Boulmer Medical Centre

Longhoughton, Alnwick, Northumberland NE66 3JF

Defence Medical Services inspection report

This report describes our judgement of the quality of care at Boulmer Medical Centre. It is based on a combination of what we found through information provided about the service, patient feedback and through interviews with staff and others connected with the service. We gathered evidence virtually in line with COVID-19 restrictions and guidance and undertook a short visit to the practice.

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

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As a result of this inspection the 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 previously carried out an announced comprehensive inspection of Boulmer Medical Centre on 29 May 2019. The practice was rated as requires improvement overall, with a rating of requires improvement for the safe and well led key questions. The practice was rated as good for the effective, caring and responsive key questions. A copy of the report from the previous inspection can be found at:

https://www.cqc.org.uk/sites/default/files/20190808_boulmer_medical_centre_final_report.pdf

We carried out this announced follow up inspection on 10 and 14 September 2021. The inspection was carried out virtually on 10 September and included a short visit by a CQC inspector on 14 September. This report covers our findings in relation to the recommendations made and any additional findings made during the inspection.

The CQC does not have the same statutory powers with regard to improvement action for Defence Medical Services (DMS) under the Health and Social Care Act 2008, which also means that the DMS is not subject to CQC's enforcement powers. However, as the military healthcare Regulator, the Defence Medical Services Regulator (DMSR) has regulatory and enforcement powers over the DMS. DMSR is committed to improving patient and staff safety and will ensure implementation of the CQC's observations and recommendations.

This inspection is one of a programme of inspections that the CQC will complete at the invitation of the DMSR in their role as the military healthcare Regulator for the Defence Medical Services.

At this inspection we found:

- The practice was well-led, and the leadership team demonstrated they had the vision, capability and commitment to provide a patient-focused service and consistently sought ways to develop and improve.

- The leadership team had a clear understanding of the issues and had developed plans to resolve or mitigate identified risks.
- 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 governance arrangements for infection prevention and control had been strengthened. Additionally, the practice had taken steps taken to minimise the risks associated with COVID-19.
- The arrangements for managing medicines, including obtaining, prescribing, recording, handling and disposal in the practice were now effective and minimised risks to patient safety.
- The practice had a system to ensure that staff completed the required mandated training.
- Effective medical cover was in place to cover the times when the practice was closed.
- Governance systems, activities and working practices had been strengthened. The healthcare governance workbook was well-developed and captured a wide range of information to illustrate how the practice was performing.
- Information systems and processes to deliver safe treatment and care were established and included referral tracking, audit of clinical record keeping and the management of referrals.
- The practice had improved lines of communication with the units and welfare team to ensure the wellbeing of patients. Links had been developed both internally and externally to enhance the support provided to patients.
- The practice pro-actively sought feedback from 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.
- Staff understood and adhered to the duty of candour principles.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

This inspection was undertaken by a CQC inspector and the inspection team comprised specialist advisors including a primary care doctor, a practice nurse, a practice manager, physiotherapist and a pharmacist. Prior to the inspection the medical centre provided us with contact details for patients who had consented to speak with us. We spoke with ten patients who provided us with feedback.

Background to Boulmer Medical Centre

Boulmer Medical Centre is located near the town of Alnwick, Northumberland and provides primary care, occupational health and a rehabilitation service to patient population of approximately 600 service personnel, including Phase 2 trainees. There were no registered patients under the age of 18 and 40 patients aged over 50 at the time of the inspection. Families and dependants are not registered at the practice and are signposted to local NHS practices. The practice is open Monday, Tuesday and Thursday from 08:00 to 16:30, Wednesday from 08:00 to 12:00 (staff training in the afternoon) and Friday from 08:00 to 16:00. Out-of-hours cover medical cover is provided by Catterick Garrison Medical Centre. From 18:30 weekdays, weekends and public holidays patients are advised to use NHS 111. Patients requiring urgent care out of hours are also signposted to the minor injuries unit in Alnwick, walk-in-services at Wansbeck Hospital and emergency care at Northumbria Specialist Emergency Care Hospital.

The staff team at the time of the inspection

Position	Numbers
Senior medical officer (SMO)	one
Civilian Medical Practitioner (CMP)	coming into post
Practice nurses	one military nurse one civilian nurse
Practice manager One	one
RAF Medic	one
Administrative staff Three	two
Physiotherapist	One
Exercise Rehabilitation Instructor	Part time

Are services safe?

