Bramcote Medical Centre

Quality report

Gamecock Barracks
Bramcote
Nuneaton
CV11 6QN

Date of inspection visit:
5 March 2020

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17 April 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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Chief Inspector's Summary

This practice is rated as requires improvement overall

The key questions are rated as:

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

We carried out an announced comprehensive inspection of Bramcote Medical Centre on 5 March 2020. 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 leadership team was new and had made significant improvements to the governance of the practice over the last six months. Leaders demonstrated they had the vision, and drive to provide a safe, effective and patient-focused service.
- There was an open and transparent approach to risk management and safety. The practice needed to review the management of significant events to ensure it was working in accordance with DMS policy.
- 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.
- Overall clinicians were aware of and working to current evidence based guidance. The way in which the primary care rehabilitation facility worked needed review to ensure it was working in accordance with organisational policy and best practice guidance.
- Staff 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.
- Quality improvement was in the early stages of development. Clinical audit based on best practice guidance needed further development.
- 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 to patients. Complaints were effectively managed to the satisfaction of the complainant.
- The infrastructure was inadequate in terms of available space and meeting infection prevention and control standards.

- Equipment available to support patients' rehabilitation programmes was insufficient to treat patients.

The Chief Inspector recommends:

- Improving the infrastructure to ensure sufficient space and equipment for clinical activity, and to ensure the premises meets the requirements of the Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'.
- The practice reviews its processes to ensure it is working in accordance with the DMS policy for managing significant events.
- Ensuring all clinical staff are supported to deliver effective patient care through peer review.
- Ensuring there is a safe and effective system in place to support staff who are working with patients in isolation of the wider staff team.
- Develop the clinical audit programme to ensure the outcomes of rehabilitation treatment and care are monitored.

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 lead inspector**.** The team comprised specialist advisors including a doctor, practice nurse, practice manager, pharmacist and physiotherapist. The inspection was shadowed by a member of the Defence Medical Services Regulator (DMSR).

Background to the Bramcote Medical Centre

Bramcote Medical Centre provides a routine primary care, occupational health and rehabilitation service to a patient population of 731 including service personnel and permanent staff for the garrison. The practice supports the 30 Signal Regiment which has a high readiness for deployment. A small cohort of patients from the new Defence Medical Rehabilitation Centre (referred to as DMRC Stanford Hall) are also registered at the practice. The majority of patients are aged between 18 and 44. At the time of the inspection, there were no registered patients under the age of 18 and six over the age of 60. Families are not registered with the majority are registered with Revel Surgery, a local NHS primary care practice.

Through a contract, Revel Surgery supports the practice with medical provision. A Primary Care Rehabilitation Facility (PCRF) is based in the medical centre and provides a physiotherapy and rehabilitation service for patients. As there is no dispensary at the practice, a contract in in place with a local pharmacy.

The medical centre is open from 08:00 to 16:30 hours Monday to Thursday and until 12:30 on a Friday. From 16:30 to 18:30 cover is provided by Revel Surgery. Outside of these hours, including weekends and bank holidays, cover is provided by NHS 111.

The staff team

Position	Numbers
Regimental Aid Post (RAP)[1] Medical Officer acting as Senior Medical Officer (SMO)	One

General Duties Medical Officer (GDMO)[2]	One
Civilian medical practitioner (CMP)	Three – (Revel Surgery)
Civilian practice nurse	One
RAP practice nurse	Two
RAP Medical Sargent acting as military practice manager	One
Civilian practice manager	One – from Stanford Hall to provide short term support
Physiotherapist	One
Exercise rehabilitation instructor (ERI)	One – temporary post
Administrative staff	Two
Medics[3]	Two

[1] Regimental Aid Posts (RAP) are front-line military medical staff posts attached to a military unit and are subject to deployment, often at short notice. When not deployed, RAP staff work in medical centres to update and maintain their clinical skills. They also have a focus on ensuring the occupational health requirements of unit personnel are up-to-date.

[2] A GDMO is a junior army doctor attached to a unit before commencing specialist Medical Officer training.

[3] In the army, a medic is a soldier who has received specialist training in field medicine. It is a unique role in the forces and their role is similar to that of a health care assistant in NHS GP practices but with a broader scope of practice.

