach to safety. An effective system was in place for managing significant events and staff knew how to report and record using this system.
- Safeguarding systems were effective in ensuring vulnerable patients, including young people were monitored.
- Leadership capacity had improved and the planned model of clinical provision was based on improving continuity of care and reducing risk to patients. Some improvement was needed in leadership capability.
- Governance structures had been strengthened, although there was scope for further improvement, including a review of governance of the Primary Care Rehabilitation Facility (PCRF).

- Staff induction, training and supervision arrangements were not sufficient.
- Improvement was needed in how high risk medicines were managed.
- Staff were aware of current evidence based guidance. They worked collaboratively and shared best practice to promote better health outcomes for patients.
- There was evidence to demonstrate quality improvement was starting to embed in practice, including the development of an annual programme of clinical audit.
- The practice sought feedback from staff and patients which it acted on. Results from a recent patient survey showed patients were treated with compassion and were involved in their care and decisions about their treatment.
- Information about how to complain was available for patients.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

The Chief Inspector recommends:

- A review of service information to ensure it is up-to-date, accessible and reflects current provision. The review should take account of operational policies, standard operating procedures, risk assessments, the business continuity plan and major incident plan.
- A standard operating procedure for the provision of acupuncture is developed.
- An induction programme specific to the practice should be developed so visiting clinicians and locums are supported with understanding practice processes and systems.
- A review of staff training and support arrangements to ensure staff have access to sufficient training and supervision so they effectively deliver care to meet the needs of the patient population.
- Clinical records should be regularly audited to ensure the improvement in record keeping is maintained.
- Further develop the practice system for tracking and monitoring referrals to include referrals made by the physiotherapist.
- Review the process for monitoring high risk medicines, taking account of routine searches and the use of Read coding.
- Review the process for direct access to physiotherapy (DAP) to ensure it is delivered in line with organisational policy.

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

Our inspection team

Our inspection team was led by a CQC lead inspector and included a range of specialist advisers: a GP, practice nurse, practice manager, pharmacist and physiotherapist.

Background to Boulmer Medical Centre

Boulmer Medical Centre is located near the town of Alnwick, Northumberland and provides primary care, occupational health and a rehabilitation service to patient population of 594 service personnel, including Phase 2 trainees. There were four registered patients under the age of 18 and one patient aged over 50 at the time of the inspection. Occupational health services for approximately 100 personnel based at RAF Spadeadam is also provided by the practice. Families and dependants are not registered at the practice and are signposted to local NHS practices.

The practice is open Monday, Tuesday and Thursday from 08:00 to 17:00, Wednesday from 08:00 to 12:00 (staff training in the afternoon) and Friday from 08:00 to 16:00. Out-of-hours cover medical cover is provided by Leeming Medical Centre. From 18:30 weekdays, weekends and public holidays patients are advised to use NHS 111.

The staff team

Position	Numbers
Senior medical officer (SMO)	Temporary SMO cover from Newcastle Medical Centre
Medical Officers (MO)	Provided on a rotational basis by other local medical centres, mainly Leeming Medical Centre
Civilian Medical Practitioner	One post – currently vacant
Practice nurses	One (30 hours per week)
Practice manager	One
Administrative staff	Three
Primary Care rehabilitation Facility (PCRF)	One physiotherapist (three days per week); one exercise rehabilitation instructor

Are services safe? | Requires improvement

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

Following our previous inspection, we rated the practice as inadequate for providing safe services. The rating related to the risks associated with: information to deliver safe care and treatment; safe and appropriate use of medicines; staffing levels and processes for learning and making improvements when things went wrong.

At this inspection, we identified the majority of the shortfalls had been addressed with some further improvements needed. The practice is now rated as requires improvement for providing safe services.

Safety systems and processes

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

- Measures were in place to protect patients from abuse and neglect, including adult and child safeguarding policies and local safeguarding contact details. All staff had received up-to-date safeguarding training at a level appropriate to their role. The practice manager checked the status of safeguarding training for locum and visiting doctors. The Senior Medical Officer (SMO) and the practice nurse were the safeguarding leads for the practice.

