Chepstow Medical Centre

Quality report

Beachley Barracks
Beachley
Chepstow
NP16 7YG

Date of inspection visit:
7 November 2019

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7 January 2020

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?	Outstanding

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? - outstanding

We carried out an announced comprehensive inspection of Chepstow Medical Centre on 31 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 the leadership team demonstrated they had the vision, capability and commitment to provide a patient-focused service that constantly sought ways to develop and improve.
- The leadership team had a detailed understanding of issues and challenges the service was vulnerable to and had strategies to mitigate these.
- An inclusive whole-team approach was supported by all staff who worked collaboratively to provide a consistent and sustainable 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 management of strategic and operational risks was well understood and strategies were in place to effectively manage the risks.
- 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 with internal and external stakeholders, and shared best practice to promote better health outcomes for patients.
- Evidence was in place 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.

- Facilities and equipment at the practice were 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:

- A joint initiative between the practice and chain of command, the 'Imjin Platoon' provided structured rehabilitation alongside meaningful military training in order to improve the rehabilitation of soldiers with musculoskeletal injuries. This has resulted in the platoon yielding successful outcomes with an improvement in deployability rates. In December 2017, the total number of downgraded service personnel for the unit was 131. By November 2019 this figure had reduced to 75, meaning the unit had one of the highest deployability rates. The MFD (medically fit for duty) rate, used as a measure of patient population health, at the time of inspection was 85.5%. In addition, clinicians had noted a marked reduction in the numbers of soldiers in the Imjin Platoon experiencing low morale and/or mental health issues associated with their downgraded status.
- Military medical staff with prolonged absence from the service of over four months were required to repeat the induction process on their return. This ensured they were made aware of any changes and provided a prompt for required training they needed to complete in order to work at the medical centre.
- In response to patient feedback, a two-weekly clinic facilitated by the regional occupational health nurse was set up in July 2019 for patients awaiting a medical board examination who were graded as P7 (medically fit for duty with major employment limitations) and P8 (medically unfit for service). Initial feedback from patients and the occupational health nurse has been positive with patients feeling better prepared.
- A mental health resilience day was organised for deployed military personnel in order to promote mindfulness, resilience and positive mental health for the soldiers and their managers. An American mental health team visited and ran a series of workshops and drop in clinics. Verbal feedback from soldiers and the commanders was positive. It led to debate among commanders on how better they can support mental health among their soldiers.

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, pharmacist and physiotherapist.

Background to the Chepstow Medical Centre

Located in Beachley Barracks, Chepstow Medical Centre delivers a primary healthcare, occupational health and force protection service to a patient population of 637 regular service personnel; 623 male and 14 female aged between 18 and 50 years. The practice supports a battalion which is subject to regular deployment. It also provides 490 reservists with an occupational and force protection service.

A Primary Care Rehabilitation Facility (PCRF) is located in the unit gymnasium near to the medical centre and provides regular service personnel with a physiotherapy and rehabilitation service. As there is no dispensary at the practice, a contract is in place with a local pharmacy.

The medical centre is open from 08:00 to 16:30 hours Monday, Tuesday and Thursday. It is open 08:00 to 12:30 on Wednesday and Friday. Emergency appointments can be accommodated in the afternoons when it is closed. From 16:30 until 18:30 access to emergency medical cover (referred to as shoulder cover) is provided by St Athan Medical Centre. Outside of these hours, including weekends and bank holidays, cover is provided by NHS 111.

The staff team at the time of the inspection

Position	Numbers
Regimental Medical Officer (RMO) - also assumes role of Senior Medical Officer (SMO)	One
Civilian medical practitioner (CMP)	One – locum
Practice nurses	Two – one civilian; one military
Civilian practice manager	One – long term leave
Military acting deputy practice manager	One
Reception	One
PCRF	One physiotherapist
Medics	Six – five on operation

