Cottesmore Medical Centre

Kendrew Barracks, Cottesmore, Oakham, Rutland, LE15 7BL

Defence Medical Services inspection report

This report describes our judgement of the quality of care at Cottesmore 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 remotely 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 carried out an announced comprehensive inspection of Cottesmore Medical Centre on 27 February 2020. The practice was rated as requires improvement overall, with a rating of inadequate for the effective key question and requires improvement for the safe and well-led key questions. The practice was rated as good for the caring and responsive key questions. A copy of the report from the previous inspection can be found at:

www.cqc.org.uk/dms

We carried out this announced follow up inspection on 14 and 15 September 2021. The inspection was carried out remotely on 14 September and included a short visit by a CQC inspector on 15 September. The Primary Care Rehabilitation Facility (PCRF) was not included as part of this inspection as no specialist advisor was available to undertake this work. 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. This was supported by an open door culture, much improved since the last inspection.
- Effective arrangements were in place for infection prevention and control. These included 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 minimised risks to patient safety. Of note, the processes around managing patients on high risk medicines had been much improved.
- Standard operating procedures (SOP) had been developed to ensure appropriate coding, outcomes and templates are consistently used by clinicians. A programme of ongoing audit of clinical records had been established to ensure standards of record keeping are monitored. However, at the time of the inspection, this had not been extended to include the nursing team.
- Effective processes were in place for capturing and acting on patient feedback. The practice had adopted a proactive approach to increase the amount of data captured through patient feedback.
- Patient feedback about the service was positive. It showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.
- The practice had developed an audit programme to improve patient outcomes but there was scope to extend this work.
- The practice had a system to ensure that staff completed the required mandated training and held the appropriate professional registrations.
- Effective medical cover was in place to cover the times when the practice was closed. This was clearly communicated to patients.
- Staff understood the Mental Capacity Act (2005) and how it applied in the context of the service they provided.
- Staff were able to give anonymous feedback and the most recent survey showed a high level of satisfaction, notably around the improved culture.
- Governance systems, activities and working practices had been strengthened and better integrated. 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 were in place to deliver safe treatment and care including referral tracking, notes summarising and the management of referrals. Audit of clinical record keeping was in place for the doctors and was due to commence for the nursing team.
- The practice had good lines of communication with the units and welfare team to ensure the wellbeing of recruits. Links had been developed both internally and externally to enhance the support provided to patients.

- The building and equipment had been improved since the last inspection and were sufficient to treat patients and meet their needs.
- The privacy and dignity of patients was respected with clinicians using privacy screens and curtains when treating patients.
- Staff understood and adhered to the duty of candour principles.

We identified the following notable practice, which had a positive impact on patient experience:

- The SMO had developed a self-help card for patients who needed mental health advice and support. A card was offered to all patients following first diagnosis.

The Chief Inspector recommends:

- Improve the documentation of clinical review meetings for the doctors and nursing team.
- Introduce a process to ensure patient consent is recorded when appropriate.

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 and a pharmacist.

Background to Cottesmore Medical Centre

Cottesmore Medical Centre provides a routine primary care service to a patient population of 2,207 consisting of 1,647 service personnel and 560 dependant civilians. The practice also provides occupational health to service personnel only. 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 366 registered patients under the age of 18 at the time of the inspection and 258 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 base experiences high levels of deployment with a routine population change every two years

The medical centre is a dispensing practice and the dispensary 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.

Opening hours are from 08:00 to 16:30 on weekdays. Cottesmore Medical Centre and RAF Wittering Medical Centre shared the weekday evening surgery (until 18:30) on a rota basis. Outside of these hours including weekends and public holidays, cover is provided by NHS 111.

The staff team at the time of the inspection

Position	**Numbers**
Senior Medical Officer (SMO)	one
Regimental Medical Officer [1] (RMO)	one (60/40 split practice/unit)
Civilian medical practitioners (CMP) Reservist doctor (CMP)	two one
General Duties Medical Officer [2] (GDMO)	one (currently deployed)
GP Registrar	one
Nurse manager Senior Nursing Officer (SNO) Civilian practice nurses Reservist occupational health (OH) nurse	one one two (one gapped) one
Healthcare assistant (HCA)	one
Pharmacy technician	two
Physiotherapist	three
Exercise Rehabilitation Instructor (ERI)	one
Military practice manager	one
Office manager	one
Administrative staff	two E1 (both gaped) two E2

Regimental aid post (RAP) - medics[3]	15 (mostly deployed)

[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?

