Kineton Medical Centre

Quality report

Kineton Marlborough Barracks,
Temple Herdewyke,
Warwickshire,
CV47 2UL

Date of inspection visit:
5 February 2020

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27 March 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?	Good

Chief Inspector's Summary

This group practice is rated as good overall

The key questions are rated as:

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

We carried out this announced follow up comprehensive inspection on 5 February 2020. The report covers our findings in relation to the recommendations made and any additional improvements made or concerns identified since our last inspection.

The previous inspection took place on 30 April 2019 and the practice was rated inadequate overall. A copy of the report from that comprehensive inspection can be found at:

https://www.cqc.org.uk/sites/default/files/20190723_kineton_medical_centre_final_report.pdf

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 drive to provide a patient-focused service that sought ways to continually 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 and recognised as the responsibility of all staff.
- The arrangements for managing medicines, including obtaining, prescribing, recording, handling, storing, security and disposal minimised risks to patient safety.
- Staff were aware of current evidence based guidance. They had received training so they were skilled and knowledgeable to deliver effective care and treatment.
- The practice worked collaboratively and shared best practice to promote better health outcomes for patients.
- There was evidence to demonstrate quality improvement had started to embed in practice, including the development of 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.
- 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:

- There was a history of pathology results being returned to the incorrect practice. Through liaison with the hospital, a specific pathology barcode request form for Kineton Medical Centre was secured and also a practice code for the laboratory forms. This code was used by all clinicians and since its introduction no results had been returned to the incorrect practice.
- The practice had a pro-active approach to injury prevention, occupational health management and health surveillance. Due to awareness of the population's work requirements, the physiotherapist had investigated the potential risk of injury due to repetitive loading tasks. Although there had not been an increase in injury presentation, the physiotherapist investigated the issue using the Health and Safety Executive body mapping tool in order to inform the unit about potential future risk. In addition, the physiotherapist offered advice appointments to non-injured patients to support with their training and to promote injury prevention.

The Chief Inspector recommends:

- Implementing the actions identified from the clinical record keeping audit (January 2020) so the application of Read coding is improved, including the coding for high risk medicines.
- Using the population manager facility on DMICP (electronic patient record system) to conduct clinical searches so the SMO has oversight of the Quality and Outcomes Framework performance for the practice.
- Undertaking scanning of clinical documents in a timely way.
- Staff who are eligible receive an appraisal of their performance in accordance with policy.
- The regional team provide the practice with a copy of assurance visit reports in a timely way.

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

Our inspection team

The inspection was led by a CQC inspector and included a primary care doctor, practice manager, practice nurse and physiotherapist specialist advisors.

Background to Kineton Medical Centre

Kineton Medical Centre provides routine primary health care and occupational health to a small patient population of 200 service personnel. The patient population comprises three military units, a security unit and five site support units.

Medical cover is provided through a contract with an NHS primary care practice, located nine miles away. Two NHS GPs provide 10.5 hours of medical care each week with one of the GPs identified as the clinical lead/Senior Medical Officer (SMO). A primary care rehabilitation facility (PCRF) is based in the practice.

The practice is open 08:00 to 16:30 Monday to Wednesday, Thursday from 08:00 to 11:00 and on Fridays from 08:00 to 13:00.

Patients have access to a GP at the practice during the following times:
Monday 08:00 to 09:30
Tuesday 08:00 to 09:30
Wednesday 08:00 to 09:30
Thursday 08:00 to 12:30
Friday 08:00 to 09:30

Outside of these times patients can attend the local NHS primary care practice and access NHS 111 from 18:30.

The staff team

Position	Numbers
Senior Medical Officer (SMO)	One providing six hours cover each week
Civilian medical practitioner (CMP)	One; recruitment for a second CMP in progress
Senior practice nurse	One
Practice nurse	One (locum)
Practice manager	One full time
Administrative staff	One full time
PCRF	One part time physiotherapist 15 hours per week with an additional seven hours overtime
Medic[1]	One – temporary post that ends in March 2020

[1] A medic is a unique role in the forces and the role is similar to that of a health care assistant in NHS GP practices but with a broader scope of practice.

Are services safe? | Good

We rated the practice as good for providing safe services.