Are services safe? | Requires improvement

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

Safety systems and processes

Systems were established to safeguard patients from abuse. Issues with the infrastructure meant the practice was not fully compliant with infection prevention and control (IPC) standards.

- A lead member of staff and deputy were identified for adult and child safeguarding. Reviewed in April 2019, the safeguarding policy was accessible to staff on Sharepoint, a web-based document management and storage system. It was also displayed in the corridor. The policy included contact details for the local safeguarding teams. A laminated sign with these contact details was located in all rooms. All staff had completed safeguarding including update training, at a level appropriate to their role.
- A vulnerable patients register was established and was held on the health governance 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 vulnerable patient's register only included the patient's DMICP (electronic patient record system) and no other patient identifiable information. A DMICP search was last undertaken in March 2020 and the register updated; 29 patients were identified. The way in which the register was maintained and minutes of the multi-disciplinary team (MDT) meetings recorded meant some information was missing and we highlighted this to the leadership team at the time of the inspection. Our review of patient records indicated appropriate alerts were used on DMICP to identify those who were vulnerable.
- At the end of the MDT meeting, time was dedicated to discussing vulnerable patients with only the relevant staff who needed to participate. A 'ghost clinic' was created on DMICP to make a

record of the discussions. One of the doctors from the Revel Surgery attended the meetings so could raise any concerns in relation to families of service personnel registered at the practice.

- There was a close working relationship between the practice and the welfare team for the garrison. The welfare team made contact with the practice if they were concerned about individuals and, equally, the practice could refer patients to the welfare team. For individuals identified as vulnerable, a risk conference was held that included a clinician from the practice. Vulnerable patients were also discussed at the Unit Health Committee meetings (UHC), a forum coordinated by unit commanders to review the health, occupational, rehabilitation and welfare needs of patients. The SMO, physiotherapist and military practice manager represented the practice at the UHC meetings.
- A list of chaperones was available on the health governance workbook. Staff who were trained as chaperones had completed a competency form and 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 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. All staff had professional indemnity cover. Information was in place to confirm staff had received the relevant vaccinations required for their role at the practice.
- A lead member of staff was identified for IPC and had completed a required training course for the role in June 2019. One of the medics was the deputy IPC lead. An IPC and environmental audit had been completed in January 2019 and a management action plan developed. We noted a small number of sharps boxes had not been disposed of within three months of opening. We highlighted this to the military practice manager who confirmed they had been removed and disposed of by the end of the inspection.
- The practice team recognised the aging infrastructure, including fixtures and fittings, were not fully compliant with IPC standards. For example, the sink taps in some clinical rooms were not compliant, damaged tiling in the men's toilet and the storage cupboard for cleaning and hazardous products. Staff reported that the roof regularly leaked, there was damp in the waiting area and the heating system was temperamental. The PCRF was too cold for patients to be treated in January 2020. This was raised as a significant event. The PCRF was supplied with an additional free-standing heater and the room temperature was regularly monitored. The military practice manager confirmed the corridor containing mould had been condemned and was no longer used for the medics to store their kit. Concerns with the building and compliance with IPC were identified on the risk register. Discussions were in progress regarding the future of the building.
- Environmental cleaning was provided by an external contractor. The cleaning schedule for each room was displayed on the door. The cleaning contract was for 90 minutes each morning and two hours at lunchtime. Practice staff advised us they supplemented this by carrying out additional cleaning. The last deep clean was undertaken over two days in January 2020. A cleaning record was signed and countersigned by the cleaning supervisor. Three independent weekly checks of cleaning were undertaken by the Quarter Master's department.
- Healthcare waste was managed and disposed of for the building so included waste generated by the co-located dental centre and Revel Surgery clinic. Consignment notes were retained at the practice, along with a waste log. Due to discrepancies between the waste log and

consignment notes, waste management was subject to regular review until the matter was resolved. A pre-acceptance audit and annual waste audit were conducted in January 2020.

