Cottesmore Medical Centre

Quality report

Kendrew Barracks
Cottesmore
Oakham
Rutland
LE15 7BL

Date of inspection visit:
27 February 2020

Date of publication:
21 May 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?	Inadequate
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires improvement

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? – Inadequate
Are services caring? – Good
Are services responsive? – Good
Are services well-led? – Requires improvement

We carried out an announced comprehensive inspection of Cottesmore Medical Centre on 27 February 2020. Defence Medical Services (DMS) are not required to register with CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. Consequently, military healthcare services are not subject to statutory CQC inspection and CQC has no powers of enforcement. However, DMSR (in consultation with DG DMS) has commissioned the CQC to undertake a comprehensive programme of inspections of all military primary and community healthcare services. This inspection programme enables us to inspect military healthcare services across the United Kingdom and overseas on behalf of DMSR.

At this inspection we found:

- The new leadership team demonstrated they had the vision, passion and integrity to provide a patient-focused service. However, the service required further development and improvement.
- Staff valued the opportunities available to them to be part of a patient-centred service.
- An effective system was in place for managing significant events and staff knew how to report and record using this system.
- The assessment and management of risks required strengthening.
- Most arrangements for managing medicines, including obtaining, prescribing, recording, handling, storing, security and disposal minimised risks to patient safety. However, there was scope to improve the monitoring of patients on high risk medicines.
- Staff were aware of current evidence based guidance. However, we were unable to gain reassurance that treatment was being delivered in accordance with guidelines as the systems to manage patients with long-term condition were being developed.
- The practice worked collaboratively and shared best practice to promote better health outcomes for patients.
- There was evidence to demonstrate quality improvement was being implemented with an annual programme of clinical audit for 2020.
- 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. Feedback from staff was less positive.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.

- Equipment at the practice were sufficient to treat patients and meet their needs. The building did not lend itself to ease of access for patients with a disability although staff had a workaround for this and had submitted plans to have the required work completed.
- Staff were aware of the requirements of the duty of candour.

The Chief Inspector recommends:

- Strengthen the processes for managing and monitoring patients on high risk medicines.
- Improve the arrangements for monitoring the patient waiting area.
- Implement a structured approach to manage and improve the recall of patients to include patients with long-term conditions, those who require vaccination and for those eligible for health screening.
- Implement a coordinated approach to identify and safely manage those patients with a mental illness and/or depressive symptoms.
- Ensure peer review is in place for all clinical staff.
- Continue to explore ways to increase the identification of those patients with caring responsibilities.

The Chief Inspector recommends to DMS Digital:

- Diagnose and improve the Information Technology (IT) access in order to ensure continuous access to the contemporaneous patient record.

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

Our inspection team

The inspection team was led by a CQC lead inspector**.** The team comprised specialist advisors including a primary care doctor, practice nurse, practice manager, physiotherapist and pharmacist.

Background to the Cottesmore Medical Centre

Cottesmore Medical Centre is an army base located in Rutland providing a routine primary care service to a patient population of 1,775 of service personnel and 523 dependant civilians. The base experiences high levels of deployment with a routine population change every two years. Dependant families who live in Kendrew Barracks can register for health care services at the medical centre or elect to register at one of four local GP practices. There were 328 registered patients under the age of 18 at the time of the inspection and 227 patients aged over 40. The barracks is the home to infantry and logistics regiments and there are two further army establishments located nearby; the Defence Animal Training Regiment (DATR) based in Melton Mowbray and Military Working Dogs (1MWD) based at St Georges Barracks in North Luffenham. In addition, the practice provides medical care to 134 military reservists.

The medical centre is a dispensing practice and is staffed by two pharmacy technicians. A Primary Care Rehabilitation Facility (PCRF) is co-located with the medical centre and provides a physiotherapy and rehabilitation service for service personnel only.

The medical centre is open from 08:00 to 18:30 hours Monday to Friday. Outside of these hours, including weekends and bank holidays, cover is provided by NHS 111.

The staff team

Position	Numbers
Senior Medical Officer (SMO)	One
Regimental aid post[1] - Medical Officer (MO)	One 60/40 split practice/unit
General Duties Medical Officer[2] (GDMO)	Two (both deployed)
Civilian medical practitioners (CMP)	Two (one locum)
Civilian nurse manager	One
Military Senior Nursing Officer (SNO)	One
Civilian practice nurses	Two (one locum)
Regimental aid post - practice nurse	One
Health care assistant	One
Regimental aid post – medics[3]	Nine (two gapped)
Military practice manager	One
Office manager	One
Administrative staff	Four
PCRF staff	Three physiotherapists (one locum) One exercise rehabilitation instructor (ERI)
Pharmacy technicians	Two (one locum)

[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 keep patients safe and safeguarded from abuse.

