# Norton Manor Medical Centre

Norton Manor Camp Taunton TA2 6PF

## Defence Medical Services Follow Up inspection

This report describes our judgement of the quality of care at Norton Manor 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 medical centre.

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|---|---|---|
| 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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# Summary

## About this follow up inspection

We carried out this announced comprehensive follow up inspection on 20 and 22 July 2021. The report covers our findings in relation to the recommendations made and any additional improvements made since our last inspection.

We carried out a previous announced comprehensive inspection of Norton Manor Medical Centre on 30 January 2019. The medical centre received a requires improvement rating overall, with a rating of requires improvement for the safe, effective and well-led domains. The caring and responsive domains were rated as good.

A copy of the previous inspection reports can be found at:

https://www.cqc.org.uk/sites/default/files/Norton_Manor_Medical_Centre_3_March_2020.pdf

The CQC does not have the same statutory powers with regard to improvement action for the 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 DMS.

**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.
- Effective arrangements were in place for infection prevention and control and these had been enhanced in response to the COVID-19 pandemic.
- 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 strong lines of communication with the units and welfare team to ensure the wellbeing of military personnel.
- Staff had completed the required mandated training.
- Staff understood the Mental Capacity Act (2005) and how it applied in the context of the service they provided.

- Safe and effective processes were in place for the management of significant events and patient complaints.
- The outcome of clinical audit was used to improve patient outcomes. The practice had developed an integrated audit programme, designed so all staff groups participated in service improvement activity.
- Standard operating procedures 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.
- Governance systems, activities and working practices had been strengthened and better integrated. A list of lead roles for the practice was clearly displayed so staff were aware of the roles and responsibilities of colleagues.
- Information systems and processes to deliver safe treatment and care had been developed including Read coding, the use of review templates, the management of long-term conditions, audit of clinical record keeping, the new patient registration process and the management of referrals.
- The arrangements for managing medicines, including obtaining, prescribing, recording, handling, storing, security and disposal in the practice minimised risks to patient safety.
- 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 emergency room had casualty clipboards in place, which enabled structured and accurate recording of vital signs and assessment. These were developed in response to a Heat Illness Quality Improvement Programme (QIP) undertaken following updated DMS guidance. Included in this were provision of a new ice machine, and further specialised medical equipment (polar pods).

**The Chief Inspector recommends:**

- Cleaning of the medical centre is formally monitored against the current cleaning contract.
- Complete a lone working risk assessment specific to the PCRF.

**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 inspector. The team comprised specialist advisors including a primary care doctor, physiotherapist and a practice manager.

## Background to Norton Manor Medical Centre

Located near Taunton, Somerset, Norton Manor Medical Centre delivers a primary healthcare, occupational health and force protection service to a patient population of 558 regular service personnel; families and dependants are signposted to nearby NHS services. There were no registered patients under the age of 18 at the time of the inspection. A Primary Care Rehabilitation Facility (PCRF) is located next to the medical centre and provides regular service personnel with a physiotherapy and rehabilitation service. As there is no dispensary at the practice, a contract in in place with a local pharmacy. The medical centre is open from 08:00 to 16:30 hours Monday, Tuesday and Thursday. It is open 08:00 to 12:30 on Wednesday and Friday. Emergencies can be accommodated in the afternoons when it is closed. From 16:30 until 18:30 access to emergency medical cover (referred to as shoulder cover) is provided by Yeovilton Medical Centre. Outside of these hours, including weekends and bank holidays, cover is provided by NHS 111.

### The staff team

| | |
|---|---|
| Doctors | One CMP (Civilian Medical Practitioner) |
| General Duties Medical Officer (GDMO) | One (unit asset non-Defence Primary Healthcare (DPHC) |
| Practice Manager | One |
| Nurses | One (part time) |
| Exercise Rehabilitation Instructors (ERI) | Two (non DPHC assets) |
| Physiotherapists | One |
| Administrators | Two (one part time civilian, one DPHC MA fulltime). |
| Medical Sergeant* | One (non DPHC asset) |
| Combat Medical Technicians* (CMTs) | Eight (non DPHC assets) |

*a medical Sergeant and CMT are soldiers who have 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 medical centres but with a broader scope of medical centre.