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:

- Managing and monitoring patients on high risk medicines; and
- Monitoring of the patient waiting area;

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

Safety systems and processes

- The practice had safety policies including adult and child safeguarding policies which were reviewed, displayed in clinical rooms and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. Policies accessible to all staff (including locums) outlined clearly who to go to for further guidance. The safeguarding policies were reviewed annually.
- Regular communication (six monthly) took place with local NHS GP surgeries and safeguarding meetings were combined to mitigate the risks associated with families registered at different practices. The health visitor and midwives attended the weekly clinical meeting and the practice had extended an invite to the school nurse.
- There was a risk register of vulnerable patients and a system to highlight them on the electronic patient record system (referred to as DMICP). A vulnerable patients register was held on DMICP with 44 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.
- Staff took steps to protect trainees from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. Practice staff attended monthly meetings with welfare teams and the Chain of Command and discussed the needs of this population group when required. Meetings had continued during lockdown using Skype.
- HARK (domestic violence) signs were displayed in male and female toilets and routine questioning about domestic violence took place during cervical screening as recommended by a recent safeguarding forum.
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. A list of trained chaperones was available to patients. Chaperone training was part of the induction and supported by annual discussion around the role and responsibilities,

being a chaperone and shared experience of carrying out the role. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

- 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 DBS check to ensure staff, including locum staff, were suitable to work with vulnerable adults and young people. DBS checks were renewed every three years for civilian staff and every five years for military staff.
- 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 February 2021 and no significant concerns had been identified. At the last inspection, there were concerns over infrastructure, particularly flooring, which had been recorded on the risk register and a statement of need (SON) submitted. At this inspection, we found that the opportunities to complete remedial work during the lockdown period had been utilised; for example, new flooring had been installed and now met with IPC guidelines (wipeable and coved skirting boards). Defence Primary Health Care (DPHC) had introduced a set of audits that were required. We highlighted that the new requirement from DPHC was to complete a six monthly self-assessment as this was overdue and no external audit had been carried out in the last 12 months. The IPC lead had only recently completed the role-specific training (in August 2021) and planned to complete the outstanding requirements.
- 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.
- There were systems for safely managing healthcare waste supported by a policy. Clinical waste and pre-acceptance audits were carried out annually, the most recent in February 2021. The practice had a nappy bin in the baby changing area and purple lidded bins used for cytotoxic waste (medicines used to treat cancer, immunosuppressant's, anti-virals or hormone based).
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. The safety certificates for water, gas, electric and legionella were held by the station safety team and copies were made available to the practice. We viewed these on the inspection day and found them to be in date. The practice manager kept a diarised note of due dates for all safety checks and an electronic folder with copies of the most recent certificate. There was a programme to flush taps in order to prevent the build-up of bacteria that can lead to legionella.

- Clinicians within the PCRF who utilised acupuncture adhered to a standard operating procedure (SOP) which detailed the use of acupuncture within the Defence Medical Services (DMS). The practical application of acupuncture within the SOP had been adapted to include more details regarding application within the practice. There was a written patient consent form for acupuncture and this was scanned onto the patient's clinical notes. There was an acupuncture specific risk assessment, patient information leaflet and health screening form.

Risks to patients

At the last inspection, the systems to assess, monitor and manage risks to patient safety were identified as areas for improvement. At this inspection, we found the practice had made the necessary improvements.

- Staffing levels and the skill mix had previously been below the required levels 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 but had been held up awaiting funding approval from region. There were arrangements for planning and monitoring the number and mix of staff needed, an effective approach to managing staff absences and for responding to epidemics, sickness, holidays and busy periods. The practice had managed to recruit locums to cover gaps and this included cover for the SMO who was due to be redeployed in October 2021. This cover included both the clinical time and management time (a CMP was temporarily stepping up until the new SMO arrived in 2022). The shortage of staff was not causing gaps in duties being carries out. However, staff expressed concerns that the pressure of covering staff shortages was not sustainable. Extra administration support had been provided immediately prior to the inspection.
- An induction system was in place for temporary staff and this had been tailored to their role. The practice manager had developed this, for example there was a specific locum induction pack different to the pack for permanent staff who had more mandatory training and station wide briefings. Locums were allocated time in a shared clinic until they felt competent to work independently. All staff are required to see heads of department (HOD) as part of their induction to discuss what they will need to know in their role. The HOD signed a form to confirm once completed.
- 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 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. All items located on the emergency trolley were monitored on a spreadsheet. The SMO was trained in advanced life support (ALS) and conducted in-house scenario based training.