- A framework of regularly reviewed safety policies was in place and accessible to staff, including locum staff. Staff received safety information about the practice as part of their induction and refresher training.
- Measures were in place to protect patients from abuse and neglect, including adult and child safeguarding policies which had last been reviewed in December 2019. Staff, including Regimental Aid Post (RAP) staff working at the practice, had received safeguarding training and update training at a level appropriate to their role.
- Clinicians had completed level 3 training in adult and child safeguarding and other staff had training appropriate for their role. A safeguarding lead and deputy were identified for the practice. Safeguarding arrangements and local contact details were displayed in clinical rooms.

- Coding and alerts were used to highlight vulnerable patients. A vulnerable patients register was held on the electronic patient record system (referred to as DMICP) with 49 identified at the time of the inspection. Meetings with the health visitor and midwife took place every six weeks to discuss vulnerable children. A note of any discussion was added to the patient record. The meetings were coordinated to take place on Wednesday afternoons when the health visitor and midwife held clinics at the practice. The needs of service personnel assessed as being vulnerable were discussed with the Welfare Officer at the monthly Unit Health Committee (UHC) meetings.
- There was a list of trained chaperones available. Notices advising patients of the chaperone service were displayed in patient areas. Staff had been subject to safety checks to ensure they were suitable to work with young people and vulnerable adults.
- The full range of recruitment records for permanent staff was held centrally. However, the practice could demonstrate that relevant safety checks had taken place at the point of recruitment, including a Disclosure and Barring Service (DBS) check to ensure staff, including locum staff, were suitable to work with vulnerable adults and young people. DBS checks were renewed every five years. Staff had received the appropriate vaccinations for their role.
- 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 all the relevant vaccinations required for their role at the practice.
- There was an effective process to manage infection prevention and control (IPC), including a lead and deputy appropriately trained for the role. The staff team was up-to-date with IPC training. An internal IPC audit had been undertaken in January 2020 and no significant concerns had been identified. There were concerns over infrastructure, particularly flooring, which had been appropriately recorded and requests to remedy had been made.
- PCRF clinicians practised acupuncture and arrangements were in place for the safe provision of this treatment, including an acupuncture health screening assessment and patient information sheet. The acupuncture risk assessment was current and a standard operating procedure (SOP) was in place.
- Environmental cleaning was provided by an external contractor who used dedicated cleaners. Cleaning schedules and monitoring arrangements were established, including cleaning before the practice opened and at lunchtime. A deep clean of the premises took place twice annually during closure periods (Easter and Christmas). We identified no concerns with the cleanliness of the premises.
- A member of staff had the lead for the safe management of healthcare waste. Consignment notes were retained at the practice and an annual waste audit was carried out in February 2020.

Risks to patients

The systems to assess, monitor and manage risks to patient safety required strengthening.

- The practice had been through a difficult period with staffing levels and skill mix impacted due to gapped posts. This had impacted on proactive patient care, in particular, there was no structured approach to health screening and to manage patients with long-term conditions. Recruitment was underway to increase the administration support and locums were being used to cover the gapped nurse post and deployed GDMOs.
- A locum induction programme 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 staff trained in life support. An emergency kit, including a defibrillator, oxygen with masks and emergency medicines were accessible to staff in a secure area of the practice; all staff knew of its location. A first aid kit and accident book was available. Weekly and monthly checks were in place to ensure the required kit and medicines were available and in-date.
- Staff were up-to-date with the required training for medical emergencies. A recent group training session held at the practice was around familiarisation with the resuscitation trolley and scenario training was planned for 2020. Staff were trained in the recognition and management of sepsis, and cards with essential information on sepsis were kept by each workstation.
- The layout at the practice did not allow the patient waiting area to be routinely monitored by practice staff. However, the area was not isolated, with the entrance to clinical rooms being within the waiting area. A business case has been approved for closed circuit television to allow the area to be monitored by reception staff.
- Staff were familiar with organisational guidance issued in relation to the Covid-19. The practice had placed a notice board at the entrance to advise patients of the symptoms and appropriate actions to take. There had been no potential cases of patients showing symptoms but the medical centre staff understood what to look out for and how to respond.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients. However, some information management work was needed to update the population eligible for health screening.

