Holywood Medical Centre

Quality report

Palace Barracks
Holywood
Northern Ireland
BFPO 806

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15 October 2019

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

Ratings

Overall rating for this service	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

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

We carried out an announced comprehensive inspection of Holywood Medical Centre on 15 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, and disposal minimised risks to patient safety. There was an effective approach to the monitoring of patients on high risk medicines. However, the arrangements for managing Patient Specific Directions (PSD) required improvement.
- 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 building was dated. Adaptations had been made to ensure it had facilities and equipment to treat patients and meet their needs. Further work was required to meet infection prevention and control guidelines.
- 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. However, the Primary Care Rehabilitation Facility (PCRF) required further IT equipment to enable them to safely meet patients needs.
- Staff were aware of the requirements of the duty of candour.

The Chief Inspector recommends:

- Improving the management of medicines, specifically, ensure the management of PSDs is safe and effective.
- Record the vaccination status of staff (Hepatitis B).
- Improve the environment to meet infection prevention and control (IPC) guidelines.
- Challenges around timely access to accurate patient records occur due to frequent loss of connectivity in DMICP. DPHC should review the access issues around DMICP in partnership with the medical centre and deliver solutions to improve access to up to date records. Improved access to DMICP should be provided for PCRF staff.

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 GP, practice nurse, practice manager and physiotherapist. The pharmacist specialist advisor visited the following week on the 22 October 2019.

Background to the Holywood Medical Centre

Located in Northern Ireland, Holywood Medical Centre provides routine primary care to service personnel, some of whom are subject to operational deployment at any time.

The age range of the population is 17 to 60 years. Dependants of personnel are not catered for at the medical centre but are registered locally elsewhere.

A Primary Care Rehabilitation Facility (PCRF) is located a distance away from the medical centre and provides a physiotherapy and rehabilitation service for service personnel only.

Although not employed by the medical centre, the practice team was supported by Regimental Aid Post (RAP) staff employed by the Field Army and attached to the unit in the station. RAP staff can be deployed at any point. They included a full time Regimental Medical Officer (RMO), and ten Combat Medical Technicians (CMT), referred to as medics. A medic is trained to provide medical and trauma 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. At the time of the inspection medics were not working within the practice setting as their training was incomplete.

The medical centre is open from 07:30 to 16:30 Monday to Thursday and Friday from 07:30 to 13:00. The arrangements for access to medical care outside of opening hours were outlined in the practice leaflet and directed patients to contact Out of Hours or 999 in Emergency. Shoulder cover is provided between the hours of 16:30 and 18:00 by a duty doctor covering for all three military Medical Centres in Northern Ireland.

The staff team

Position	Numbers
Senior Medical Officer (Joint SMO/CMP)	two (two doctors share one DPHC SMO post.)
Medical Officers (MO)	one RMO
General Duties Medical Officer (GDMO)	one
Civilian practice nurses	two
Military practice manager	one
Physiotherapist (job share)	Two physios share one post.
Exercise Rehabilitation Instructor (ERI)	one
Administrators	two
Administrator (PCRF)	one administrator covers Monday-Friday until 12:30pm

Are services safe?

Requires improvement

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

Safety systems and processes

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

- Measures were in place to protect patients from abuse and neglect, including adult and child safeguarding policies. The safeguarding policy was last reviewed in September 2019. Staff, including RAP staff working at the practice, had received safeguarding training and update training at a level appropriate to their role. RAP staff are clinicians who are attached to units rather than employed to work directly at the medical centre. A safeguarding lead and deputy were identified for the practice. Safeguarding arrangements and local contact details were displayed in clinical rooms for staff to access.
- Policies were accessible to all staff and clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. The SMO confirmed that there were no children currently registered at the practice. However, the practice was aware of the duty of care to the

children of serving personnel. Vulnerable patients were discussed with the chain of command at the Unit Health Committee (UHC) meetings which were attended by the SMO, chain of command and the welfare team. We spoke with a member of the welfare team and they were complimentary about the care and support the practice provided to vulnerable patients.