Risks to patients

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

- For over 12 months the practice had experienced a significant turnover of staff. The majority of the current team took up post from mid-2019 with the SMO joining the team in September 2019. Staffing levels and skill mix had improved considerably and at the time of the inspection staff reported levels were sufficient to meet the needs of the patients. A staffing rota was used to manage absences to ensure appropriate staffing levels were maintained. The SMO and military practice manager were subjected to movement or deployment. This risk to continued leadership was identified on the risk register and the regional team had measures in place to address it.
- A locum induction pack was in place to familiarise temporary staff with systems and processes.
- The practice was equipped to deal with medical emergencies and all staff were suitably trained in emergency procedures, including training in life support. An emergency kit, including a defibrillator, oxygen with masks and emergency medicines were accessible to staff in a secure area of the practice; all staff knew of its location. A first aid kit and accident book was available. Regular checks were in place to ensure the required kit and medicines were available and in-date.
- All staff participated in regular training relevant to medical emergency situations, with the last training session held in January 2020. Staff received spinal injury and climatic injury training in February 2020. The GDMO facilitated sepsis training for the team in June 2019. Information about sepsis was displayed in reception and clinical rooms. The risk of Covid-19 was identified on the risk register and measures were in place to minimise the risk, including an information display to advise patients.

Information to deliver safe care and treatment

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

- Individual patient records were written and managed in a way that kept patients safe. The clinical records we looked at on DMICP showed information needed to deliver safe care and treatment was appropriate. Appropriate Read coding was used by all clinicians except the PCRF staff. Although the Direct Access Physiotherapy (DAP) had been in operation for three years, the DAP code was not being applied to clinical records. Furthermore, the mandatory injury causation template was not being used. Despite this, the PCRF records showed that patients received appropriate care.
- The doctors routinely audited each other's clinical records. For example, the GDMO's consultations were audited in September 2019 and again in January 2020. The SMO's consultations were audited twice in the last 12 months. We noted no significant concerns or themes had been identified from the audits. A peer review of nurses' record keeping was completed at Lichfield Medical centre in December 2019. The Regional Rehabilitation Officer (RRO) identified from an audit in February 2020 that no auditing of PCRF records was taking place. This resulted in a physiotherapist from within the region undertaking an audit of the physiotherapists clinical records. One of the nurses completed a quarterly audit the consultation records for medics.
- The practice had implemented the Defence Primary Health Care (DPHC) new patient registration process. New patients completed this form on arrival and were given a new patient

appointment with the nurse. The nurses reviewed the forms prior to the appointment and then passed to the administrative team for scanning onto DMICP. The summarising of records was managed using a DMICP search and this showed all registered patients had their records summarised within the last two years.

- 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. Clinic lists were printed daily in the event of a system failure.
- Patients were seen at Revel Surgery when the practice closed. Rather than patients registering as temporary patients, the SMO piloted the use of a DMICP laptop at the surgery so consultations could be directly recorded onto the patient's record. The laptop frequently lost connectivity so the practice reverted to patients registering temporarily.
- Supported by a standard operating procedure (SoP), referrals were effectively managed. The referring doctor either tasked the referral electronically to the administrative team via DMICP or passed a hard copy for action. The referral tracker was held on the health governance workbook with the DMICP number as the only identifier. All actions taken to monitor and hasten each referral was recorded on the tracker and in the patient's DMICP record. The tracker included a colour code to quickly identify any action required. The referral process was completed when a clinic letter was received back thus confirming the patient had attended the appointment. The tracker was checked weekly and at the time of the inspection there were no two-week wait or urgent referrals requiring action, and all routine referrals were progressing appropriately.
- A process was in place for the safe management of samples. The practice used LabLinks and a sample log was maintained, which was regularly checked by the nurses. DMICP coding was appropriately used. Samples were taken to the hospital by military transport. From the clinical records we looked at, results were effectively managed with action taken by the clinician in a timely way. A sample audit was undertaken by the nursing team each month and no concerns with the management of samples had been identified.

Safe and appropriate use of medicines

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

- Safe procedures were in place for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment. The SMO was the lead for medicines management and a practice nurse had the delegated responsibility for the outsourced prescriptions.
- Medicine stock was checked regularly. Appropriate arrangements were established for the safe management and destruction of controlled drugs (CD). We noted that CDs were logged correctly and all were in-date. Monthly account checks were established and a quarterly independent check also took place. CDs were destroyed by an independent officer and there was a document in place to confirm this.
- Medication requiring refrigeration was monitored daily to ensure it was stored within the correct temperature range. Prescription forms were securely stored and their use monitored.
- Patient Group Directions (PGD) were in place to permit nurses to administer medicines in line with legislation. PGDs were audited every six months. We noted some of the paper copy PGDs went out-of-date in November 2019 prior to the next six-monthly audit. The nurses agreed to check them each month.
- Requests for repeat prescriptions were safely managed and no telephone requests were accepted. For any repeats requests that exceeded the review date or over the issue count, the

doctor contacted the patient to arrange a telephone consultation review or to request the patient attend the practice if bloods were required. A system was in place to update DMICP if changes to a patient's medication was made by secondary care or an out-of-hours service.