Following our previous inspection, we rated the practice as inadequate for providing safe services. We found inconsistencies in processes to keep patients and staff safe including gaps in:

- clinical staffing levels and skill mix;
- audit of clinical records;
- medicines management;
- medical emergency training for staff;
- summarisation of records; and

- health and safety, including access to safety checks for the building and facilities.

At this inspection we found the recommendations we made had been actioned.

Safety systems and processes

Systems were in place to keep patients safe and safeguarded from abuse.

- A framework of regularly reviewed safety policies was available and accessible to all staff working at the practice. Staff received safety information about the practice as part of their induction and refresher training.
- Measures were in place to protect patients from abuse and neglect. Adult and child safeguarding policies were in place. All staff had received up-to-date safeguarding training appropriate to their role and knew how to identify and report concerns. The SMO was the safeguarding lead and the senior practice nurse deputised in their absence; both had completed level 3 safeguarding training.
- Coding and alerts were used on the electronic patient record system (referred to as DMICP) to identify patients who were vulnerable. A vulnerable patient register was held on the practice health governance workbook, a system designed to bring together a comprehensive range of governance activities, including the risk register, significant events tracker, lessons learnt log, training register, complaints and quality improvement activity. Minutes of the governance and assurance meetings showed the register was reviewed by the staff team. There were no patients under the age of 18 registered at the practice. We checked a range of patient records who were assessed as vulnerable and correct Read coding, alerts and reviews were in place.
- All staff had received chaperone training and had been subject to safety checks to ensure they were suitable to work with young people and vulnerable adults. Notices were displayed advising patients of the chaperone service available.
- The full range of recruitment records for permanent and locum staff were held centrally. The practice manager could demonstrate relevant safety checks had taken place at the point of recruitment, including a Disclosure and Barring Service (DBS) check to ensure staff were suitable to work with vulnerable adults and young people. DBS checks were renewed every five years. The GPs were on the performers list and had DBS checks undertaken as part of that process. The performers list is a process that provides an extra layer of reassurance for the public that NHS GPs are suitably qualified, have up to date training and have passed other relevant safety checks to ensure they can provide a service to vulnerable people.
- Arrangements were in place to monitor the registration status of clinical staff with their regulatory body. All staff had professional indemnity cover.
- The senior practice nurse was identified as the lead for infection prevention and control (IPC) and were due to attend the IPC link course in March 2020. An IPC audit had been completed by the IPC lead from another medical centre and the practice received a compliance score of 92%.
- The practice had a dedicated external contract cleaner who worked to an agreed cleaning schedule. The cleaning manager carried out monthly audits and attended practice management meetings quarterly. Arrangements were within the contract for deep cleaning.
- Clinical waste was stored in a locked and secured yellow bin. A waste log was in place and consignment notes retained. Clinical waste was removed twice weekly with sharp waste removed monthly. Waste medicines were returned to the supplying pharmacy. An annual waste audit was completed in April 2019 and again in January 2020.

Risks to patients

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

- Since the last inspection clinical capacity at the practice had improved. Although the contracted clinical time for GP provision had not increased, nursing levels had improved. A locum practice nurse had been appointed six months ago and, shortly before this inspection, a military senior practice nurse had joined the team. In addition, a medic had been supporting the practice on a short term basis. The possibility of support from an exercise rehabilitation instructor (ERI) at another medical centre was under discussion.
- A locum induction pack had been developed and had been used when the locum nurse started working at the practice.
- The practice was equipped to deal with medical emergencies. Emergency medicines and equipment were checked regularly. Our check of the emergency kit confirmed the required medicines and equipment were available and in-date. We noted the batteries for the automated external defibrillator (AED) had expired. The practice manager confirmed after the inspection these had been replaced.
- Staff were up-to-date with training to manage medical emergencies. Records showed, and staff confirmed, the team received spinal and thermal injury training in December 2019, and sepsis training in November 2019.
- The waiting area could not be observed by staff and CCTV had been installed so the area was being monitored from reception.