- Coding and alerts were used to highlight vulnerable patients. A vulnerable patient register was held on the electronic patient record system (referred to as DMICP). The SMO, the chain of command and the welfare team held a register of all downgraded personnel assessed as unfit for duty.
- Chaperone training has been conducted in March 2019 for all clinical staff. The chaperone policy and notices were displayed advising patients of the service; no administrative staff were used to chaperone patients.
- The full range of recruitment records for permanent staff was held centrally. However, the practice manager could demonstrate that relevant safety checks had taken place including a DBS check to ensure staff were suitable to work with vulnerable adults and young people. DBS checks were renewed every five years. They also monitored each clinical member of staff's registration status with their regulatory body. All staff had professional indemnity cover. However, we noted the practice did not have information 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 and deputy lead for IPC who was appropriately trained for the role. The staff team was up-to-date with IPC training. An IPC audit had been undertaken in August 2019 and concerns had been identified. The practice is an old building with lots of signs of wear and tear. There were areas of exposed brick work and plaster throughout the building as well as large cracks and peeling paint, carpets are old and heavily stained in areas. The flooring in three clinical rooms was partially carpeted. There were stains on the ceiling from previous water leaks. These issues were logged on the practice risk register. The regional team were fully aware and plans were in place to fix these issues.
- Environmental cleaning was provided by an external contractor. Cleaning schedules and monitoring arrangements were established. Spot checks were conducted weekly by the IPC lead. The practice manager had met with the cleaning manager to agree an ongoing programme of deep clean for the facility; two rooms had been completed and another was scheduled for that week. We identified no concerns with the cleanliness of the premises.
- Two PCRF clinicians practised acupuncture and arrangements were in place for the safe provision of this treatment, including an acupuncture health screening assessment and patient information sheet. There was an acupuncture risk assessment in place.
- 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 adequate to meet the needs of the patients. There was a mix of military and civilian staff. The clinicians staggered their leave to ensure continuity of cover. Due to careful forward planning, the use of locum staff was minimal. The practice, including the PCRF, did however have an induction pack that included bespoke information for locum staff.
- The practice was equipped to deal with medical emergencies and all staff were suitably trained in emergency procedures, including staff trained 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 were available. Weekly and monthly checks were in place to ensure the required kit and medicines were available and in-date. A defibrillator was also available in the PCRF and in the gymnasium.
- Staff were up-to-date with the required training for medical emergencies. They participated in regular training relevant to emergency situations. Staff were also trained in the recognition and management of sepsis. Posters about sepsis were displayed throughout the practice. We saw that doctors had received training in 'return from travel'. This was in response to patients returning from overseas presenting with tropical diseases.

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 care records we looked at on DMICP showed information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- A process was established for scrutiny and summarising of patients' records and this was monitored by the practice manager. On arrival, patients were required to complete a new patient form and give it to reception staff, they were also encouraged to book a new patient appointment with a nurse. The form was then passed to the nurse for the notes to be summarised and DMICP updated. At the time of the inspection 99% of the patient records had been summarised.
- Staff described a frequent loss of connectivity with DMICP meaning clinics could be delayed. If this happened, the practice business resilience plan was followed, and only emergency patients were treated. Reception staff had a system in place whereby at the end of each day they printed off the clinic list for the following days patients so the practice was aware of who they are expecting to attend. The practice had put together emergency outage packs which included paper copies of essential documents. Once used these were subsequently scanned onto DMICP.
- There was limited computer access in the PCRF, with only two terminals and three staff requiring access to DMICP. This meant that contemporaneous patient notes could not be recorded. A request was made for another computer in January 2018, but this had yet to be actioned. The PCRF also had no scanner meaning that any paper records/ consultations had to be carried over to the main practice for scanning onto DMICP; this could be up to 24 hours later.
- Planned secondary healthcare referrals were electronically generated from the practice to the central team (MPAC) who acted as the liaison between primary and secondary care within Northern Ireland. MPAC maintained registers of referred patients and as such monitored care pathways and timelines. Alongside this process, the practice had rigorous processes in place to monitor referrals. Referrals were followed up if there were any concerns in relation to

inactivity or delays with patients being seen. There had been no incidents regarding lost referrals since the last inspection.