# Are services safe?

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

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

- staffing levels and skill mix was not sufficient or available to meet the needs of the patient population
- peer review of medical records
- the system for learning from significant events

At this inspection we found these recommendations had been met.

## Safety systems and processes

- The practice had safety policies including safeguarding policies for adults and under 18s which were reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. Policies were regularly reviewed and were accessible to all staff, including locums. They outlined clearly who to go to for further guidance.
- All staff received up-to-date safeguarding and safety training appropriate to their role. All clinicians had received Level 3 training. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check. There was a list of trained chaperones within treatment and consultation rooms to guide staff.
- The status of safeguarding and vulnerable patients was discussed at the monthly meetings with the welfare officer. In addition, the needs of vulnerable patients were discussed at the Unit J1 Health Committee (UHC) meetings. We spoke with the welfare officer for the camp who told us they provided a welfare service to military personnel and dependents for matters such as home sickness, domestic abuse, sexual assault, self-harm, mental health and housing issues. They confirmed they had a good relationship with the medical centre and communication between them and outside agencies was good.
- The team made weekly contact with all military personnel considered vulnerable. The team had a network of contacts with internal and local services such as the Multi-agency Safeguarding Hub (MASH) team.
- The medical centre worked closely with Department of Community Mental Health (DCMH) and the army and unit welfare services.
- Coding was applied to clinical records to identify patients considered vulnerable. A monthly search of DMICP (electronic patient record system) was undertaken to ensure the register of vulnerable patients and patients under the age of 18 was current. When we reviewed the vulnerable patient DMICP search we saw the appropriate alerts in place.

- The full range of recruitment records for permanent staff was held centrally. However, the medical centre could demonstrate that relevant safety checks had taken place for for staff, at the point of recruitment, including a Disclosure and Barring Service (DBS) check to ensure staff were suitable to work with vulnerable adults and young people.
- Staff were up to date with their hepatitis B vaccination and there was a hepatitis B register available to view.
- A process was in place to manage infection prevention and control (IPC). The current IPC lead was the locum nurse they were appropriately trained and completed an IPC audit in June 2021. This audit was well-constructed, captured performance and recorded actions for improvement. The actions were clearly identifiable and included realistic deadlines.
- Environmental cleaning was provided by an external contractor. On appointment, the practice manager identified shortfalls in the cleaning service provided by domestic staff and engaged with the cleaning supervisor. The meeting led to a deep clean being undertaken and new domestic staff being appointed and trained. Cleaning standards had improved and were visually monitored by the practice manager, but these were not recorded. The cleaning standards were not monitored against the cleaning contract.
- Healthcare waste was appropriately managed and disposed of. It was collected every two weeks. Consignment notes were retained at the medical centre and a waste log was in place. An annual waste audit was carried out in June 2021.
- The medical centre had a COVID-19 Standard Operating Procedure (SOP) in place. Triage was in place to prevent symptomatic patients entering the building and appropriate emergency responses were in place.
- Acupuncture was undertaken by physiotherapy staff. The appropriate acupuncture SOP, risk assessment, patient information leaflet and written consent form were in place.

## Risks to patients

At the previous inspection we found staffing levels did not allow adequate cover for unforeseen circumstances such as sickness absence and resulted in undue pressure on staff. The staffing levels were a potential risk to patients including limited capacity for clinical leadership. The CMP had been in post since September 2019; before this the post had been filled by locum staff. Lead roles relating to healthcare governance were undertaken by the CMP or the practice manager. The practice was not well staffed with a key gap in nursing provision.