- We confirmed through a search of DMICP that no patients were prescribed high risk medicines (HRM). However, a process was established for the management of and monitoring of patients prescribed HRMs.
- Medical alerts were received by the practice through the group mailbox. The equipment care lead was responsible for medical device alerts and a practice nurse for drug alerts. Alerts were discussed at either the clinical governance or practice meetings depending on which forum was the most relevant. Identifying if a woman of childbearing age were prescribed sodium valproate (used to treat epilepsy and mental health conditions) was undertaken as part of the search for HRMs.

Track record on safety

Improvements were needed to ensure the safety of patients, staff and others visiting the practice.

- The civilian practice manager was the lead for health and safety. The periodic electrical safety check was carried out in June 2018. A legionella risk assessment was undertaken in September 2014. Arrangements were in place to check the safety of the water, including the flushing of all taps weekly. An annual equipment check was carried out in March 2019 and portable appliance testing in January 2020.
- A fire risk assessment for the building was undertaken in June 2017 and next scheduled for June 2020. A fire safety management plan was in place for the premises. A member of staff was the lead for fire and carried out weekly and monthly tests of the fire system. Fire records showed staff had an evacuation practice in June 2019. Staff were up-to-date with fire safety training.
- Safety processes for the practice were monitored and reviewed. The risk register was regularly reviewed by the health and safety lead. Risk assessments pertinent to the practice were in place and all had been reviewed and updated since August 2019, including and safety data sheets for hazardous substances.
- To summon support in the event of an emergency staff had access to personal alarms in clinical areas. We tested a personal alarm in the audiology room during the inspection and staff responded in a timely way. However, the SMO advised us that the personal alarm in the upstairs audiology room would only be heard if a member of staff was in the foyer/corridor downstairs. A lone working risk assessment and measures to mitigate the risk were in place for staff seeing patients in this room on their own.
- The PCRF team treated patients in the garrison gym. To manage lone working, staff checked in and out with the medical centre, although we did not see this happen when we visited the gym during the inspection.
- There was a shared waiting area within the dental centre. The reception in the dental centre was an open area and staffed during clinic times. A view of the waiting area from the reception was partially obscured by a pillar. We were advised funding had been agreed for observational CCTV and the practice was waiting for it to be fitted.

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. The Revel Surgery doctors did not have electronic access to the system to report an event or incident. Any significant events they wished to raise were passed to the SMO or military practice manager to process. Following the inspection, the practice confirmed that the doctors had been given access to the ASER system.
- We noted from the pre-inspection information submitted that the reporting of significant events was both limited and sporadic throughout 2018 and 2019. Staff confirmed this was correct and most likely related to the frequent turnover of staff, in particular changes of leadership. The position had improved for 2020 with five significant events reported since January this year.
- We reviewed three significant events that had occurred in the last six months. One had been managed appropriately, including correct recording, the undertaking of a root cause analysis and lessons learnt discussed at a team meeting. The other two significant events, although investigated, had not been correctly reported. The duty of candour log had not been completed for one of these. Staff said these oversights would be addressed immediately. 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.
- Staff advised us that significant events were discussed at the healthcare governance meetings and the meeting minutes from February 2020 confirmed this.