- The system for managing tissue samples sent for analysis was both stringent and time intensive. This was because Lablinks and DMICP did not communicate with each other. A standard operating procedure (SoP) was in place with the aim to ensure samples were taken safely, appropriately recorded on DMICP and results reviewed and actioned by the appropriate clinician in a timely manner (routine results were available within two days). We found that samples and results were effectively managed in accordance with the SoP. This included daily checks of the samples log and any outstanding results being followed up. Results received at the practice were logged, dated, stamped and scanned onto the patient's record. They were then passed to the doctor to review. We saw that monthly audits were undertaken and they showed 100% compliance.

Safe and appropriate use of medicines

The practice did not have fully reliable systems for the appropriate and safe handling of medicines. Specifically, the management of Patient Specific Directions (PSD).

- The dispensary at Aldergrove was the main dispensary for other military medical centres in Northern Ireland. Effective processes that could be tracked were in place for dispensing to these medical centres.
- Medicines requiring refrigeration were transported in cool boxes. Staff identified no problems with temperature control during transit, medicines were transported within a validated cool box with directive from the manufacturer describing how long temperatures could be maintained.
- Standard operating procedures in relation to medicines were up-to-date.
- We saw stock medication was securely stored at the practice. Dispensary keys were held in a secure safe with only authorised staff having knowledge of the code.
- The fridge for medicines, including vaccines was monitored daily (except weekends and public holidays) to ensure temperatures were within the correct parameters.
- Prescription pads were securely stored and there were systems in place to monitor their use. Patient Group Directions (PGD) had been adopted by the practice to allow nurses to administer medicines in line with legislation. The PGDs were audited to ensure compliance and the three yearly competence checks of PGD users were up-to-date.

The management of PSDs was not safe or effective. A PSD is the written instruction, signed by a doctor, dentist, or non-medical prescriber for medicines to be supplied and/or administered to a named patient after the prescriber has assessed the patient on an individual basis. We saw no evidence in the DMICP record to confirm if the patients had been assessed by the doctor. There were several instances where a full course of vaccinations had been given and not all were supported by a PSD nor a prescription. We saw PSDs that did not specify a dose nor the route of administration. The PSDs for the supply of anti-malarial medicine did not specify the quantity to be supplied.

- Requests for repeat prescriptions were safely managed and no telephone requests were accepted. A repeat prescription book was maintained and monitored by the administrators. A process was in place to update DMICP if changes to a patient's medication was made by secondary care or an out-of-hours service.
- A process was established for the management of and monitoring of patients prescribed high risk medicines (HRM). A register of HRM used at the practice was held on Sharepoint and all doctors had access to this. Alerts, coding, diary dates and monthly searches were used to

identify and manage patients on HRM. Shared care agreements were in place for the patients that required them.

Track record on safety

The practice had a good safety record.

- Measures to ensure the safety of the facilities and equipment were in place. The practice manager was the lead for health and safety. Electrical and gas safety were up-to-date. Arrangements were in place to check the safety of the water. 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 January 2019. Safety data sheets were in place for hazardous substances. Equipment checks, including the testing of portable electrical appliances were in-date. The PCRF provided evidence that the equipment held at the various gyms used to treat patients had been serviced.
- The practice did not have a fixed alarm system in place, but all rooms had a hand-held alarm. The alarms and team response were tested regularly, and these tests were recorded.
- The PCRF had an alarm in the reception area, this was tested on the day of the inspection but could not be heard outside of the PCRF. A lone working SoP was in place, but this still offered little mitigation against the risks associated with lone working.

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 were discussed and lessons learnt identified at the practice meetings. Significant events were not closed until all actions had been completed. The ASER system was also used to report good practice and quality improvement initiatives.
- Improvements were made as a result of investigations into significant events. For example, a small wallet sized card was made detailing what patients need to do if presenting at an out-of-hours (OOH) facility. This followed an issue with miscommunication by the local NHS facility following an OOH appointment and in addition the patient being unaware of the process they needed to follow.
- The practice manager was responsible for managing medicine and safety alerts. These were cascaded from Aldergrove pharmacy technicians to the practice mailbox. The system was checked for alerts each day and any alerts logged on a spreadsheet. Alerts were emailed to staff with a read receipt. They were also discussed at the practice meetings.