- Staff were trained in how to respond to a medical emergency, for example, the administration team had completed additional training in telephone triage. A flow sheet had been developed to support the administration staff in recognising COVID-19 symptoms and signposting to the most appropriate clinician. The practice's previous commitment to pre-hospital care had now been dropped so there was no longer a need for specialist equipment.
- Clinicians knew how to identify and manage patients with severe infections including sepsis. Sepsis training was refreshed annually and there were signs and information cards to inform patients and staff. Further training refreshed annually included cold injuries, heat injuries, basic life support and anaphylaxis.
- When there were changes to services or staff, the practice assessed and monitored the impact on safety using a comprehensive risk assessment template.
- There was wet globe bulb testing (WBGT-used to determine appropriate exposure levels to high temperatures) monitoring at the time of inspection in the gymnasium. PCRF staff had attended training on heat injury and heat illness prevention. There was a risk assessment in place for heat stress. The medical centre did not have an air conditioning system but had an approved SON.
- A COVID-19 risk assessment had been completed. Measures introduced to minimise the risk of spreading infection during the COVID-19 pandemic included:
    - the majority of appointments were done via telephone with face-to-face appointments offered only when required,
    - a one way system was implemented into the building,
    - signs placed throughout to encourage social distancing,
    - an automated hand sanitiser dispenser was placed at the main entrance and exit,
    - a 'red room' was used for patients presenting with COVID-19 symptoms. This room was close to the exit so could be accessed without having to walk through the main part of the building, and
    - personal protective equipment (PPE) was provided to staff. This included face masks that protect staff from airborne infection (known as FP3 masks) when seeing patients.

Information to deliver safe care and treatment

At our last inspection we identified that management information work was needed to update the population eligible for health screening and there was no formal review process for carrying out medication reviews for patients with long-term conditions. Improvements had been made.

- Staff now had the information they needed to deliver safe care and treatment to patients. Effective systems had been implemented to provide visibility of those patients eligible for screening and for recall of patients for medication reviews.

- 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 14 patient records outstanding, these had only been received in the last week
- 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 seen. Consultation notes were recorded on to paper copies and scanned onto DMICP at a later date. Following the approval of a business case, practice staff had now been issued with laptops that could be connected when the local server was down. Each clinical room had a folder with relevant documentation to be used in the event of a power outage.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. 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 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. The system had been strengthened following the last inspection and now included internal referrals; for example, physiotherapists monitored the referrals they made to the Regional Rehabilitation Unit (RRU).
- 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 nurse manager who ran monthly patient searches on all registers. Patients were then reviewed by the nursing team who entered the date, required tests and requesting clinician onto a tracking sheet. A sample review of clinical records showed that appropriate Read codes and templates were used.

Safe and appropriate use of medicines

Systems for appropriate and safe handling of medicines had improved following the previous inspection when gaps had been identified in the arrangements for managing patients on high risk medicines (HRM):

- A lead and deputy were identified as the subject matter experts for medicines management with the day-to-day management of medicines delegated to the pharmacy technicians. Safe procedures were in place for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment. We found all items were within date and appropriately stored.

- 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.
- An improved process had been implemented for the management of and monitoring of patients prescribed HRM. A register of HRM used at the practice was now in place and was regularly reviewed by the SMO. Recorded on a spreadsheet, the register included diary dates and monthly searches used to identify and manage patients on HRM. We highlighted at the last inspection that other clinicians had not engaged with managing patients on HRM. All doctors had been involved in the re-design of the new spreadsheet and now all used it, prompted by an alert on DMICP. The SMO had audited engagement with colleagues (last audit was October 2020). A re-audit was pending and the practice had shared the new system as a purple ASER (a system used in the military to share significant good practice).
- There were 14 patients prescribed an HRM and we looked at a range of these records. We noted that alerts were in place and monitoring was carried out in accordance with the recommended frequency. Shared care agreements (SCA) were in place for the patients that required them and the SMO was proactive in chasing up with secondary care providers when required. SCAs are important to provide clear responsibilities between clinicians involved in the patient's care.
- Written procedures (SOPs) were in place to support safe dispensing practice. Doctors, nurses and medics had signed the SOPs applicable to them; for example, access for key coded doors and lone working. Competencies of medics were assessed to confirm compliance with SOPs; for example, the pharmacy technician assessed medics for dispensary competencies. Medics were not permitted to work in the dispensary without the pharmacy technician present.
- Staff had access to British National Formulary (BNF) and prescribing formulary. 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 been implemented. This programme included Patient Group Directions (PGD) and Patient Specific Directions (PSD) audits (April 2021 and July 2021). A review of the antibiotic audit showed 100% compliance with local guidelines produced by the Clinical Commissioning Group (CCG). Each clinician had links to the guidelines and to the NICE antimicrobial stewardship page on their desktops.
- PGDs had been developed to allow appropriately trained nurses to administer medicines in line with legislation. The PGDs were current and signed. PSDs were in place and signed by the prescriber to permit medics to administer vaccinations; an entry was made in each patient's notes by an independent prescriber. The SMO had carried out an audit of PSDs in July 2021, 100 records had been manually searched by SMO and 100% were found to have an entry in place.
- The practice's arrangements for the access, storage and monitoring of prescription stationary were effective. Blank prescription pads and prescription paper were stored securely and an effective tracking system was followed.
- 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. Prescriptions were signed before medicines were dispensed and handed out to patients.

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 periodically with frequencies included on the register, no review date extended beyond 12 months. 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 2021. Equipment checks, including the testing of portable electrical appliances were in-date.
- 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. Since the last inspection, the practice had installed CCTV (closed circuit television) in waiting rooms so reception could monitor these areas in the event of a medical emergency. Snap checks were carried out to ensure the waiting area was being monitored and panic alarms were tested weekly.
- Risk assessments in place included needle stick injury, lifting and handling, legionella management and lone working.