Are services effective?	**Requires improvement**

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

Effective needs assessment, care and treatment

The practice had processes to ensure care and treatment was provided in accordance 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 GDMO was the lead for providing staff with updates regarding current research and guidance, including NICE (National Institute for Health and Care Excellence) and the Scottish Intercollegiate Guidelines Network (SIGN).
- Clinical policies and guidelines were discussed at the multidisciplinary team meetings. We noted NICE guidance on sore throat had been presented at a meeting in February 2020 and prescribing discussed at a meeting in March. NICE guidance was added to the health governance workbook with a recording made that staff were aware of the guidance.
- Staff were kept abreast of clinical and medicines updates through the 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.
- The musculoskeletal health questionnaire (MSK-HQ) to assess outcomes for patients was not being used despite it being an organisational mandatory requirement. Other than a functional activity assessment (FAA), no formal method of measuring clinical performance was in use. Rehab Guru, software for rehabilitation plans and outcomes, was not being used and there was no alternative standard professionally produced document to record advice and/or exercise programmes for patients. The physiotherapist was aware of 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 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.

- One of the nurses was the lead for the management of long-term conditions (LTC) and maintained a record of the monthly searches on the healthcare governance workbook. There were small numbers of patients with a diagnosis of either asthma, diabetes and high blood pressure. All were being managed appropriately. We looked at a selection of clinical records which confirmed consistent review templates and coding were used.
- Patients presenting with a mild to moderate anxiety or low mood were assessed and treated if appropriate in accordance with step 1 of the mental health disorders care pathway for primary care and Departments of Community Mental Health (DCMH). A range of booklets and signing posting to self-help websites were available for patients. Referrals were made to the DCMH if a patient's 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 for assessments and planning care. A community psychiatric nurse held a clinic at the practice but they were absent from the service at the time of the inspection.
- 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 80% of patients. We were advised that this figure was low for two reasons. Firstly, the audiometry machine had been broken so patients could not be recalled until recently. Secondly, registered patients from DMRC Stanford Hall had been reluctant to travel to Bramcote Medical Centre for their audiometry assessment. Stanford Hall is a 54-minute drive from the garrison.
- We also noted from clinical records that some occupational medicals were overdue for patients from DMRC Stanford Hall. Again, we were advised this was due to the reluctance of patients to travel. Promoting the uptake of this patient cohort was being addressed by the SMO. The use of SKYPE consultations had already started.
- One of the nurses was recently nominated as the lead for audit. Staff reported that quality improvement, in particular clinical audit, had been very limited until the SMO joined the practice in August 2019. Clinical audit used to review outcomes to ensure treatment and care was being provided in accordance national and local standards was still in the early stages of development. A forward audit calendar plan had not been developed.
- Although the audit log on the healthcare governance workbook was not up-to-date, we determined that the following first cycle audits had been completed: antibiotic prescribing; medicines management (regional led); cervical cytology; smoking status of patients with cardiac/respiratory conditions and a PGD audit.

- Quality and audit was a standing agenda item at the healthcare governance meetings, confirmed by the minutes of the November 2019 and February 2020 meeting minutes. It was recorded that the SMO was completing a contraception audit and the GDMO was due to undertake a gout audit. No audits had been undertaken by the PCRF.
- Doctors from Revel Surgery provided minor surgery. A log of minor surgery was maintained but there was no evidence that the doctors had been completing an annual minor surgery audit. The audit lead completed a minor surgery consent audit in late 2019. Provision of medical care by Revel Surgery was due to cease at the end of 30 April 2020 and minor surgery would not be undertaken unless a suitably qualified doctor was appointed.

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.

- An induction programme was in place for new staff new to the practice. Identifying the programme was too generic, the civilian practice manager had developed and piloted a new simplified induction pack which was specific to the practice. It took into account specific roles and was also suitable for locum staff. Feedback from the new staff who had completed it was positive.
- Mandated training was monitored weekly by the practice manager. Staff were reminded of any training due to be completed by email. Protected time was available to staff on Tuesday afternoon for training. The status of training was good with a few staff out-of-date for defence specific training. Clinicians had received specialised training required to support with meeting the needs of the patient population. For example, the SMO was trained to undertake diving medicals, one of the nurses had undertaken the mental health first aid course and two nurses were trained in asthma management.
- A programme of ongoing development training was in place with in-house training sessions available to staff each week. Clinicians were also supported with continual professional development (CPD) and revalidation. For example, the GDMO attended the quality improvement forum and also completed a clinical session once a month at a local accident and emergency department.
- A process of peer review was established for clinicians. For example, nurses attended Lichfield Medical Centre for peer review, although this could reasonably be facilitated in-house between the nurses. The peer reviewer for the physiotherapist had been absent from the service for some time and alternative arrangements had not been put in place. In addition, regional meetings and forums were established for staff to link with professional colleagues in order to share ideas and good practice. For example, the PCRF was represented at the regional rehabilitation forum.

