Yeovilton Medical Centre

Quality report

Ilchester
BA22 8HT

Date of inspection visit:
23 July 2019

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27 August 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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Chief Inspector's Summary

This practice is rated as good overall

We carried out an announced comprehensive inspection of Yeovilton Medical Centre on 23 July 2019.

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? – Good

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

At this inspection we found:

- There was an open and transparent approach to safety. An effective system was in place for managing significant events and staff knew how to report and record using this system. However, this system was under utilised.
- Some improvement was needed to keep patients and staff fully safe within the dispensary.
- The arrangements for managing medicines, including emergency medicines and vaccines, minimised risks to patient safety.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- Staff were aware of current evidence-based guidance. They had received training, so they were skilled and knowledgeable to deliver effective care and treatment.
- There was evidence to demonstrate quality improvement was embedded in practice, including clinical audit used to drive improvements for patients. There was scope to extend PCRF audit work.
- The practice proactively sought feedback from staff and patients which it acted on. Results from the patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available.
- There was a good leadership structure and staff felt engaged, supported and valued by management.
- Staff were aware of the requirements of the duty of candour.
- Staff spoke positively about their roles within the practice and worked well as a team.

- The practice had a comprehensive governance system in place and all staff understood their role and responsibilities.

The Chief Inspector recommends:

- Ensure that when chaperones are used, this is documented on the clinical system (referred to as DMICP).
- Ensure that all relevant staff can access the Lablinks system.
- Ensure staff and patients are kept fully safe by the use of an alarm system (dispensary) and replacing the dispensary door lock.
- Ensure that the system for repeat prescription requests is fully effective.
- Ensure significant event reporting is comprehensive and that the systems already in place are used to support any identified actions and this is shared for future learning.
- Ensure the system for reviewing new patients records includes accurate Read coding so the practice can ascertain if patient records are up to date.

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

Our inspection team

Our inspection team was led by a CQC inspector**.** The team included a GP specialist adviser, a practice nurse specialist adviser, a practice manager adviser, two medicines team inspectors and two Primary Care Rehabilitation Facility (PCRF) advisers.

Background to Medical Centre

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

Yeovilton Medical Centre provides a service to the Air Station at Yeovilton. There are approximately 3000 patients all of which are military service personnel, predominantly aged between 18 and 55. In addition to routine GP services, the practice provides a range of other services including, vaccinations, sexual health, smoking cessation, cervical cytology, over 40's health screen and chronic disease management. A Primary Care Rehabilitation Facility (PCRF) and a dispensary are located within the building.

In addition to routine GP services, the treatment facility offers physiotherapy and rehabilitation services. Family planning advice is available within the practice and maternity and midwifery services are provided by NHS practices and community teams. Mental health referrals are made to the Department of Community Mental Health (DCMH) Portsmouth.

The practice is open on Monday to Friday 07:45 to 18:30. After this, patients are referred to local out of hours services/emergency department.

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

Position	Numbers
Civilian Medical Practitioners	Four Civilian Medical practitioners (CMPs) One civilian locum GP
Principal Medical Officers (PMO)	One Principal Medical Officer (PMO) One Deputy Principal Medical Officer (DPMO)
Medical Officers	Three General Duties Medical Officers (GDMO's) non DPHC staff (currently deployed).
Practice nurses	One military Senior Nursing Officer (SNO) One civilian locum practice nurse
Practice Manager	One military practice manager

Administrative staff	Seven civilian administrative staff One civilian locum pharmacy technician
Medics	14 military medics
Primary Care Healthcare Facility (PCRF)	Four physiotherapists (one military and three civilian) Two Exercise Rehabilitation Instructors (ERI) both military

Are services safe? | Requires improvement

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

Safety systems and processes

- The practice had systems to keep both adults and patients under 18 years of age safe and safeguarded from abuse. The practice had safety policies including safeguarding policies for adults and under 18s which were reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. There are regular meetings with the unit welfare team and the executive team. We saw minutes of these meetings in which patients service numbers and names were listed which is not in keeping with data protection. Whilst the minutes were not practice minutes we would expect to see this raised by the practice as a significant event to raise awareness of the management of identifiable information.
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check. All clinicians, including medics, were chaperone trained. The front office held a list of staff to which anyone could refer to, this was useful for locum clinicians. We talked with staff who gave examples of when a chaperone was offered, however we noted this had not been recorded on the clinical system (known as DMICP).
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required.
- There was an effective system to manage infection prevention and control.
- There were systems for safely managing healthcare waste.
- The practice ensured that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions.