- There were some gaps in the care records we looked at on DMICP. For example, there was no formal review process for carrying out medication reviews for patients with long-term conditions.
- A process was established for scrutiny and summarising of patients' records and this was monitored by the nurse manager. New patients completed a registration form, which was checked by the receptionist and then passed to the nurses for further checks. Summarisation of service personnel was completed on DMICP. The units on the base rotated every two years meaning large changes to the patient list required processing. A member of the administration team was responsible for ensuring medical records were received. At the time of the inspection there were 50 patient records, received in the last six weeks, waiting to been summarised (the last rotation had been between August 2019 and September 2019 with 1,000 people leaving and arriving). There had been a delay in the practice receiving the notes with most notes having not arrived until January 2020.
- 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. Packs were available to be used in the event of a system outage. Consultation notes were recorded on to paper copies and scanned onto DMICP at a later date. A business case had been submitted for laptops that could be connected when the local server was down.
- Referrals to other departments and external health care services, including urgent referrals, were managed by two dedicated administrative staff. They responded to requests from the doctors and booked patient appointments through the NHS e-Referral service (e-RS). If an appointment was not available based on patient availability then the administrator followed it up on behalf of the patient. Referrals were logged and monitored and the administrators closed them off once appointments had been completed. For urgent two-week-wait referrals, patients

left the practice with an appointment. Referrals made from the PCRF were integrated with the wider referral tracking system for the practice. Physiotherapists monitored the referrals they made to the Regional Rehabilitation Unit (RRU) and other services.

- There was an effective system in place to ensure specimen samples were taken safely, appropriately recorded on DMICP and results reviewed and actioned by a clinician within seven days. We found that the system was effectively managed by the healthcare assistant (HCA) who entered the date, required tests and requesting clinician onto a tracking sheet. In the absence of the HCA, the nurses took over the responsibility.

Safe and appropriate use of medicines

The practice had reliable systems for the appropriate and safe handling of medicines. However, the arrangements for managing patients on high risk medicines (HRM) required strengthening.

- A lead and deputy were identified as the subject matter experts for medicines management with the day-to-day management of medicines delegated to a pharmacy technicians. Safe procedures were in place for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment.
- Dispensary stock was checked regularly. Appropriate arrangements were established for the safety of controlled drugs (CD), including destruction of unused CDs. Medication requiring refrigeration was monitored twice a day to ensure it was stored within the correct temperature range. Prescription forms were securely stored and their use monitored.
- Patient Group Directions (PGD) had been developed to allow appropriately trained nurses to administer medicines in line with legislation. The PGDs were current and signed. Patient Specific Directions (PSD) were in place and signed by the prescriber to permit medics to vaccinate patients. However, PSDs had not been used since November 2019.
- Requests for repeat prescriptions were safely managed and no telephone requests were accepted. The process for repeat prescriptions was maintained and monitored by the pharmacy technicians. A process was in place to update DMICP if changes to a patient's medication was made by secondary care or an out-of-hours service.
- A process was established for the management of and monitoring of patients prescribed HRM. A register of HRM used at the practice had recently been implemented and was regularly reviewed by the SMO. However, other clinicians had not engaged with this. Diary dates and monthly searches were used to identify and manage patients on HRM. Shared care agreements were in place for the patients that required them. These were stored and managed on DMICP, an electronic document management and storage system, which all clinicians had access to.
- There were 12 patients prescribed an HRM and we looked at a range of these records. We noted that one patient did not have alerts to notify when monitoring was required. Patients had shared care agreements (SCA) in place and the SMO proactively chased updates with the hospital. SCAs are important to provide clear responsibilities between clinicians involved in the patient's care.
- We saw that the prescribers were working to both local and national guidelines for prescribing. A structured programme of audit, including an audit of antibiotic prescribing, had recently been implemented but it was too soon to see any performance and improvement in the management of medicines. We highlighted that consideration should be given to include regular PGD audits.

Track record on safety

The practice had a good safety record.