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 RMO was the lead for adult and child safeguarding with the physiotherapist deputising in the absence of the RMO. All clinical staff had completed level 3 safeguarding training and other staff had received safeguarding training at a level appropriate to their role. The local safeguarding policy was last reviewed in September 2019. It, along with local contact details, was displayed for staff to access promptly.
- 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) and regular searches of the system were used to update the register. Patients identified as vulnerable were reviewed at the monthly clinical meeting, which the October 2019 minutes confirmed; there were 16 vulnerable patients at the time of the inspection.
- The Unit Welfare Team described to us an effective working relationship with the practice whom they met with on a weekly basis to discuss the needs of patients who were vulnerable.
- 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.
- Arrangements were in place to monitor the registration status of clinical staff with their regulatory body. The practice manager confirmed clinical staff were up-to-date with their professional registration. They also had professional indemnity cover and had received the relevant vaccinations required for their clinical role at the practice.
- There was an effective process to manage infection prevention and control (IPC), including both the practice nurses leading and deputising for IPC. They were suitably skilled and experienced for the role. The staff team was up-to-date with IPC training. An integrated medical centre and PCRF IPC audit was completed in 2019.
- Environmental cleaning was provided by an external contractor. Cleaning schedules including frequency of cleaning were displayed in each room. The IPC lead carried out spot checks of the premises to monitor cleaning standards. The annual deep clean of the premises took place in November 2019. We identified no concerns with the cleanliness of the premises.
- A member of staff had the lead for the safe management of healthcare waste. A waste log was in place and consignment notes retained at the practice. An annual waste audit was carried out in October 2019.

Risks to patients

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

- Through staff interviews and waiting times statistics, we determined that staffing levels and skill mix was sufficient to meet the needs of the patient population. The team comprised a mix of Regimental Aid Posts (RAP) and civilian staff, with the civilian staff providing stability and consistency when military staff deployed. A RAP is a front-line military medical staff post attached to a military unit that is subject to deployment, often at short notice. When not deployed, RAP staff work in medical centres to update and maintain their skills. They also have a focus on ensuring the occupational health requirements of unit personnel are up-to-date. The RAP team working at Chepstow Medical Centre included the RMO, military practice nurse and medic. 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.
- From August 2019 and due to the deployment of the RMO, a CMP (retired military doctor) at Brecon Medical Centre facilitated a weekly clinic at the practice.
- For the last two years there had been no permanent CMP with the post filled by locum doctors. A locum induction pack was in place to familiarise temporary staff with systems and processes. The CMP described a thorough induction, including a two month mentorship, when they took up post in January 2019. Recruitment for a vacant Exercise Rehabilitation Instructor (ERI) post was underway. Staffing levels was a standing agenda item at the monthly management meetings.
- The practice was equipped to deal with medical emergencies and all staff were suitably trained in emergency procedures, including basic 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. The emergency trolley was secured to the wall and we highlighted to the staff that this could delay access in an emergency. They agreed to reduce this level of security to support with quicker access to the trolley. Daily and monthly checks were in place to ensure the required kit and medicines were available and in-date. A first aid kit and accident book was available.

- The staff team participated in regular training relevant to emergency situations and update training was scheduled to capture staff who were deployed with the unit and due back in November 2019. Scenario based training was held each week. Over the last 12 months scenario training included the management of spinal injuries delivered by the physiotherapist, sepsis and climatic injuries facilitated by the CMP and the management of head injuries was delivered by the RMO. 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 15 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.
- Clinical records for all clinicians were routinely audited. The directive from region was for a standardised approach therefore the same audit template was used for all clinicians. The records for doctors were audited in February 2019 and those completed by medics in March 2019. The CMP had audited the clinical records maintained by the practice nurse. and the physiotherapist.
- A process was established for scrutiny and summarising of patients' records. The practice nurse was responsible for completing the summarisation of records. Ninety-nine per cent of records had been summarised 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, Innsworth Medical Centre could supply an appointment list and contact details for patients. The most recent loss of connectivity was in October 2019 and lasted for 21 hours. This was reported as a significant event.
- Referrals to other departments and external health care services, including urgent referrals, were made be clinicians and tracked by the practice manager. The NHS e-Referral service was mainly used for referrals in England. Referrals to Welsh NHS services were made by email. All referrals for the practice were logged on a spreadsheet and checked daily.
- A standard operating procedure (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 arrangements for managing medicines and vaccines were appropriate and safe. This included arrangements for obtaining, recording, storing and handling of medicines.

- The RMO was the dedicated staff lead and the practice nurse the deputy lead for medicines management within the practice. As it was not a dispensing practice, support was also

provided from a pharmacy technician at a nearby medical centre, and there were regular visits from the regional pharmacist. There was an effective relationship with the local pharmacy that dispensed the prescriptions.