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 weekly meetings for clinicians and, if relevant to the wider staff team, at the practice meetings and health care governance meetings. Staff were also kept informed of clinical and medicines updates through the Defence Primary Health Care (DPHC) newsletter circulated to staff each month.
- The ERI provided all patients with an individual exercise programme and ran classes on a four-week progressive programme. Rehab Guru, software for rehabilitation plans and outcomes, was used but this was hindered as the unit prevented patients from using their mobile phones in the gym. Paper copies were given to patients instead. This issue had been raised at UHC as it was preventing good practice and full access to programmes, but the unit had not changed the policy to date.
- The PCRF had good communication with the unit and we saw evidence that they were flexible in their approach to providing care. They worked knowing that many of their patients were on short notice to deploy and so adapted their treatment planning accordingly, for example, patients were given exercise programmes to work on while away and were given advice on self-management.
- The PCRF team referred to the Defence Rehabilitation website for best practice guidance. For example, ERIs used it for guidance on equipment management, training and best practice guidance.

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.

- We found the care of patients with long-term conditions was good. For example, those patients with diabetes, hypertension and asthma. There was an experienced member of staff who was responsible for long-term condition management. 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.

We looked at a range of clinical records and were assured that the care of patients with a mental illness and/or related symptoms was being effectively and safely managed. Appropriate templates were used to assess patients and plan their care. Clinicians worked closely with the Department of Community Mental Health (DCMH) and referred patients when required. The practice undertook an audit on depression in September 2019 which confirmed good management. The audit also looked at the use of templates used to capture information. Despite good audit outcomes, the practice held a teaching session to refresh staff. Mental health assessment and best practice guidelines were displayed in each clinical room.

- 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 97% of patients.
- Quality improvement, including clinical audit, was clearly embedded in practice and seen as the responsibility of all staff. Audit activity was recorded and monitored by the practice manager 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: minor surgery, results handling, notes audits, prescribing audits, chronic disease management and high-risk medicines. The practice held a dedicated audit meeting twice a year although audit was also discussed at all meetings.
- The PCRF showed it valued audit and we evidenced many examples where patient care had been improved as a direct result. For example, it was found that patients with tendinopathy had not had positive outcomes following rehabilitation and success rates had been lower than expected. Some research was undertaken by the ERI and the management of the condition was changed. An audit was then undertaken to ensure the success rate of the current achilles and patella tendinopathy rehabilitation programme. Results showed improvement in all 11 patients currently undergoing rehabilitation.

Effective staffing

Continuous learning and development was promoted for staff. The staff database was monitored by the practice manager 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 had a comprehensive and supportive induction. This included supernumerary time and supervised practice.
- Mandated training was monitored and the staff team was in-date for all required training. 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 General Duties Medical Officer (GDMO) was working at the practice. A GDMO is a junior army doctor attached to a field unit before commencing higher level specialist training. There was a well laid out induction for the GDMO and also allocated tutorial time and a weekly portfolio review with their supervisor.
- A process of clinical supervision was in place for PCRF staff and a supervision log was maintained. A SoP was in place for PCRF staff and it covered protected time of up to five days each year for goal specific training in accordance with individual staff objectives.
- Regional meetings and forums were established for staff to link with professional colleagues in order to share idea and good practice. For example, nurses were supported to attend the regional nurse's forum to link with their colleagues.

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 met with the welfare team 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.
- A SoP was in place outlining the process to follow for patients leaving the military. Doctors provided patients transitioning from the military with a release medical. They also referred patients to the welfare team for support with the transition, and if appropriate to the Department of Community Mental Health (DCMH). Patients were 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.