Information to deliver safe care and treatment

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

- The new guidance on registering and deregistering patients (Defence Primary Health Care standard operating procedure GN28) had been implemented since the last inspection. This meant patients' clinical records were scrutinised and summarised through this process, usually when the patient attended for a health check. If patients refused the health check then the nurse summarised their notes anyway. A monthly search was undertaken, which confirmed summarisation was up-to-date at the time of the inspection.
- The range of patient records we reviewed on DMICP showed clinical record keeping was detailed and of a good standard. However, we noted inconsistencies with the use of Read coding. For example, coding was not always by clinical condition or diagnosis, rather consultations and reviews were broadly coded as 'patient reviewed' or 'telephone encounter'. Our findings correlated with the outcome of the clinical record keeping audit undertaken by the SMO in January 2020. Improving the use of Read coding was identified as requiring action. The practice manager confirmed after the inspection clinicians had been made aware to link Read codes to conditions and to cease using generic coding.
- Staff described occasional freezes or lost connectivity with DMICP. The patient appointment list was printed so in the event of no access to DMICP, the list was used and consultation notes scanned onto DMICP at a later point.
- A process was established to undertake an annual audit of clinical records for GPs. It was last undertaken in January 2020 and presented by the SMO for discussion at the governance and assurance meeting. It showed that record keeping was of a good standard. Actions were also identified to support continuous improvement. The clinical records for the nurse were subject to

an external audit in November 2019. A self-assessment audit of the physiotherapist's clinical records was completed July 2019.

- Patients attended the NHS primary care practice when Kineton Medical Centre was closed or did not have a GP available. At the previous inspection, there was no process in place to monitor the numbers of patients attending the NHS practice. Furthermore, there was no protocol or standard operating procedure (SoP) in place for the transfer of NHS consultation records for inclusion in the patient's DMICP record. The NHS practice had since been provided with a DMICP laptop so could add consultation records straight onto the patient's record. This new arrangement was working well.
- There was an effective system in place for the management of referrals and the administrator oversaw the process. The medic and practice manager were familiar with the system and managed referrals in the absence of the administrator. Two referral registers were in operation; one for referrals by a GP to external agencies and one for internal referrals made by the physiotherapist. Urgent referrals were highlighted on the registers in red. The registers were monitored weekly, including assurance that the referral had been received. In addition, a check was made to confirm whether the patient attended the appointment. The physiotherapist also kept and maintained their own register of referrals.
- Even though we found specimens were well managed at the previous inspection, the practice had undertaken further work to ensure the previous problem of results being returned to the NHS practice rather than to Kineton Medical Centre did not reoccur. Through liaison with the hospital, a specific pathology barcode request form for Kineton Medical Centre was secured and also a practice code for the laboratory forms. This code was used by all clinicians and it meant results for Kineton patients were returned to the correct practice. A SoP was in place and a specimen register, which the nurse regularly checked along with the inbox for returned results.

Safe and appropriate use of medicines

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

- The SMO was the lead clinician responsible for medicines management at the practice. All prescriptions and dispensing were outsourced to a local pharmacy. The dispensary was used only to hold medicine stock from the local pharmacy. These were recorded with a system in place to monitor when medicines were issued. All medicines, including vaccines, medical gases, emergency medicines were stored securely. Medicines requiring refrigeration were monitored regularly to ensure they were stored within the correct temperature range.
- Blank prescriptions were securely stored and their use tracked by the nurses. Patient Group Directions (PGD) had been developed to allow the nurse to administer medicines in line with legislation. These were up-to-date and signed by the SMO. PGD medicines were stored securely.
- A list of high-risk medicines (HRM) was identified for the practice. A register to monitor the prescribing of HRM was in place and documented searches of prescribed HRM were carried out each month. Hospital issued HRMs were not managed in accordance with the Defence Primary Health Care (DPHC) guidance note. While the patients were identified on the HRM register, they were not identified on DMICP prescriptions, which meant they may not show on a search. We were advised after the inspection that the SMO had time booked with the team to review patients on HRMs and to provide a briefing on the coding to use to ensure all patients were captured.
- We reviewed the clinical records for patients identified on the HRM register and noted they were being monitored appropriately with Read coding and alerts consistently used. A shared

care agreement was in place for the patients who required this. Minutes confirmed that patients on an HRM were discussed at the governance and assurance meetings to ensure reviews were up-to-date.

Track record on safety

The practice had a good safety record.