At this inspection we found improvement had been made with the provision of a regular part time locum nurse (this role was about to be made permanent). They were key in driving improvement at the medical centre, were proactive in sharing lead roles and had a good understanding of what was required to keep patients safe.

- The team comprised a mix of Regimental Aid Posts (RAP), military and civilian staff, with the civilian staff providing stability and consistency when military staff deployed. A RAP is a frontline military medical staff attached to a military unit who are subject to

deployment, often at short notice. When not deployed, RAP staff work in medical centres to update and maintain their skills. They also have a focus on ensuring the force heath protection requirements of unit personnel are up to date. The RAP team working at Norton Manor Medical Centre included one General Duties Medical Officer (GDMO) and eight medical assistants. A medic is trained to provide medical support on various operations and exercises.

- The PCRF staffing was currently sufficient to provide care to the current patient population. However, the ERIs were unit assets (not DPHC). This posed a risk as they were often pulled away to cover other unit responsibilities. There were multiple historical examples of this happening leaving gaps in provision. There was no process in place to protect the role potentially causing ramifications such as worsening muscular skeletal injuries (MSK) downgrade rates.
- The staff team was suitably trained in emergency procedures, including basic life support, sepsis and anaphylaxis. All staff had received a presentation delivered by medical staff to enable identification and prompt identification of heat illness and sepsis. Heat illness and sepsis was clearly displayed around the centre and in treatment rooms. We saw treatment rooms also had casualty clipboards in place, which enabled structured and accurate recording of vital signs and assessment. These were developed in response to a Heat Illness Quality Improvement Programme (QIP) undertaken following updated DMS guidance. Included in this were provision of a new ice machine, and further specialised medical equipment (polar pods).

## Information to deliver safe care and treatment

- A process was established to ensure summarisation of patients' notes. Patient notes were summarised by the medic and nurse as part of the new joiners' protocol which provided a clear pathway/algorithm for staff to follow. The summarising search showed 83% of notes were in date for summarisation and a plan was in place to complete this fully.
- A peer review programme of clinicians' DMICP consultation records was in place using a consistent methodology. We saw a peer review programme of nursing notes was in place.
- The PCRF undertook a notes audit done in May this year. The results were positive, and these were discussed at multi-disciplinary meetings.
- Co-ordinated by the administration team, an effective central system was in place for the management of both internal and external referrals.
- A good process was in place for the management of specimens. A record was maintained of all samples sent so when results were returned, they could be tracked, and any missing results identified.

## Safe and appropriate use of medicines

The arrangements for managing medicines and vaccines were appropriate and safe. This included arrangements for obtaining, recording, storing and handling of medicines.

- The CMP was the lead for medicines management and the practice manager the deputy. Norton Manor was not a dispensing practice so there was an effective relationship with the local pharmacy that dispensed the prescriptions. There had been regular audits undertaken by the regional pharmacist.
- Repeat prescriptions were only accepted in person, were reviewed regularly and processed within 48 hours.
- All prescription forms were stored and managed safely. There were no controlled drugs held at the practice, but controlled drug prescribing was audited quarterly to identify any trends.
- High risk medicines (HRM) were managed effectively in accordance with the SOP. Alerts, coding and diary dates were used to identify and manage patients prescribed an HRM; confirmed through our review of clinical records. Shared care agreements were in place.
- Patient Specific Directions (PSD) were in use to allow non-prescribing staff to supply simple treatments or carry out vaccinations in a safe way. PSDs were used by medics for vaccination clinics. A vaccination protocol was in place and had been reviewed. Medics using PSDs had completed mandated vaccination training. We saw confirmation to show the doctor had reviewed the DMICP record prior to vaccination and confirmed administration under PSD was appropriate.
- Out-of-hours, secondary care prescriptions and amendments to current therapy as directed by secondary care were recorded and actioned by the doctors.
- Requests for repeat prescriptions were managed in person or by email, in line with policy. 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.
- We saw evidence to show that patients medicines were reviewed regularly. The doctor's notes in DMICP were comprehensive. DMCIP and all doctors and relevant clinicians had access to this.