- Measures to ensure the safety of facilities and equipment were in place. The practice manager and office manager were the leads for health and safety, both had completed role-specific training. Electrical and gas safety certificates were up-to-date. Arrangements were in place to check the safety of the water. A fire risk assessment of the building was undertaken annually and the fire system was tested weekly. Staff were up-to-date with fire safety training and were aware of the evacuation plan.
- Safety processes for the practice were monitored and reviewed, which provided a clear and current picture that led to safety improvements. Risk assessments pertinent to the practice were in place and had been reviewed in December 2019; PCRF risk assessments were reviewed in January 2020. Safety data sheets were in place for hazardous substances. The station lead for health and safety carried out an annual assessment and the next was due in October 2020. Equipment checks, including the testing of portable electrical appliances were in-date. The PCRF provided evidence that the equipment held at the various gyms used to treat patients had been serviced.
- An alarm system was available in clinical areas to summon support in the event of an emergency and a lone working policy was current and signed by all staff. The practice was waiting for approval to have CCTV fitted in waiting rooms so reception could monitor these areas in the event of a medical emergency.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff used the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events, incidents and near misses. All staff had electronic access to the system, including locum staff. Staff provided several varied examples of significant events confirming there was a culture of effectively reporting incidents. Significant events were discussed at the healthcare governance and practice meetings. Significant events were not closed until all actions had been completed.
- Improvements were made as a result of investigations into significant events. For example, the door between the medicines store and dispensary was kept locked as a result of an ASER that identified unauthorised access had been gained.
- The pharmacy technicians were responsible for managing medicine and safety alerts. The system was checked for alerts each day and any alerts logged to include any action taken. Alerts were emailed to staff with a read receipt. They were also a standing agenda item at practice meetings. We checked two recent alerts and found they had both been received and managed appropriately.

Are services effective?	**Inadequate**

We rated the practice as inadequate for providing effective services.

Effective needs assessment, care and treatment

The practice were strengthening processes to keep clinicians up to date with current evidence-based practice.

- A framework of regular clinical meetings was being implemented to include updates with current legislation, research and guidance, including NICE (National Institute for Health and Care Excellence) and the Scottish Intercollegiate Guidelines Network (SIGN). Discussion around updates were standing agenda items at the monthly healthcare governance meetings and the weekly clinical meeting. Clinical meetings with the health visitor, midwives and nurses were held on a regular basis and had continued during the temporary closure of the practice. However the concerns we found during our inspection around, for example, medicines management, indicated that these discussions were not always leading to improvements in clinical practice. Whilst staff had access to guidelines from NICE, we saw instances where these were not being followed to deliver care and treatment that met patients' needs, specifically the management of DMARDs and long term conditions.
- In addition to participating in the wider practice meetings, the PCRF team held two formal meetings with the doctors each month to discuss individual patients. In addition they had their own monthly departmental meeting to discuss current practice, share updates and for informal peer discussion.
- Our review of PCRF patient records showed Rehab Guru, software for rehabilitation plans and outcomes, was used for exercise programmes for some patients.
- The PCRF team referred to the Defence Rehabilitation website for best practice guidance. For example, ERIs used it for guidance on equipment management, training and best practice guidance.

Monitoring care and treatment

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

The SMO had developed searches that identified all patients with a long-term condition. However, this was not fully implemented at the time of inspection so we were unable to gain reassurance that the long-term condition registers were current, and that the management of patients with a long-term condition, including recall, monitoring and treatment was in place.

- We were provided with the following patient outcomes data during the inspection:
    - The numbers on the diabetic register were low. For one patient, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control.
    - For two patients with diabetes, the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.
    - There were 23 patients recorded as having high blood pressure, 16 had a blood pressure reading of 150/90 or less.
    - There were 31 patients with a diagnosis of asthma. Fifteen patients had an asthma review in the preceding 12 months which included an assessment of asthma control using the three Royal College of Physicians questions.

The practice recognised that it was not meeting all the QOF targets and were addressing this at the time of the inspection. We found that long-term condition templates were not always being used and this resulted in errors on the clinical system when conducting searches.

- The Medical Centre had not applied Read codes for mental health conditions consistently and so we were unable to gain a comprehensive view of care and treatment for patients with anxiety and depression. However, we saw that links had been established with the Department of Community Mental Health (DCMH) and desktop cards were in clinical rooms to encourage consistency of Read codes. Read codes are used to search for patients with a specific diagnosis or condition and are important to monitor performance.
- 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 82% of patients (15% of the practice population required annual audiometric assessments and this skewed the data, showing the overall population).
- A programme of quality improvement had recently been implemented but it was too soon to review the impact. The PCRF was integrated into the audit programme for the practice. A lead and deputy for audit had been appointed and a structured audit programme was in place for 2020.
- Delivery of rehabilitation was limited by the infrastructure as there was minimal gym space in the PCRF which meant the there was insufficient room to add desirable strength and conditioning equipment. The main station gym was used as an alternative and there was no impact on the key performance indicators.

