Tidworth Medical Centre

Quality report

Queen Elizabeth Memorial Health Centre
St Michaels Avenue
Tidworth
Wiltshire
SP9 7EA

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19 November 2019

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, and information given to us by the practice and patients.

Ratings

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

Chief Inspector's Summary

We carried out an announced comprehensive inspection at Tidworth Medical Centre on 19 November 2019. Defence Medical Services (DMS) are not registered with the Care Quality Commission (CQC) under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014 and are not required to be. Consequently, DMS services are not subject to inspection by the CQC and the CQC has no powers of enforcement. This inspection is one of a programme of inspections that the CQC will complete at the invitation of the Surgeon General in his role as the Defence Authority for healthcare and medical operational capability.

At this inspection we found:

- The practice had systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice improved their processes.
- The practice demonstrated an ethos of patient centred care.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Clinical record keeping was detailed and clear and would be easy for a locum clinician to follow. However, we found a small number of vulnerable patients not highlighted on the clinical system.
- The practice was found to be delivering care and treatment according to evidence-based guidelines and there was a formal process for discussion and implementation of new guidance or change in existing guidelines.
- Patients found the appointment system easy to use and could access care when they needed it. However, access to the reception by telephone was an issue.
- A structured programme of quality improvement work was being implemented although repeat audit cycles did not always provide clear visibility.
- Staff had developed strong links with military bases located nearby.

We saw two areas of notable practice:

- The practice had been proactive in the implementation of a transgender patient protocol that provided education and guidance to all staff.
- A domestic violence and abuse policy had been drawn up by the safeguarding lead. This included risk factors, management of suspected abuse and contact numbers. Barcode stickers were available throughout the practice to be used as a discrete method of providing the 24 hour domestic abuse helpline number to patients.

The Chief Inspector recommends:

- Ensure that alerts are in place for all vulnerable patients within their clinical records.
- Complete infection prevention and control training the link practitioner.
- Further strengthen the referral tracking process to ensure patients are receiving timely treatment.
- Improve the system for managing alerts to ensure it is failsafe.

- Improve the governance framework and processes around the safe management of medicines to include the system for monitoring patients on high risk medicines.
- Continue to improve the regularity of review for patients diagnosed with a long-term condition.
- Re-introduce peer review of clinical notes for nursing staff.
- Improve the uptake of health checks for patients aged 40 and over.
- Improve the arrangements for maintaining clinical oversight of Personnel Recovery Unit patients.
- Continue to take action to improve the telephone access.

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

Our inspection team

Our inspection team was led by a CQC lead inspector. The team of specialist advisors included two doctors, two practice nurses, a physiotherapist, practice manager and a pharmacist. There was also a doctor, pharmacist and physiotherapist shadowing.

Background to Tidworth Medical Centre

Tidworth Medical Centre, also known as Queen Elizabeth Memorial Health Centre, is one of the largest medical centres within Defence Primary Healthcare (DPHC), based in Wiltshire and consisting of a Medical Centre and a Primary Care Rehabilitation Facility (PCRF). The centre provides a primary care service to approximately 7,500 serving military personnel and approximately 2,500 military dependents. The list size increased significantly in 2019 following the rebasing of units to Tidworth and the closure of an NHS GP practice in the village where families of serving personnel were registered. Staffing levels had been increased but the practice had experienced difficulty filling vacant roles in the summer .

The centre provides medical support to over twenty different units with multiple roles including Infantry units, Armoured regiments, Royal Engineers, Royal Electrical and Mechanical Engineers, Medical regiments and other support units and headquarter formations including the Army Headquarters in Andover. The centre also provides the medical support to the Tidworth Personnel Recovery Unit (PRU) which is where the most complex medical cases are managed from across the whole South West Region.

Occupational health, travel health and physiotherapy services are provided on site. Family planning advice is available, with referral onwards to NHS community services. Maternity and midwifery services are hosted at the practice and provided by NHS practices and community teams. Medicals offered include boxing and sports diving.

The practice is open:

Monday	08:00-12:30 hrs and 13:30-16:30 hrs
Tuesday	08:00-12:30 hrs and closed in the afternoon for staff training, urgent cases only

Wednesday 08:00-12:30 hrs and 13:30-16:30 hrs
Thursday 08:00-12:30 hrs and 13:30-16:30 hrs
Friday 08:00-12:30 hrs and 13:30-16:00 hrs

Outside of these hours, patients can contact the duty doctor and duty nurse at Tidworth Medical Centre for emergency cover up to 18:30. From 18:30 on week days, weekends and public holidays patients can access emergency care through NHS 111.