Lessons learned and improvements made

The practice shared learning and made improvements when things went wrong.

- There was a system and policy for recording and acting on significant events (referred to as ASERs) and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were systems for reviewing and investigating when things went wrong. There was evidence that the practice learned and shared lessons, identified themes and took action to improve safety in the practice. Staff we spoke with could recall the learning from recent significant events and minutes of meetings showed lessons learnt were discussed at the practice meeting. For example, a recent ASER highlighted patients were not always presenting for appointments when being called in for force protection vaccinations. An investigation highlighted that improvements could be made in the

communication with the Chain of Command. As a result, and following discussion with the unit, a more coordinated approach had been adopted, and had proven successful following a review of vaccinations completed on soldiers recently deployed.

- 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 four recent alerts and found they had been received and managed appropriately.

Are services effective?

Following our previous inspection, we rated the practice as inadequate for providing effective services. We found processes were not effective in:

- patient recall for those with long-term conditions, those requiring vaccination and those eligible for health screening;
- safely managing those patients with a mental illness and/or depressive symptoms;
- providing a structured programme of peer review for clinical staff; and
- the uptake of child immunisations to achieve World Health Organisation (WHO) targets.

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

We rated the practice 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. Practice meetings had been held and minutes contained a record of discussion of best practice guidance. These minutes includes links so staff could easily review the content through electronic access.

- Our review of patients' notes showed that NICE best practice guidelines were being followed. For example, the GDMO led on a recent project to review the management of hypertension. This resulted in changes to protocol reflecting NICE 2019 hypertension guidance.
- Staff we spoke with could refer to this and gave examples of updates they had acted on and discussed within the practice.
- The DPHC team produced a newsletter that was circulated to clinicians providing further information and a summary of relevant safety updates.
- Guidelines were recorded on the healthcare governance workbook together with links and a record of when and who they were sent to. This was managed by the SMO with support from the GDMO and discussed in both the monthly practice and healthcare governance meetings as well as the weekly clinical meetings.

Monitoring care and treatment

The practice undertook quality improvement work to review the effectiveness and appropriateness of the care provided. This work had led to improvement since the last inspection, and of note, the process for monitoring of patients with long-term conditions was now comprehensive and effective.

- The DMS have a responsibility to deliver the same quality of care as patients expect in the NHS. 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 was the lead for the management of patients with long-term conditions (LTC) supported by the practice nurse who coordinated patient recalls. The population manager facility (referred to as 'popman') was used to identify and monitor patients with an LTC. A total of 32 patients were recorded as having high blood pressure and 31 had a record of their blood pressure having been recorded in the last nine months. A total of 81% (26 patients) had a follow-up blood pressure reading of 150/90 or less (this is in an indicator for mild hypertension). There were eight patients on the diabetic register and six had a total cholesterol of 5mmol/or less, an indicator of positive cholesterol control. There were 45 patients on the asthma register, 40 patients had been reviewed in the last 12 months and one was a new diagnosis. Those patients categorised as at risk were reviewed monthly.
- The nurse provided us with an overview of the current status for each patient, including the action taken if patients failed to respond to recall letters.
- We looked at a range of patient records and were assured that the care of patients with a mental illness and/or depressive symptoms was being effectively and safely managed. Patients presenting with a mild to moderate anxiety or low mood were assessed in accordance with the pathway and treated initially at the practice (step 1) or referred to the Department of Community Mental Health (DCMH) team if their clinical need was assessed as greater than what step 1 could provide. The practice had chosen to use their own coding as they felt the DMICP template was not designed for primary care. The SMO felt their system provided a better follow up as patients were involved in decisions. We reviewed a sample of patients from the mental health register and found effective and appropriate follow-up appointments were provided. The SMO had used his own money to produce a credit-card sized information card with contact numbers and crisis plans. These were given to patients at first mental health diagnosis.
- 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 85% of patients.
- The practice had implemented a structured programme of audits to monitor and systematically review clinical and non-clinical outcomes to ensure treatment and care was being provided in accordance national and local standards. The programme had recently been implemented (in October 2020), therefore many of the audits were first cycle and it was too soon to see positive outcomes. We noted the audit programme for the nursing team was limited, the practice had reached out for support from colleagues at a nearby medical centre. Work had started on standardisation of Read codes and templates for each long-term condition. Audits undertaken in 2020/21 included:
    - antibiotic prescribing;
    - high risk medicines;
    - PSD and PGD;