Effective staffing

The practice told us that time constraints had limited the learning and development opportunities for staff. The staff database was monitored by the practice manager to ensure staff were up-to-date with mandated training. Clinical supervision was in place and extended to all staff, but peer review, although planned, had not been implemented at the time of inspection.

- A generic and role-specific induction was in place for new staff to the practice.
- Protected time was given for completion of mandated training. The practice manager monitored progress using the healthcare governance workbook and had a future plan for all staff to be in-date for all required training.
- Two General Duties Medical Officers (GDMO) were assigned to the practice. The SMO told us that time with the GDMOs had been very limited due to deployment. There was system in place for the SMO to provide clinical supervision, this included sitting in on consultations held by the GDMO.
- There was no formal process of peer review for the PCRF team. This meant that opportunities to learn and improve were being overlooked. Staff told us that ad hoc peer review had taken place and formal supervision was provided by the regional rehabilitation team.
- Regional meetings and forums were established for staff to link with professional colleagues in order to share idea and good practice. For example, nurses were supported to attend the regional nurse's forum to link with their colleagues. However, staff told us that it was difficult to secure funding for courses through the regional team. For example, the nursing team told us

that vocational training was readily available for new nurses but was limited for updates and specialist 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 reviewed showed appropriate staff, including those in different teams, services and organisations were involved in assessing, planning and delivering care and treatment. The SMO had travelled to Cyprus to coordinate the handover of the last unit to be posted into Cottesmore.
- The practice had developed good working relationships both internally and with health and social care organisations. For example, monthly meetings were coordinated to take place on Wednesday afternoons when the health visitor and midwives were in clinics hosted by the practice. External links had been established with the local clinical commissioning group (CCG) and primary care network.
- A doctor was nominated to represent at one of the various UHC and welfare meetings to discuss the occupational health needs of the units, the needs of patients who were medically downgraded and those who were vulnerable. The PCRF was also represented at these meetings.
- Doctors provided patients transitioning from the military with a release medical and a summary of care record. Information on support services available to military veterans was given out at the final medical.
- The SMO had written to local NHS GP practices to introduce the safeguarding leads as a point of contact should there be any concern with the welfare of families and dependants of serving personnel.

Helping patients to live healthier lives

Health promotion activity was evident with the HCA as the appointed lead and responsible individuals named for specific programmes. The practice leads were working to establish a coordinated approach to health screening.

- Clinical records we reviewed 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.
- The health promotion that did take place was underpinned by national priorities and initiatives to improve the population's health including, stop smoking campaigns and tackling obesity.
- Health promotion displays were available in patient areas. These were dated and refreshed in line with the strategy. At the time of the inspection there were displays about bowel cancer and prostate cancer.
- Health fairs were held on the base unit gymnasium and the practice was represented by doctors, nurses, PCRF staff as well as invited teams for sexual health and police for safe driving. The health fairs were held annually with the next one scheduled for June 2020.
- A mental health information display was available for patients that took into account wellbeing and mindfulness. It included details about websites patients could access for further information. Patients seen by clinicians were provided with service community guide, contact details for outside agencies and credit card-sized self-help cards.

- The SMO was the allocated lead for sexual health and three of the clinicians had completed foundation level 1 (referred to as STIF). Clinicians from the local sexual health team held weekly clinics at the practice. Where appropriate patients were referred to local genitourinary clinic for screening. There was a dedicated noticeboard in the waiting area with information for patients and signposting to local sexual health services and condoms were available at the practice.
- Patients had access to appropriate health assessments and checks. The service was NHS-led and the practice was informed if patients did not attend for screening However, the practice did not maintain an oversight and although monthly searches were carried out, there was scope to improve the recall system for patients eligible for bowel and breast cancer screening, childhood immunisations and for over-40 health check. Following the inspection, the practice provided data to show that they had identified the eligible population and had started to recall patients. DPHC policy does not require over-40 health checks to be completed and a health check is completed as part of the new patient assessment.
- There was a system to recall patients who did not attend for cervical cytology screening. Non-attenders were written to and a note added to their record to encourage opportunistic screening. Eighty-two per cent of patients who met the criteria had received a cervical smear in the last three to five years. The NHS target was 80%.