- The paper copies of the child and vulnerable adult policies that were displayed for staff to reference were not current as they were older versions than those available on-line.
- Appropriate codes and alerts were used to highlight vulnerable patients. A search was undertaken each month for vulnerable patients to ensure the register held on the electronic patient record system (referred to as DMICP) was current. An informal weekly team meeting (referred to as the safety huddle) was used to discuss concerning patients.
- All staff had received chaperone training and notices advising patients of the chaperone service were displayed in clinic rooms. Staff had been subject to safety checks to ensure they were suitable to work with young people and vulnerable adults.
- The full range of recruitment records for permanent staff was held centrally. However, the practice could demonstrate that relevant safety checks had taken place at the point of recruitment, including a Disclosure and Barring Service (DBS) check to ensure staff, including locum staff and visiting doctors were suitable to work with vulnerable adults and young people. DBS checks were renewed every five years.
- Arrangements were in place to monitor the registration status of clinical staff with their regulatory body. All staff had professional indemnity cover. A check was in place to monitor the hepatitis B vaccination status of staff.
- There was an effective process to manage infection prevention and control (IPC), including a lead for IPC who was suitably experienced and skilled for the role. Quarterly IPC audits were undertaken and a full audit completed by the practice nurse from Newcastle Medical Centre in November 2018. Actions identified had been addressed.
- The physiotherapist practiced acupuncture. A defence regional assurance visit on 10 May 2019 identified that a standard operating procedure (SoP) was not available for this procedure. We were not provided with an acupuncture SoP at this inspection.
- Environmental cleaning was provided by an external contractor twice a day who worked to cleaning schedules. Arrangements were in place to monitor cleaning standards. A deep clean of the premises was not included in the contract and the need for this was currently being discussed. We identified no concerns with the cleanliness of the premises.
- Systems were in place for the safe management of healthcare waste. Consignment notes were retained at the practice and an annual waste audit carried out in April 2019 showed 100% compliance.

Risks to patients

Systems were established to assess, monitor and manage risks to patient safety. Some improvement was needed.

- Since the previous inspection the contract with the local primary care practice for provision of a GP service had expired. The practice had unsuccessfully tried on three occasions to recruit a civilian medical practitioner (CMP) and were due to re-advertise the position. Clinical sessions had been facilitated through the use of locum GPs and by doctors at other defence medical centres. The practice identified that this arrangement did not fully support consistent patient care and access to the required skill set, such as aviation medicine. From June 2019, it had been negotiated that Leeming Medical Centre would provide Boulmer Medical Centre with doctors, all of whom were skilled and experienced in aviation medicine.
- A checklist was in place for a locum's first day at the practice. There was not a specific detailed induction in place for visiting doctors, including locums, to familiarise them with the specific

working processes for Boulmer Medical Centre and information about local NHS and social services. We noted some of the significant events related to locums and/or visiting doctors who were not aware of processes at the practice, such as safeguarding. One of the doctors at Leeming Medical Centre had developed an induction pack but it had yet to be introduced.

- The physiotherapist was not in work at the time of our inspection. Locum cover was being provided where possible. There was no induction pack specific to the Primary Care Rehabilitation facility (PCRF) for a locum to refer to.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures, including staff trained in basic life support and intermediate life support. An emergency kit, including a defibrillator, oxygen with masks and emergency medicines were accessible to staff in a secure area of the practice; all staff knew of its location. A first aid kit and accident book were available. Daily checks were in place to ensure the required kit and medicines were available and in-date.
- Staff were up-to-date with the required training for medical emergencies. A policy and flowchart were available to support staff with the identification and management of sepsis. Staff could access sepsis training on-line, although it was not being monitored as to whether staff had completed the training. Similarly, staff had not received training in thermal injuries but flow charts were displayed in clinical areas to support staff with identifying and managing a thermal injury.

Information to deliver safe care and treatment

Information to deliver safe care and treatment to patients had improved.