We rated the practice as good for providing safe services.

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

- Operational policies, standard operating procedures, risk assessments, the business continuity plan and major incident plan
- The induction programme
- Training and supervision for staff
- Clinical records
- Referrals management
- High risk medicines management

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

Safety systems and processes

The practice had systems to keep patients safe and safeguarded from abuse.

- Measures were in place to protect patients from abuse and neglect, including adult and child safeguarding policies and local safeguarding contact details. All staff had received up-to-date safeguarding training at a level appropriate to their role. The practice manager checked the status of safeguarding training for locum and visiting doctors. The Senior Medical Officer (SMO) and the practice nurse were the safeguarding leads for the practice.
- Appropriate codes and alerts were used to highlight vulnerable patients. A search was undertaken each month for vulnerable patients to ensure the register held on the electronic patient record system (referred to as DMICP) was current. Patients of concern were regularly discussed within the practice. Where appropriate, vulnerable patients were discussed at welfare meetings with the patient's consent. As far as possible confidentiality was upheld whilst also supporting patients to access the support they needed. Patients we spoke to confirmed that they felt that their confidentiality was upheld.
- All staff had received chaperone training and notices advising patients of the chaperone service were displayed in clinic rooms. Staff had been subject to safety checks to ensure they were suitable to work with young people and vulnerable adults.
- The full range of recruitment records for permanent staff was held centrally. However, the practice could demonstrate that relevant safety checks had taken place at the point of recruitment, including a Disclosure and Barring Service (DBS) check to ensure staff, including locum staff and visiting doctors 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. A check was in place to monitor the hepatitis B vaccination status of staff.
- There was an effective process to manage infection prevention and control (IPC), including a lead for IPC who was trained for the role. Quarterly IPC audits were undertaken, however there was scope to improve the records maintained to show issues identified and mitigating action taken.
- The physiotherapist practiced acupuncture. PCRF staff had worked with the Regional Rehabilitation Unit (RRU) at Catterick to establish a standard operating procedure (SOP) for acupuncture. This included management of consent. For complex patient management that might involve acupuncture, the physiotherapist was able to access guidance and support from the RRU at Catterick.
- Environmental cleaning was provided by an external contractor twice a day who worked to cleaning schedules. Arrangements were in place to monitor cleaning standards. A deep clean of the premises was included in the contract. We identified no concerns with the cleanliness of the premises.
- Systems were in place for the safe management of healthcare waste. Consignment notes were retained, although there was scope to maintain a comprehensive waste log.

Risks to patients

There was an effective system to assess, monitor and manage risks to patient safety.

- Since our last inspection, a full time Senior Medical Officer (SMO) had come into post at Boulmer Medical Centre. The SMO is MAME (Military Aviation Medical Examiner) qualified and so able to prescribe for and treat patients with aviation-related occupations. If needed, doctors from Leeming Medical Centre could support with aviation medicine. As a result patients at Boulmer were receiving better continuity or care and patients who needed to access aviation medicine were able to do so promptly. Patients we spoke with confirmed this. The practice had recently successfully recruited a civilian medical practitioner (CMP) and they were due to come into post shortly following our inspection.
- An induction system was in place for temporary staff and this had role specific elements. All staff had completed a workplace induction, and this has been recorded on the staff database.
- Clinicians adhered to military guidance around sickness periods for personnel. They communicated effectively with Chain of Command so that line managers knew which tasks personnel could safely undertake.
- The practice was equipped to deal with medical emergencies. The staff team was up to date in medical emergency procedures, including basic and advanced life support training, use of the automated external defibrillator (AED) and anaphylaxis. Thermal injuries and sepsis training had been undertaken across the clinical staff team and posters were available for reference in treatment rooms. Staff had received medical emergency training in the last 12 months which included dealing with chest pain and

major sports injuries. There were weekly training simulating various types of emergency. All staff were involved in station wide emergency scenarios and training.