It is important that military personnel have sufficient immunity against the risk of contracting certain diseases. The World Health Organisation sets a target of 95% for vaccination against diphtheria, tetanus, pertussis and polio and measles, mumps and rubella. Based on clinical records, the following illustrates the current vaccination data for military patients:

- 95% of patients were recorded as being up to date with vaccination against diphtheria.
- 95% of patients were recorded as being up to date with vaccination against polio.
- 90% of patients were recorded as being up to date with vaccination against hepatitis B.
- 93% of patients were recorded as being up to date with vaccination against hepatitis A.
- 95% of patients were recorded as being up to date with vaccination against tetanus.
- 98% of patients were recorded as being up to date with vaccination against yellow fever.
- 99% of patients were recorded as being up to date with vaccination against MMR.
- 80% of patients were recorded as being up to date with vaccination against meningitis.

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

Child Immunisation

The practice had resumed the management of childhood vaccinations three weeks prior to the inspection (following the temporary closure of Cottesmore Medical Centre, this had been managed by a nearby military medical centre). Following the inspection, the practice provided an update that showed they had reviewed all eligible patients and recalled them appropriately. Results are below:

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged one who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB)	15	31	49%	Not met WHO target However, 13 patients have appointments booked, six patients are newly registered and one patient was unable to receive vaccinations due to ill health
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster)	18	21	86%	Not met WHO target The remaining three patients had been identified and appointments booked. Two of the patients were newly registered.
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster)	18	21	86%	Not met WHO target The remaining three patients had been identified and appointments booked. Two of the patients were newly registered.
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR)	18	21	86%	Not met WHO target The remaining three patients had been identified and appointments booked. Two of the patients were newly registered.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance. However, there was no monitoring of the process for seeking consent; for example, through audit of clinical notes.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making. This included the PCRF who took written consent for treatments such as acupuncture.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. Staff we spoke with were aware of the Mental Capacity Act (2005) and how it could apply to their practice. The principles of the MCA were on every clinical noticeboard. Further training regarding mental capacity was due to take place in March 2020.
- Templates used, for example when performing acupuncture, included a record of consent.

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 February 2019 Patient Experience Survey (30 respondents) showed patients were happy with how they were treated. A total of 43 CQC comment cards completed prior to the inspection were complimentary about the service received. Nine of the comment cards were mixed; five cards commented on problems with access and four comments referenced poor communication.
- The practice had an information network available to all members of the service community, known as HIVE. This provided a range of information to patients who had relocated to the base and surrounding area. Information included what was available from the local unit and from civilian facilities, including healthcare facilities.
- The practice had a concise information leaflet to ensure patients were clear about the facilities available including key members of the practice team, contact numbers, opening times and clinics provided.

Involvement in decisions about care and treatment

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

- Interpretation services were available for patients who did not have English as a first language and all clinical staff had a card that instructed them on how to use the service.
- The Patient Experience Survey showed 92% of patients were involved in decisions about their care. Feedback on the CQC patient feedback cards highlighted that patients received information about their treatment to support them with making informed decisions about their treatment and care.
- The practice had processes in place to identify patients who were also carers. The practice information leaflet included a section inviting patients who were carers to identify themselves and there was a section on carers in the January newsletter. A register of carers was maintained although only a small number of patients had been identified as having a caring responsibility.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Screening was provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. Clinic room doors were closed during consultations.
- The waiting area was sited away from the reception desk so conversations at the desk could not be heard. However, the layout of the reception area meant that conversations between patients and reception staff could be overheard when waiting at the desk. A project to make improvements had been started and was awaiting funding. A notice at the reception desk advised patients that a private room would be offered should they wish to discuss sensitive issues.
- The practice could facilitate patients who wished to see a clinician of a specific gender. All the nurses were female so a patient requesting a clinician of specific gender that could not be accommodated were referred to another medical centre in the region.
- A male sexual health nurse provided clinics weekly that were hosted by the practice.

Are services responsive to people's needs? | Good

We rated the practice as good for providing responsive services.