- All staff who administered vaccines had received immunisation training as well as the mandatory anaphylaxis (serious allergic reaction) training.
- Repeat prescriptions were only accepted in person, were reviewed regularly and processed within 48 hours. The doctors were in the process of following up on outstanding repeat medicine reviews. Data showed that 71% of reviews had been completed with 15 patients left to review. The RMO highlighted that most reviews concerned historical prescribing of topical creams.
- All prescription forms were stored and managed safely. There were no controlled drugs held at the practice but controlled drug prescribing was audited quarterly to identify any trends.
- High risk medicines (HRM) were managed effectively in accordance with the SoP. Alerts, coding and diary dates were used to identify and manage patients prescribed an HRM; confirmed through our review of clinical records. All patients who were prescribed these or had a chronic illness were reviewed by the CMP and nurse at a monthly virtual chronic disease clinic. At the time of the inspection no patients required a shared care agreement.
- Patient Group Directions (PGD) and Patient Specific Directions (PSD) were in use to allow non-prescribing staff to supply simple treatments or carry out vaccinations in a safe way. PGDs were appropriately managed as staff had received training and had been authorised by the doctor. This had recently been successfully audited. Medic protocols were not currently being used but the RMO understood the requirements to implement this safely.
- Out-of-hours, secondary care prescriptions and amendments to current therapy as directed by secondary care were recorded and actioned by the doctors.

Track record on safety

The practice had a good safety record.

- Measures to ensure the safety of the environment and facilities were in place. The practice manager was the lead for health and safety and was supported by the camp health and safety team, who carried regular assessments of the premises. These included an environmental risk assessment in July 2019, electrical safety checks, a legionella risk assessment in 2018 and temperature checks of the water each month. 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.
- Processes were established to ensure equipment was in good condition and regularly serviced. Equipment servicing and 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 staff used hand-held alarms which were located in each room. We activated two alarms during the inspection; staff responded to the alarm in the medical centre within 15 seconds. The same response in the PCRF was slower. There was a lone working SoP for the PCRF and a response log to the alarm being tested was maintained. It showed response times were quicker than on the day of the inspection. The physiotherapist could see patients in the medical centre if there were concerns about lone working.

- The waiting room could not be observed from reception. Shortly after the inspection the practice manager provided evidence to show CCTV had since been fitted.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- The CMP was the practice lead for significant events. Staff used the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events and incidents. 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, including positive events. Significant events and lessons learnt were discussed at the practice and healthcare governance meetings; this was confirmed by the minutes of both meetings held in October 2019. Wasted stock due to a drop in fridge temperatures was raised as a significant event and as a result new fridges were purchased with one fridge acting as back-up.
- All medicine safety notices and alerts were logged on a spreadsheet, actioned appropriately and discussed at the monthly meeting. The practice nurse checked the national alert website twice a day as they were not receiving the alert via the DPHC cascade.

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.
- The RMO was the lead for evidence-based practice and the physiotherapist deputised in their absence. 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 healthcare governance meetings held each month. For example, at the October 2019 meeting the NICE guidance regarding chronic pain management and suicide prevention guidance were discussed. A log was maintained of guidance received and reviewed.
- 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 the physiotherapist's patient records showed the musculoskeletal Health Questionnaire (MSK- HQ) was used to monitor trends along with cause of injury rates. Rehab Guru, software for rehabilitation plans and outcomes, was used for exercise programmes for patients. The physiotherapist referred to the Defence Rehabilitation website for 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 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 Defence Primary Healthcare (DPHC) practices, we are not using NHS data as a comparator.