- Health promotion displays were available in patient areas. These were dated and refreshed in line with the strategy. At the time of the inspection there were displays about sexual health, flu, testicular cancer and hand washing.
- Two clinicians had completed the required training in sexual health (referred to as STIF). Information was available for patients requiring sexual health advice, including sign-posting to other services. Where appropriate patients were referred to local genitourinary clinic for screening. Condoms were available at the practice. In the foyer, information about local sexual health pathways was displayed for patients.
- Patients had access to appropriate health assessments and checks. Regular searches were undertaken for patients eligible for bowel and breast screening and appropriate action taken if patients met the criteria. 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 100% 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. 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.
    - 96% of patients were recorded as being up to date with vaccination against hepatitis B.
    - 96% 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.

- 73% of patients were recorded as being up to date with vaccination against typhoid
- 87% of patients were recorded as being up to date with vaccination against MMR

The unit commanders were responsible for ensuring their personnel kept up-to-date with vaccinations. They appropriately did this through the Joint Personnel Administration (JPA) system. The practice carried out an assurance check.

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 gained 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 had received training.
- A minor surgery audit confirmed that 100% of procedures undertaken had consent recorded in the notes.
- Following a recent significant event regarding the use of some vaccines to be used 'off licence' (off-licence use means that the medicine is being used in a way that is different to that described in the licence), a consent form was developed for the patients to sign. This was shared throughout the other bases in Northern Ireland.

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 - September 2019 Patient Experience Survey (27 respondents) showed patients were happy with how they were treated. It showed 100% of these patients would recommend the practice to friends, family and colleagues. The two patients we spoke with and the 36 CQC comment cards completed prior to the inspection were very complimentary about the friendly, considerate and caring attitude of staff both in the practice and the PCRF.
- 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.
- The practice had a concise information booklet to ensure patients were clear about the facilities available including key members of the practice team, contact numbers, opening times and clinics provided.

- The practice maintained a log of compliments. Examples of these included:
    - A patient thanked the staff for providing useful information for them and their family prior to an overseas posting.
    - The physiotherapy department were thanked by the other Northern Ireland practices for their help when their caseloads were high to reduce patients waiting times.
    - A patient expressed their appreciation of the responsive care they had received from one of the doctors when they were due to be posted out the following day.

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 and staff provided an example of when they recently used the service.
- The practice patient survey showed 99% of patients were involved in decisions about their care. Feedback on the CQC patient feedback cards highlighted that patients received information about their treatment to support them with making informed decisions about their treatment and care.
- The practice proactively identified patients who were also carers. A SoP was in place to support the carer identification process. In addition, the practice information leaflet included a section inviting patients who were carers to identify themselves and there was a poster in the waiting area. A register of carers was maintained, and it identified four 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 staff 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. There was also a radio in reception and a TV in the waiting room. There is also a sign asking patients to stand back until they are called forward and a poster advising patients the opportunity to speak to a member of staff in private if required.
- All physiotherapists had their own treatment rooms. The ERIs worked in a new rehabilitation suite to reduce the need for assessing patients in the gym.
- The practice could facilitate patients who wished to see a GP of a specific gender. The physiotherapists were male and female.

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.
- An access audit as defined in the Equality Act 2010 was completed for the premises in August 2019. The issues identified in the audit were highlighted during a recent visit by the Infrastructure team and a Statement of Need (SoN) had been submitted to install automatic doors. The SoN also included other infrastructure deficiencies such as inadequate flooring and lack of hand washing sinks in clinical rooms. These issues were included in the risk register. Whilst 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. Clinic rooms were available on the ground floor. There were accessible WC facilities available on site. Two parking bays were allocated for patients with a disability.
- The PCRF was fully accessible to patients.
- All staff had received training in diversity and inclusion. There was information available on the board in the waiting room.

Timely access to care and treatment

Patients' needs were met in a timely way.