The centre is staffed by a combination of military and civilian staff. There are 60 posts outlined in the table below:

Position	Numbers
Military Senior Medical Officer (SMO)	one
Civilian Medical Practitioner (CMP)	five
General Duties Medical Officer	three
Locum doctors	two
Military Senior Nursing Officer	one
Civilian advanced nurse practitioner (ANP)	two
Civilian practice nurse (PN) **Military practice nurse**	two two
Locum nurse	two
Civilian healthcare assistant (HCA)	three
PCRF staff	one military physiotherapist six civilian physiotherapists

	seven locum physiotherapists two military exercise rehabilitation instructors (ERI) two civilian ERIs two locum ERIs
Civilian pharmacy technician	one
Locum pharmacy technician	two
Military practice manager (PM)	one
Military deputy practice manager (DPM)	one
Civilian business manager	one
Civilian office manager	one
Civilian administrative staff	seven
Locum administrative staff	two
Storeman	one
Contracted staff	A team of domestic staff
Regimental Aid Posts (RAP) are medical support staff who belong to the regiment	10 Regimental Medical Officers (RMO) 45 Combat Medical Technicians (medics)

Are services safe?	Inadequate

We rated the practice as inadequate for providing safe services.

Safety systems and processes

Systems were established to keep patients safe, including processes to safeguard patients from abuse. Improvements were needed to strengthen some of these systems.

- A civilian medical practitioner (CMP) was the lead for adult and child safeguarding and an advanced nurse practitioner (ANP) deputised in their absence. The practice had safety policies including adult and child safeguarding policies which were reviewed, communicated to staff displayed in some parts of the practice. Safeguarding information was displayed in all clinical rooms and policies included external contacts. 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 within the practice.
- The safeguarding leads, senior medical officer (SMO) and ANP lead had completed level 3 training. Clinicians had all completed a minimum of level 3 safeguarding training. Non-clinical staff had received safeguarding training, including update training, at a level appropriate to their role.
- There was a system to highlight vulnerable patients on records and a risk register of vulnerable patients. Staff were alerted to a vulnerable patient by automated alerts from the electronic patient record system (known as DMICP). Although we noted a small number of vulnerable patients without an alert. Vulnerable adults were managed by the RMOs and discussed at monthly Unit Health Committee (UHC) meetings. Vulnerable children were discussed at monthly virtual clinics attended (via electronic link) by two member of the practice's safeguarding team, school nurses, health visitors, army welfare and a representative from the child services provider.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. Although there was a nurse coordinator for Personnel Recovery Unit (PRU) patients, there was scope to improve this with better clinical oversight from the doctors.
- Staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check (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 chaperone policy was readily available to patients in a dedicated leaflet. In addition, advice on chaperones was provided in the patient information leaflet. A list of trained chaperones was available.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. DBS checks were undertaken where required.
- A practice nurse was the infection prevention and control (IPC) lead at the practice. No specific IPC lead training had been completed but the SNO demonstrated a good understanding of requirements and knowledge of guidelines. A request to fund training for a link practitioner course had been declined at regional level. The training requirement had been added to the risk register.

- The last comprehensive IPC audit was completed in February 2019 and the practice was seen to be 91% compliant. There was a list of recommendations and an action plan to address issues raised by the audit. For example, sharps bins were not being used correctly and subsequently, training had been provided. Areas of the building had been identified as non-compliant with current IPC guidelines, for example, sinks for handwashing in the nurses' rooms. These areas had been factored into the planned refurbishment due to commence in 2020.
- There was a team of contracted cleaners managed by a cleaning supervisor who had an office within the building. All clinical rooms had cleaning schedules and spot checks were completed weekly. The rooms had been deep cleaned in March 2019 and further deep cleaning was scheduled for December 2019.
- There was an effective system for the safe management of healthcare waste. Consignment notes were retained at the practice and an annual waste audit was carried out in July 2019. All areas were compliant and four action points from the audit had been completed.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. These included regular checks and risk assessments for fire safety, water safety (including legionella), gas and electricity.

Risks to patients

Systems to assess, monitor and manage risks to patient safety were established.