- At the previous inspection we identified inconsistencies and gaps in record keeping, including the use of Read codes and DMICP templates. At this inspection, we looked at 25 clinical records and found that record keeping had improved. The patient's pathway was clearer and easier to track. This was supported by a consistent use of Read coding and templates. Decision making, particularly those in relation to occupational matters, were now being documented. A process, such as a records audit, was not in place to ensure this improvement in record keeping was maintained.
- A process was established for the scrutiny and summarising of patients' records. Due the current staffing gaps, we were advised the Regional Clinical Director (RCD) had agreed to defer the introduction of the new Defence Primary Healthcare (DPHC) patient registration process. Instead, new patients completed an arrival sheet. Administrative staff no longer summarised or Read coded clinical records and this role was now assigned to the practice nurse. At the time of the inspection, 76% of the records had been summarised.
- Staff described occasional loss of connectivity with DMICP, two to three times each month for approximately two hours at a time. If this happened, the business resilience plan was followed and only emergency patients were treated.
- The process for managing referrals had improved since the last inspection. For example, the Read code for patients referred to the Department of Community Mental Health (DCMH) was now consistently used. Internal and external referrals, including urgent referrals, were coordinated by the doctor, tasked to a dedicated member of the administrative team who then monitored their progress. The physiotherapist monitored the referrals they made, including those to the Regional Rehabilitation Unit (RRU) and other services. In the absence of the physiotherapist, the exercise rehabilitation instructor (ERI) or dedicated referral lead had no means of tracking the referrals made.

- The process for the management of specimens and test results had improved since the last inspection. Protocols had been developed and a clear system was established to track the progress of specimens and results. The practice nurse checked the system two daily. Specific time slots were allocated to the doctors to check results. If a doctor was not available then the SMO or a doctor at Leeming Medical Centre was contacted.

Safe and appropriate use of medicines

Improvements had been made to the management of medicines systems. Further improvement was needed.

- The practice nurse was the lead for medicines management. Safe procedures were in place for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment.
- Stock medicines were regularly checked. No controlled drugs were held on the premises. Medication requiring refrigeration was monitored twice a day to ensure it was stored within the correct temperature range. Prescription forms were securely stored and their use monitored.
- Patient Group Directions (PGD) had been developed to allow appropriately trained nurses to administer medicines in line with legislation. The PGDs were current and signed. A recent audit completed by the SMO showed PGDs were appropriately used.
- Repeat prescriptions were safely managed with only written requests accepted. Patients on long-term medicines were reviewed in a timely way by the doctor and the consultation documented, including the assignment of an appropriate Read code. A process was in place to update DMICP if changes to a patient's medication was made by secondary care or an out-of-hours service.
- In relation to the management of patients prescribed high risk medicines (HRM), the doctor recorded the review dates for prescription monitoring, including the frequency for blood testing. Alerts were used to identify patients on HRM and shared care agreements (SCA) were in place for the patients that required them. Two patients on 'red' medicines (prescribed by a hospital consultant) were not identified on searches due to a Read code not being assigned.
- The duration between DMICP searches for HRM was not consistent; we noted a gap of four months since the previous search. A search had not been undertaken to ensure a named medicine had not been prescribed for women of childbearing potential.
- Two registers for HRM were in use but they did not synchronise. After the inspection, the SMO confirmed that one of these registers had been removed and the most comprehensive one (maintained by the practice nurse) retained. The doctors providing a service at the practice were made aware of this change.

Track record on safety

The practice had a good safety record. There was scope for further improvement.

- Measures to ensure the safety of facilities and equipment were in place. Health and safety checks were undertaken by external contractors. Electrical and water safety checks were up-to-date. A fire risk assessment of the building was undertaken annually. Firefighting equipment tests were current. Staff were up-to-date with fire safety training and were aware of the evacuation plan.
- Risk assessments pertinent to the practice and gym (where the ERI worked) were in place, including those for hazardous substances, operating electrical equipment and lone working. Some of these risk assessments needed to be updated in accordance with DPHC policy,

including assessments relevant to the building, and outsourcing pharmaceuticals. Equipment checks, including the testing of portable electrical appliances was in-date.

- A lone working policy was in place. An alarm system was available in clinical areas to summon support in the event of an emergency.

Lessons learned and improvements made

The process for learning and making improvements when things went wrong had improved.

- Staff used the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events, incidents and near misses. All regular staff working at the practice had electronic access to the system. Staff provided several varied examples of significant events confirming that the culture of reporting incidents had improved since the last inspection.
- We looked at a selection of significant events and noted that action was taken. Action was not always taken in a timely way, such as developing an induction pack for locums and visiting GPs to ensure they were aware of practice systems. The ASER system was also used to report good practice and quality improvement initiatives.
- The practice acted on themes identified from the significant events. As a result of some events relating to visiting doctors/locums unaware of practice processes and/or inexperienced in the specific needs of the aviation population, the practice had negotiated that just Leeming Medical Centre would provide medical cover from June 2019.
- The administrative team checked each day for alerts and informed the practice nurse if any were received. Alerts were reviewed by the practice nurse who then forwarded any relevant ones to the doctors.