## Track record on safety

- Measures to ensure the safety of facilities and equipment were in place. Electrical and gas safety checks were up to date. Water safety measures were regularly carried out with a legionella inspection undertaken in July 2021. A fire risk assessment of the building was in place. Firefighting equipment tests were current. Staff were up to date with fire safety training and were aware of the evacuation plan.
- A system for logging and monitoring the servicing of all clinical/non-clinical equipment was established, this included equipment in the PCRF.
- The medical centre had a risk and retired risk register which was last reviewed in July this year. They also had an issue log and retired issue log which was also updated in July this year. Risk assessments were in each room and they include both clinical and non-clinical risks. These were last reviewed in June 2021.

- The medical centre had a fixed alarm system in clinical areas which alerted the reception and the guardroom; these alarms were tested but records of the checks were not held. This was put in place following the inspection. The PCRF did not have a fixed alarm but the physiotherapist had a handheld alarm. We noted there was no lone working risk assessment specific to the PCRF in place.
- A COVID-19 risk assessment had been completed for the medical centre along with risk assessments for individual staff. The medical centre had developed an SOP in relation to COVID-19 and the use of personal protective equipment (PPE). The medical centre manager advised that this was regularly discussed with the staff team.
- Staff had the information they needed to deliver safe care and treatment to patients most of the time. If there was an unplanned DMICP outage, the medical centre would ensure planned clinics were printed for the following day so in the event of an outage they were aware of the patients they are expecting to attend. If there was a prolonged outage the Business Resilience Plan was referred to meaning only emergency appointments were available and paper forms were used to record the consultation for upload to the clinical system at a later time. There was a Memorandum of Understanding (MOU) in place with Yeovilton where they could support if the IT outage if necessary.

## Lessons learned and improvements made

At the previous inspection we found that learning was not always captured and shared following a significant event. At this inspection we saw improvements had been made.

- All staff had access to the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events and incidents. The staff database showed that all staff had completed ASER training.
- From interviews with staff and evidence provided, it was clear there was a culture of reporting incidents from those staff able to access the system. Both clinical and non-clinical staff gave examples of incidents reported through the ASER system including the improvements made as a result of the outcome of investigations. An ASER log was maintained on the healthcare governance workbook (HGW), a system that brings together a comprehensive range of governance activities including any changes made.
- A system was in place for managing patient safety alerts. All alerts were received by email from the Regional Pharmacy Technician and added to the practice alert register on Sharepoint. The register included details of actions taken. Alerts were discussed at the weekly practice meeting but the detail of the alert or a link to the register were not included in the minutes so it would be difficult for anyone not at the meeting to know what alerts had been discussed or action required.

# Are services effective?

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

Following our previous inspection, we rated the medical centre as requires improvement for providing effective services. We found inconsistencies in processes for providing effective services including gaps in:

- processes to keep clinicians up to date with current evidence-based practice
- the process to undertake regular peer review of recorded clinical consultations

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

## Effective needs assessment, care and treatment

Improvements had been made to the arrangements in place to ensure staff had a forum to keep up to date with current medical centre and guidance. Our review of patient records indicated that clinicians carried out assessments and provided care and treatment in line with national standards and guidance, supported by clear clinical pathways and protocols.

- Clinicians were aware of relevant and current evidence-based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The CMP attended a meeting at Yeovilton Medical Centre at least monthly, sometimes more often; where there was a forum to share new guidance and NICE recommendations.
- Our review of clinical records demonstrated that all clinicians carried out assessments and provided care and treatment in line with national standards and guidance, supported by clear clinical pathways and protocols. The ERI used Rehab Guru, software for rehabilitation plans and outcomes, for exercise programmes for patients. They also referred to the Defence Rehabilitation website for best medical centre guidance.
- Clinicians confirmed that periodic review of medical records took place with nurses, general practitioners, physiotherapists and medics reviewing one another's consultation records and Read coding. Our review of patient records indicated that improvements has been made in the processes for clinical record keeping since our last inspection.
- Staff were kept abreast of clinical and medicines updates through the DPHC newsletter circulated to individual staff and to the medical centre each month. Participation with regional events and forums also provided an opportunity for clinicians to keep up to date although this had been temporarily halted due to Covid restrictions.