- There were arrangements for planning and monitoring the number and mix of staff needed and a clear approach to managing staff absences; for example, Combat Medical Technicians (CMT) provided cross cover for clinics when required. Regional management told us that the staffing levels at the practice had been impacted by a large influx of patients at nearby bases resulting in additional staff requirements. This created a need to fill some gaps in staffing, all of which had been filled or were being recruited for. Longstanding civilian and locum staff provided continuity of care.
- A role-specific induction pack for locum staff detailed essential contact numbers, policies and protocols.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. Basic life support courses was held monthly and the practice extended the invite to staff from other practices in the region. Heat illness training had been delivered to staff in October 2019. Sepsis training that included scenario based discussion groups was completed or planned for all staff. A support tool built into DMICP assisted clinical staff identify potential sepsis.
- Staff understood their responsibilities to manage emergencies on the premises and held equipment and medicines that were regularly checked. A small number of items had expired use by dates or indeterminable expiry dates and although the blood glucose monitor was being checked, the frequency of checks was not weekly as per policy. Staff training included simulated exercises in how to respond to an emergency.

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. A system in place ensured the practice nurse was advised of any new joiners and leavers. This included

alerts for anyone with a long-term condition, any treatment overdue and for those patients with responsibilities as a carer. Usually notes were summarised within two weeks, although due to a big influx of new patients, there was a backlog of summarising. This was being managed by prioritising at-risk groups such as children and those patients with a long-term condition.

- There was structured review of clinical notes against a set criteria that formed part of the audit programme. Each ANP had an assigned doctor for peer review. The nurses completed ad hoc case reviews, a structured programme was being implemented.
- Staff described occasional loss of connectivity with DMICP, meaning clinics could be delayed. If this happened, the business resilience plan was followed, pre-assembled packs were used to record written notes that were later scanned onto patient notes. The practice followed DPHC policy to only see urgent patients when connectivity was lost although continuity was supported by having laptops with SIM cards to overcome connectivity failure.
- There was a system in place to manage hospital letters and this showed who had read and actioned the letters for each patient.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. There was scope to improve communication between doctors and providers of care to the PRU patients in order to maintain oversight.
- There was a system in place to govern referrals. The referrals administration team recorded the date or referral and associated correspondence that included a follow-up call to the patient and to the secondary care provider. However, there was no evidence of escalation when a referral appeared overdue. For example, a two week wait referral was found to be five weeks old with no record of attendance or of the patient not attending. This had not been escalated and there was a potential risk that the procedure had not been completed.
- Sample testing results were processed daily and tracked by three members of the nursing team who had access to the register. Sample results were received electronically and one of the team reviewed the results daily.

Safe and appropriate use of medicines

The practice had systems in place for appropriate and safe handling of medicines. However, improvements were needed.

- A senior doctor was the lead for medicines management and for the dispensary. Written procedures required review to ensure safe practice; for example, terms of reference had not been updated and there were gaps in the monitoring of controlled drugs (CDs).
- The systems for managing and storing medicines in the dispensary required strengthening. The storage of vaccines in the fridges was not in accordance with guidelines; temperature checks on fridges had not been recorded daily, and some vaccines were on the floor of the fridge or touching the fridge walls (vaccines should be stored in such a way that air can freely flow around them).
- Staff had access to British National Formulary (BNF) and prescribing formulary. Staff prescribed, administered and supplied medicines to patients in line with legal requirements and current national guidance. The administration of medicines for smoking cessation was not being carried out in accordance with national guidance but this was changed on the day of inspection.
- Patient Group Directions (PGD) had been developed to permit the practice nurses to administer medicines in line with legislation, they were current and had been authorised by a

signatory. However, the certificates were signed by the regional pharmacy technicians, this would normally be signed off by the regional pharmacist or nurse advisor. Nurses were issuing medication for smoking cessation following assessment and recommendation from the healthcare assistant (HCA). This practice was stopped on the day and the standard operating procedure (SOP) changed.

- Patient Specific Directions (PSD) were in place and signed by the prescriber to permit medics to vaccinate patients.
- The system in use for high risk medicines (HRM) required strengthening. There were alerts on the patient record to inform that a shared care agreement (SCA) was in place and an audit had been carried out in August 2019. However, there was no register, the practice relied on DMICP searches which sometimes included patients who had left the practice. SCAs for patients on high risk medicines (HRMs) were not in place for some patients and were not easily accessible as not accurately Read coded on the electronic patient notes.
- The practice held stock of CDs which were appropriately stored, however, improvement was needed in the record keeping required. For example, the stock of a specific medicine showed a stock discrepancy (30 tablets had been gained) that had not been explained.
- The practice kept prescription stationery securely and monitored its use.
- Prescriptions were signed before medicines were dispensed and handed out to patients.
- The system for requesting repeat prescriptions was not in line with DPHC policy as it allowed telephone requests. Patients were able to request by email or in person using a written request slip.

Track record on safety

The practice had a good health and safety record.

