Shawbury Medical Centre

Quality report

RAF Shawbury,
Shropshire,
SY4 4DZ

Date of inspection visit:
9 October 2019

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15 November 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, information given to us by the practice and patient feedback about the service.

Ratings

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

Chief Inspector's Summary

This practice is rated as good overall

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

We carried out an announced comprehensive inspection of Shawbury Medical Centre on 9 October 2019. Defence Medical Services (DMS) are not registered with the CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014 and are not required to be. Consequently, DMS services are not subject to inspection by the CQC and the CQC has no powers of enforcement. This inspection is one of a programme of inspections that the CQC will complete at the invitation of the Surgeon General in his role as the Defence Authority for healthcare and medical operational capability.

At this inspection we found:

- The practice was well-led and leaders demonstrated they had the vision, passion and integrity to provide a patient-focused service that sought ways to develop and improve.
- An inclusive team approach was supported by all staff who valued the opportunities available to them to be part of a patient-centred service.
- There was an open and transparent approach to safety. An effective system was in place for managing significant events and staff knew how to report and record using this system.
- The assessment and management of risks was comprehensive, well embedded and recognised as the responsibility of all staff.
- The arrangements for managing medicines, including obtaining, prescribing, recording, handling, storing, security and disposal minimised risks to patient safety. There was an effective approach to the monitoring of patients on high risk medicines.
- Staff were aware of current evidence based guidance. They had received training so they were skilled and knowledgeable to deliver effective care and treatment.
- The practice worked collaboratively and shared best practice to promote better health outcomes for patients.
- There was evidence to demonstrate quality improvement was embedded in practice, including an annual programme of clinical audit used to drive improvements in patient outcomes.
- The practice proactively sought feedback from staff and patients which it acted on. Feedback showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- Equipment at the practice was sufficient to treat patients and meet their needs.

- Staff were aware of the requirements of the duty of candour.

We identified the following notable practice, which had a positive impact on patient experience:

The practice introduced a medicines advice poster and leaflet titled 'Self-medication & controlling' for aircrew and air traffic control. The leaflet aimed to ensure that patients in the role of aircrew or air traffic control understood the impact of prescription medicines and non-prescription medicines on their occupational roles, including the controls required when taking such medicines. With any concerns or queries about their medicines out-of-hours, the leaflet advised patients about how to access a doctor with a Military Aviation Medical Examiner (MAME) qualification.

The Chief Inspector recommends:

All clinicians are made aware of and consistently adhere to the procedure outlining the action to take if patients are assessed as unfit for duty.

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

Our inspection team

The inspection team was led by a CQC lead inspector**.** The team comprised specialist advisors including a doctor, practice nurse, practice manager and physiotherapist.

Background to the Shawbury Medical Centre

RAF Shawbury is a phase 2 training station for the Defence Helicopter Flying School and Defence College of Air Space Operations. Shawbury Medical Centre provides a routine primary care service to a patient population of 1,200 including service personnel, families and dependents. One hundred and forty two young people and children were registered patients at the time of the inspection. The practice provides occupational health to service personnel only.

A Primary Care Rehabilitation Facility (PCRF) is located near to the medical centre and provides a physiotherapy and rehabilitation service for service personnel only. As there is no dispensary at the practice, a contract in in place with a local pharmacy. The practice also provides emergency airfield and crash cover.

The medical centre is open from 08:00 to 18:30 hours Monday, Tuesday, Thursday and Friday. It is open 08:00 to 12:00 on Wednesday and closes in the afternoon for staff training. Emergencies can be accommodated in the afternoon. Outside of these hours, including weekends and bank holidays, cover is provided by NHS 111.

The staff team

Position	Numbers
Senior Medical Officer (SMO)	One
Deputy SMO	One
Civilian medical practitioners (CMP)	Two – both part-time

Civilian practice nurses	Two
Practice manager	One
Deputy practice manager	One
Administrative staff	Two – one vacant
Reception	One
PCRF	Two physiotherapists; one Exercise Rehabilitation Instructor (ERI)
Medics	Eight

Are services safe?