## Monitoring care and treatment

- Long-Term Conditions (LTCs) were currently managed by the locum nurse. SOPs outlining the management and monitoring arrangements for LTCs were in place.

Regular searches took place that demonstrated a thorough system consistent with good medical practice. The medical centre provided us with the following data:

  - The small numbers of patients on both the hypertension and diabetic registers were regularly monitored in accordance with best medical practice guidance. Processes were in place to identify and monitor patients at risk of developing diabetes, including through over 40s health checks.
  - Patients with a diagnosis of asthma had received an asthma review in the preceding 12 months.
  - Audiology statistics showed 68% of patients had received an audiometric assessment within the last two years. This number was reduced due to the impact of the pandemic and in line with DPHC policy.

- Through review of clinical records and discussions with the CMP, we were assured that the care of patients with a mental illness and/or depressive symptoms was being effectively and safely managed, often in conjunction with the Department of Community Mental Health (DCMH).
- We looked at the clinical records of patients currently receiving support from the PCRF. We saw that it took a holistic view of patients, including mood, sleep and lifestyle. Patients could be signposted to different outside agencies for further support and advice. We saw that referrals to the Regional Rehabilitation Units were made promptly with minimal wait time for the patient.
- The CMP was the lead for healthcare governance and the practice manager deputised in their absence. At the last inspection we saw quality improvement, including clinical audit, was in the early stages of development for the practice and audits by the PCRF were limited.
- Throughout the COVID-19 pandemic, a broad programme of quality improvement work including clinical audit has continued and this had led to improved outcomes for patients. All staff were involved and delivered their own audit work this included administrative, clinical and PCRF staff. A number of rolling audits were in place around the management of long-term conditions. All results of audits and recommendations are discussed at the monthly practice meeting.

## Effective staffing

- The medical centre had enhanced the DPHC induction programme to include elements specific to Norton Manor Medical Centre and had included links to relevant documents for reference. Staff also took part in a DPHC induction webinar. We saw evidence of a completed induction programme for the current locum nurse.
- The medical centre had a training calendar, we saw there was a record of mandatory training and compliance was good across the medical centre team. The practice manager monitored compliance and discussed required training activity in practice meetings. Time was available to staff every Wednesday afternoon to complete mandatory training.

- All staff had received a yearly appraisal. The CMP and nurse revalidation were recorded on the staff database. The nurse attended monthly clinical supervision sessions with colleagues at Commando Training Centre Lympstone.
- The physiotherapist had a mentor in Plymouth and had meetings with them every six weeks. There was also arrangement in place for local peer review with ERIs and the doctors.
- Staff administering vaccines had received specific training which included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to online resources and discussion at clinical meetings.

## Coordinating care and treatment

- The CMP attended the J1 Unit Health Committee (UHC) meetings at which the health and care of vulnerable and downgraded patients was reviewed. The CMP had forged good safeguarding links with community teams.
- The PCRF communicated well with the medical centre both in person and electronically, they told us this worked well.
- For patients leaving the military, pre-release and final medicals were offered. During the pre-release phase the patient received an examination and a medication review. A summary print-out was provided for the patient to give to the receiving doctor, and a letter if the patient was mid-way through an episode of care. A structured mental health questionnaire was also completed.
- The practice had developed good working relationships both internally and with local health and social care organisations. An effective relationship had been established with a local NHS primary care practice.
- The medical centre is located next door to the PCRF service which provided physiotherapy assessment and treatment. Referral into the service is either via a primary care clinician or through DAP (direct access for patients). Patients were able to obtain swift access to the PCRF and strong partnership working arrangements resulted in co-ordinated and person-centred care for patients.