- The practice manager was the lead for health and safety. A safety, health, environmental and fire risk assessment (referred to as a SHEF assessment) had been completed. Risk assessments pertinent to the practice were in place, including lone working and risk assessments for products hazardous to health. The health and safety officer for the camp reviewed the risk assessments annually. A risk assessment and policy were in place to support the physiotherapist with the safe delivery of acupuncture.
- The Support Unit was responsible for electrical, gas and water safety checks. Evidence was in place that these checks had been completed. Equipment maintenance, including portable appliance testing, had been undertaken. The medic monitored the equipment register and checked carried out checks of the equipment weekly. Fire safety management arrangements included regular checks and testing of firefighting equipment. Staff were up-to-date with fire safety training
- Staff had access to personal alarms to summon assistance in the event of an emergency. These were regularly tested and the test dates documented.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- The practice 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 contracted and locum staff. Staff provided examples of significant events confirming there was a culture of effectively reporting incidents.
- Minutes confirmed that significant events were discussed at the healthcare governance and assurance meetings. Significant events were not closed until all actions had been completed. Improvements were made as a result of investigations into significant events. For example, the management of specimens was revised following a theme identified from significant events.
- All medicine and patient safety alerts were sent to the practice group mail box and also logged. Staff checked the mail box to ensure all alerts were accounted for. Minutes showed that alerts received were discussed at the healthcare governance and assurance meetings. Any urgent alerts were sent directly to the practice by the SMO. For example, the SMO emailed the practice manager on 31 January 2020 with national guidance related to Coronavirus, requesting that all staff were made aware of the SoP.

Are services effective?	**Good**

We rated the practice as good for providing effective services.

Following our previous inspection, we rated the practice as inadequate for providing effective services. We found inconsistencies in processes for providing effective services including gaps in:

- the management of long-term conditions;
- force protection recall, including audiometry;

- staff training and induction;
- peer review for nurses;
- transfer of clinical records; and
- management of the national screening programme.

At this inspection we found the recommendations we made had been actioned.

Effective needs assessment, care and treatment

The practice assessed needs and delivered care in accordance with relevant and current evidence based guidance and standards.

- Processes were established to ensure clinical staff were kept up-to-date with evidence based guidance and standards, including guidance from the National Institute for Health and Care Excellence (NICE) and the Scottish Intercollegiate Guidelines Network (SIGN). All new or updated guidance was logged on the health governance workbook. Relevant guidance was a standing agenda item at the healthcare governance and assurance meetings. For example, at the meeting in January 2020 guidance in relation to the flu vaccination (QS190) and supporting adult carers (NG150) were discussed. The practice also received the DPHC newsletter that included NICE and medicines management updates.
- The physiotherapist carried out a holistic assessment for all patients that took account of their occupation, lifestyle and involvement with sport in order to develop an individual treatment plan. Our review of patient records showed Rehab Guru, software for rehabilitation exercise therapy, was used for exercise programmes for patients. We did note the Rehab Guru code was not recorded on consultations.

Monitoring care and treatment

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

- The nurse was the lead for the management chronic conditions. The practice was not using the routine method for conducting searches; through the population manager facility on DMICP (referred to as ‘popman’). The SMO used pop-ups alerts to manage reviews/clinical checks for individual patients who were attending for a consultation. Not using popman meant the SMO did not have oversight of how the practice’s QOF performance. In addition, this method did not support with the active recall of patients. The nurses and GPs did not have access to popman and we were advised that popman training was planned.
- Through an alternative method, monthly documented chronic disease searches were undertaken by the nurse. The searches informed the chronic disease register and included the last and next review dates for patients. DMICP templates were consistently used for annual reviews. Because of very low numbers, clinicians were familiar with the patients diagnosed with a chronic disease. Chronic disease was a standing agenda item at the healthcare governance and assurance meetings.