Information to deliver safe care and treatment

- There was a system to manage pathology results. There were clear lines of responsibility and a tracking and review system was in place. However not all nursing staff we spoke with could demonstrate a full working knowledge of the system in place and this should be remedied to ensure that staff absence does not constitute a risk. A biannual pathology specimen audit was undertaken and we saw results for May 2021 which showed 100% with the audit criteria.
- The practice had a process for the electronic summarising of patient notes. The practice nurses ran a search each month to identify any patients that require the 3 yearly note summary. The report was last run in August 2021 and DMICP shows that notes summaries were up to date. The requirement for note summary search is included in the practice manager's monthly task summary which ensures all key tasks are completed.
- Clinical records were peer reviewed and complex and noteworthy cases were discussed at Care & Concern Meetings. We saw minutes which showed that these discussions focussed on shared learning and improvement. In addition a 'Regional Peer Review meeting' between local PCRFs had been established within region. Each Physiotherapist presented a clinical case for discussion and review. A similar peer meeting was held for the ERI team and RRU staff attended to provide senior oversight and development of junior staff.
- Referrals and hospital appointments were well managed and patients were supported to obtain the timeliest access to secondary care. The practice used the e-Referral System (e-RS) to manage referrals to the NHS, including the urgent two-week referrals. The nursing team maintained oversight of internal referrals to the department of community mental health (DCMH) and PCRF staff had oversight of referrals to the regional rehabilitation unit (RRU). The practice was informed by the hospital if patients failed to attend for their appointment. This was recorded in the patient's clinical record and a request made for the patient to make an appointment with their doctor. All referrals were tasked to the SMO for review and further action.
- Staff told us that the medical centre was not often adversely affected by DMICP outages other than planned outages. Where unplanned outage occurred, clinical records were printed and the centre reverted to emergency appointments only. Medication requests would be outsourced for the duration of the outage.

Safe and appropriate use of medicines

Systems for appropriate and safe handling of medicines had improved following the previous inspection:

- Regular checks were routinely carried out on medicines, including vaccines, and emergency medicines and equipment. We found all items were within date and appropriately stored.
- The practice's arrangements for the access, storage and monitoring of prescription stationary was good. Blank prescription pads and prescription paper were stored securely, and an effective tracking system was in place.
- Staff had access to British National Formulary (BNF) and prescribing formulary. An antibiotic prescribing audit ensured that prescribing practice was in line with local guidelines.
- Prescriptions were signed before medicines were dispensed and handed out to patients.
- Patients taking high risk medicines (HRMs) were monitored within recommended timescales. We found an effective system was in place and patients on HRMs were well managed and the relevant monitoring checks were recorded as completed before a repeat prescription was issued. Shared care agreements were in place for patients who required them.
- PGDs (Patient Group Directions) were in use to allow non-prescribing staff to carry out vaccinations in a safe way. PGDs were appropriately managed, staff had received training and authorisation by the SMO had been recorded. However a previous version of the authorisation form was in use and needed updating. The practice stated that PSDs (Patient Specific Directions) were not currently used. All patients requiring medication were referred to a prescriber. PGD audits were carried out annually.
- Controlled drugs (CDs) were not held on site.

Track record on safety

The practice had a good safety record.

- The practice manager was the lead for health and safety. A risk register, policies and risk assessments pertinent to the practice were in place, including lone working and risk assessments for products hazardous to health. A range of risk assessments specific to the PCRF were in place.
- A COVID-19 risk assessment had been completed to reflect changes in working practices. The changes made included chairs spaced out in the waiting area, signage indicating distancing and a dedicated area to see patients presenting with potential symptoms of the virus. Risk assessments and checks were undertaken for patients entering the building. A COVID-19 risk assessment was in place for the PCRF gym.
- Systems were in place and up to date for the safe management of utilities, including electricity, equipment, gas and water safety. A fire risk assessment was in place and fire extinguishers checks maintained. Staff were up to date with fire safety training undertaken as part of the DPHC mandated training policy.
- There was a fixed alarm system in all clinical areas. The alarm system was tested each Monday and the tests recorded by the nursing team.

Lessons learned and improvements made

There was a process for learning and making improvements.

- Staff used the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events, incidents and near misses. All staff working at the practice had electronic access to the system. Staff provided several varied examples of significant events confirming that there was an embedded culture of reporting incidents.
- We reviewed a selection of significant events and noted that action was taken. The ASER system was also used to report good practice and quality improvement initiatives. The practice acted on themes identified from the significant events.