## Helping patients to live healthier lives

- The nurse was the lead for health promotion and had had the appropriate training and experience in this field. We saw there was extensive information available in the waiting area to support patients. Chlamydia testing kits (without age restriction) were offered as part of new joiner registration. Arrangements have been made for the local sexual health service to visit the base to undertake sexual health screening once restrictions allow.
- The CMP also had the appropriate sexual health training and provided sexual health support and advice. Patients were signposted to local sexual health services for procedures not undertaken at the medical centre. Alcohol screening and chlamydia

testing information had been introduced as part of the new joiners process, along with the introduction of clinics for; smoking cessation, cervical cytology, over 40s health checks, new joiners, ear irrigation, specialist wound care and management and chronic disease management and review. Some of these were remote/telephone based and some were in person within the medical centre.

- The number of women aged 25 to 49 and 50 to 64 whose notes recorded that a cervical smear had been performed in the last three to five years was 17 eligible women and 17 had been undertaken. This represented an achievement of 100%. The NHS target was 80%.
- There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using public health information posters and they ensured a female sample taker was always available.
- Regular searches were undertaken to identify patients who required screening for bowel, breast and abdominal aortic aneurysm in line with national programmes. At the time of the inspection there were no patients identified that met the criteria for bowel screening.

An effective process was in place to recall patients for their vaccinations. All non-essential vaccinations had been stopped to minimise the risk of spreading COVID-19'

Vaccination statistics were identified as follows:

- 93% of patients were in-date for vaccination against polio.
- 91% of patients were in-date for vaccination against hepatitis B.
- 96% of patients were in-date for vaccination against hepatitis A.
- 93% of patients were in-date for vaccination against tetanus.
- 100% of patients were in-date for vaccination against MMR.
- 93% of patients were recorded as being up to date with vaccination against diphtheria.
- 100% of patients were recorded as being up to date with vaccination against meningitis.
- 76% of patients were recorded as being up to date with vaccination against typhoid.

## Consent to care and treatment

- The practice obtained consent to care and treatment in line with legislation and guidance.
- Clinicians understood the requirements of legislation and guidance when considering consent and decision making. 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 decide.

- Staff we spoke with were aware of the Mental Capacity Act (2005) and how it could apply to their practice.

# Are services caring?

## Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- We were unable to collate responses from patients using CQC paper comment cards in order to comply with COVID-19 restrictions. However, we did speak with three patients on the telephone. This conversation was very positive about the service experienced.
- Staff explained that they sometime saw patients who spoke English as a second language. They could access a translation service if they needed it.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed, they could offer them a private room to discuss their needs.
- The medical centre had asked its patients to complete a written survey and had received 30 responses. 100% of respondents stated that staff treated them with compassion and respect.
- 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.

## Involvement in decisions about care and treatment

- Patients identified with a caring responsibility were captured on a DMICP register, it included what had been discussed at the monthly practice/clinical meeting and any actions identified.
- We were advised patients usually identified themselves as a carer through the new patient registration form or when the Welfare Officer shared this information with the medical centre. Alerts were added to all registered carers and they were offered flexibility with appointments.
- Referrals and hospital appointments were managed by the administrative team and patients were well supported to obtain the timeliest access to secondary care. A standard referral template letter was in use by clinicians and an audit had been done to ensure that referrals were being written in the most effective way. Internal referrals (to other healthcare services within the military) had been included since the last inspection.
- Results from the practice's patient experience survey (30 responses were collated) showed that patients felt they were involved in their treatment:
- Ninety-eight per cent of respondents said they had been given clear healthcare information as a basis for decision making.
- One hundred per cent of respondents said they would recommend the medical centre to others.