- We checked a range of clinical records and confirmed patients with asthma, diabetes and high blood pressure were being effectively managed and reviewed in a timely way.
- We discussed with the doctor the management of patients with a mental health need and also reviewed a range of clinical records. We were assured patients were well managed and receiving care appropriate to their needs. Patients with a mental health need who were identified as vulnerable were included on the vulnerable adult register if appropriate. All patients prescribed medication for their mental health condition were referred to the Department of Community Mental Health (DCMH) and were coded as vulnerable. The community psychiatric nurse from the DCMH visited the practice each week to review patients. The practice also signposted patients to the welfare team for additional support.
- 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 95.6% of patients. The clinical records we looked at showed audiometric assessments were appropriately undertaken and recorded in accordance with the Hearing Conservation Programme.
- At the previous inspection, quality improvement activity (QIA) was very limited. Since then the physiotherapist had been identified as the lead for QIA and they had attended training for the role. We found QIA had improved as the practice had developed a more cohesive approach to monitoring care and service provision. This was being achieved through a variety data searches, significant event analysis and patient feedback surveys. Clinical audit activity had increased with audits undertaken to measure the effectiveness of care against evidenced-based standards. Completed audits since the last inspection included:
    - A minor surgery audit in November 2019 (undertaken annually).
    - Cervical screening audit undertaken in January 2020 (first cycle)
    - Lower back pain management audit - January to September 2019 (first cycle)
    - Medical Employment Standards compliance - May to September 2019 (first cycle)
    - Reliability and compliance with the manual input of statistics to DMICP in November 2019
    - Medicines management audit undertaken by the regional pharmacist in January 2020
    - Clinical record keeping (doctors) audit in January 2020 (second cycle)
    - Clinical record keeping (medic) audit in January 2020
    - Clinical record keeping (physiotherapist) audit in July 2019
    - Health and safety audit completed by the regional governance lead in January 2020
    - Pharmacy audit undertaken in October 2019
- Due to awareness of the population’s work requirements, the physiotherapist had investigated the potential risk of repetitive loading tasks causing injury during a set task involving rotation and lifting. Although there had not been an increase in injuries presenting during this task, the physiotherapist investigated it using Health and Safety Executive body mapping tool in order to inform the unit about potential risk for future tasks. We identified this as a good example of injury prevention, occupational management and health surveillance.

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 induction process was in place. The practice manager was in the process of developing role specific induction packs. A comprehensive bespoke induction pack was in place for the PCRF. Staff we spoke with described a thorough induction that included shadowing experienced members of staff and observation of their practice. The SMO advised us they would provide a new GP with specific training and supervision in relation to defence primary care as part of their induction.
- At the previous inspection there were large gaps in staff mandated training. The database showed staff were now up-to-date with training and staff confirmed this was the case. The status of training was reviewed at the practice meetings. The SMO had received occupational health training when the contract first started, including training in sports diving and heavy goods vehicles medicals.
- A programme of ongoing development training was in place with in-house training held once a month to support clinicians with continual professional development (CPD) and revalidation.
- The GPs received peer review, supervision and appraisal through their NHS practice. The nurses had developed a process for peer-to-peer supervision. The senior practice nurse was new to the service so not yet due an appraisal. The physiotherapist had not had an appraisal in the last 12 months as a suitable appraiser was not available. This had been added to the risk register.
- Regional meetings and forums were established for staff to link with professional colleagues in order to share ideas and good practice. For example, nurses were supported to attend the regional nurse's forum to link with their colleagues and the physiotherapist attended regional in-service training on a quarterly basis at the regional rehabilitation unit (RRU).

Coordinating care and treatment

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

- Through the networks established by the GPs in the NHS primary care practice, there were good links with local health and social service teams. The families of service personnel often registered at the NHS practice so there were good links with the practice midwife particularly in terms of safeguarding and meeting the needs of carers. The practice also had good relationships with the regional RRU and DCMH.
- Clinicians attended the monthly unit health committee (UHC) meetings, a forum led by unit commanders and involving the welfare team to discuss patients' needs, including occupational health updates. Minutes from the September 2019 meeting demonstrated that, mental health, injury surveillance/prevention, preventative health and health promotion were standing agenda items. Individual case reviews took place at these meetings in a way that protected patient confidentiality.
- The clinical records we looked at showed appropriate staff, including those in different teams, services and organisations were involved in assessing, planning and delivering care and treatment.
- Patients due to leave the military received a pre-release and final medical. For patients assessed as vulnerable, and with their consent, the GPs sent a summary of their needs to the receiving GP. Patients also were support with resettlement through the unit and welfare team.