Good

We rated the practice as good for providing safe services.

Safety systems and processes

Systems were established to keep patients safe and safeguarded from abuse.

- The SMO was the lead for adult and child safeguarding and deputising arrangements were also established. The safeguarding policy was last reviewed in February 2019. All clinical staff had completed level 3 safeguarding training and non-clinical staff had received safeguarding training, including update training, at a level appropriate to their role. Safeguarding arrangements and local contact details were displayed for staff to access.
- In July 2019 the SMO wrote to the local NHS primary care practices as some families of service personnel chose to register at a practice other than Shawbury Medical Centre. The letter provided information about safeguarding arrangements at the practice and details of the welfare service at RAF Shawbury, and how patients could access this.
- For the purpose of consistency, the practice had identified and agreed the codes to use on the system to highlight vulnerable children, young people and adults. The list of codes was available to all clinicians. In addition, an alert was placed on each vulnerable patient's record so they could be identified with ease. A vulnerable patients register was held on the electronic patient record system (referred to as DMICP).
- The multidisciplinary clinical meetings held each month reviewed patients coded as vulnerable and the vulnerable patients register was updated accordingly. The SMO attended the station welfare meetings where the needs of vulnerable patients were discussed to ensure they were being effectively and safely supported.
- Staff had received chaperone training and a list of trained chaperones was available. A notice advising patients of the chaperone service was displayed in the patient waiting area. 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, were suitable to work with vulnerable adults and young people. DBS checks were renewed every five years. Staff had received the appropriate vaccinations for their role.

- Arrangements were in place to monitor the registration status of clinical staff with their regulatory body. All staff had professional indemnity cover. Information was in place to confirm staff had received the relevant vaccinations required for their role at the practice.
- There was an effective process to manage infection prevention and control (IPC), including a lead for IPC who was suitably skilled and experienced for the role. They had recently taken up post and had applied for the Defence Primary Healthcare (DPHC) recommended IPC training. The lead attended the IPC regional forum. The staff team was up-to-date with IPC training.
- The medical centre was subject to an IPC audit in April 2019. The ERI completed a separate IPC audit for the PCRF in August 2019. The current management action plan (MAP) incorporated the findings from both audits. Through the establishment of an IPC working group, the actions identified in the MAP had been or were being addressed.
- Environmental cleaning was provided by an external contractor. Cleaning schedules including frequency of cleaning were displayed in each room. The IPC lead had set up regular meetings with the cleaning manager to regularly review the contract and cleaning standards. A deep clean of the premises took place annually, although had been delayed this year due to infrastructure issues that required addressing before the deep clean. We identified no concerns with the cleanliness of the premises.
- A member of staff had the lead for the safe management of healthcare waste. Consignment notes were retained at the practice and an annual waste audit was carried out in September 2019.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

- Staff we spoke with said staffing levels and skill mix was sufficient to meet the needs of the patients. The team comprised a mix of military and civilian staff, which meant the civilian staff provided stability and consistency. A locum induction pack was in place to familiarise temporary staff with systems and processes. Although the lead physiotherapist (military) was on occupational exercise, PCRF staff identified no concerns with the current staffing levels. As military staff were subject to deployment, ‘staff movement’ was a topic for discussion at the practice meetings.
- The practice was equipped to deal with medical emergencies and all staff were suitably trained in emergency procedures, including training in 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 was available. Daily and monthly checks were in place to ensure the required kit and medicines were available and in-date.
- All staff participated in regular training relevant to emergency situations. In conjunction with the fire department, staff received training in August 2019 about how to manage a suspected climatic injury. In the same month training was delivered to the team regarding the management of spinal injuries and falling from a height. Sepsis training was delivered to the team in September 2019. Posters about sepsis were displayed in the practice.