Risks to patients

- There was a system to assess, monitor and manage risks to patient safety.
- There were arrangements for planning and monitoring the number and mix of staff needed. There was an effective approach to managing staff absences and for responding to epidemics, sickness, holidays and busy periods.
- Fire safety was well managed. The practice had up to date fire risk assessments and carried out regular fire drills. Clinical equipment was checked in line with Defence Medical Services policy to ensure it was working properly.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. There was a well-equipped treatment room of a good size, suitable layout and double door ambulance access. There was a spinal board available. We spoke with staff and asked them the location of some emergency equipment; not all were aware of where to find some items, for example the defibrillator.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Sepsis indication and management tools were available in all clinical rooms. Staff had individual sepsis cards for quick reference that fitted into the identification badges they wore. Front desk staff had a good awareness to seek early advice and seek clinical assistance in the event of a patient appearing unwell in reception.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- The system to manage hospital appointments was effective and patients were well supported to obtain the most timely access to secondary care. Hospital letters were scanned and tasked to a clinician for their review. An audit of hospital appointments was undertaken to improve the process, to check appointment letters had been received and that patients that did not attend (DNAs) were being contacted. Audit outcomes were used as an overarching patient safety improvement for monitoring referrals and attendance at secondary care.
- The system to manage pathology results was failsafe. However, we noted that only the GPs and not the Senior Nursing Officer (SNO) or locum nurse had access to Lablinks which hindered their ability to carry out their roles easily, particularly with long term condition monitoring. This appeared to be an IT issue and needed to be escalated for resolution. Following the inspection, the practice informed us that this had been rectified and that the Senior Nursing Officer had full access to Lablinks.
- New patients were required to complete new joiners information paperwork as soon as they arrived at the base. This was promptly reviewed by a clinician. However, the Read coding was not always accurate so it was unclear if there was any backlog in summarising patients notes.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. This included good links with the emergency department at local general hospital who facilitated weekly sessions with the GDMOs from the practice to maintain their skills and share learning. The PMO had plans to further develop this relationship in the future.
- The physiotherapist had good working relationships with the Exercise Rehabilitation Instructors (ERIs) in the gym and the wider medical team, and evidence was seen of joint meetings with other multi-disciplinary team (MDT) staff with clear actions recorded on DMICP.

Safe and appropriate use of medicines

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

- There was a dedicated lead and deputy staff member for medicines management within the facility. A registered pharmacy technician provided dispensing services from the medical centre.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use. All staff who administered vaccines had received the immunisation training as well as the mandatory anaphylaxis training.
- The controlled drugs keys were held securely and access was limited.
- Repeat prescriptions were only accepted by email or in person and were reviewed regularly with the patients. Repeat medicines were processed within 48 to 72 hours. We noted that requests for repeat prescriptions were sent directly to the pharmacy technician at their individual military email address instead of a group mailbox which would be a more effective and reliable system. We were informed by the practice after the inspection that a Group mailbox option was now in place for repeat prescriptions.
- All prescription pads were stored and managed safely.
- High risk medicines were managed effectively. We saw patients who were prescribed these all had shared care agreements (SCA) in place. They were regularly monitored with blood tests undertaken at the required times. An audit had been completed to ensure all patients who should have an SCA in place did so and if they were correctly coded on the clinical system. The results showed 100% compliance and that all patients who required them had an agreement in place but that not all had been coded or an alert set on the patient record. This had been immediately actioned and improved. This audit was scheduled every six months.
- Standard operating procedures (SOPs) were in place to support a safe dispensing practice. There was a system for staff to record that they had read and understood them. All MHRA safety notices and alerts were correctly logged on a spreadsheet and actioned. Only those alerts considered to be relevant were sent to the clinical staff.
- PGDs (Patient Group Directions) and PSDs (Patient Specific Directions) were in use to allow non-prescribing staff to carry out vaccinating in a safe way. PGDs were appropriately managed as staff had received training.
- Out of hours, secondary care prescriptions and amendments to current therapy as directed by secondary care were receipted and scanned onto the system. A message was sent to the referring doctor to action anything that was necessary. In the absence of the referring doctor, the duty doctor was tasked to action any medication changes.