Are services effective? | Good

We rated the practice as good for providing effective services.

Following our previous inspection, we rated the practice as inadequate for providing effective services. The rating related to improvements needed in relation to use of evidence based practice, monitoring care and treatment and coordinating care.

From this inspection, we identified that action had been taken to address the shortfalls. The practice is now rated as good for providing effective services.

Effective needs assessment, care and treatment

Clinicians were up to date with current evidence-based practice.

- Clinical meetings were held each month and clinical leads attended these meetings, including the SMO. The minutes of the meetings from March and May 2019 showed a range of matters were discussed including audit, medication reviews, summarising and chronic disease management.
- National guidance and updates, such as NICE (National Institute for Health and Care Excellence), were not a standing agenda item at the clinical meetings and staff said these were discussed informally. We reviewed 25 clinical records and concluded that treatment and care was in line with current legislation, standards and guidance, supported by clear clinical pathways and protocols.
- The PCRF team worked to the Directory and Defence Rehabilitation (DDR) best practice guidelines. The physiotherapist was not in work at the time of our inspection and the exercise

rehabilitation instructor (ERI) was managing patients referred to the PCRF but not the direct access patients (DAP). The PCRF team held monthly meetings to discuss the progress of patients.

Monitoring care and treatment

The practice used data collected for the Quality and Outcomes Framework (QOF) 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 nurse was the lead for the management of patients with long term conditions and they carried out monthly searches, recalling patients when appropriate.

We were provided with the following patient outcomes data during the inspection:

- There were six patients on the diabetic register. Five patients had their last measured total cholesterol at 5mmol/l or less which is an indicator of positive cholesterol control. All six patients had a last blood pressure reading of 150/90 or less which is an indicator of positive blood pressure control.
- There were 29 patients recorded as having high blood pressure. All patients had a record for their blood pressure taken in the past nine months. Twenty seven patients had a blood pressure reading of 150/90 or less.
- There were five patients with a diagnosis of asthma and all had an asthma review in the preceding 12 months, including an assessment of asthma control using the three Royal College of Physicians questions. A consistent template was used for asthma reviews.

Information from the Force Protection Dashboard, which uses statistics and data collected from military primary health care facilities, was also used to gauge performance. Service personnel may encounter damaging noise sources throughout their career. It is therefore important that service personnel undertake an audiometric hearing assessment on a regular basis (every two years). Audiometric assessments were in date for 90% of patients.

Clinical audits undertaken during 2017 and 2018 included those related to cytology, diabetes and asthma. A clinical audit programme from January to June 2019 was in place and was managed by the practice nurse. Audits completed in 2019 included: the impact of direct access physiotherapy (first cycle); secondary care referral audit to review waiting times; the use of antibiotics and the medical management of patients with atrial fibrillation (abnormal heart rhythm). An audit of the management of patients with diabetes was due to take place in June 2019. Staff identified the clinical meetings as the forum for sharing and discussing the outcome of clinical audit. It was too early to see the impact of recent clinical audits undertaken.

Effective staffing

Staff were supported with training and development to enhance the provision of effective care for patients.

- A generic and role-specific induction was in place for new permanent staff to the medical centre. However, there was no specific induction pack for new PCRF staff. Mandated training was monitored by the practice manager and the staff team was in-date for required training. The

ERI was new and working through the mandatory training programme. An annual programme of ongoing development training (referred to as trade training) was in place with in-house training sessions held each month. All staff were expected to participate and deliver training. For example, the practice manager facilitated a training session on significant events in February 2019 and the practice nurse led on an audit training session in March 2019.

- Staff had specific training for their role. For example, the practice manager and administrative staff had completed the practice management course. The doctors providing a service at the practice had specific training to meet the patient population need, including Military Aviation Medical Examiner (MAME) training.
- Arrangements were in place for peer review, revalidation and appraisal. For example, the practice nurse had informal peer supervision from the practice nurse manager at Catterick Medical Centre and had an appraisal from the regional nurse. They were also supported with the revalidation process which was completed in August 2018.
- The physiotherapist received peer review by a physiotherapist from another PCRF. In the absence of the physiotherapist, the ERI was receiving supervision and peer review from a physical training instructor (PTI) at the gym. Although the PTI was ERI trained, their training was not current, so they were not in a position to provide clinical supervision.