  - pre-acceptance healthcare waste;
  - equipment care; and
  - diversity.
- The PCRF had their own audit plan integrated into the audit schedule.
- 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.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up-to-date records of skills, qualifications and training were maintained.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, mentoring, clinical supervision and support for revalidation. The induction process had a separate annex for each professional cadre.
- Mandated training was monitored by the practice manager. Staff were sent an email each month reminding them of training they needed to complete and a link to the training. Compliance in mandatory training was at 94%.
- All doctors interviewed were aware of the peer review arrangements in the practice, run after clinical meetings and using a standard form. Not all had been able to take advantage of this due to other commitments outside of the control of the practice. Peer review normally took place twice per annum per clinician, colleagues paired up to review one another's records with each practitioner then completing a template for reflection.
- The nurses were given protected time each Wednesday afternoon to complete continuing professional development (CPD) work. The nursing team had completed training for family planning and sexual health although updates were required. The nurse manager was an independent prescriber and training was in date. The peer review programme for nurses was due to commence, we saw a template from the nurse manager that was to be used. We were told informal case discussion took place but this was currently not documented. The nursing team was all new (all nurses had been employed in May 2021).
- The healthcare assistant (HCA) was in date with training, for example, ear irrigation and phlebotomy, and the nurse manager carried out regular competency checks.

- Internal and external training sessions were available to staff. For example, the practice manager was part way through a degree course in practice management (management and leadership in health and social care) and health and safety (IOSH) training. The practice nurse had completed 'IPC Link' training since the previous inspection.
- The medics had SOPs and terms of reference (TOR) to set out their duties. They had specific training after nine weeks of being posted to allow them to work autonomously and a competency check as part of the induction which included being shadowed by a doctor, time in the PCRF, time in dispensary and on reception.

Coordinating care and treatment

Staff worked together and with other care professionals to deliver effective care and treatment. The practice met with welfare teams and line managers to discuss vulnerable patients who were both trainees and permanent staff.

- The practice had established links with local NHS services. These included connecting with the local clinical commissioning group, MASH (multi-agency safeguarding hub) and local safeguarding teams. Links had been established with the local council and members had attended a recent health fair on the base. These links had been used to improve signposting and information available to carers and of note, the SMO or nurse manager attended all local safeguarding meetings in person.
- The practice had developed links with other practices to improve the handover of patients. For example, for patients who were considered complex, the SMO held a call with the new GP to provide detailed information.
- On leaving the military patients underwent a release medical and summary of their clinical notes. Signposting and information on civilian life was delivered by the unit.

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. Annual blood tests were used to check for gestational diabetes and pre-diabetes. Patients were also identified opportunistically when presenting with symptoms where diabetes needed to be excluded.
- One of the nurses had the lead for health promotion and was supported by a deputy. The health promotion strategy was underpinned by national priorities and initiatives to improve the population's health including, stop smoking campaigns and tackling obesity. It also took account of the patient population need and seasonal variation impacting health. For example, a 'stoptober' display was in place to promote smoking cessation.
- The practice offered basic sexual health advice and the lead nurse had now completed the 'Sexually Transmitted Infection Foundation' course (referred to as STIF).

Chlamydia testing kits were positioned in the medical centre and in toilets around the station. Free condoms were provided on request. Information was available for patients requiring sexual health advice, including signposting to other services. Where appropriate patients were referred to local genitourinary (GUM) clinic for screening. The practice hosted a weekly sexual health clinic run by the local sexual health service. In the patient waiting area, information about local sexual health pathways was displayed for patients on a dedicated board. Each clinical room had a poster with the details of the sexual health clinic.

- Medical centre staff attended unit open days and manned stalls to provide health promotion information to personnel. The most recent fair held in September 2021 had attracted an attendance of 450 personnel. The event included external providers such as the sexual health service and local council. Notice boards were used in the waiting area for health promotion campaigns. These were dated and refreshed in line with the strategy. At the time of the inspection there were displays about mental health, healthy heart and COVID-19. There was a programme whereby promotions were refreshed in line with seasonal and/or topical demand. Information leaflets and booklets were normally on display but had been removed due to COVID-19. Social media and the television screen in the patient waiting area were used to promote health related topics.
- Medics had supported the NHS with COVID-19 testing. Vaccination parades were held at the medical centre for regional military personnel. Weekends and bank holidays had been utilised to speed up the vaccination programme. The practice manager had linked with the clinical commissioning group (CCG) to fast track patients due for deployment.
- A mental health information display was available for patients that took into account wellbeing and mindfulness. It provided details about websites patients could access for further information.
- 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 total of 261 patients were eligible for the over 40s health check. All had received an invite to attend and 159 checks had been completed.
- A monthly 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. We saw that the patient recall system was effective and screening had taken place within the recommended timescales.
- The number of women aged 25 to 49 (there were no women patients aged 50 to 64) whose notes recorded that a cervical smear had been performed in the last three to five years was 227 out of 277 eligible women. This represented an achievement of 87%. The NHS target was 80%. Invite letters were sent out and followed up if not responded to. The nurse manager contacted patients by telephone if there had been no response.