Helping patients to live healthier lives

Staff were proactive and sought options to support patients to live healthier lives.

- The practice nurse was the health promotion lead. A forward-planning health promotion calendar was in place and based on national priorities and initiatives to improve the population's health. Health promotion displays were located in the waiting area and included a 'time to talk' display, alcohol awareness and sexual health. Information about sepsis and the Coronavirus was also displayed.
- The physiotherapist offered advice appointments to non-injured patients to support with their training and as part of injury prevention. The physiotherapist maintained an information board for patients outside the PCRF and provided information on musculoskeletal injuries in the waiting room.
- The practice participated in the health promotion fairs for the camp which were organised at unit level. The next one was due to take place in May 2020.
- One of the GPs was the sexual health lead and also led on women's health. Clinicians referred patients to the walk-in sexual health clinic in Banbury. The practice could also refer patients the defence medical consultant for sexual health. Condoms were available in the toilets.
- Searches to identify patients eligible for the national screening programmes were carried out on a regular basis. It was just cervical screening that patients met the eligibility criteria. Seventeen patients were identified as eligible and all were followed up appropriately.
- 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:
    - 99% of patients were recorded as being up to date with vaccination against diphtheria.
    - 99% of patients were recorded as being up to date with vaccination against polio.
    - 100% of patients were recorded as being up to date with vaccination against hepatitis B.
    - 100% of patients were recorded as being up to date with vaccination against hepatitis A.
    - 99% of patients were recorded as being up to date with vaccination against tetanus.
    - 100% of patient were recorded as being up to date with vaccination against typhoid.
    - 100% of patient were recorded as being up to date with vaccination against MMR.
    - 99% of patient were recorded as being up to date with vaccination against meningitis.
- The practice worked collaboratively with Chain of Command to ensure all personnel requiring additional immunisations in line with operational requirements were identified and vaccinated within an appropriate timeframe. Monthly searches were undertaken to recall patients for vaccinations. If patients did not respond after the second recall letter then the practice informed the Chain of Command.

Consent to care and treatment

The practice obtained patient 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, including the key principles of the Mental Capacity Act. Staff said they received in-house training regarding consent and also completed on-line training.
- The process for seeking consent was monitored through the auditing of clinical records. Consent was taken for minor surgery and this was confirmed through the annual minor surgery audit. The physiotherapist took written consent when treating a patient with acupuncture. The physiotherapist highlighted that the written consent taken was not always being scanned onto the patient's record in a timely way. As a result, they had set up a scanning register to monitor that it was taking place.

Are services caring?	Good

We rated the practice as good for caring.

Following our previous inspection, we rated the practice as requires improvement for providing caring services because a process was not in place to identify carers.

At this inspection we found the recommendation we made had been actioned. The practice is now rated as good for providing caring services.

Kindness, respect and compassion

Staff supported patients in a kind and respectful way.

- Throughout the inspection staff were courteous and respectful to patients arriving for their appointments or contacting the practice by telephone.
- Results from the January 2020 patient experience survey (10 respondents) showed patients were satisfied with the care and service they received. The 14 CQC comment cards completed prior to the inspection were all complimentary about the caring and attentive attitude of staff.
- The practice had an information network available to all members of the service community, known as HIVE and information about the service was displayed in the waiting area. It provided a range of information to patients who had relocated to the base and surrounding area. Information included resources at the unit, civilian services, including healthcare facilities.

Involvement in decisions about care and treatment

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

- The patient survey indicated respondents felt 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.
- In relation to physiotherapy and rehabilitation, expectations were discussed with each patient to ensure bespoke goals and a treatment plan was identified for the patient.
- An interpretation service was available for patients who did not have English as a first language.
- Patients with a caring responsibility were identified through the new patient registration process and through the welfare team. Information was displayed advising patients to identify if they had a caring responsibility. An alert was added to the patient's clinical record so they were easily identified. Searches were regularly carried and any carers identified were highlighted at the healthcare governance and assurance meetings. A register was maintained on the health

governance workbook. No patients were identified as having a caring responsibility at the time of this inspection.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Clinic room doors were closed during consultations. Privacy screening was provided in consulting rooms for when patients were being examined or treated. There were no privacy curtains or screening in the physiotherapy room but only one patient was seen at a time and the door was closed.
- The waiting area was located away from the reception minimising the risk of conversations being overheard. If patients wished to discuss sensitive issues or appeared distressed at reception they could be offered a private room to discuss their needs.
- Patients had the option of seeing a male or female GP. A female GP from the NHS primary care practice provided the cervical screening service. The physiotherapist was female so patients could be referred to Lichfield PCRF if they wished to see a male.