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.
- Relationships with local health and social care organisations was through Revel Surgery and staff had started to develop relationships when the contract with Revel Surgery ends.

- Both the Commanding Officer and welfare Officer advised that relationships with the practice was excellent. The SMO or the GDMO and physiotherapist attended the station Unit Health Committee (UHC) meetings each month. The physiotherapist had a proactive and integrated relationship with the physical trainers for the unit.
- Doctors provided patients transitioning from the military with a release medical. Doctors also spoke directly with the receiving NHS GP for patients with more complex needs. Patients could be referred to the welfare team for support with the transition, and if appropriate to the DCMH. Patients were also signposted to SSAFA, a UK charity providing welfare and support for serving personnel in the British Army, veterans and military families.

Helping patients to live healthier lives

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

- Clinical records showed that staff encouraged and supported patients to be involved in monitoring and managing their health. Staff also discussed changes to care or treatment with patients as necessary.
- One of the nurses was the lead for health promotion. The health promotion strategy was underpinned by national priorities and initiatives to improve the population's health. At the time of the inspection there was a display about prostate cancer. The strategy also took account of the patient population need and seasonal variation impacting health. The practice also participated in the garrison health and wellbeing days coordinated by the unit.
- One of the nurses was the lead for sexual health and had completed the required training for the role (referred to as STIF). They carried out basic screening and referred patients to the local genitourinary clinic if appropriate. Doctors also had the option to refer patients to the specialist sexual health services in Birmingham. A sexual health information board and condoms were available at the practice. Access to maternity services was managed by Revel Surgery.
- Patients had access to appropriate health assessments and checks. The national screening programmes was coordinated by Revel Surgery and appropriate action taken if patients met the criteria. DMICP searches were undertaken to ensure patients eligible for cytology screening were recalled. Ninety-four per cent of eligible patients had been screened.
- 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:
    - 92% of patients were recorded as being up to date with vaccination against diphtheria.
    - 93% of patients were recorded as being up to date with vaccination against polio.
    - 92% 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.
    - 92% of patients were recorded as being up to date with vaccination against tetanus.
    - 94% of patient were recorded as being up to date with vaccination against typhoid.
    - 92% of patient were recorded as being up to date with vaccination against MMR.

- 91% of patient 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. Consent was recorded for cervical cytology and written consent was taken for minor surgery.

Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. Staff we spoke with were aware of the Mental Capacity Act (2005) and how it could apply to their practice. They received training in this subject matter in February 2020.

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 2020 patient experience survey showed patients were happy with how they were treated. The two patients we spoke with and the 37 CQC feedback cards completed prior to the inspection were very complimentary about the friendly, considerate and caring attitude of staff.

Involvement in decisions about care and treatment

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

- A translation service was available for patients who did not have English as a first language. This was included in the patient information leaflet. Although, the translation service had not been used directly with patients, the civilian practice manager advised us that it was used to translate patient records.
- The patient experience survey showed all patients received sufficient information about their condition and were involved in decisions about their treatment options. The CQC patient feedback cards indicated patients received information about their care to support them with making informed decisions.
- The practice was proactive with identifying patients who were also carers. This was achieved through the new patient registration process and through liaison at the UHC meetings. Coding and alerts were used on DMICP to promptly identify carers. A search was conducted each month to ensure the carers register was up-to-date. Information for carers was displayed in the patient waiting area.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Screening was provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. Clinic room doors were closed during consultations.

- The layout of the reception area and waiting area meant that conversations between patients and reception would not be overheard. If patients wished to discuss sensitive issues or appeared distressed at reception they were offered a private room to discuss their needs.
- The practice could facilitate patients who wished to see a clinician of a specific gender. This could mean travelling to another practice as there was no female physiotherapist and only female nurses.

Are services responsive to people's needs? | Good

We rated the practice as good for providing responsive services.