Are services effective?

We rated the medical centre as good for providing effective services.

Effective needs assessment, care and treatment

- Clinicians were aware of relevant and current evidence-based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. Clinical meetings had been held and minutes contained a record of discussion of best practice guidance.
- Our review of patients' notes showed that NICE best practice guidelines were being followed. Staff we spoke with could refer to this and gave examples of updates they had acted on and discussed within the practice.
- The PCRF team referred to the Defence Rehabilitation website for best practice guidance. We reviewed DMICP notes to find all had the musculoskeletal (MSK) outcome completed and the Read codes were correct.
- The Defence Primary Health Care (DPHC) team produced a newsletter that was circulated to clinicians providing further information and a summary of relevant safety updates.
- Guidelines were communicated via the DPHC newsletter and discussed in healthcare governance meetings.

Monitoring care and treatment

The practice undertook quality improvement work to review the effectiveness and appropriateness of the care provided. The Defence Medical Services (DMS) have a responsibility to deliver the same quality of care as patients expect in the National Health Service (NHS). Because the numbers of patients with long term conditions are often significantly lower at Defence Primary Healthcare Services (DPHC) practices, we are not using NHS data as a comparator.

- The civilian nurse is the lead for chronic health, supported by the military nurse and with oversight from the SMO.
- We found that systems were in place to support patients to manage chronic conditions, although there were issues around the reliability of the population manager facility (referred to as 'popman') used to identify and monitor patients with long term conditions. Staff therefore used their own clinical searches to recall patients.
- The medical centre provided step 1 of the mental health pathway. The Welfare Officer worked closely with the medical centre and provided recent examples of how they worked together to safely and effectively support individual patients. Our review of patient records showed patients were effectively supported, safeguarded and referred to the Department of Community Mental Health (DCMH) as appropriate to their assessed risk.

- 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 86% of patients. This was low as guidance had been issued from strategic command during the COVID-19 pandemic to reduce face-to-face appointments.
- A programme of audits to monitor and systematically review clinical and non-clinical outcomes was in place to ensure treatment and care was being provided in accordance national and local standards. The programme was limited due to the small size of the practice. Antibiotics prescribing had been reviewed and clinical notes had been audited, along with waste management. There was scope to extend this work, for example to examine outcomes for patients with long term conditions.
- An internal quality assurance tool, the Defence Medical Services (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.
- There were three patients on the diabetic register. For all three patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For two of these patients, the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control. We saw that there was scope to ensure that diabetic patients were up to date for foot and retinopathy checks.
- There were 15 patients recorded as having high blood pressure. All these patients had a record for their blood pressure taken in the past nine months. Ten patients had a blood pressure reading of 150/90 or less.
- There were seven patients with a diagnosis of asthma. Five patients had an asthma review in the preceding 12 months which included an assessment of asthma control using the three RCP questions. We saw that two different clinical templates were being used and there was scope to use on approach for consistency.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and chronic disease management.

- An induction programme was in place for permanent staff. It took account of DPHC requirements, local expectations and the role of the staff member appointed. Mandated training was monitored by the practice manager who confirmed training was up to date for all staff.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing

support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating doctors and nurses.

- All staff were all encouraged to gain more experience and skills. Internal and external training sessions were available to staff. At the time of this inspection, no staff member was trained in sexual health, although one of the nurses was undertaking this training.

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 looked at showed appropriate staff, including those in different teams, services and organisations were involved in assessing, planning and delivering care and treatment. At our previous inspection, we noted that it had not been possible for a clinician to attend welfare meetings and the Welfare Officer had highlighted that discussions about the needs of vulnerable patients had therefore been limited. Since the previous inspection, the SMO had come into post and now regularly attended welfare meetings. The ERI attended Unit Health Committee meetings to discuss patients and the provision of rehabilitation and fitness courses.
- Patients due to leave the military received a leaving medical and a summary of their health needs to pass to their new GP. The practice also referred patients to the welfare team for support with the transition.