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 September 2021 provides vaccination data for patients using this practice (regional and national comparisons were not available):

- 92% of patients were recorded as being up to date with vaccination against diphtheria.
- 92% of patients were recorded as being up to date with vaccination against polio.
- 91% of patients were recorded as being up to date with vaccination against Hepatitis B.
- 89% of patients were recorded as being up to date with vaccination against Hepatitis A.
- 92% of patients were recorded as being up to date with vaccination against Tetanus.
- 91% of patients were recorded as in date for vaccination against MMR
- 98% of patients were recorded as in date for vaccination against meningitis.

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. Monthly searches were undertaken to recall patients for vaccinations.

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 National Health Service (NHS) services was managed to ensure continuity of care.

Child Immunisation

A member of the nursing team managed the childhood vaccination programme through monthly patients searches for all eligible patients to be recalled. 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 (HepB) ((i.e. three doses of DTaP/IPV/Hib/HepB)	27	27	100%	Meets WHO target

The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster)	26	25	96%	Meets WHO target
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)	26	25	96%	Meets WHO target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR)	27	24	89%	Not met WHO target Of the remaining three patients, two had appointments booked. One patient was newly registered and waiting for their medical records to be updated.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance. For example, verbal consent was recorded in DMICP and PCRF staff took written consent for acupuncture procedures. There was no audit on consent and a check of the records found three consultations where appropriate consent had not been recorded, one for ear irrigation, one for an intimate swab and one for a routine blood test. Minor surgery audits were carried out annually, the last one showed 100% compliance in the recording of consent.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (MCA) 2005. Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

When providing care and treatment for young recruits aged between 16 and18 years, staff carried out assessments of capacity to consent in line with relevant guidance.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The medical centre had taken account of patients' personal, cultural, social and religious needs; for example, practice staff we asked could explain how they would support patients if going through gender reassignment.
- The practice gave patients timely support and information. Translation services were available and promoted in each clinical area, at reception and in the patient waiting area. All clinicians had a pack on their desks which included the contact details for translation services.
- Two members of the practice team were trained in basic British Sign Language (BSL).
- A notice on the reception desk informed patients that if they wanted to discuss sensitive issues or appeared distressed, they could offer them a private room to discuss their needs. The practice manager planned to introduce a card to support patients request an appointment for a sensitive subject.
- 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. A 'Carers' Champion' had been appointed in July 2020.

Involvement in decisions about care and treatment

- The clinicians and staff at the practice recognised that the trainee personnel they provided care and treatment for, could be making decisions about treatment for the first time. Staff demonstrated how they gauged the level of understanding of patients, avoided overly technical explanations of diagnoses and treatment, and encouraged and empowered young patients to make decisions based on sound guidance and clinical facts.
- The e-referral service had been implemented and was used to support patient choice as appropriate. (e-referral is a national electronic referral service which gives patients the choice of date and time for their first outpatient appointment in a hospital).
- Results from the practice's Patient Experience Survey from January 2021 to September 2021 (88 responses were collated);
    - 99% said they felt they had been given clear information regarding their treatment and care.

- 100% of patients who responded said that they were treated with kindness and compassion.

The data presented by the practice was not benchmarked against regional and national averages for DMS, or against the previous year's performance.

- Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of organisations. We saw information that was age appropriate and relevant to the patient demographic which was prominently displayed and accessible. For example, we saw dedicated notice boards to promote 'healthy hearts'. The leaflets had temporarily ben removed due to COVID-19 measures.
- 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.
- Practice staff told us that the station welfare staff kept a register of patients who were also carers and provided extra support as required. Carers were identified as part of the new patient registration process. The register included both carers and cared for patients. Carers and cared for patients were Read coded and recalled for annual flu immunisations and were prioritised for COVID-19 vaccinations. There was an open door policy for support to be provided and staff knew of services that carers could be signposted to.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Privacy screening was provided in doctors', nurses' and medics' consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. Clinic room doors were closed during consultations.
- The practice had identified the fact that conversations with receptionists could be overheard by patients in the waiting room, due to the open plan nature of the waiting area. A project to make improvements had been completed since the last inspection. The previously open reception area had been modified to promote confidentiality. The seating was set back from the reception desk, signage asked patients to stand back while waiting to be seen and background noise (television) had been introduced to assist with privacy. 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. A sexual health nurse provided clinics weekly that were hosted by the practice.
- The patient experience survey showed 100% of patients felt their privacy and dignity was always respected.