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. The 13 clinical records we looked at on DMICP showed information needed to deliver safe care and treatment was available to relevant staff in an accessible way.

Because of the risks associated with acupuncture, including the risks for aircrew, the PCRF completed an acupuncture risk assessment and consent form with each patient. Patients were also provided with post-acupuncture advice. In particular, post-acupuncture information included advice not to fly for 12 hours after treatment.

Despite a procedure in place outlining the action to take if a patient was deemed unfit for operational duties, PCRF staff were not consistently following this procedure which presented a potential risk to the safety of the patient and others.

- Clinical records for all clinicians were routinely audited. A process was established for scrutiny and summarising of patients' records. Nurses were responsible for completing the summarisation of records. Three sets of notes were awaiting summarisation at the time of the inspection.
- Staff described occasional loss of connectivity with DMICP, meaning clinics could be delayed. If this happened, the business resilience plan was followed and only emergency patients were treated. If needed, patients could be seen at Cosford Medical Centre.
- Referrals to other departments and external health care services, including urgent referrals, were managed by a dedicated administrator who had provided training on the role so other administrators could manage referrals in their absence. They responded to requests from the doctors and mainly booked patient appointments through the NHS e-Referral service. All referrals, including those made by the PCRF, were logged on a spreadsheet and checked daily. For urgent two-week-wait referrals, patients left the practice with an appointment.
- The doctors held a referral meeting each Thursday and used the referral log to monitor referrals and look at referral patterns.
- A SoP was in place with the aim to ensure samples were taken safely, appropriately logged out and results logged, and results actioned by the appropriate clinician in a timely way. From the clinical records we looked at, results were effectively managed in accordance with the SoP.

Safe and appropriate use of medicines

The practice had reliable systems for the appropriate and safe handling of medicines.

- Safe procedures were in place for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment. A lead and deputy were identified as the subject matter experts for medicines management. Overseen by the deputy practice manager, the day-to-day management of medicines was delegated to two medics. A medic is trained to provide medical support on various operations and exercises. In a medical centre setting, their role is similar to that of a health care assistant in NHS GP practices but with a broader scope of practice.
- Dispensary stock was checked regularly. Appropriate arrangements were established for the safe management and destruction of controlled drugs (CD). CDs were held at the practice for emergency situations and were checked each month by the SMO and deputy SMO. They were checked quarterly by a representative from the station.
- 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.

- One of the nurses was a prescriber and their prescribing was audited by one of the doctors. Patient Group Directions (PGD) had been developed to permit one of the nurses to administer medicines in line with legislation; they were current and signed at the time of inspection.
- Requests for repeat prescriptions were safely managed and no telephone requests were accepted. A system was in place to update DMICP if changes to a patient's medication was made by secondary care or an out-of-hours service.
- A process was established for the management of and monitoring of patients prescribed high risk medicines (HRM). The practice adhered to the regional policy and guidance on HRM, and all doctors had access to this. Alerts, coding and diary dates were used to identify and manage patients prescribed an HRM; this was confirmed through our review of clinical records. The medics carried out monthly searches and the search list was passed to the doctors for review. Shared care agreements were in place for the patients who required them.
- A range of audits in relation to medicines and prescribing had been completed in the last 12 months including an antibiotic prescribing audit, nurse prescribing audit, vaccine administration audit and audit of over labelled usage. A PGD audit was undertaken every three months with the most recent completed in September 2019.
- Initiated by the SMO and subsequently approved by the Command Flight Medical Officer (CFMO), the practice introduced a medicines advice poster and leaflet titled 'Self-medication & controlling' for aircrew and air traffic control. The leaflet aimed to ensure that patients in one of these roles understood the impact of prescription medicines and non-prescription medicines on their occupational roles, including the controls needed to be in place when taking such medicines. With any concerns or queries about their medicines out-of-hours, the leaflet advised patients about how to access a doctor who was qualified as a Military Aviation Medical Examiner (MAME). This initiative was identified as a quality initiative project.