Helping patients to live healthier lives

The practice identified patients who may need extra support and signposted them to relevant services. For example:

- Patients at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.
- The nurses led on health promotion. The health promotion strategy was underpinned by national priorities and initiatives to improve the population's health including, stop smoking campaigns, women's health and tackling obesity. It also took account of the patient population need and seasonal variation impacting health. We saw that health promotion information was available on boards in the reception area. There had not been a health fair since the previous inspection due to COVID-19 but these would re-start if risks could be mitigated.
- The two nurses had not yet received the appropriate sexual health training and so patients were signposted to local sexual health services for procedures not undertaken at the practice.
- The practice recalled patients for preventative health checks. Health checks can help to identify any conditions that patients may be at-risk of and could be avoided by preventative treatment and lifestyle choices.

- A quarterly search was undertaken for all patients aged 50 to 64 years who were entitled to breast screening. The practice also engaged with all national screening programmes and had a mechanism to ensure that eligible patients were referred into the bowel cancer or abdominal aortic aneurysm (AAA) screening programs.
- The number of women aged 25 to 49 (there were four women patients aged 50 to 64) whose notes recorded that a cervical smear had been performed in the last three to five years represented an achievement of 100%. The NHS target was 80%. Invite letters were sent out and followed up if not responded to.

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. The data below from August 2021 provides vaccination data for patients using this practice (regional and national comparisons were not available):

- 98% of patients were recorded as being up to date with vaccination against diphtheria.
- 98% of patients were recorded as being up to date with vaccination against polio.
- 95% of patients were recorded as being up to date with vaccination against Hepatitis B.
- 97% of patients were recorded as being up to date with vaccination against Hepatitis A.
- 98% of patients were recorded as being up to date with vaccination against Tetanus
- 99% of patients were recorded as in date for vaccination against MMR
- Units were responsible for ensuring their personnel kept up to date with vaccinations. 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. Recall for routine vaccination halted during the COVID-19 pandemic and has now recommenced.
- On leaving the Armed Forces, personnel underwent a release medical with the approach tailored to individual patient's needs. The welfare team were engaged throughout the process to ensure all issues were adequately addressed. Transition to NHS services was managed to ensure continuity of care.

Consent to care and treatment

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making. They had received in-service training and had a good understanding of the Mental Capacity Act (2005) and how it would apply to the patient population.
- Doctors records showed that consent was appropriately taken and recorded. The physiotherapists recorded consent to share information with the Chain of Command. Our review of nursing records showed consent was routinely documented.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

- Staff and patients provided us with a number of examples where the practice had gone the extra mile to ensure patients received individualised and compassionate care. Staff confirmed that they had provided on site palliative support and had been able to offer time and support to patients and family members. Similarly we noted that patients who were feeling depressed had been offered extended time to chat and to discuss their concerns. Confidentiality was upheld by the staff team and this in turn meant that patients were more comfortable to share their worries. We spoke with ten patients who had consented to speak with us over the telephone and those with mental health needs confirmed that the medical centre staff had supported them very well. Two patients specifically mentioned how well supported they had felt by the SMO. One patient told us that in previous years they did not feel that their clinical records had been treated with confidentiality but that this had changed in the past two years.
- We spoke with the Welfare Officer and also the Commanding Officer as part of this inspection and both noted a good working relationship with the medical centre, two way sharing of information and a compassionate approach for patients who required extra support and reassurance.
- The practice had an information network available to all members of the service community, known as HIVE. This provided a range of information to patients who had relocated to the base and surrounding area. Information included what was available from the local unit and from civilian facilities, including healthcare facilities.
- There was a note for carers in the practice leaflet and a screen in reception prompted patients to think about whether they were a carer and whether additional support might be useful. The practice had a guidance note for staff on how to support carers. Carers were identified during the new patient registration process and coded accordingly. Patients with a caring responsibility were encouraged to book a double appointment to discuss any support they may require.
- The GPAQ (General Practice Assessment Questionnaire) had been sent to patients and 180 responses submitted. This is a high response rate for a small medical centre and shows that patients were interested in the care they received. 100% of patients who responded said that their healthcare professional treated them with respect and dignity and that their privacy was ensured. 99% of respondents said that they were treated with kindness and compassion.

Involvement in decisions about care and treatment

- Patient feedback suggested the health care needs of patients were effectively addressed and they received appropriate information to make decisions about care and treatment.