- A SoP was in place for the management of long-term conditions (LTC). The RMO was the lead and the practice nurse the deputy lead for LTC. Regular DMICP searches were carried out to ensure all patients with an LTC were identified. A virtual clinic was held each month and we found that it was an effective and well managed approach given the small numbers of patients with an LTC. For example, there was one patient with diabetes, three with high blood pressure and three with a diagnosis of asthma. Consistent templates were used to review patients, such as the DMICP asthma template.
- The staff team attended training facilitated by the Department of Community Mental Health (DCMH) regarding the mental health disorders care pathway for primary care. Patients presenting with a mild to moderate anxiety or low in mood were assessed in accordance with the pathway and treated initially at the practice (step 1) or referred to the DCMH if their clinical need was assessed as greater than what step 1 could provide. Through review of clinical records and discussions with the doctors, we were assured that the care of patients was being effectively and safely managed. Appropriate templates were used to assess patients and plan their care. Referral trends to the DCMH were reviewed at the clinical meetings.
- 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 the patient population.
- The RMO was the lead for healthcare governance and the CMP deputised in their absence. Quality improvement, including clinical audit, was embedded in practice. It was used to systematically review clinical outcomes to ensure treatment and care was being provided in accordance national and local standards. The audit log illustrated all the staff team were active participants in the audit process, including system searches, administrative and clinical audits.
- Clinical audit topics in the last 18 months included PGDs, cervical cytology, diabetes, asthma, lower back pain (LBP), femoral pain syndrome, antidepressant use and prescribing. Most audits were first cycle and the audit planner for 2020 showed which topics were identified to be repeated, such as antidepressant use. Audit was discussed at the healthcare governance meetings. For example, minutes of the October 2019 meeting illustrated that the physiotherapist discussed the outcome of the LBP audit and confirmed it would be repeated in six months.
- A log was maintained of quality improvement projects (QIP) the practice had been involved with. Nineteen QIPs were identified since September 2019 including QIPs in relation to the mental wellbeing of service personnel deploying, staff wellbeing, weight management and vulnerable patients leaving the military.

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 two staff inducted in 2019, described a comprehensive and supportive induction. This included supernumerary time and supervised practice.
- Military medical staff with prolonged absence from the service of over four months were required to repeat the induction process on their return. This ensured they were made aware of any changes and provided a prompt for required training they needed to complete in order to work at the medical centre.
- Mandated training was monitored by the practice manager. The staff team was in-date for all required training; any training gaps could be explained and accounted for. A programme of ongoing development training was in place with in-house training sessions available to staff each week. Training topics were agreed based on the patient population need. This training supported professionally registered clinicians with their continual professional development (CPD) and revalidation.
- There was a strong emphasis on encouraging staff to expand their knowledge base and develop their skills. Staff had or were undertaking additional training and learning. For example, the acting practice manager was undertaking a practice management course and a medic was completing a degree. The physiotherapist had completed the defence health and wellbeing course and had submitted a proposal to facilitate a DOFit programme; an evidence-based course aimed at supported individuals to return to optimal fitness.
- The monthly clinical meetings facilitated clinical discussion/peer review and all clinical staff participated in these meetings. In addition, regional meetings, training and forums were established for staff to link with professional colleagues in order to share ideas and good practice. For example, the practice nurse used video conferencing to join with training facilitated by other medical centres.
- The physiotherapist received supervision/peer support each month. The practice nurse and physiotherapist carried out a communication peer review on a two monthly basis. The physiotherapist also had two monthly recorded peer review from a Band 7 physiotherapist at another service.

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. An effective relationship had been established with a local NHS primary care practice where most of the families of service personnel were registered. In addition, the practice had good links with the local midwifery service and Gloucester Carer Support Agency.