Track record on safety

The practice had a good safety record.

- Measures to ensure the safety of facilities and equipment were in place. The practice manager was the lead for health and safety. Electrical and gas safety checks were up-to-date. Arrangements were in place to check the safety of the water, including the flushing of all taps weekly. A fire risk assessment of the building was undertaken annually. The fire system was tested each week. Staff were up-to-date with fire safety training and were aware of the evacuation plan.
- Safety processes for the practice were monitored and reviewed, which provided a clear and current picture that led to safety improvements. Risk assessments pertinent to the practice were in place and they had been reviewed in February 2019, including safety data sheets for hazardous substances. Equipment checks, including the testing of portable electrical appliances were in-date. The PCRF provided evidence that the equipment used to treat patients had been serviced.
- To summon support in the event of an emergency, an alarm system was available in clinical areas except for one of the doctor's rooms. This room was located next to the practice manager's office so the doctor could seek assistance readily. They also, along with other staff, had a hand-held personnel alarm. We tested a hand-held alarm during the inspection and staff responded in a timely way. The PCRF was in a separate building and the alarm system was connected to the medical centre. CCTV was installed in waiting rooms so reception could monitor these areas in the event of a medical emergency.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff used the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events, incidents and near misses. All staff had electronic access to the system, including locum staff. Staff provided several varied examples of significant events confirming there was a culture of effectively reporting incidents. Significant events and lessons learnt were discussed at the practice meetings and governance meetings; this was confirmed by the minutes of the practice meeting held in October 2019 and governance minutes from the meeting in September 2019.
- Improvements were made as a result of investigations into significant events. For example, a significant event in relation to acupuncture led to a revision of the induction programme for locum staff working in the PCRF.
- The medics were responsible for managing medicine and safety alerts. The system was checked for alerts each day and any alerts logged on a spreadsheet. Alerts were emailed to staff and were also discussed at practice meetings if appropriate. If an alert related to a medicine then a search was carried out to determine if any patients were prescribed the medicine.

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.

- Patient records informed us that clinicians carried out assessments and provided care and treatment in line with national standards and guidance, supported by clear clinical pathways and protocols. Arrangements were established to ensure staff were up-to-date with current legislation, research and guidance, including NICE (National Institute for Health and Care Excellence) and the Scottish Intercollegiate Guidelines Network (SIGN). These were discussed at the clinical meetings. For example, a range of NICE and other guidance was discussed at the September 2019 meeting including the management of preterm labour and birth, hearing loss in adults and the management of motor neurone disease.
- Staff were kept abreast of clinical and medicines updates through the Defence Primary Health Care (DPHC) newsletter circulated to the practice each month. Participation with regional events and forums also provided an opportunity for clinicians to keep up-to-date.
- Our review of PCRF patient records showed Rehab Guru, software for rehabilitation plans and outcomes, was increasingly being used for exercise programmes for patients. The PCRF team referred to the Defence Rehabilitation website for best practice guidance. For example, in relation to tendinopathy and tendon loading.