Are services responsive to people's needs? | Good

We rated the practice as good for providing a responsive service.

Following our previous inspection, we rated the practice as requires improvement for providing responsive services. This was due to an incomplete access audit and no clear guidance on home visits.

At this inspection we found the recommendations we made had been actioned. The practice is now rated as good for providing responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patient needs and preferences.

- Both the patient experience survey (practice-wide), the PCRF survey (December 2019) and CQC feedback comment cards completed prior to the inspection highlighted that the practice was responsive with securing an appointment for patients in a timely way.
- An access audit as defined in the Equality Act had been completed for the premises. Reasonable adjustments had been made as the premises was accessible via automatic doors, wide corridors and doorways. A wheel chair space had been created in the waiting area and a disabled parking space identified.
- The practice manager was the diversity and inclusion lead with the administrator as the deputy. All staff were in-date for equality and diversity training. A diversity and inclusion notice was displayed in the waiting room for patients to access.

Timely access to care and treatment

Patients' needs were met in a timely way.

- The practice accommodated patients with an emergency need and the medic triaged emergency patients each day between 08:00 and 09:30. The medic referred patients on to the GP or nurse as appropriate. Routine appointments with a GP could be accommodated within 48 hours. Same day appointments were available with a nurse. Medicals were carried out each

Thursday. If there was a need for a medical that the practice was unable to undertake then the patient was referred to another medical centre.

- A direct access physiotherapy (DAP) service was in place for patients and the uptake for this service was at 85%; an increase from 75% last year. The physiotherapist could see a new patient within five working days, an urgent patient within one day and follow-up patients within one day. There was a two to three month wait for the Multidisciplinary Injury Assessment Clinic (MIAC).
- Patients had access to the NHS practice if a GP was not available at Kineton Medical Centre. Out-of-hours, including weekends and public holidays, patients could contact NHS 111.
- Although there had not been a request for a home visit in a long time, a policy was in place and the arrangement for home visits was outlined in the practice information leaflet. Telephone consultations could also be accommodated.

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 outlined in the patient information leaflet to support patients with understanding the complaints process.
- The practice manager was the lead for complaints. A process was established to record and manage complaints. This was communicated to patients through the practice leaflet. The practice received three complaints in the last 12 months and they had been managed effectively. Minutes demonstrated that complaints were a standing agenda item at the healthcare governance and assurance meetings.

Are services well-led? | Good

We rated the practice as good for well-led.

Following our previous inspection, we rated the practice as inadequate for providing well-led services. We found inconsistencies in processes for providing well-led services including gaps in

- leadership capacity and lead roles;
- support from the regional team;
- adherence to the Duty of Candour;
- risk management, including the business continuity plan; and
- contract monitoring.

At this inspection we found the recommendations we made had been actioned. The practice is now rated as good for providing well-led services.

Leadership capacity and capability

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

- At the previous inspection we found there was insufficient leadership capacity and capability within the system. This had improved considerably. The practice manager who was new to post at the last inspection had since gained experience of governance systems with the support of the regional team. It was clear these systems were now embedded in practice and provided a coherent structure for the day-to-day running of the service.

- At the previous inspection, we identified the SMO had insufficient contracted time for all the roles involved with clinical leadership. This was still the case as the SMO was providing staff training, undertaking administration duties and governance activities outside of their contracted hours. With the appointment of a permanent experienced senior practice nurse, the area manager advised us there was scope for the nurse to take on some of the clinical leadership responsibilities once they became established in the role.
- Staff spoke highly of the leadership team stating that the introduction of structure had led to more coherent working arrangements. They said the SMO responded in a timely way to any clinical queries, even if these were outside of the SMO's contracted working hours. Furthermore, staff were complimentary about the input and support provided by the regional management team. The SMO was in regular communication with the area manager.