Track record on safety

- The practice manager was the lead for health and safety. Risk assessments were in place including needle stick injury, lifting and handling and lone working. The PCRF had a specific risk assessment for the safe use of needle acupuncture.
- There were alarms throughout the building with the exception of the dispensary which had none. Staff did not have personal alarms.

- There was key coded entry into the dispensary but the lock on the door was missing making it not fully secure.

Lessons learned and improvements made

- There was an electronic organisational-wide system (referred to as ASER) for recording and acting on significant events, incidents and near misses. All staff knew how to raise and report an incident. However, we saw examples where incidents were not raised meaning learning and improvement opportunities were missed. For example, a patient who had been referred to the Department of Community Mental Health for post-traumatic stress disorder (PTSD) had an excessive wait being 71st on the waiting list for treatment to begin. This had not been raised as an issue. Because of this, the practice were caring for the patient themselves in the interim. ASERs were an agenda item on the healthcare governance meetings held every three months.
- We noted no ASERs had been raised within the PCRF for 12 months.

Are services effective? | Good

We rated the practice as good for providing effective services.

Effective needs assessment, care and treatment

The practice had processes to keep clinicians up to date with current evidence-based practice.

- Clinical staff assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. NICE (National Institute for Health and Care Excellence) and other practice guidance was a standing agenda item at the weekly clinical meetings open to attendance by all clinicians. For example, we saw some new guidance was recently discussed regarding the care of the patient with hay fever.
- Both the physiotherapist and the ERI attended the Regional Rehabilitation Unit meetings to discuss evidence-based guidance, to share good practice and receive updates.
- The PCRF had all the equipment and space it needed to deliver a safe and effective service.

Monitoring care and treatment

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

- We found the care of patients with long term conditions was good. For example, those patients with diabetes, hypertension and asthma. There were dedicated leads and deputies named for chronic disease management and a detailed register was in place. They carried out regular searches, recalling patients when appropriate. We looked at a selection of patient records and were assured that clinicians were consistent in how patients were reviewed. A detailed chronic disease strategy was being put into place including a dedicated long-term condition clinic which will be commencing in September 2019.
- We saw that patients who had been treated for new depressive symptoms in the past year had been reviewed between 10 and 56 days after diagnosis. We were assured their care was being

effectively and safely managed, often in conjunction with other relevant stakeholders such as the welfare team and the Department of Community Mental Health (DCMH).

- Improving Access to Psychological Therapies (IAPT) was run and managed by DCMH Portsmouth, the practice could not refer directly. DCMH stream into this service via a waiting list. 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. There was not a significant wait for an initial assessment which was approximately 15 working days, this could be expediated dependent on need/risk. The time frames in accessing IAPT is currently prolonged and this continues to affect all practices in the region who are supported by DCMH Portsmouth. Therefore, there is some risk carried by the GP's, but this is mitigated by regular face-face GP-patient review. This risk was on the risk register.
- 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 73% of patients.
- An internal quality assurance tool, the Defence Medical Services (DMS) Common Assurance Framework (CAF) was used to monitor safety and performance. The DMS CAF was formally introduced in September 2009 and since that time has been the standard healthcare governance assurance tool utilised by DMS practices to assure the standards of health care delivery within DMS.
- There was evidence that clinical audit was taking place. Audit activity was recorded and monitored by the practice managers through the healthcare governance (HCG) workbook, a system that brings together a comprehensive range of governance activities, including the risk register, significant events, patient safety alerts, Caldicott log, building fault log, quality improvement and audit. An audit calendar was in place that identified the audits to take place going forward. Clinical audits undertaken for the practice included: results handling, notes audits, prescribing audits, chronic disease management and high-risk medicines. A minor surgery audit was planned in the near future as only a small number (five) surgeries had been completed to date.
- Audits by the PCRF were limited. However, we did see one audit of patient referrals to the PCRF physiotherapy triage clinic. It used retrospective data from January – April 2018 and showed only 48% of the clinics were filled. The recommendations were to re audit in January 2019 as the clinics were in their infancy and data was limited. No further audit had been undertaken but we were told was planned for October 2019.