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 SMO was the lead for the management of long-term conditions (LTC). One of the nurses was the deputy lead and was responsible for overseeing the management of LTCs including the recall of patients.
- To ensure consistency and increase the reliability of searches, the practice had produced an agreed list of Read codes for clinicians to use. For example, codes were identified for LTCs including hypertension, epilepsy, diabetes and asthma. In addition, the list included the coding to be used for patients being assessed and/or treated for depression.
- Patients with diabetes, high blood pressure and asthma were being well managed. For example, the 19 patients diagnosed with asthma all had an asthma review in the last 12 months which included an assessment of asthma control using the three Royal College of Physicians '3 questions' screening tool. Furthermore, reviews were carried out consistently using the asthma template on DMICP.
- Through review of clinical records and discussions with the doctors, we were assured that the care of patients with a mental illness and/or depressive symptoms was being effectively and safely managed, often in conjunction with the Department of Community Mental Health (DCMH). Appropriate templates were used to assess patients and plan their care. A community psychiatric nurse held clinics at the practice.
- 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 96% of patients.
- Quality improvement, including clinical audit, was embedded in practice and seen as the responsibility of all staff. Clinical audit was used to systematically review clinical outcomes to ensure treatment and care was being provided in accordance national and local standards. Although the PCRF was undertaking audits, there was limited audit activity in terms of clinical outcomes for patients. A lead for audit was identified and an audit programme established for 2019. All audit activity from 2013 was logged on the health governance workbook and clearly showed that audits were regularly repeated.
- Completed audits were presented and discussed at the practice meetings. There was evidence to demonstrate the practice acted on the outcomes of audit to improve outcomes for patients. For example, practice meeting minutes from September 2019 showed action points and a re-audit date were identified for audits related to over labelled stock, referrals, nurse prescribing and the use of PGDs. An asthma, diabetes and audiology audits were identified for presentation at the next meeting in October 2019.
- The SMO provided 13 examples of quality improvement projects (QIP) the practice had been involved with. These included the introduction of the National Early Warning Sign (NEWS) tool to assess an acutely unwell patient. Another QIP related to the development of a mental health resource leaflet for patients being supported with their mental needs in primary care (stage 1) or those awaiting an appointment with the DCMH.

Effective staffing

Continuous learning and development was promoted for staff. The staff database was monitored to ensure staff were up-to-date with training and development.

- A generic and role-specific induction was in place for new staff to the practice. All staff, including a recently inducted member of staff, described a comprehensive and supportive induction. This included supernumerary time and supervised practice.

- Mandated training was regularly monitored. A staff list of training overdue was displayed and staff were required to respond to this. The staff team was in-date for all required training; any training gaps could be explained and accounted for. Clinicians had received specialised training where required to support with meeting the needs of the patient population. This included training in aviation medicine (referred to as MAME training) and diving medicine. One of the nurses was also MAME trained, which enhanced access to aviation medicine for aircrew.

- A programme of ongoing development training was in place with in-house and external training sessions available to staff each week. Clinicians were also supported with continual professional development (CPD) and revalidation through protected time each week.

- A process of peer review was established for all clinicians. In addition, regional meetings and forums were established for staff to link with professional colleagues in order to share ideas and good practice. For example, the PCRF was represented at the regional rehabilitation forum and the prescribing nurse attended a regional prescribers forum held quarterly.

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 reviewed showed appropriate staff, including those in different teams, services and organisations were involved in assessing, planning and delivering care and treatment.

- The practice had developed good working relationships both internally and with local health and social care organisations. For example, discussions, often on a daily basis, took place with the chief clerk regarding service personnel the practice had concerns about. Good links were established with the health visiting and midwifery teams at the local medical centre. A weekly clinic was held with the DCMH for advice and training.

- The SMO, practice manager, physiotherapist and ERI attended the station Unit Health Committee (UHC) meetings each month where the health, occupational and rehabilitation needs of patients were discussed, including patients who had been downgraded.

- Doctors provided patients transitioning from the military with a release medical. A handover letter was completed for patients with complex needs. Patients could be referred to the welfare team for support with the transition, and if appropriate to the DCMH. Patients were also signposted to SSAFA, a UK charity providing welfare and support for serving personnel in the British Army, veterans and military families.

Helping patients to live healthier lives

Staff were 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.

- A nurse had the lead for health promotion and the ERI was the deputy. This was a new arrangement and both were exploring ways of working together to improve population health. For example, a weight management group and a menopause café were being considered. The lead and deputy attended the station health and wellbeing committee. Clinicians also participated in the station health wellbeing days. The PCRF was particularly active with these fairs and at the last event provided advice for running and training plans.

- 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.