- Patients assessed as needing enhanced mental health input were referred to DCMH Brize Norton and to the satellite clinic held at St Athan Medical Centre.
- An effective working relationship was established with the Chain of Command and Unit Welfare Team. Unit Health Committee (UHC) meetings were held each week (informal) and each month (formal) where the health, occupational and rehabilitation needs of patients were discussed, including patients who had been downgraded.
- The physiotherapist met every two weeks with the physical training instructor (PTI) for the unit. In the absence of an ERI, the PTI delivered strength and conditioning training to injured personnel so this meeting meant patients being seen by the PTI could be reviewed.
- Doctors provided patients transitioning from the military with a release medical. With the consent of patients, an enhanced handover letter was completed for patients identified as vulnerable which was included with the summary letter. 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 Forces, 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 staff encouraged and supported patients to be involved in monitoring and managing their health. Staff also discussed changes to care or treatment with patients as necessary.
- The practice nurse was the lead for health promotion. As the practice was co-located with the dental practice, they liaised with the co-located dental team regarding the health promotion strategy. The strategy was underpinned by national priorities and initiatives to improve the population's health. At the time of the inspection the health and wellbeing campaigns being run included, a smoking cessation clinic, over-40s health checks, testicular cancer awareness, mental health awareness and sexual health.
- In January 2020 the physiotherapist and PTI plan to jointly run a DOFit course to address lifestyle management issues with the aim to run the course quarterly.
- A joint initiative between the medical centre and chain of command, the 'Imjin Platoon' was established in 2018 to provide structured rehabilitation alongside meaningful military training in order to improve the rehabilitation of soldiers with MSK injuries. Clinically led from the PCRF, the platoon has yielded successful outcomes with an improvement in deployability rates. In December 2017, the total number of downgraded service personnel for the unit was 131. In November 2019 this figure had reduced to 75, meaning the unit now has the second highest deployability rate. The MFD (medically fit for duty) rate, used as a measure of patient population health, at the time of inspection was 85.5%. In addition, the practice had noted a marked reduction in the numbers of MSK injured soldiers in the Imjin Platoon experiencing low morale and/or mental health issues. The practice identified this initiative as a quality improvement project (QIP).
- A mental health resilience day was organised for deployed soldiers in order to promote mindfulness, resilience and positive mental for the soldiers and their managers. An American mental health team visited and ran a series of workshops and drop in clinics. Verbal feedback from soldiers and the commanders was positive. It led to debate among commanders on how

better they can support mental health among their soldiers. The practice identified this initiative as a QIP.

- The RMO and the practice nurse were the leads for sexual health and had completed the required training for the role (referred to as STIF). Patients were screened at the practice and referred if appropriate to the local genitourinary clinic. 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. With the exception of cytology, there were no patients who met the criteria for the screening programmes. Searches were undertaken to ensure patients eligible for cytology screening were recalled. Cytology was provided by a local NHS primary care practice and all patients eligible for cervical screening had received a smear test.
- 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:
    - 98% of patients were recorded as being up to date with vaccination against diphtheria.
    - 98% of patients were recorded as being up to date with vaccination against polio.
    - 93% of patients were recorded as being up to date with vaccination against hepatitis B.
    - 97% of patients were recorded as being up to date with vaccination against hepatitis A.
    - 98% of patients were recorded as being up to date with vaccination against tetanus.
    - 97% of patients were recorded as being up to date with vaccination against MMR.
    - 90.6% 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. The CMP delivered received training on this subject matter in September 2019. A poster outlining the five core principles of The Act and the stages of assessment was displayed in clinical areas.
- Monitoring the process for seeking consent was captured through the audit of clinical records completed for each clinician throughout the year.

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 April 2019 and September/October 2019 patient experience survey (27 respondents in total) showed patients were satisfied with the service they received at the practice. The two patients we spoke with and the 25 CQC comment cards completed prior to the inspection were very complimentary about the friendly, compassionate and caring attitude of staff.
- An information network known as HIVE was located outside the camp and was available to all patients. This provided a range of information to patients who had relocated to the base and surrounding area.

Involvement in decisions about care and treatment

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

- An interpretation service was available for patients who did not have English as a first language.
- The patient experience survey showed all patients who responded had 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 had a process in place to identify patients who had a caring responsibility. The needs of these patients were discussed at the meetings with the Unit Welfare Team and the practice clinical meetings. Information for carers was displayed on the patient information board the patient waiting area. A register of carers was maintained and it identified two patients with a caring responsibility.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Clinic room doors were closed during consultations. Screening had been fitted in consulting rooms. However, it had been fitted incorrectly in some clinical rooms; around the inside of the clinic door rather than around the treatment bed. The practice had a workaround to this in order to maintain patients' privacy and dignity during examinations, investigations and treatments. The practice manager confirmed that a request had been submitted for the curtain tracking to be re-fitted in the correct areas.
- The layout of the reception area and waiting area meant that conversations between patients and reception would not be overheard. A 'yellow card' system was in place for patients to indicate if they wished to speak to a member of staff privately.
- The practice had arrangements in place to support patients who wished to see a clinician of a specific gender. For example, patients could be referred to Innsworth Medical centre/PCRF.

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 their patient population and tailored services in response to those needs. Opening hours were organised to meet the needs of the battalion and to ensure the least disruption to the battalion working hours.
- The patient experience survey indicated that all respondents would recommend the practice to family and friends. The two patients we spoke with said the practice was 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 had been completed for the premises. The practice had made as much reasonable adjustment as possible. For example, specific car parking spaces were designated to patients with a disability. An accessible WC facility was available.