- The practice manager, supported by the deputy practice manager, was the health and safety lead and both and had received training specific to the role. There were completed risk assessments in relation to safety issues. All practice staff received basic health and safety training. They attended the health and safety (referred to as SHEF) meetings for the barracks.
- Risk assessments were in place for the building and had been reviewed and approved by the host unit safety officer. Electrical and gas safety checks were up-to-date. Arrangements were in place to check the safety of the water and a fire risk assessment of the building was undertaken annually. The fire system was tested each week. Staff were up-to-date with fire safety training and were aware of the evacuation plan.
- There were five separate waiting areas and the volume of traffic meant patients could be observed by practice staff and highlight any potential risk if someone suddenly becomes unwell. There was no CCTV but staff told us that administration office doors were left open to gain visibility of waiting areas and the duty nurse checked the waiting areas after each clinic.
- There was a fixed alarm system in the clinical areas of the practice and at reception. Portable alarms were provided in clinical rooms and in the PCRF.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system (known as ASER) and policy for recording and acting on significant events and incidents. Staff had received training in using the system and understood their duty

to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.

- There were adequate systems for reviewing and investigating when things went wrong. Staff had access to the significant event reporting system and understood how to use it.
- The system for receiving and acting on safety alerts required strengthening. Alerts were documented on a register and cascaded by email and discussed at practice meetings. Evidence of discussion was not clearly documented meaning those unable to attend could miss important information. The register did not include a recent Central Alerting System (CAS) alert issued in August 2019 warning of increased risk of breast cancer with hormone replacement therapy.

Are services effective?	Requires improvement

We rated the practice as requires improvement 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) evidence-based practice guidelines. Discussion around best practice guidance and changes to practice in light of newly issued guidance was a standing agenda item on monthly governance and practice meetings.
- The Defence Primary Health Care (DPHC) team produced a newsletter that was circulated to clinicians providing further information and a summary of relevant safety updates. Staff we spoke with could refer to this and gave examples of updates they had acted on and discussed within the practice.
- There was a wide-ranging skill set across the PCRF team that included cognitive behavioural therapy (CBT) and women's health. Our review of PCRF patient records showed Rehab Guru, software for rehabilitation plans and outcomes, was used for exercise programmes for patients (Rehab Guru is an exercise prescription software that allows medical professionals to send structured exercise programmes and educational information to individuals). However the PCRF did not provide sufficient areas for exercise rehabilitation instructors (ERI) and there was limited space for reception/administration staff.
- The PCRF team was invited to joint meetings and learning forums for the whole practice meetings. The department had their own monthly meeting, standing agenda items included clinical guidelines.

Monitoring care and treatment

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

Clinical staff were appointed to lead on each long-term condition, they were responsible for monitoring treatment and managing the patient recall system. The recent influx of patients had impacted the performance indicators, a backlog of reviews was being worked through that

included a requirement to standardise operating procedures and templates (for patients rebased from Germany and from the NHS practice that had closed) to provide accurate data.

The practice provided the following patient outcomes data to us from their computer system on the day of the inspection:

- There were 23 patients on the diabetic register. We reviewed the treatment and care offered to these patients and found that current NICE guidance had been followed. For 57% (13) of these diabetic patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. There had been a delay in receiving patient notes from those rebased at Tidworth. This meant the practice had only started to recall, see and treat some of these patients in the last two months. For 20 of the patients, the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.
- There were 128 patients recorded as having high blood pressure. We reviewed the treatment and care offered to these patients and found that current NICE guidance had been followed. A total of 57% (73) of patients tested in the past nine months had a last blood pressure reading of 150/90 or less. A standard operating procedure was being developed to improve the patient recall and standardise the data (some patients rebasing from abroad had been on a different system which required a different data set).
- There were 145 patients with a diagnosis of asthma. A total of 72% (104) had received an asthma review in the preceding 12 months which included an assessment of asthma control using the three Royal College of Physicians questions. The lead for asthma was upskilling staff to carry out asthma reviews in order to improve the performance data for annual reviews completed.
- The practice regularly monitored patients with depression. We reviewed four patients who had a diagnosis of depression added in the last 12 months and were due for review. Patients were initially managed for eight weeks before being signposted, when appropriate, to support services that included Improving Access to Psychological Therapies (IAPT) and Department of Community Mental Health (DCMH) based at Tidworth. We found a small number of patients with depression who had been identified as vulnerable but did not have an alert on the clinical system. The SMO checked monthly to ensure appropriate management of patients with depression.
- 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 100% of patients.
- There was a structured programme of clinical audit with some first cycle audits completed; for example, an audit of insomnia. Second cycles were completed or planned. Although some second cycle audits were not relevant. For example, the second cycle of the insomnia audit was not directly comparable because different questions had been asked, therefore it was not effective in monitoring continuous improvement.
- The nursing staff carried out quality improvement work that included consultation, Patient Group Directions (PGD) and cytology audits. These were continuous cycle audits and appropriate action was taken when required.
- The PCRF carried out audits as part of their quality improvement programme.