- A wide range of 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 posters for symptoms that may suggest a sexual health screening appointment would be useful and on the importance of vaccinations, spotting potential signs of sepsis, seeking help for a mental health concern and the significance of health screening to identify disease early. There was also a specific display for patients who might be deployed abroad which provided guidance around the medicals they needed to register for and any vaccinations they would need.
- 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 them to personnel within the military who could guide them through the exit process and transition to NHS care and other support functions.
- Staff explained that they occasionally saw patients who spoke English as a second language. They could access a translation service if they needed it.

## Privacy and dignity

- Screening was provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. Clinic room doors were closed during consultations.
- The layout of the reception area and waiting area meant that conversations between patients and reception would unlikely be overheard. If patients wished to discuss sensitive issues or appeared distressed at reception, they were offered a private room to discuss their needs.
- The medical centre could not always facilitate patients who wished to see a clinician of a specific gender so patients could be directed to an alternative medical centre or PCRF if needed.

# Are services responsive to people's needs?

## Responding to and meeting people's needs

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

- The facilities and premises were bespoke and appropriate for the services delivered.
- An access audit (as defined in the Equality Act 2010) had been completed in June 2021 by the physiotherapist.
- The medical centre offered home visits to its patients and a policy was available to staff and patients around when a home visit might be necessary and appropriate. A register was maintained to log home visits.
- The medical centre had a transgender policy in place and staff told us about the importance of ensuring that patients were addressed according to their wishes and that they were invited for appropriate health screening.
- No hearing induction loop was in available on the premises. The practice had identified this in the access audit undertaken in June 2021 but no patient search had been undertaken to clarify this nor any actions taken.
- In response to restrictions associated with COVID-19, the first point of access for patients had moved to telephone or e-Consults with most consultations undertaken in this way. E-Consults were triaged by the doctor and actioned during the same session in which they were received. Dependant on the patient's clinical need, the option of a telephone or face-to-face appointment or e-mail reply could be offered.
- Telephone requests were added to a doctor's routine clinic as appropriate. Same day appointments were available.
- Physiotherapy could be sought via the doctor or by a direct access physiotherapy (DAP) service available through self-referral. Patients were booked into telephone triage slots as referred patients. Routine and follow up physiotherapy and ERI appointments were available within one day.

## Timely access to care and treatment

- In response to restrictions associated with COVID-19, the practice had fully integrated the use of e-Consult to reduce the number of people accessing the medical centre. Face-to-face consultations were offered if clinically required
- A duty medic clinic was held each morning for patients requiring an urgent appointment. The doctor was available should the nurse need to refer the patient on. Routine appointments were available within two days with a doctor or on the same day for the nurse. Access for vulnerable patients was prioritised.
- The waiting time for both a routine and urgent physiotherapist or ERI appointment was within one day. Patients referred to the Regional Rehabilitation Unit (RRU) were seen

within an acceptable time frame and a patient referred to the Multidisciplinary Injury Assessment Clinic (MIAC) had a wait of three to six weeks.

- Results from the practice's patient experience survey (30 responses were received) showed that patient satisfaction levels with access to care and treatment were generally high. For example:
    - 28 patients said they could access their healthcare easily.
    - 29 patients said they were satisfied with the method of their appointment.
- Details of how patients could access the doctor when the medical centre was closed were available through the base helpline. Details of the NHS 111 out of hours service was in the medical centre leaflet.

## Listening and learning from concerns and complaints

- The practice manager was the lead for complaints which were managed in accordance with the DPHC complaints policy and procedure. Written and verbal complaints were recorded and discussed at the medical centre meetings. A complaints audit had not been undertaken as there were no complaints recorded since 2016.
- The PCRF had no complaints recorded in the past 12 months.

# Are services well-led?

**We rated the medical centre as good for well-led.**

Following our previous inspection, we rated the medical centre as requires improvement for providing well-led services. We found governance structures needed strengthening, embedding and to be understood by all staff. This included the introduction of up to date terms of reference that reflected any extended duties, the clinical audit programme, re-introducing a patient survey and the clinical review process for clinicians.