Responding to and meeting people's needs

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

- Staff understood the needs of its population and tailored services in response to those needs. Appointments slots were organised to meet the needs of specific population groups. For example, one of the CQC comments cards complimented the practice team for understanding and respecting their ethnic beliefs and for finding a workaround solution.
- Specific clinics were in place including vaccination and chronic disease.
- Child-centred Wednesday afternoons had been introduced. Childhood immunisations and safeguarding meetings were held then to coincide with the family planning and baby clinics (hosted by the by the community team) provided by the health visitors and midwives. This ensured relevant personnel were in attendance at the centre at the same time.
- Additional evening appointments had been introduced to improve access for school-aged children and working spouses.
- The Patient Experience Survey indicated that 90% of respondents would recommend the practice to family and friends.
- An access audit as defined in the Equality Act 2010 was completed for the premises in January 2020. The building did not lend itself to ease of access for patients with a disability. The practice had made as much reasonable adjustment as possible. The PCRF department was upstairs and with no lift in the building, a treatment room was made available on the ground floor. Notices at reception advised patients of where the accessible WC facilities were available on site.
- Facilities were available for families, including a private room for breast feeding and baby changing facilities.

Timely access to care and treatment

Wait times for routine doctor's appointments were longer than average for DPHC practices, although shorter than NHS waits. There were long waits for occupational medicals which created an operational risk. However, the situation had been impacted by the loss of a CMP and the subsequent cancellation of their clinics. The practice confirmed that the situation had been resolved within two weeks of the inspection.

- 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. The wait for a routine appointment with a doctor was 16 days which is comparable to NHS GP practices. Occupational medicals were not available until 23 April 2020. This could have an impact on patients who were due for their grading review. Following the inspection the practice advised that wait times had been improved to three days for a routine doctor's appointment and nine days for an occupational medical.
- Non-attendance at appointments was monitored for the practice, including the PCRF. The non-attendance rate was 15% for June 2019. An audit of waiting times was planned to monitor improvement having introduced the text reminder system in November 2019.
- Arrangements were in place for patients to access NHS 111 when the practice was closed, including emergency care.
- Home visits were not routinely provided but any request would be referred to the duty doctor. Telephone consultations and telephone triage were available with clinicians.
- A direct access physiotherapy (DAP) service was scheduled to be introduced in April 2020. The practice had introduced DAP in 2017 but had stopped the service due to a lack of uptake. Patients prioritised as urgent were given the next available appointment ideally within five working days and patients with a routine need were seen within 10 working days.

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 help patients understand the complaints process. The complaints procedure was displayed in clinical rooms for staff to access.
- The practice manager was the designated responsible person who handled all complaints. The office manager took on this role in their absence. The practice managed complaints in accordance with the DPHC complaints policy and procedure. Both written and verbal complaints were recorded and linked to the health governance workbook.
- Any complaints were discussed at the practice meetings and lessons identified. Changes to practice were made if appropriate and used to improve the patient experience.

Are services well-led?	Requires improvement

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

Leadership capacity and capability

The leadership team demonstrated an awareness of the issues and discussed the planned improvements. However, the capacity of the current team was limited due to gapped posts, long-

term sickness absence and the limited support provided from unit medical staff (due to deployment and training). Locum staff were being used to cover gapped posts.

- Leaders demonstrated the managerial experience and capability to address the issues encountered in the previous 12 months. However, the demands of the ongoing improvement work were a potential threat to the capacity of the medical centre to deliver its services.
- Staff comments on how the practice was led were mixed. They said that the SMO and practice manager demonstrated a collaborative approach to leading the practice and supporting staff. However, they felt that the nursing team could be managed with a more inclusive approach.

Vision and strategy

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

- The practice worked to the DPHC mission statement of:

  "DPHC will deliver a unified, safe, efficient and accountable primary healthcare and dental care services for entitled personnel to maximise their health and to deliver personnel medically fit for operations."

- The practice had developed its own vision statement which was to:
  - Keep patients safe by delivering the highest standards of care.

Culture

The SMO and practice manager promoted a culture at the practice that was inclusive and where staff were treated equally. The nursing staff felt that a more inclusive culture could be developed within the team.

- The SMO and practice manager had introduced quarterly team building days, social events and a daily mid-morning break when all staff were encouraged to attend. However, results from the February 2020 staff survey showed that 13 out of 20 staff said that did not feel like co-workers gave each other respect.
- The PCRF was integrated with the wider practice, including an integration of governance systems; for example, the audit lead was a physiotherapist.
- Staff described an open and transparent leadership style from the SMO and said they would feel comfortable raising issues. They felt that improvements made were having a positive impact. Both formal and informal opportunities were in place so staff could contribute their views and ideas about how to develop the practice.
- Improvements in systems were underway to help staff understand the specific needs of their patient population and so tailored the service to meet those needs. For example, the registers of patients with long-term conditions had been completed and a patient recall programme had been commenced.
- Openness, honesty and transparency were demonstrated when things went wrong. A no-blame culture was evident; complaints and incidents were seen as opportunities to improve the service.
- The practice had systems to ensure compliance with the requirements of the duty of candour, including giving those affected reasonable support, information and a verbal and written apology. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.