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 organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice 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, the practice had introduced a 'quiet time' when appointments were offered to children with learning disabilities and autism spectrum disorder (ASD). Patients were accommodated at quieter times; for example, at the end of clinics or in the afternoon on quiet days. Patients with ASD had an alert on the system to identify them to practice staff.
- Specific clinics were in place including vaccination and chronic disease. Additional evening appointments had been introduced to improve access for school-aged children and working spouses.
- Child-centred Wednesday afternoons helped coordinate childhood immunisations and safeguarding meetings. These were held 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.
- An access audit as defined in the Equality Act 2010 was completed for the premises in November 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. Resultant actions included a new sign at the front of the building to make patients aware that parking spaces were for disabled parking only. The main door at the entrance to the building had been replaced with a fully automatic door in June 2021. Consultations were carried out in a ground floor room when the patient had difficulty using the stairs.
- There was no hearing loop but the practice stated that they had no patients on their register with visual or hearing impairment. Funding had been applied for but rejected by region. The practice planned to explore the potential need in more detail and use findings to present a business case if required.
- Facilities were available for families, including a private room for breast feeding and baby changing facilities.
- The practice had a policy available to staff or patients around when a home visit might be necessary and appropriate. However, the policy was not included in the practice leaflet.

- The practice trained staff in equality and diversity and there was a 'diversity and inclusion' lead and deputy. Staff could access the lead on station and a poster in the waiting area detailed all qualified leads on station and the point of contact in the medical centre. The lead had role specific training booked for October 2021.

Timely access to care and treatment

Patients' needs were met in a timely way.

- The medical centre accommodated patients with an emergency need on the day they presented at the practice. Routine appointments with a doctor could be facilitated the same day and gradings were proactively managed and all had appointments booked. Nurses had capacity to see a patient within one day.
- Outside of routine clinic hours, evening surgery was provided on a rota basis with RAF Wittering Medical Centre (16 miles away). From 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.
- The nearest accident and emergency department was located at the Peterborough City Hospital (approximately 25 miles away, detailed in the practice leaflet).
- Results from the practice's patient experience survey (91 responses were received) showed that patient satisfaction levels with access to routine care and treatment were high;
    - 93% of patients said they were able to access healthcare easily.
    - 100% of patients felt satisfied with the method of their appointment (in person, by telephone or by E-consult).
- Electronic consultations with a clinician could be organised but details were not outlined in the practice information leaflet. The practice leaflet did provide comprehensive details for out of hours services.

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.

- Defence Primary Health Care had an established policy and the practice adhered to this. 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 in the practice. 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.

- We reviewed complaints and found 12 that had been submitted by patients in the past 12 months. We saw that there were processes in place to share learning from complaints. Complaints management was comprehensive and we reviewed a recent complaint to find that it was managed appropriately and to the satisfaction of the complainant.
- Information was available to help patients understand the complaints system, including in the patient information leaflet.

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 in capacity, governance arrangements and appropriate and accurate information.

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

Leadership, capacity and capability

The leaders at the medical centre had been working hard to address areas they had identified as requiring improvement as well as building resilience and continuity within the team. 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 was seen to have been well managed, areas that required improvement such as high-risk medicines, had been actioned.

- The practice team had benefited from continuity with the SMO protected from deployment. and a higher number of staff now being civilian and therefore not subject to deployment. At the last inspection we highlighted that the high turnover of staff led to instability with limited support available from the unit medics.
- Staff felt that they could raise concerns if they had them. A practice-wide meeting had been established where all staff could get together to share and learn from key messages. Staff spoke highly on internal communication.
- The practice felt that support from the regional management team could be improved in particular in regard to recruitment of administration staff. Staff spoke of delays in recruitment and a reluctance to advertise externally due to funding issues. The practice manager spoke positively of support from regional headquarters.
- Leaders were knowledgeable about issues and priorities relating to the quality of services. As a result, key risks were being addressed.
- There was flexibility within leadership roles to ensure continuity in each department. The practice manager had worked hard to ensure key roles had at least one second point of contact.
- The practice had been approved as a teaching practice in October 2020. It now provided opportunities for GDMO placements, GP Registrars, phase two CMTs and student nurse placements.

Vision and strategy

The practice had a clear vision and credible strategy that had been central in delivering improvements in both the working environment for staff, and the provision of high quality, sustainable care to their patients.

- The practice had formulated their own mission statement developed through engagement with the station: ‘To keep patients safe by delivering the highest standards of care, in support of the DPHC vision’. The DPHC visons was to ‘provide and commission safe and effective healthcare which meets the needs of the patient and the Chain of Command in order to contribute to fighting power’.
- Staff were aware of and felt fully engaged in the vision, values and strategy and their role in achieving them. Part of the staff induction included a section on the vision and values together with supporting business plans to achieve the practice priorities.
- The leadership team were working on a succession plan to address known future changes in key personnel.
- The medical centre planned its services to meet the needs of the practice population and liaised with unit personnel to promote their vision and values.