Effective staffing

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

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, mentoring, clinical supervision and support for revalidation.
- Medics ran urgent care clinics (fresh cases), vaccination clinics and force protection clinics. The medics used treatment room protocols and issued medication in line with current guidance. We noted that these were authorised by the previous PMO and had not updated since the new PMO had taken up post. This was rectified on the day of the inspection. All had

completed their relevant vaccine administration training. Medics were overseen by the nursing team and their clinical notes reviewed. Post emergency debriefs took place to share and discuss lessons learned.

Coordinating care and treatment

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

- The practice met with welfare teams and line managers to discuss vulnerable patients. PCRF staff fostered close working relationships, through daily informal meetings over coffee with the medical centre staff and more formally at weekly management meetings, and fortnightly multi-disciplinary meetings.
- The PCRF had good relationships with the Multidisciplinary Injury Assessment Clinic (MIAC) and the regional podiatry service.
- The SNO had established relationships with nearby Blandford Medical Centre to offer cytology clinics and act as a mentor for others in this field. The two practices also covered each other for cytology services during periods of annual leave.

Helping patients to live healthier lives

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

- The practice supported national priorities and initiatives to improve the population's health including, stop smoking campaigns and tackling obesity. Advice on prevention of musculoskeletal (MSK) injury was available from physiotherapy staff at the practice, as well as the clinicians providing services. The practice attended unit health fairs to endorse and promote good health.
- The practice had established links with Somerset sexual health service who provided chlamydia kits. There was a good uptake from patients accessing self-test kits from the practice with 150 kits returned to sexual health for testing in 2018. Condoms were also available. Access to the sexual health clinic was displayed and information was also available from the nurses.
- The PMO undertook contraceptive implants and coil (inter-uterine device, (IUD) fitting. There was an appropriate clinical room and specialist couch to undertake these procedures.
- We noted that there was no patient information available signposting patients, out of hours, to mental health services either on the front door, within the practice leaflet on the out of hours telephone message.
- The PCRF staff participated in the delivery of the aircrew conditioning programme which was an injury mitigation strategy developed specifically for aircrew.
- Patients had access to appropriate health assessments and checks. A monthly search was undertaken for all patients aged 50-64 years who were entitled to breast screening. The practice also engaged with all national screening programmes and had a mechanism to ensure that eligible patients were referred into the bowel cancer or abdominal aortic aneurysm (AAA) screening programs.
- There was a policy to offer telephone or email reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using public health information posters and they ensured a female

sample taker was always available. We saw records that confirmed that 95% of women had received screening or were waiting to be called.

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

- 94% of patients were recorded as being up to date with vaccination against diphtheria.
- 94% of patients were recorded as being up to date with vaccination against polio.
- 76% of patients were recorded as being up to date with vaccination against Hepatitis B.
- 94% of patients were recorded as being up to date with vaccination against Hepatitis A.
- 94% of patients were recorded as being up to date with vaccination against Tetanus.
- 85% of patients were recorded as being up to date with vaccination against Typhoid.
- 80% of patients as being up to date with Measles, Mumps and Rubella.
- 99% of patients as being up to date with Yellow Fever.

Consent to care and treatment

- Minor surgery was carried out at the practice. We saw written formal written consent was sought. PCRF staff took written consent for acupuncture procedures.
- Clinical 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 under 18 years, staff carried out assessments of capacity to consent in line with relevant guidance.

Are services caring? | Good

We rated the practice as good for caring.

Kindness, respect and compassion

Staff supported patients in a kind and respectful way.