- Health promotion displays and leaflets were available in patient areas. These were dated and refreshed in line with the strategy. At the time of the inspection there was information about alcohol use, mental health and sepsis. In response to patient feedback about being bored in the waiting area, the practice introduced a 'Current affairs in health' display. This provided detailed research-based information including information about a rise in measles in the UK, risks of smoking during pregnancy and the correlation between decreased antibiotic prescribing and a reduction in superbug cases. This was identified as a QIP.

- One of the nurses was the lead for sexual health and had completed the required training for the role (referred to as STIF). One other nurse and two doctors were also STIF trained. Where appropriate patients were referred to local genitourinary clinic for screening. Condoms were available at the practice.

- Patients had access to appropriate health assessments and checks. Regular searches were undertaken for patients eligible for the national screening programmes and appropriate action taken if patients met the criteria. DMICP searches were undertaken to ensure patients eligible for cytology screening were recalled. Ninety-eight per cent of eligible patients had been screened.

- This was the status of childhood immunisations at the time of the inspection:

    - Children aged under 12 months were 92% up to date with their immunisations.

    - Children aged under 24 months were 91% up to date with their immunisations.

    - Children aged under 5 years were 87% up to date with their immunisations.

- 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. Unit commanders were responsible for ensuring their personnel kept up-to-date with vaccinations. Based on clinical records, the following illustrates the current vaccination data for military patients:

    - 95% of patients were recorded as being up to date with vaccination against diphtheria.

    - 95% of patients were recorded as being up to date with vaccination against polio.

- 90% of patients were recorded as being up to date with vaccination against hepatitis B.
- 100% of patients were recorded as being up to date with vaccination against hepatitis A.
- 95% of patients were recorded as being up to date with vaccination against tetanus.
- 100% of patients were recorded as being up to date with vaccination against MMR.
- 100% of patients were recorded as being up to date with vaccination against meningitis.

Consent to care and treatment

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

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making. This included the PCRF who took written consent for treatments such as acupuncture.
- 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. They received training in this subject matter in September 2019.
- Monitoring the process for seeking consent was undertaken through an audit completed by the deputy SMO in September 2019. This audit let to better consistency with coding to demonstrate consent had been discussed with the patient.

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 we observed staff were courteous and respectful to patients arriving for their appointments.
- Results and comments from the July to September 2019 patient experience survey showed patients were happy with how they were treated. For example, all patients (27 respondents) said staff were kind and helpful all were happy with how their concerns were managed. The four patients we spoke with and the four CQC comment cards completed prior to the inspection were very complimentary about the friendly, considerate and caring attitude of staff.
- An information network known as HIVE was available to all patients. This provided a range of information to patients who had relocated to the base and surrounding area. HIVE provided information about facilities available on the station and locally including civilian 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.

- The patient experience survey showed all patients received sufficient information about their condition and were involved in decisions about their treatment options. The CQC patient feedback cards indicated patients received information about their care to support them with making informed decisions.

- The practice proactively identified patients who were also carers, including through the new patient registration process and alerts on DMICP. Information for carers was outlined in the practice information leaflet and displayed in the patient waiting area. A register of carers was maintained and it identified six patients with a caring responsibility.

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 would unlikely be overheard. If patients wished to discuss sensitive issues or appeared distressed at reception they were offered a private room to discuss their needs. Confidentiality presented more of a risk in the PCRF and measures were in place to mitigate the risk, including the use of a radio.

- The practice could facilitate patients who wished to see a clinician of a specific gender.

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

Services were organised and reviewed to meet patient needs and preferences where possible.

- Staff understood the needs of its population and tailored services in response to those needs. Appointments slots were organised to meet the needs of specific population groups. For example, early morning appointments were available for aircrew and afterschool appointments for children. In addition, specific time slots were identified to meet the tight training schedule for trainees in the School of Air Operations Control (SAOC).

- The patient experience survey indicated that all respondents would recommend the practice to family and friends. The four patients we spoke with said the practice were accommodating with meeting their appointment needs and also with requests to see the patient's preferred clinician.