Vision and strategy

Throughout the inspection it was clear the practice had worked hard since the last inspection to effectively deliver a service in accordance with the following vision statements:

- The DPHC vision was identified as, 'Safe practice – by design'.
- The specific vision for Kineton Medical Centre stated, 'Safe, patient-centred care'.
- The PCRF worked to the vision of, 'Education, empowerment, recovery'.

Culture

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

- Contrary to the last inspection, staff described a coherent and integrated team in which they felt respected, supported and valued at both practice and regional level. They told us they would feel comfortable raising concerns, which they believed would be acted on.
- 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.
- 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. A whistle blowing policy was in place.
- The practice clearly demonstrated a patient-centred focus. Staff understood the specific needs population and tailored the service to meet those needs. For example, the clinic appointment times accommodated the specific needs of aircrew and children.

Governance arrangements

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

- There was a staffing structure and staff had allocated roles and responsibilities, including delegated lead roles and deputy leads in specific topic areas. Additional roles and responsibilities were not reflected in terms of reference and/or job descriptions.
- The health governance workbook had been effectively developed since the last inspection and all staff had access to it. Staff described how the workbook provided a systematic and consistent approach to the management of the service as the processes for monitoring the service were held in one place.

- Communication and information sharing systems had been strengthened since the last inspection, including the development of structured practice and health governance meetings. These were well attended by the staff team.
- SoPs had been developed specific to the practice. The identification of lead roles had reduced the burden on the SMO being responsible for the majority of activities at the practice. For example, the physiotherapist taking the lead for QIA.
- QIA had improved since the last inspection, particularly clinical audit.

Managing risks, issues and performance

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

- The process to identify, understand, monitor and address current and future risks including risks to patient safety had been developed since the last inspection. Risk to the service were logged on the risk register and kept under scrutiny through regular review at the healthcare governance and assurance meetings. The practice manager highlighted that the practice was keen to promote and ensure a continuous risk aware culture.
- Processes were in place to monitor national and local safety alerts, incidents, and complaints.
- The business continuity plan had been revised to take account of the relationship with the NHS practice. For example, DMICP access was available at the NHS practice so in the event of a DMICP outage at Kineton Medical Centre, patients could be seen at the NHS practice. A major incident plan was established for the camp.
- Procedures were in place for managing staff performance. Relationships had been developed with other medical centres to support with the performance management process, such as peer review and clinical supervision for the nurses.
- Contract monitoring meetings regarding the NHS contract were taking place biannually with the last meeting taking place in October 2019.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- The internal quality assurance tool, the DMS Common Assurance Framework (CAF) was used to monitor safety and performance. The DMS CAF was formally introduced in September 2009 and since that time has been the standard healthcare governance assurance tool utilised by DMS practices to assure the standards of health care delivery within DMS. A domain of the CAF was reviewed at each of the health care governance meeting.
- We were advised that an external assurance visit (referred to as the HGAV) was undertaken in August 2018 by the regional team. The practice had not received the report at the time of the inspection.

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.

Examples of how the practice responded to and actioned feedback included, condoms provided in the toilet and a television had been installed in the waiting room.

- Good and effective links were established with internal and external organisations including the welfare team, RRU, the DCMH, local NHS services and social services.
- Staff had opportunities to provide feedback and views about the service and were encouraged to do so.

Continuous improvement and innovation

The practice was keen to make improvements to the service and this was clearly evident through the positive changes made as a result of the last inspection. Improvements were also made based on the outcome of feedback about the service, complaints, audits and significant events. The practice maintained a log of quality improvement projects (QIP) on the health governance workbook. The following are some of the QIPs identified by the practice and also improvements we noted during the inspection:

- Information cards for the local pharmacy were included with prescriptions to prompt patients to access advice about their medicines.
- Pharmacy data was populated on a regional spreadsheet. This allowed the practice to view the prescription statistics each month and monitor for any stock wastage.
- The practice secured a pathology barcode request form and a practice code for the laboratory forms. Since then no results had gone to the incorrect medical centre.
- Access to patients records at the NHS practice has been achieved through the provision of a dedicated laptop with DMICP access.
- The identification of a quality improvement lead for the practice.
- A wheelchair accessible space had been allocated in the waiting room and a disabled parking space identified.