Culture

Through discussion with practice staff, it was clear that the practice culture had improved since the last inspection. Key systems had been reviewed to make them more effective and staff we spoke with referred to an ‘open door’ and ‘no blame’ culture:

- Staff stated they felt respected, supported and valued. Discussion with staff members indicated that morale was high and in particular staff were complimentary about the leadership. These comments were supported by positive outcomes from the staff survey held in August 2021.
- The practice focused on the needs of patients. For example, health checks had continued throughout lockdown despite some external resistance.
- Leaders and managers had taken action to address gaps in the performance of the practice, specifically in response to those issues highlighted at the last inspection and in particular the strengthening of processes around medicines management.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They spoke of how the culture was much improved since the last inspection and had confidence that both suggestions and concerns would be both listened to and acted on.
- A mid-morning beak was arranged and all staff encouraged to attend to permit a break from work and create a working environment that was enjoyable. Team building days were arranged quarterly.
- There were processes for providing staff with professional development. This included appraisal and career development conversations. All staff received annual appraisals and were supported to meet the requirements of professional revalidation where necessary. Staff were encouraged to complete courses aimed at their professional development. For example, the practice manager was part way through a degree course in practice management.

- The practice actively promoted equality and diversity. Staff had received equality and diversity training.

Governance arrangements

Having consolidated and clarified responsibilities, roles and systems of accountability to support good governance and management, the practice had built in more resilience with leads, deputies and cross working, in particular using civilian staff who provided continuity. Improvements had been built on since the last inspection:

- The practice had implemented a system to monitor all patients on high risk medicines (HRMs). The SMO had developed this in collaboration with the dispensary and prescribers. At the last inspection we highlighted a lack of engagement from other clinicians. This had improved and prompts had been put onto DMICP. Shared care protocols were in place for patients taking high risk drugs. A regular audit was carried out to monitor the register of patients on HRMs and this had been shared as a purple ASER (an example of significant good practice shared externally).
- 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. Through engagement, the practice had developed strong links with external safeguarding teams.
- Practice leaders had established a suite of policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. All polices and SOPs were on a register that provided visibility of review dates.
- A structured audit programme was in place. It was too soon to see positive outcomes but repeat cycles planned would provide visibility on quality improvement.
- A comprehensive meeting schedule was established and had been consolidated since the last inspection. This included healthcare governance departmental and PCRF ‘Journal Club’ meetings held monthly, and clinical, full practice meeting and heads of department meetings held weekly. Discussion at each meeting was recorded and made available to those unable to attend.

Managing risks, issues and performance

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

- Practice leaders had established a governance structure that provided oversight of risk and the quality of service.
- The practice maintained a risk register a record of short-term issues. We saw that these were reviewed regularly and acted on.
- Although there had been no performance issues with staff, leaders were aware of policies to be followed and where to access support if advice was needed.

- All staff were in date for ‘defence information passport’ and ‘data security awareness’ training.
- There was a business resilience plan and a station major incident plan that were reviewed regularly and tested through simulation. All staff were informed of BCP updates via email and all had completed business continuity 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. A practice wide meeting had been established and had 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 CAS alerts. Meetings were used for forward planning, for example, forward planning had contributed to the success of the last health fair, well supported by attendance from patients and from external healthcare providers.
- 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.
- As part of the medical centre, the PCRF used the same eCAF as the medical centre. It was maintained by all staff who each had responsibility for a domain.

Engagement with patients, the public, staff and external partners

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

- There were various options in place to encourage patients to provide feedback on the service and contribute to the development of the service. A patient experience survey was undertaken throughout the year. The practice had repeatedly tried to establish a patient participation group (PPG) but there had been no uptake.
- Patients could leave feedback anonymously via a suggestion box and could record feedback in a complaints and compliments book. A notice board in the waiting area provided a summary of feedback for patients. This included actions taken, for example, patients requested a separate area for breastfeeding and a dedicated space was allocated in the nurse’s office.
- Staff were encouraged to give feedback through a questionnaire (completed annually) and through a suggestions box situated in the staff room.
- There was evidence that the practice acted on feedback from patients. For example,

  - A step leading towards the pharmacy was made into a ramp for wheelchair users.
  - The staff survey highlighted comments from patients on not knowing how to access the out of hours and other services available to them. The poster on front door was enlarged, available services were advertised on the social media and a credit card size take away card was created and placed at reception for patients to take away.
- Good and effective links with internal and external organisations were established, including with the welfare team, Regional Rehabilitation Unit (RRU) and of note with the local safeguarding team. The practice had developed working arrangements with the local clinical commissioning groups (CCGs) and local primary care networks (PCNs).

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation. The practice developed a plan of improvement following the last inspection and had succeeded in addressing the gaps found. The practice maintained a quality improvement log on the health governance workbook. The practice had completed a number of quality improvement projects (QIPs) which were detailed on the quality improvement log. QIPs were also communicated to DPHC Regional Headquarters and shared with the sister practice at RAF Wittering. There was a good examples of quality improvement that included:

- A comprehensive set of SOPs had been developed to include chronic disease management and notes summarising.
- The infrastructure had been improved with new flooring throughout the downstairs and a redesign of the reception are to better promote patient confidentiality.
- A text messaging service for patients had been implemented. This was used to ask that patients contact the practice to make an appointment, to inform patients of any changes to their appointment and to ask patients to complete the online patient satisfaction survey.