- An access audit as defined in the Equality Act 2010 was completed for the premises in July 2019. The building did not lend itself to ease of access for patients with a disability. The practice had made as much reasonable adjustment as possible. For example, a ramp was available to support wheelchair users with accessing the building. Clinic rooms were all on the ground floor. An accessible WC facility was available. Parking bays were allocated for patients with a disability.

- Facilities were available for families, including a private room for breast feeding, baby changing facilities and a play area.

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 could be accommodated within three days. Same day appointments were available for children. There was a five to six week wait for medicals. If there was an urgent need for a medical that the practice was unable to accommodate, then the patient was referred to another local military medical centre.

- Non-attendance at appointments was monitored. The non-attendance rate was displayed in the patient waiting area for September 2019. It showed a total of 885 minutes of clinician time wasted through missed appointments (the highest rate was for the PCRF).

- A duty medic was available from the time the practice closed and they had access to a duty doctor. From 18:30 hours and at weekends and public holidays patients had access to NHS 111.

- Telephone consultations were available with clinicians. For example, the nurses had two slots per day for telephone consultations. Home visits could be accommodated and this service was used frequently by patients with specific needs that meant travelling to the medical centre was a challenge for them. A home visit register was maintained.

- A direct access physiotherapy (DAP) service was in place for military patients only. A new patient referred to the physiotherapist or ERI could be seen within three days and urgent patients were mostly seen on the same day.

- A DAP audit was completed in January 2019 to determine if the administration for self-referral was effective. The audit showed that at 80% the practice was not meeting the compliance standard set at 85%. Actions were identified to improve administration of the process. A re-audit was planned for January 2020.

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 and outlined in the practice leaflet to support patients with understanding the complaints process. The complaints procedure was displayed in clinical rooms for staff to access.

- The practice manager was the designated responsible person who handled all complaints. The deputy practice manager took on this role in their absence. Complaints were managed in accordance with the DPHC complaints policy and procedure. Both written and verbal complaints were recorded on the complaints register.

- Any complaints were discussed at the clinical and/or practice meetings and lessons identified. Changes to practice were made if appropriate and used to improve the patient experience. The complaints register showed two complaints were received in the last 12 months and they had been effectively managed.

Are services well-led?	Good

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

Leadership capacity and capability

The leadership team had the experience, skills and drive to deliver high-quality sustainable care.

- On the day of inspection, we saw a practice that was well-led. The leaders not only demonstrated managerial experience, capacity and capability, it was clear they were focused on improving the service to provide the best possible service for their patients.
- Staff spoke highly of how the practice was led. They said managers demonstrated a collaborative approach to leading the practice and supporting staff. The regional management team worked closely with the practice which the practice found supportive.

Vision and strategy

Throughout the inspection it was clear staff were committed to providing and developing a service that embraced the mission and vision.

- The mission for RAF Shawbury was:
    - 'To deliver world leading helicopter crews and air operations staff for defence'
- The practice worked to the DPHC mission statement of:
    - 'Sustainably deliver and commission safe and effective healthcare which meets the needs of the patient and the chain of command'
- The aim of the practice was:
    - 'Always provide evidence-based, safe, holistic and crucially patient-centred care to all our PAR [population at risk] at all times'
- On the day of the inspection, we found the practice was working to and achieving its aim.

Culture

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

- An inclusive culture underpinned the approach of the practice. All staff had an equal voice, regardless of rank or grade.
- 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 clinic appointment times accommodated the specific needs of aircrew and children.

- Openness, honesty and transparency were demonstrated when things went wrong. A no-blame culture was evident; patient feedback and incidents 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.

- Leaders clearly demonstrated that the needs and welfare of staff were priority. Staff were encouraged and supported to be the best they could be through training and developing their skills. Supervision and appraisal was in place for all staff.

- The practice actively promoted equality and diversity and staff had received training in this area.

Governance arrangements

There was an effective overarching governance framework in place which supported the delivery of good quality care.

- 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, including staff who had lead roles for specific areas.