- There was some evidence of clinical supervision for nursing staff but there was no structured peer review and appraisal of staff. A programme for supervision and appraisal was planned for April 2020. This extended to all staff and a template had been developed in readiness.
- The practice actively promoted equality and diversity and staff had received training in this area.

Governance arrangements

The governance arrangements had been strengthened to support the delivery of good quality care. However, work was needed to embed strong governance arrangements in order to deliver sound high-risk medicine and long-term condition management, staff support systems and impactful quality improvement work.

- A clear staffing structure was implemented in April 2019 and had been updated in July and December. Staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. Terms of reference were being completed to support job roles.
- The practice worked to the health governance (HG) workbook, a system that brings together a comprehensive range of governance activities, including the risk register, significant events tracker, lessons learnt log, training register, policies, meetings, quality improvement and audit. All staff had access to the workbook which provided links to meeting minutes, policies and other information.
- A range of communication streams were used at the practice. A schedule of regular practice, healthcare governance had been implemented. Standing agenda items included significant events, alerts and NICE guidelines.
- A structured audit programme had been introduced for 2020 to measure the effectiveness and success of clinical and administrative practice but it was too soon to evidence any positive impact.

Managing risks, issues and performance

There were effective processes for managing risks and issues. The systems for managing performance had been developed and were being embedded.

- Risk to the service were well recognised, logged on the risk register and kept under scrutiny through regular review. There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety. Processes were in place to monitor national and local safety alerts, incidents, and complaints.
- A system was being developed to monitor performance target indicators. The practice was in the process of gaining the required information to monitor child health and cytology. There were established and effective systems to monitor summarising and failed attendances. The unit managed the recall of forces personnel who required medicals and vaccinations,
- A business continuity plan and major incident plan were in place. Staff had signed to acknowledge these as part of their induction.
- Procedures were in place for managing poor performance and these took account of military and civilian staff.

Appropriate and accurate information

The practice was making improvements to ensure it had appropriate and accurate information to deliver safe care and treatment. Gaps identified at the inspection included patients eligible for health screening.

- Some quality and operational information was used to ensure and improve performance. The views of patients were routinely sought in line with DMS policy and staff provided examples of changes this feedback had triggered.
- The practice manager was starting to use the Common Assessment Framework (CAF) as an effective governance tool. We saw that meetings were used to discuss future planning; for example, a number of staff were due to leave and the impact on future staffing arrangements had been discussed. A number of different meetings were held regularly to learn from one another, discuss recent guidance changes and to review their approach in clinical settings.
- 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. This extended to the PCRF.

Engagement with patients, the public, staff and external partners

There was some evidence that the practice involved patients, staff and external partners to support high-quality sustainable services.

- There were various options in place to encourage patients to provide feedback on the service and contribute to the development of the service. A patient experience survey was undertaken throughout the year. In addition, patients could leave feedback via through the suggestion box. Patients were informed of the response to their feedback through a 'You said we did' display. For example, patient feedback had resulted in extra appointments being made available outside school hours.
- The practice had conducted a staff questionnaire in February 2020 which achieved a response rate of 50%.
- The practice was exploring options to develop a patient focus group but had found a lack of interest from patients when attempts were last made to form a group. The most recent attempt had been made using the December 2019 and January 2020 newsletters.
- Good and effective links with internal and external organisations including the welfare team, RRU, the DCMH, local NHS services and social services.

Continuous improvement and innovation

The recent challenges with infrastructure and staffing had limited the amount of continuous improvement work in the last 12 months. We found that improvements were implemented based on the outcome of feedback about the service, complaints, audits and significant events.

Quality improvement activity we identified included:

- The introduction of business cards with essential numbers and contact details for support services; for example, pathways to support patients with mental health difficulties.
- Child centred Wednesday afternoons to coordinate the care with health visitors and midwives.
- The introduction of a text message reminder service to advise patients on the time and date of their upcoming appointment.

- Introduction of defined primary health care and occupational health clinics.
- Restructuring of the safe-guarding meetings with defined leads and close collaboration with local teams and unit welfare.
- SEPSIS cards to provide staff with essential information.
- Standardisation of clinical trolleys in all doctors' rooms.
- The standardisation of notice boards in all clinical rooms.