Coordinating care and treatment

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

- 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.
- A recommendation was made at the last two inspections to review arrangements regarding the absence of clinical representation at the station welfare meetings when the health needs of patients were being discussed, including the needs of vulnerable patients. We spoke with the Welfare Officer who highlighted that discussions about the needs of vulnerable patients was limited without the presence of a clinician.
- Due to the absence of a regular doctor, the practice manager had continued to represent the practice at these meetings. The practice manager liaised with the unit and doctors prior to the meeting to determine which patients needed to be discussed. They then provided the doctor with an outcome from the meeting. The SMO confirmed that once Leeming Medical Centre started to provide regular doctors (from June 2019) then a doctor would be in regular attendance at these meetings. The ERI attended the station welfare meetings to discuss patients and the provision of rehabilitation and fitness courses.
- Patients due to leave the military received a leaving medical and a summary of their health needs to pass to their new GP. The practice also referred patients to the welfare team for support with the transition.

Helping patients to live healthier lives

The practice was proactive and sought options to support patients to live healthier lives.

- Clinical records showed that staff encouraged and supported patients to be involved in monitoring and managing their health. Staff also discussed changes to care or treatment with patients as necessary.

- The health promotion strategy was underpinned by national priorities and initiatives to improve the population's health including, stop smoking campaigns and tackling obesity. It also took account of the patient population need and seasonal variation impacting health. The practice participated in station health fairs.
- Health promotion displays were available in patient areas. These were dated and refreshed in line with the strategy. At the time of the inspection there was information displayed in the patient waiting area about alcohol use, smoking, mental health and healthy eating.
- The practice nurse had completed training in sexual health at the sexual health clinic in Morpeth. Information was available for patients requiring sexual health advice, including sign-posting to other services. Chlamydia screening kits were available for patients. If appropriate patients were referred to local genitourinary clinic for screening.
- Patients had access to appropriate health assessments and checks. Monthly searches were undertaken for patients eligible for the national screening programmes and appropriate action taken if patients met the criteria. Patients eligible for cervical screening had all received a smear.

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. Based on clinical records, the following illustrates the current vaccination data for military patients:

- 98% of patients were recorded as being up to date with vaccination against diphtheria.
- 98% of patients were recorded as being up to date with vaccination against polio.
- 88% of patients were recorded as being up to date with vaccination against hepatitis B.
- 97% of patients were recorded as being up to date with vaccination against hepatitis A.
- 98% of patients were recorded as being up to date with vaccination against tetanus.

The practice nurse carried out searches each month to check the status of vaccinations.

Consent to care and treatment

Consent to care and treatment was in line with legislation and guidance. This was not always the case for acupuncture.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We did note from our review of records that patient consent for acupuncture was not always recorded.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. Staff we spoke with were aware of the Mental Capacity Act (2005) and how it could apply to their practice.

Are services caring?	Good

We rated the practice as good 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 and comments from the January to May 2019 Patient Experience Survey showed patients were happy with how they were treated and 89% would recommend the practice to family and friends. Of the four patients we spoke with, two expressed concern about seeing different doctors. Five patients completed a CQC feedback comment card prior to the inspection. Whilst feedback was complimentary about the caring attitude of staff, comments were made about the lack of continuity of care from doctors.
- 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

Staff supported patients to be involved in decisions about their care.

- Interpretation services were available for patients who did not have English as a first language. Although staff said they had not needed to use this service, they were aware of how to access it.
- The Patient Experience Survey showed 100% of patients were involved in decisions about their care.
- The practice proactively identified patients who were also carers. Read codes to use to identify carers. A register of carers was maintained and eight carers were identified at the time of the inspection. If appropriate, the needs of carers were discussed at the weekly safety huddle meeting.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Screening was provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. Clinic room doors were closed during consultations.
- The layout of the reception area and waiting area meant that conversations between patients and reception could not be overheard.
- If patients wished to discuss sensitive issues or appeared distressed at reception, they were offered a private room to discuss their needs. A room was also available if patients wished to book a secondary care appointment with the referral administrator in private. In addition, a privacy screen had been installed outside the dispensary hatch.
- The practice could facilitate patients who wished to see a GP of a specific gender, even if that meant a patient had to travel to another medical centre.