- Throughout the inspection staff were courteous and respectful to patients arriving for their appointments. We were given several examples of the kindness and helpfulness given to patients by reception staff.
- Results and comments from the July 2019 Patient Experience Survey (50 respondents) showed patients were happy with how they were treated and 96% would recommend the practice to family and friends. The four patients we spoke with and the 39 CQC comment cards completed prior to the inspection were very complimentary about the care they received.
- The practice had an information network available to all members of the service community, known as HIVE. This provided a range of information to patients who had relocated to the base and surrounding area. Information included what was available from the local unit and from civilian facilities, including healthcare facilities.

- 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.

Involvement in decisions about care and treatment

- The Choose and Book service had been implemented and was used to support patient choice as appropriate. (Choose and Book is a national electronic referral service which gives patients the choice of date and time for their first outpatient appointment in a hospital).
- Results from the practice's Patient Experience Survey in July 2019 (50 responses were collated) showed 82% of patients were involved in their care, 10% said they did not feel involved in decision making and 8% said it was not applicable to them.
- Interpretation services were available for patients who did not have English as a first language.
- The practice proactively identified patients who were also carers. A carers' poster was displayed by the front door of the practice. Five patients were identified as having caring responsibilities.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect. Patients we spoke with confirmed this. We saw all staff interacting with patients in a friendly yet respectful manner.
- All physiotherapists had their own treatment rooms. The ERIs worked in an open plan gym space but a treatment room could be used if required. Confidentially posters were displayed throughout the department. The waiting room was separate to the reception desk where administration was located. Administrative support dealt with one patient at a time to maintain confidentiality, other patients were asked to wait a distance away from the desk when someone was being addressed by the administration staff. A radio was on at reception to muffle sounds.

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, 90% of the patients seen with clinical presentations needed occupational healthcare. We saw the practice was proactive in ensuring these patients were fit for duty. The practice data showed they were managing this well. The other 10% were patients with long term conditions and the practice had a good system in place to effectively manage these patients.
- The practice provided medical cover for the airfield 24 hours a day. GPs with a MAME (Military Aircrew Medical Examiners) qualification were available throughout the day during practice hours. Out of hours cover was provided by all GPs this included non-MAME trained clinicians. The practice had a local agreement where if specialist advice was required then a MAME trained GP would be made available. Two further GPs were booked to undergo MAME training later this year.

- The facilities and premises were bespoke and appropriate for the services delivered. An access audit as defined in the Equality Act 2010 was completed for the premises in July 2019. Access was good throughout with level access throughout.
- The practice did not routinely offer home visits to its patients. However, there was a policy available to staff and patients around when a home visit might be necessary, and a log was maintained. This information was available in the practice leaflet.
- A podiatry clinic was held every six weeks.
- Clinics were held until 18:30 to provide appointments for shift workers. Urgent slots were available twice a day, urgent afternoon slots were reserved for shift workers if required.
- Telephone consultations were available at patient request.
- A psychologist from the Department of Community Mental Health held a clinic at the practice every two to four weeks dependent on patient need.

Timely access to care and treatment

- Urgent appointments were available on the same day and patients with an urgent need were seen 07:45 to 08:00 every morning. Routine appointments were usually available within three days
- Outside of opening hours patients were diverted to the NHS 111 service as appropriate. Details of how patients could access these services out of hours service when the practice was closed were available through the station guardroom, station arrivals brief, station routine orders, medical centre out of hours answer phone message, practice leaflet and was displayed on the outer doors of the medical centre.
- The most recent patient survey (July 2019) showed that 84% of patients were happy with the time of their appointment.
- For routine physiotherapy appointments, the waiting time was within 10 working days. Patients with an urgent need were seen within 48 hours but usually the same day. Direct access was not available. This decision was taken as the team felt that it would disadvantage aircrew as they had to have an initial consultation with a clinician that was MAME trained. Aircrew would still have to see a GP first then the physiotherapist which would be a separate standard compared to the rest of the camp if they had direct access.
- The PCRF offered a triage clinic where patients were assessed by a medic during the urgent morning appointments available. These were available three mornings a week. If the patient presented with an acute injury they were booked into a 15-minute physiotherapy triage slot. The physiotherapist would then determine whether the patient needed a new patient appointment or could be managed with appropriate advice and acute injury management. The service allowed quicker access for acute injuries and provided ongoing training for the medics. The clinic has been audited and demonstrated that this system was effective.
- We spoke with four patients on the day of our inspection. They told us that they could secure appointments when they needed them and were confident that they would be seen quickly.