Timely access to care and treatment

Patients' needs were met in a timely way.

- The practice accommodated patients with an emergency need and staff advised us that no patients were turned away and would be seen on the same day. Routine appointments with the nurse and doctor could be accommodated on the same day or within 24 hours.
- The waiting time for both a routine and urgent physiotherapist appointment was one day. A follow up physiotherapy appointment could be accommodated within three days. The key performance indicators for the PCRF were being met with ease as the patient population numbers were low whilst the unit was deployed. Patients referred to the Regional Rehabilitation Unit (RRU) were seen within an acceptable time frame and a patient referred to the Multidisciplinary Injury Assessment Clinic (MIAC) had a wait of less than 20 days.
- Patients requiring specialist medicals, such as a diving medical were referred to St Athan Medical Centre.
- A two-weekly clinic facilitated by the regional occupational health nurse was held for patients awaiting a medical board examination who were graded as P7 (medically fit for duty with major employment limitations) and P8 (medically unfit for service). This clinic was initiated in response to patient feedback and had been identified as a quality improvement project (QIP).
- Emergency cover on week days between the time the practice closed until 18:30 hours was provided by the duty medic with access to a doctor provided by St Athan Medical Centre. Patients had access to NHS 111 from 18:30 hours weekdays, at weekends and public holidays.
- Telephone consultations were available with doctors. The home visit policy was outlined in a SoP and in the patient information leaflet. A SoP to support administrative staff with managing requests for home visits was in place. A home visit register was maintained. If patients were at home sick with no access to military transport then they were advised to register temporarily at a local NHS primary care practice.
- A direct access physiotherapy (DAP) service was not in place. The reason for not introducing DAP was due to low patient numbers because of deployment. There was a plan to introduce DAP when the full unit returned in November 2019.
- Non-attendance at appointments was monitored and displayed on the patient information board. In October 2019 eight appointments were missed with clinician time lost totalling 150 minutes.

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 that outlined how to make a complaint. All staff were aware of the complaints process.
- The RMO was the designated responsible person for complaints with the day-to-day management of complaints delegated to the practice manager. Complaints were managed in accordance with the DPHC complaints policy and procedure. Both written and verbal complaints were recorded on the complaints register. We noted that just two verbal complaints had been received in the last 18 months. Complaints, including lessons learnt, were discussed at the governance meetings.

Are services well-led?	Outstanding

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

Leadership capacity and capability

The leadership team demonstrated high levels of experience, capability and resourcefulness to deliver high-quality sustainable care to the patient population.

- The RMO provided safe and effective clinical leadership for the practice despite being subject to deployment. The RMO had been deployed from March to October 2019 and described how 40% of their workload when deployed involved provision of continued leadership to the practice. Staff confirmed the RMO was accessible for guidance and advice whilst away.
- The RMO had a detailed understanding of issues and challenges the service was vulnerable to and had strategies to mitigate these. For example, the RMO was forward thinking to ensure continuity when key military staff were absent from the service. This included forecasting ahead and planning for periods of deployment, lobbying regional headquarters to secure adequate staffing levels and ensuring an effective staff team to provide continuity. To achieve this, there was a healthy mix of DPHC and military staff with DPHC staff undertaking key lead or deputising roles to promote continuity of care delivery.
- The practice manager was long term absent from the service when we inspected. A medic was acting into the role. Despite having minimal experience, they had a detailed understanding of what was required to effectively fulfil the role, including management of systems and processes to ensure a well-governed and sustainable service. They described how the RMO and wider staff team had supported them with developing into this role.

Vision and strategy

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

The practice worked to the following DPHC mission statement:

- ‘Provide and commission safe and effective healthcare which meets the needs of the patient and chain of command in order to contribute to fighting power’

The practice values and vision were identified as:

- Respect for patients and the role they have committed their lives to, in service of their country.
- Work with patients and their CoC to optimise the health of our PAR [population at risk]
- Value and respect the opinions and skills of all members of the medical team.
- Develop staff as clinicians and leaders so as to improve the quality of the care we deliver.