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

We rated the practice as good for providing responsive services.

Following our previous inspection, we rated the practice as requires improvement for providing effective services. The rating related to limited access for patients who needed to see a doctor trained in aviation medicine.

From this inspection, we identified that action had been taken to address the shortfalls. The practice is now rated as good for providing effective services.

Responding to and meeting people's needs

Where possible services were organised and reviewed to meet patient needs and preferences.

- Since the previous inspection, the contract with the local NHS primary care provider had expired. Initially provision was provided through a combination of locums doctors borrowed from various defence primary care services. This approach was not meeting patients' needs or expectations due to a lack of continuity and access to aviation trained doctors. At the time of the inspection, only aviation trained doctors were providing a service. To promote continuity, from June 2019 only Leeming Medical Centre would provide doctors until such time as the practice recruited its own doctors.
- Staff understood the needs of its population and tailored services in response to those needs. For example, lower back injuries was a trend for the patient population so a back and core stability class was facilitated by the ERI.
- An access audit as defined in the Equality Act 2010 had been completed for the premises. The practice had made as much reasonable adjustment as possible. Clinic rooms were all on the ground floor. Disabled parking, a ramp and accessible WC facilities were available.

Timely access to care and treatment

Patients' needs were met in a timely way.

- The practice accommodated patients with an emergency need and staff advised us that no patients were turned away and would be seen on the same day. Routine appointments and medicals could be accommodated within four working days. Same day appointments were available for patients with an urgent need. Usually patients could see the nurse on the same day of their request.
- Arrangements were in place for patients to access Leeming Medical Centre when the practice was closed and NHS 111 out-of-hours.
- Telephone consultations were available with clinicians. Due to no regular doctors, home visits could not be facilitated at the time of the inspection.
- A direct access physiotherapy (DAP) service was in place. It was not in operation at the inspection due to the absence of the physiotherapist. Patients were being seen by the ERI or referred to another PCRF in the absence of the physiotherapist.

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 displayed in the waiting area, outlined in the practice leaflet and on the Facebook page to help patients understand the complaints process.
- The practice manager was the designated responsible person who handled all complaints. and managed complaints in accordance with the DPHC complaints policy and procedure. Both a complaints and compliments log were maintained.
- Any complaints were discussed at the practice meetings and lessons identified.

Are services well-led?	Requires improvement

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

Following our previous inspection, we rated the practice as inadequate for providing well-led services. The rating related to the risks associated with insufficient clinical leadership, limited quality improvement activity and weak risk management.

Action had been taken to address the deficits but was limited by the absence of a regular doctor for the practice. Following our review of the evidence provided, the practice is now rated as requires improvement for providing well-led services.

Vision and strategy

- The practice aimed to work to the DPHC vision of:

  "Safe practice – by design."

- The specific mission statement for the practice was:

  "Deliver safe, effective, responsive and compassionate primary care; in support of the operational requirements of RAF Boulmer."

- Since the last inspection the operational model of medical provision had changed and provision by the local NHS primary care provider had ended. Initially medical care was provided by a combination of locums and doctors borrowed from other defence primary care services. It was recognised through patient feedback and a theme of significant events that this model of provision was not meeting the need of patients, particularly in relation to the provision of continuous care.
- The practice was due to re-advertise for a Civilian Medical Practitioner (CMP). A post had also been identified for an RAF Medical Officer but it was some time before this post would be filled. As an interim measure, from June 2019 Leeming Medical Centre would solely provide Medical Officer (MO) cover for the practice. The MO rota until September 2019 showed five doctors providing cover, all of whom were trained in aviation medicine.

Leadership capacity and capability

The capacity of the leadership team had improved since the last inspection.

- The SMO from Newcastle Medical Centre, approximately 50 miles away, had been supporting the practice nurse with providing clinical leadership for the practice. This was a temporary arrangement until such time as the Medical officer post was filled. The SMO was available by telephone to respond to queries and aimed to visit the practice every two weeks. The SMO also attended clinical meetings when possible. The practice manager advised us that they received good support from the regional team.
- The practice acted in a timely way on the recommendations from the previous inspection. A management action plan had been developed and the majority of actions had been addressed.
- Lead roles, including governance roles, were assigned to individual staff but there were no deputising arrangements. For example, it was only the practice nurse who undertook clinical searches of DMICP at the practice. Having just one member of staff skilled and experienced in undertaking a specific role was a risk as there was no capability in the system if that member of staff was unavailable, particularly in the case of short notice absences.