Listening and learning from concerns and complaints

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

- The DPHC 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.

Are services well-led?	Good

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

Leadership capacity and capability

- On the day of inspection the leaders in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure good quality care. There was a clear leadership structure and staff felt supported by management. Staff told us the practice leaders were approachable and always took the time to listen to all members of staff.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- All staff were involved in discussions about how to run and develop the practice, and the PMO encouraged all members of staff to identify opportunities to improve the service delivered by the practice.
- The practice was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included support training for all staff on communicating with patients about notifiable safety incidents. The leaders encouraged a culture of openness and honesty.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- The practice worked to the DPHC mission statement: “Provide and commission safe and effective healthcare which meets the needs of the patient and the chain of command” and also to the Yeovilton specific vision of: “Valuing people, safely delivering operation output”
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The medical centre planned its services to meet the needs of the practice population.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice. A locum member of staff told us that there was excellent teamwork within the staff group with nothing being too much trouble for other members of staff when helping and supporting each other. On inspection day, positive staff interactions were noted.
- Medics were empowered to work towards the top of their level of expertise. They ran clinics, including urgent care triage of patients. They also had opportunities to work alongside pre-hospital care medics at the base Air Show which was open to the public. Medics also undertook peer review of each other’s consultation notes. They reviewed the consultation structure and its content, made recommendations if needed and then discussed their findings together. These were then collated to see where improvement or further training maybe needed.

- Nurses were given protected time for professional development and evaluation of their clinical work.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- 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.
- We saw in the staff room a "Complement a Colleague" initiative. This was an anonymised system of positively acknowledging colleagues' contributions at work. We also saw several letters of thanks in the staff room from colleagues who had worked in the practice (e.g. student placements / former staff) praising the inclusive culture and supportive learning environment.

Governance arrangements

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

- There was a clear staffing structure in place and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. Terms of reference were in place to support job roles.
- A programme of clinical and internal audit was in place, and the practice recognised the importance of its use for monitoring quality and to make improvements moving forward. The PCRF audit programme had scope for improvement.
- A comprehensive understanding of the performance of the practice was maintained. The nursing officer monitored achievement against clinical indicators in QOF and reported if there were areas which required focus.

Managing risks, issues and performance

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

- The PMO understood the risks to the service and kept them under scrutiny through the risk register.

Appropriate and accurate information

The practice generally had appropriate and accurate information.

- An understanding of the performance of the practice was maintained. The practice manager used the Common Assessment Framework (CAF) as an effective governance tool. A practice wide meeting was held every two weeks and had provided a forum for effective discussion and shared learning. Minutes from meetings we reviewed demonstrated that key agenda items had been discussed including safeguarding, NICE guidance and CAS alerts. Meetings were used

for forward planning, for example, to ensure that patient needs were met during busy clinic times and periods of staff sickness.

Continuous improvement and innovation

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking. From minutes of meetings we reviewed, we noted that the leadership of the practice focussed on improving the quality of care for all patients. The practice made use of internal and external reviews of incidents. Learning was shared and used to make improvements. We saw examples of new initiatives being instigated including

- Healthcare Governance Breakout Group – The purpose of this group was to consider problems and the development of improvements within the practice. All staff were invited to participate and contributed to the agenda for group discussion. Three groups considered different topics and how the practice could improve. They looked at three areas, fresh cases (urgent appointments), treatment room clinics and practice processes.
- A more junior level quality improvement group was also held to encourage the younger less experienced staff members to talk freely without any senior management present. An example of a positive change born from these meetings was moving the medics break time forward by 15 minutes to allow an additional prelim clinic every day. This was to meet the increasing need for occupational medicals.