Responding to and meeting people's needs

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

- Staff understood the needs of its population and tailored services in response to those needs. For example, an emergency clinic was facilitated each morning at 08:00. Additional surge force protection clinics were held as required to ensure the population held at high readiness to deploy were prepared.
- 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 was completed for the premises in June 2019. A further audit was scheduled for March 2020.The building did not lend itself to ease of access for patients with a disability. For example, the audiology room was upstairs with no lift access. The practice had made as much reasonable adjustment as possible, such as an accessible WC facility. Parking bays were allocated for patients with a disability.

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 and occupational medicals with a doctor could be accommodated within one day and it was two days for a nurse appointment. The physiotherapist could accommodate new and existing patients within two days. If there was an urgent need for a medical the practice was unable to accommodate, then the patient was referred to another local military medical centre.
- One of the doctors from Revel Surgery provided a family planning service. When the contract ended patients would need to travel to Cosford Medical Centre or the family planning clinic in Nuneaton a 10-minute drive from the garrison. Patients requiring cervical cytology would need to attend Cosford Medical Centre (55-minute drive from the garrison) as none of the nurses at the practice were trained to undertake this procedure.
- When the practice closed and until NHS 111 was operational at 18:30 hours, the Revel Surgery provided access to a doctor for emergencies. The surgery had access to a DMICP laptop so could record ant consultations directly onto the patient's record.
- Telephone consultations were available with clinicians. Home visits could be accommodated and this service was outlined in the patient information leaflet. Staff advised us that a home visit had never been requested.

- A DAP service was in place for patients. Because the appropriate Read code was not used, the practice was unable to confirm the uptake of the DAP service.
- Capacity to deliver timely assessment, treatment and care in the premises was hampered by a lack of space. For example, the nurses had just one treatment room so they had to rotate their clinics. This did not significantly impact patient care.
- The one PCRF room had caused a challenge when a temporary ERI joined the practice. A large room within the garrison gym had been refurbished to use as a PCRF facility but no equipment was available. The PCRF said a business case had been put forward for equipment. However, regional headquarters had not received this. Despite the lack of equipment, patients were receiving effective and timely care, and this was reflected in the PCRF key performance indicators.

Listening and learning from concerns and complaints

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

- Information was displayed in the waiting area and outlined in the practice leaflet to support patients with understanding the complaints process. The complaints procedure was displayed in clinical rooms for staff to access.
- The practice manager was the designated responsible person who handled all complaints. Complaints were managed in accordance with the DPHC complaints policy and procedure. Both written and verbal complaints were recorded on the complaints register.
- Any complaints were discussed at the clinical and/or practice meetings and lessons identified. Changes to practice were made if appropriate and used to improve the patient experience. The complaints register showed five complaints were received in the last 12 months and they had been effectively managed.

Are services well-led?	Good

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

Leadership capacity and capability

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

- Even though the leadership team was new with areas of the practice requiring further development, we found the practice was well-led. It was clear the leadership team was focused on developing an effective staff team to provide the best possible service for its patients.
- Staff who were in post during the first half of 2019 highlighted how the governance of the practice had significantly improved with the current leadership team. They described how previously neglected governance systems had been or were in the process of being developed under the new leadership team. In addition, they described a more structured service and cohesive team. The regional management team worked closely with the practice which staff found supportive.
- Both the SMO and military practice manager were subject to deployment which could jeopardise the current stability of the leadership. This was a recognised risk at local and regional level so measures were in place to manage this should it happen. The SMO was acting in the role until a civilian SMO was recruited. It was anticipated that the recruited SMO would provide consistency of clinical leadership as they would not be subject to deployment.

Vision and strategy

Throughout the inspection it was clear staff were committed to developing and providing a service that embraced the DPHC mission of:

The practice worked to the DPHC mission statement of:

> "To provide and commission safe and effective healthcare which meets the needs of the patient and the Chain of Command in order to contribute to Fighting Power."

Culture

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

- An inclusive culture underpinned the approach of the practice. All staff had an equal voice, regardless of rank or grade.
- Staff described an open and transparent leadership style and said they would feel comfortable raising issues. They felt respected, supported and valued. Both formal and informal opportunities were in place so staff could contribute their views and ideas about how to develop the practice.
- The practice clearly demonstrated a patient-centred focus. Staff understood the specific needs population and tailored the service to meet those needs. For example, the ability to facilitate short notice force protection clinic to accommodate high readiness for deployment.
- Openness, honesty and transparency were demonstrated when things went wrong. A no-blame culture was evident; patient feedback and incidents were seen as opportunities to improve the service.
- The practice had systems to ensure compliance with the requirements of the duty of candour, including giving those affected reasonable support, information and a verbal and written apology.
- Leaders clearly demonstrated that the needs and welfare of staff were priority. Staff were encouraged and supported to be the best they could be through training and developing their skills.
- The practice actively promoted equality and diversity through the identification of a lead for this topic. Staff had received equality and diversity training.