- The practice worked to 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. All staff had access to the workbook which provided links to meeting minutes, policies and other information.

- Some elements of the PCRF was integrated with the wider practice governance systems practice. However, there was scope for further integration, such as the IPC arrangements being included in the wider practice IPC audit and PCRF staff taking lead roles in key areas.

- An effective range of communication streams were used at the practice. A schedule of regular practice, clinical, management and governance meetings were well established.

- Clinical and non-clinical audit was a routine method used to measure the effectiveness and success of clinical and administrative practice. A comprehensive audit programme was established with clear evidence of action taken to change practice and improve the service for patients.

- The practice was subject to a regional health governance visit in February 2019. A lengthy action plan followed this visit and the majority of the actions had been met except for those outside the remit of practice staff, such as the infrastructure.

Managing risks, issues and performance

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

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety. Risk to the service were well recognised, logged on the

risk register and kept under scrutiny through regular review at the governance meetings. The top risks to the service were the ageing infrastructure and maintaining consistent staffing levels, mainly in relation to doctors and medics.

- Processes were in place to monitor national and local safety alerts, incidents, and complaints. We highlighted to the SMO the potential risk with the fitness to fly procedure not being consistently adhered to. They agreed to address this promptly.

- The leadership team was mindful of potential risk to the service, most notably the turnover of key military staff. The practice manager was being posted to another medical centre a week after the inspection and the SMO was due to leave. Measures were in place to ensure these posts were filled so patient care was not compromised.

- A system was in place to monitor performance target indicators. In particular the system took account of medicals, vaccinations, child health, cytology, summarising and non-attendance rates.

- A business continuity plan was in place and staff were familiar with the content. A major incident plan was established for the station and a link to this was available on the HG workbook.

- Procedures were in place for managing poor performance. We were given an example of how a potential breach of confidentiality was effectively managed by the practice.

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 for the practice and included the PCRF. 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 involved patients, staff and external partners to support high-quality sustainable services.

- There were various options in place to encourage patients to provide feedback on the service and contribute to the development of the service. A patient experience survey was undertaken throughout the year. In addition, patients could leave feedback via through the suggestion box. Patients were informed of the response to their feedback through a ‘You said we did’ display.

- An attempt at setting up a patient participation group proved unsuccessful as patients showed interest.

- Good and effective links were established with internal and external organisations including the welfare team, RRU, the DCMH, local NHS services and social services.

Continuous improvement and innovation

Continuous improvement was embedded in the culture which was one of improving the service for patients. The practice maintained a log of QIPs on the HG workbook. We found that improvements were implemented based on the outcome of feedback about the service, complaints, audits and significant events.

The following QIPs were formally identified by the practice:

- A PCRF downgraded personnel fitness intervention (DPFI) was trialled between September and November 2018 in response to a significant number of personnel downgraded for musculoskeletal injuries and not receiving physiotherapy and rehabilitation.
- Development of a mental health information resource for patients receiving stage 1 support through primary care and patients awaiting an appointment with the DCMH.
- Introduction of the NEWS scoring tool routinely used in the NHS to assess patients presenting as acutely unwell.
- Development of a standard operating procedure (SOP) for the duty doctor to ensure consistency of the role and clarity of the duties the duty doctor should undertake.
- Development of an SOP for the management of pathology results to ensure clarity and consistency with how results were managed.
- Creation of an agreed range of Read codes to be used for the practice. These related to vulnerable patients, LTCs, mental health, chaperoning, carers and consent. The aim of an agreed range of codes was to support consistency leading to more reliability with searches.
- Introduction of peer-to-peer time following an audit that identified clinicians worked differently. This peer-to-peer was added to clinics and it meant clinicians had capacity to sit in on each other's consultations to support shared learning.
- Use of a SMART board (interactive board) in the PCRF for rehabilitation sessions with patients.
- Introduction of specific appointment times for SAOC trainees to meet their tight training timetable.
- Introduction of a patient information board titled 'Current affairs in health'.