Culture

The culture at the practice was inclusive and staff were treated equally.

- An inclusive ethos underpinned the approach of the practice. All staff had an equal voice, regardless of rank or grade. Leaders promoted involvement of staff. For example, all staff were encouraged to deliver the training programme and engage with audit.
- Staff described an open and transparent leadership style and said they would feel comfortable raising issues. They felt respected, supported and valued. Both formal and informal opportunities were in place so staff could contribute their views and ideas about how to develop the practice.
- The practice clearly demonstrated a patient-centred focus. Staff understood the specific needs population and tailored the service to meet those needs. For example, the model of medical cover was changed to ensure patients had timely access to aviation medicals.
- Openness, honesty and transparency were demonstrated when things went wrong. A no-blame culture was evident; patient feedback and significant events were seen as opportunities to improve the service.
- The practice had systems to ensure compliance with the requirements of the duty of candour, including giving those affected reasonable support, information and a verbal and written apology. 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.
- The practice actively promoted equality and diversity and staff had received training in this area.

Governance arrangements

Governance arrangements had improved since the last inspection. There was scope for further improvement.

- There was a clear staffing structure in place and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas.
- One of the administrators had the lead for maintaining the health governance (HG) workbook, a system that 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.
- Operational systems had been reviewed and revised since the last inspection. For example, the management of specimens was clearer and included a failsafe mechanism and the management of significant events was now in accordance with DPHC policy. Although the referral tracking process had been strengthened, this was not the case for PCRF referrals. The system in place was insufficiently developed to allow another member of staff to track referrals in the absence of the physiotherapist.
- The Direct Access Physiotherapy (DAP) policy was not being followed and this had not been identified through governance monitoring processes. For example, patients were not completing a referral form, appropriate coding was not assigned to identify it was a self-referral and a first injury template was not being used. In addition, there was no evidence as to how referrals were triaged as urgent or routine.
- A range of policies were in place for the practice. Some of these required updating, including the safeguarding and whistle blowing policies.

- Communication streams had been strengthened since the last inspection. A schedule of regular practice and clinical meetings were in place. A weekly 'safety huddle' had been set up and this forum was used to coordinate work for the week and discuss concerning patients. It would be useful if a record was maintained of these meetings and the practice manager said they would do for future meetings.
- The practice nurse was the lead for clinical audit. An audit programme was established. It was still early days to see the see the impact clinical audit was having on driving quality improvement for the practice.

Managing risks, issues and performance

The processes for managing risks, issues and performance had been strengthened.

- Following the previous inspection, the SMO and practice manager from Newcastle medical Centre spent time at the practice addressing the risks we identified. For example, the clinical records for patients with long term conditions were audited to ensure patients were receiving safe and effective care, including recalls, follow up and appropriate Read coding.
- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety. The risk register was kept up-to-date. For example, not using the new patient registration process, as agreed with the Regional Clinical Director had been included, on the risk register.
- Processes were in place to monitor national and local safety alerts, incidents, and complaints.
- A system was in place to monitor performance target indicators. In particular the system took account of medicals, vaccinations, cytology, summarising and non-attendance rates.
- A business continuity plan was in place. The risk assessment (Annex A – SMC manning) and subsequent plan did not appear to reflect the ongoing issues with staffing, including the recent absence of the physiotherapist.
- The major incident plan for the station was being revised and in a draft format at the time of the inspection.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- An internal quality assurance tool, the 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.

Engagement with patients, the public, staff and external partners

The practice had processes to seek feedback from patients.

- Options were in place to encourage patients to provide feedback on the service and contribute to the development of the service. A patient survey was undertaken with one question asked of patients each month. In addition, patients could leave feedback through the suggestion box.
- The practice manager had developed good relationships with the unit through attendance at the station welfare meetings. In addition, the practice had good links with internal and external organisations including the RRU, the DCMH, local NHS services and social services.

Continuous improvement and innovation

Staff were keen to develop the service and improvement was evident since the previous inspection as the practice had pro-actively addressed the recommendations we made. However, the practice was hampered by unstable staffing levels, particularly a lack of consistency with doctors.