At this inspection we found that all areas had improved, and recommendations completed.

## Vision and strategy

- Throughout the inspection it was clear staff were committed to providing a service that embraced the mission, values and vision. Following the inspection, we spoke with the Regional Clinical Director who provided a detailed account of the vision and plans for the future. Central to this was a plan to continue to re-organisation of practices into groups (currently regions) and with this an opportunity to increase networking and sharing of resources.

## Leadership, capacity and capability

- The CMP and practice manager were the leaders for the medical centre, and they had the experience and drive to deliver good sustainable care. The leaders not only demonstrated managerial experience, capacity and capability, it was clear they had vision, passion with a focus on providing the best possible service for their patients. They clearly understood the medical centre priorities and demonstrated they had capability to drive service change for the benefit of patients.
- Staff told us there was an open culture within the medical centre and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff we spoke with told us that they enjoyed working at the medical centre and that the team approach was supportive. Most staff had worked from home during the pandemic combined with also providing on site services at the medical centre. Several staff had been deployed to assist with the national COVID-19 response.

## Culture

The practice had a culture of high-quality sustainable care, and staff had worked to address issues identified at the last inspection.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.

- The practice focused on the needs of patients and action had been taken (in conjunction with the regional team and DPHC) to address concerns identified in 2019 in order to ensure that safe and effective care was provided to patients consistently. This included challenging and taking action to address poor performance in some areas of practice.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- All clinical staff were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.

## Governance arrangements

At the previous inspection we found the overarching governance framework in place did not always support the delivery of good quality care. At this inspection we saw improvements had been made and the governance arrangements were good.

- There was a clear staffing structure in place and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. Terms of reference (ToR) were in place to support job roles, including staff who had lead roles for specific areas.
- The establishment of the nurse post had ensured secondary clinical roles could be shared more evenly across the staff team. The lack of a dedicated receptionist to cover the front desk was a concern for the management team but this was articulated in the risk register and will be pursued via a business case with the regional team.
- The medical centre worked to the health governance workbook (HGW), a system that brings together a comprehensive range of governance activities, including significant events tracker, lessons learnt log, training register, policies, meetings, quality improvement and audit. Staff had access to the workbook which provided links to meeting minutes, policies and other information. A programme of clinical and internal audit was in place.
- A comprehensive understanding of the performance of the medical centre was maintained. The CMP monitored achievement against clinical indicators and reported if there were areas which required focus.
- A schedule of regular practice meetings was in place, within this meeting clinical and governance issues were discussed. All staff attended the meetings and minutes were maintained.

## Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance. Staff had effectively addressed issues that were previously identified.

- There were processes to identify, understand, monitor and address current and future risks including risks to patient safety.
- Practice leaders had oversight of national and local safety alerts and action had been taken as appropriate.
- The medical centre maintained a risk register and was aware of the risks facing its staff and patients.

## Appropriate and accurate information

- Quality and operational information was used to ensure and improve performance.
- There were 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 were various options in place to encourage patients to provide feedback on the service and contribute to the development of the service. Due to COVID-19, options for patients to provide feedback while visiting the practice were limited. Patients had the option to provide feedback on the service through the patient survey.
- We spoke with three patients by telephone after the inspection, some comments received described the staff as outstanding, very professional., supportive and kind.
- Good and effective links were established with internal and external organisations including the welfare services, mental health services, local health boards and local NHS providers.

## Continuous improvement and innovation

We identified that significant improvements had been made to the service since the last inspection. The change in leadership team clearly had had an impact as there was evidence of a revision of the governance structure, innovative practice and improvements being made, including quality improvement projects. The following is a summary some of the improvements we identified:

- The emergency room had had casualty clipboards in place, which enabled structured and accurate recording of vital signs and assessment. These were developed in

response to a Heat Illness Quality Improvement Programme (QIP) undertaken following updated DMS guidance. Included in this were provision of a new ice machine, and further specialised medical equipment (polar pods, awaiting delivery).