Examples of how the practice was achieving this was demonstrated through:

- The effective networks and relationships that had been developed to enhance support for the practice, including with the Unit Welfare Team, CoC, DCMH Brize Norton, Innsworth Medical Centre, St Athan Medical Centre, the local NHS primary care practice and Gloucester Carers Agency.
- Involvement with the setting up of the Imjin Platoon to provide structured rehabilitation alongside meaningful military training for soldiers with MSK injuries. This had led to improved outcomes for patients and an increase in deployability for the CoC.
- Development of staff to ensure continuity and succession planning during periods of deployment.

Culture

The leadership of the practice demonstrated a commitment to ensuring equality and inclusion across the workforce.

- Staff spoke highly of the culture, strong collaborative team work and support from the leadership team. They said everyone had an equal voice, regardless of rank or grade.
- The inclusive culture was evident throughout the inspection. For example, all clinicians actively participated in the delivery of the presentation to the inspection team. The PCRF was dislocated from the medical centre yet the physiotherapist was fully included in all governance activity and held key lead roles for the practice. Furthermore, the locum CMP was a key member of staff in driving forward the audit programme. The CMP also provided training on various topics for the staff team.
- 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 Imjin Platoon, the DOFit programme and organising clinic times to meet the working hours of the battalion.
- 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. These were discussed as a team at formal meetings.
- The practice had systems to ensure compliance with the requirements of the duty of candour, including giving those affected reasonable support, information and a verbal and written apology. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.

- The RMO clearly demonstrated that the needs and welfare of staff were a 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. Roles in specific topic areas were allocated to ensure continuity when military staff were absent from the service. 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. The workbook was used to its full effect and was up-to-date. 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, clinical, and governance meetings were well established. All staff attended the meetings relevant to their role and minutes were maintained of all meetings.
- 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.

Managing risks, issues and performance

There were clear 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 vacancies for DPHC staff, deployability of military staff and access to a female doctor and male physiotherapist. These risks were mitigated through good relationships with other services and identifying to regional headquarters at the earliest any potential shortfalls in staff.
- Processes were in place to monitor national and local safety alerts, incidents, and complaints.
- A business continuity plan was in place and staff were familiar with the content.
- Procedures were in place for managing poor performance.

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.
- The practice was subject to a healthcare governance visit (referred to as HGAV) by the regional team in October 2018. A large number of areas lacked full assurance with medicines management rated as 'no assurance'. Despite the practice not receiving the HGAV report until October 2019 and 10 days before this inspection, it was clear that all areas of concern had been addressed in the 12 months since the HGAV. We spoke with the Regional Director about the practice's delayed access to the HGAV report. They were new to post so could not account for this delay with the practice receiving the report.
- The practice team said it was well supported by the regional governance team, including the regional pharmacist.

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. It was evident that the practice made changes based on patient feedback. For example, an answerphone was secured for the PCRF following patient feedback.
- A patient participation group (PPG) was discussed with the CoC in 2018 and set up in August 2019; the delay was due to deployment. Joint with the dental centre, the first meeting was held in September 2019 and was well attended. Meeting minutes were made available to all in attendance.
- A process was in place for staff to provide formal feedback about the service.
- Good and effective links were established with internal and external organisations including the Unit Welfare Team, CoC, RRU, the DCMH, local NHS and social services.

Continuous improvement and innovation

Continuous improvement was embedded in the culture which was one of seeking to continually improve the service for patients. The practice maintained a log of quality improvement projects (QIP) on the HG workbook. We found that improvements were implemented based on the outcome of feedback about the service, the outcome of audits and significant events.

The following QIPs were formally identified by the practice:

- A mental health resilience day organised for deployed personnel in order to promote mindfulness, resilience and good mental health for the soldiers and for their commanders. An American mental health team visited and ran a series of workshops and drop in clinics.
- Based on patient feedback, an occupational health nurse clinic was set up to prepare downgraded patients for medical boards.

- Based on patient feedback, a display board was created linking the medical centre and the PCRF.
- Proposal to implement the DOFit programme based on a trend of weight increase for patients in rehabilitation.
- Weekly meetings with the CoC and Unit Welfare team to promote enhanced communication and working relationships with the CoC and provide a better service for the soldiers.
- Feedback from staff regarding the lunchtime running group implemented by the practice nurse suggested this initiative was having a positive impact on the physical and mental health of staff. The group has also helped in bonding the team through shared experiences.