Governance arrangements

An overarching governance framework in place which supported the delivery of good quality care. Some improvement was needed.

- There was a clear staffing structure in place and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. Terms of reference were in place to support job roles, including staff who had lead roles for specific areas.
- The practice worked to the health governance workbook. All staff had access to the workbook which provided links to meeting minutes, policies and other information. Although the workbook was comprehensive, we did note not all audit activity had been captured.
- The practice was subject to a regional health governance assurance visit (HGAV) in July 2018 and the team was working with a management action plan (MAP) following that visit. Action plans were also in place for the SMO, practice management and nursing team.

- An effective range of communication streams were used at the practice. A schedule of regular practice, MDT and healthcare governance meetings had been established. Minutes were comprehensive and showed the staff team had worked diligently over the last six months to strengthen governance processes.
- Quality improvement, in particular clinical audit based on best practice guidance, was in the early stages of development. There was no evidence that the PCRF team had undertaken audit to measure outcomes for patients. We were not provided with evidence to show that a forward planning audit calendar had been developed.

Managing risks, issues and performance

Although processes for managing risks, issues and performance were in place, there was scope for improvement.

- There was a process to identify, understand, monitor and address current and future risks including risks to patient safety. Risk to the service were recognised, logged on the risk register and kept under scrutiny through regular review at the governance meetings. The top risks to the service were the ageing infrastructure/facilities and maintaining consistent staffing levels. These risks were kept under review by the regional team.
- A process was in place to monitor national and local safety alerts, incidents, and complaints. However, the process for managing significant events needed further development to ensure the practice was working in accordance with the DMS ASER policy.
- The practice monitored performance target indicators. In particular the system took account of medicals, vaccinations, cytology, summarising and non-attendance rates. The PCRF was not using the usual (or alternative) methods to measure patient outcomes, including Read coding, templates and structured exercise programmes.
- A business continuity plan was in place and staff were familiar with the content. A major incident plan was established for the garrison.
- Procedures were in place for managing staff performance. A process of appraisal was in place for all staff. Besides the GDMO, there was no appraisal recorded for the doctors, including the contracted doctors. However, NHS GPs are required to be on the National Performers List for England and are required to have an up-to-date appraisal to remain on the list so that system provided assurance that the contracted doctors had an appraisal. 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 patients.
- Although we found the duty of candour log on the health governance workbook had not been updated with a recent issue, staff clearly understood their responsibilities in relation to the principles.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- An internal quality assurance tool, the DMS Common Assurance Framework (CAF) was used to monitor safety and performance for the practice and included the PCRF. The DMS CAF was formally introduced in September 2009 and since that time has been the standard healthcare governance assurance tool utilised by DMS practices to assure the standards of health care delivery within DMS.

Engagement with patients, the public, staff and external partners

The practice involved patients, staff and external partners to support high-quality sustainable services.

- There were various options in place to encourage patients to provide feedback on the service and contribute to the development of the service. A patient experience survey was undertaken throughout the year. In addition, patients could leave feedback via through the suggestion box. Minutes from the healthcare governance meetings demonstrated that staff acted on feedback. For example, the practice was trying to secure funding to purchase a water machine for the waiting area.
- Good and effective links were established with internal and external organisations including the welfare team, RRU, the DCMH, local NHS services and social services.

Continuous improvement and innovation

Over the last six months the practice was continually striving to improve the service for patients. The practice maintained a log of QIPs on the health governance workbook.

The following QIPs were formally identified by the practice:

- Implementation of 'Pre-deployment medical booklet'. The GDMO presented this quality improvement initiative at Lichfield.
- Guidance cards developed for the vaccination schedule and located at all work stations. This was working well with staff continually checking for updates.
- Clarifying safeguarding arrangements and ensuring this information was available at all work stations.