- Our review of patient records showed that the PCRF team appropriately used physical training recovery, maintenance and light duties prescriptions to guide patients' return to fitness.
- An interpretation service was available for patients who did not have English as a first language. We were advised it had not needed to be used.
- The practice acted in a compassionate way toward any patient that had to be discharged on health grounds. We saw that the practice reassured these patients and signposted to personnel within the military who could guide them through the exit process and transition to NHS care and other support functions.
- Patients were asked to respond to a survey about the quality of care they received recently. The medical centre received seven responses. Six out of the seven respondents confirmed that they had felt involved in their treatment options and six respondents stated that they felt listened to.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Privacy screening was provided in all consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. Clinic room doors were closed during consultations.
- There was a clearly marked box to ask patients to stand back at reception until called forward. The medical centre had rooms available for patients who wished to discuss a matter in private.
- If patients wished to see a clinician of a specific gender, they could be referred to another military practice.

Are services responsive to people's needs?

We rated the practice as good for providing responsive services.

Responding to and meeting people's needs

The practice understood the needs of its population and organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- Patients were able to have longer appointments with a doctor and nurse if they needed to.
- Same day appointments were available for those patients needing urgent care.
- In response to restrictions associated with COVID-19, a remote triage model including, the use of eConsult and telephone consultation was implemented by the practice. Face-to-face consultations were facilitated if clinically required.
- Patients were able to receive travel vaccines when required.
- A text service was in operation as an appointment reminder.
- The practice trained staff in equality and diversity and there was a 'diversity and inclusion' lead within the medical centre.
- Some patients required input from a clinician who was qualified in aviation medicine. The SMO was suitably qualified and access to aviation medicals was swift.

Timely access to care and treatment

Patients' needs were met in a timely way.

- The practice accommodated patients with an emergency need on the day they presented at the practice. Routine appointments with a doctor were available with little waiting time. Nurses had capacity to see a patient on the same day if required. The patient questionnaire provided positive feedback on access to appointments.
- Outside of routine clinic hours after 18:30 hours patients were diverted to the NHS 111 service and/or e-consult (a message could be left for the practice to follow up on the following working day if not urgent). If the practice closed on an afternoon for training purposes, patients could still access a doctor in an emergency. In this way, the practice ensured that patients could directly access a doctor between the hours of 08:00 and 18:30, in line with DPHC's arrangement with NHS England. There were appointments made available to shift workers who could not attend during routine hours.
- Results from the practice's patient experience survey in August 2021 (seven responses were received) showed that patient satisfaction levels with access to routine care and treatment were high;
    - 100% of patients felt satisfied with their experience of making an appointment.

- The practice leaflet has been updated since our inspection to confirm that home visits are available if a clinician deems this to be appropriate.

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.

- DPHC had an established policy and the practice adhered to this. The practice manager was the designated responsible person who handled all complaints in the practice with the SMO as deputy. No verbal complaints had been made in the past two years, but staff confirmed that these would also be captured and investigated in the same way as written complaints. There were two complaints recorded in 2021 and no theme linked them.
- We spoke with ten patients as part of this inspection and they all confirmed that they would be confident to raise an issue if they needed to. Most knew that information about how to do this was on display in the medical centre reception area.

Are services well-led?

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

At our previous inspection, we rated the practice as requires improvement for providing well-led services. We identified shortfalls resulting from shortfalls in staffing, particularly clinical leadership.

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

Leadership, capacity and capability

Since our last inspection a Senior Medical Officer had been appointed and was established in their role. A CMP had recently been recruited and was due to join the team in October 2021. Significant work had been undertaken and it was evident that a cohesive and comprehensive plan had been implemented by the practice management team. The impact of COVID-19 had been well managed.

The senior staff in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. The SMO was visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff.

- Staff told us the practice held regular team meetings. We saw evidence of minutes and agendas for these, which included clinical meetings, half day training meetings and all staff meetings. Staff meetings were held monthly, and every member of staff was invited. Staff could add items to the agenda prior to the meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported by the more senior staff in the practice.

Vision and strategy

The practice aimed to work to the DPHC vision of:

"***Provide and commission safe and effective healthcare which meets the needs of the patient and the chain of command to contribute to Fighting Power***."

The specific mission statement for the medical centre was:

"***Deliver safe, effective, responsive and compassionate primary care; in support of the operational requirements of RAF Boulmer***."