- The practice ran urgent triage clinics from 07:30 to 08:30 each day and offered urgent 'on the day' doctor and nurse appointments. The practice has recently introduced 'green slots' to offer to patients who may have mental health concerns. Shoulder cover was in place from 16:30 - 18:00 Monday to Thursday and 13:00 - 18:00 on Friday. OOH cover commenced at 18:00 and was provided by NHS North Downs and Ards.
- Routine appointments could be accommodated within two days. An appointment for a medical could be made within five days.
- The practice used a text message process as a reminder for patients to attend their appointments.
- Non-attendance at appointments was monitored for the practice, including the PCRF.
- Home visits and telephone consultations were available with clinicians.
- A direct access physiotherapy (DAP) service was in place for patients. Data showed that currently 55% of patients accessed physiotherapy this way which suited the populations needs. Patients prioritised as urgent were given the next available appointment ideally within one working day and patients with a routine need were seen within five working days. The waiting time to see the ERI was one working day.
- The PCRF had undertaken a survey, completed over a period of four months between May and August 2019. Positive feedback was given by 94% of those asked with no negative responses (6% were non-applicable). Patients said they would recommend the practice to their friends and family. They said their appointments were held at a convenient time and place and that they felt involved in decisions about their care.

Listening and learning from concerns and complaints

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

- Information was displayed in the waiting area, outlined in the practice leaflet to help patients understand 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. A doctor took on this role in their absence. The practice managed complaints in accordance with the DPHC complaints policy and procedure. No complaints had been received by the practice or the PCRF in the past two years.

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 had vision, passion with a focus on providing the best possible service for their patients.
- The doctors, the practice nurses and the administrators were all civilian staff and had worked at the practice for many years, as a result they were able to promote consistent leadership. This provided stability when future planning.
- 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 staff team.
- Staff working within the PCRF said they felt included in the practice despite being located away from the main building. They said the practice manager was approachable and inclusive, using instant messaging services (SKYPE) and kept the PCRF included in all communications.

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 practice worked to the DPHC mission statement of:
    - “DPHC is to provide and commission safe and effective healthcare which meets the needs of the patient and the Chain of Command in order to contribute to Fighting Power”
- On the day of the inspection, we found the practice was working to and achieving its aims.

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.
- The PCRF was integrated with the wider practice, including an integration of governance systems.

- 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.
- Openness, honesty and transparency were demonstrated when things went wrong. A no-blame culture was evident; complaints and incidents were seen as opportunities to improve the service.
- The practice team last reviewed their Practice Development Plan in September 2019 which covered communication, administration, infrastructure, CPD and personnel. Their PDP supports the DPHC Mission and Vision plan.
- 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 were in place for all staff.

Governance arrangements

There was an effective overarching governance framework in place which supported the delivery of good quality care. However, there was scope for some improvement.

- There was a clear staffing structure in place and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. Terms of reference were in place to support job roles.
- 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.
- An effective range of communication streams were used at the practice. A schedule of regular practice meetings was well established.
- 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.
- Some aspects of medicines management required improvement.

Managing risks, issues and performance

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

- Risks to the service were well recognised, logged on the risk register and kept under scrutiny through regular review. This included the improvement required throughout the building to meet IPC standards.

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety. Processes were in place to monitor national and local safety alerts, incidents, and complaints.
- A business continuity plan was in place.
- Procedures were in place for managing under performance. We were given an example of how service changes had recently been made with regards to CMTs not working out of the DPHC practice. Force protection was delivered by the nurses, this was due to the CMTs not being up to date with their training and therefore them not being able to fully undertake their role. The practice envisaged reintroducing these staff back into the practice when the issues have been resolved.

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. For example, patient feedback requested that a television be sourced for the waiting room; this had been done.
- The practice has attempted to develop a patient focus group. This was ongoing.
- Good and effective links with internal and external organisations including the welfare team, Regional Rehabilitation Unit (RRU), the DCMH and local NHS services.
- The practice ran a staff survey in September 2019 which provided positive responses. The staff said they felt able to raise any points during practice meetings and with colleagues at any time due.

Continuous improvement and innovation

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

- Quality improvement activity we identified included:
    - The implementation of a new consent form for the use of medicines off-licence.
    - The change of room use into a rehabilitation suite which is now a functional area that benefits all staff and allows patients to be assessed in privacy.