- Since the last inspection an SMO had come into post and, in conjunction with his team, was providing clinical leadership and also improved continuity of care. Patients we spoke with overwhelmingly recognised that this new model of care provision was working better for them as they were able to access an aviation trained clinician when they needed to and had more vulnerable patients could engage with a clinician they knew and trusted.
- Staff we spoke with at Boulmer Medical Centre told us that their focus was on improving outcomes for patients registered at the centre, whilst recognising the need to meet the occupational health requirements for the RAF.

Culture

- Staff demonstrated a patient-centred focus. Staff worked hard to respond to the needs of patients in a safe, effective and timely way. Staff described a no blame culture where they felt supported to improve ways of working.
- The PCRF was an integral part of the medical centre and staff worked as a team to deliver a clear rehabilitation pathway for patients with musculoskeletal needs.
- Equality and inclusion of all staff was evident, staff told us their contributions to the service were listened to and that they felt valued. Team meetings were held regularly.
- Staff said there was an open-door policy with everyone having an equal voice, regardless of rank or grade. All were familiar with the whistleblowing policy and said they were comfortable raising any concerns.
- Processes were established 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. There was a duty of candour register within the healthcare governance workbook. Staff had received training in the subject.

Governance arrangements

- There were consolidated and clarified responsibilities and systems of accountability to support good governance and management. Since the last inspection, improvements had been made in the governance framework, specifically around: the induction programme, training and supervision for staff, maintenance of accurate clinical records, referrals management and high risk medicines management.
- The leadership team had revised and/or developed systems and processes in accordance with DPHC expectations and the needs of the patient population. In particular, the practice manager had developed a comprehensive healthcare governance workbook which provided a detailed overview of how the service was being monitored. The practice effectively used the healthcare governance workbook to capture and monitor governance activity. All staff had access to the workbook which provided links to meeting minutes, policies and other information.

- Joint working with the welfare team, pastoral support and Chain of Command was in place with a view to safeguarding vulnerable personnel and ensuring co-ordinated person-centred care for these individuals.
- Shared care protocols were in place for patients taking high risk drugs and an effective system implemented for the controlled storage and tracking of prescription stationary.
- Practice leaders had established a number of policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. Clinical waste procedures had been strengthened. There was scope to do further work around the accuracy of clinical coding in order to ensure that clinical searches were capturing all patients that required recall.

Managing risks, issues and performance

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

- There was an established a governance structure that provided oversight of risk and the quality of service. The medical centre maintained a risk register and a record of short-term issues, and had plans in place for major incidents. We saw that these were reviewed regularly, acted on and staff had been trained. A business resilience plan was in place and was regularly reviewed. Staff confirmed that they knew what to do in the case of emergency such as loss of power. The medical centre had a role in the unit major incident plan, and this was exercised regularly with both tabletop exercises and practical tests.
- Regularly reviews, risk assessments and audit was having a positive impact on safety. These covered a number of areas including COSHH (substances hazardous to heath), lone working, slips trips and falls and the management of sharps.
- The practice manager was able to describe processes that could be used to manage poor performance. These included welfare support, re-training, appraisal or, if required, disciplinary processes.
- All staff were in date for ‘defence information passport’ and ‘data security awareness’ training.

Appropriate and accurate information

- An understanding of the performance of the practice was maintained. The practice manager used the Common Assessment Framework (CAF) as an effective governance tool. A number of different meetings were held regularly and extended to the whole team. Cross-practice meetings had been established and provided a forum for effective discussion and shared learning. Minutes from meetings we reviewed demonstrated that key agenda items had been discussed including safeguarding, NICE guidance and patient safety alerts.

- There were robust arrangements at the medical centre in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

- 180 patients at the medical centre had provided feedback about their clinician through the GPAQ survey (General Practice Assessment Questionnaire) and levels of satisfaction were high. There was evidence that the practice acted on feedback from patients and a board of actions taken was in display in the reception area.
- An additional patient feedback form had recently been sent out to all patients and seven responses received.
- The SMO sits on the Station Executive committee to ensure prompt and effective communication. Good and effective links with internal and external organisations were established, including with the welfare team, RRU and DCMH.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation. The practice maintained a quality improvement log on the health governance workbook.