Effective staffing

Continuous learning and development was promoted for staff. The staff database was monitored to ensure staff were up-to-date with training and development.

- A generic and role-specific induction was in place for new staff to the practice. All staff, including a recently inducted member of staff, described a comprehensive and supportive induction. This included supernumerary time and supervised practice.
- 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. Staff were given opportunities to develop; for example, an ANP had a diploma from the Faculty of Sexual and Reproductive Healthcare (FRSH) and the practice manager had completed training in primary care and health management.
- The practice provided staff with ongoing support. This included a protected time, one-to-one meetings, appraisals, mentoring, clinical supervision and support for revalidation.
- The practice was a learning centre for doctors and nurses. Students we spoke with on the day praised the role-specific induction process and the team approach. Each student received pre-joining communications and was given a bespoke pack that included a placement timetable and information on the garrison.
- A 'journal club' was held weekly for discussion among doctors and ANPs. Minutes were recorded to inform those unable to attend.
- Nursing staff were appropriately qualified and their competence was assessed regularly. They could demonstrate how they kept up to date. Nursing staff whose role included immunisation had received specific training and could demonstrate how they stayed up to date. Further courses completed by the nurse included sexual health and spirometry (a test used to assess the lungs and diagnose conditions that affect breathing).
- The practice had a 'bi-annual assurance' system that maintained and monitored the competencies for all CMTs within the practice. However, there was no evidence of recent peer review for nurse's notes.
- The PCRF team benefited from a comprehensive mentorship process that had been developed in-house. Staff were given protected time each month for continued professional development (CPD) part of which included group-led training on a specific topic.

Coordinating care and treatment

Staff worked well together and with other care professionals to deliver effective care and treatment.

- The practice had developed good working relationships with local health and social care organisations. For example, links were established with the health visiting and midwifery teams who provided clinics from the medical centre. Other examples of corroborative working with the practice involved the Wiltshire Smoking Cessation Team and the NHS diabetes prevention team.
- The practice was registered as a 'Veterans Friendly Practice'. Doctors provided patients transitioning from the military with a release medical. A handover letter was completed for patients with complex needs. Patients could be referred to the welfare team for support with the transition, and if appropriate to the DCMH. Patients were also signposted to SSAFA, a UK

charity providing welfare and support for serving personnel in the British Army, veterans and military families.

- The SMO attended garrison health committee meetings and RMOs attended the UHC meeting for their own unit. Nursing and PCRF teams regularly attended unit health committee meetings. There was a formal process to request a multidisciplinary team meetings, staff told us these could be easily arranged when required.

Helping patients to live healthier lives

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

- Clinical records showed that staff encouraged and supported patients to be involved in monitoring and managing their health. Staff also discussed changes to care or treatment with patients as necessary.
- A nurse had the lead for health promotion and was supported by the nursing team, HCAs and medics. The health promotion strategy was underpinned by national priorities and initiatives to improve the population's health including, stop smoking campaigns and tackling obesity
- Health promotion displays and leaflets were available in patient areas. These were current and relevant to the practice population. At the time of the inspection the main activity involved promotion for the flu vaccination, other subjects included women's health, smoking and mental health.
- One of the nurses was the lead for sexual health and had completed the required training for the role (referred to as STIF). An RMO and ANP had completed FSRH diplomas in August 2019. Women's health clinics run by the Salisbury sexual health team were hosted on Thursday afternoon and females from nearby military medical centres could attend. This provided patients access to a comprehensive sexual health service. The medical centre also provided an antenatal service that included appointments with a hospital consultant and ante-natal ultrasound scanning. Contact details for 24-hour access to sexual health advice were available to patients.
- All new patients were asked to complete a proforma on arrival. Notes were scrutinised by administration staff and then reviewed by the nurse and GP. The practice nurse followed up any areas of concern, such as raised blood pressure. Notes were normally summarised within two weeks from receipt of the new patient registration form. There was a backlog of 130 civilian patient records. This had resulted from an increase in new patient registrations following the closure of a nearby NHS practice and the rebasing of soldiers from Germany. The practice prioritised the notes of children and adults with known medical issues identified.
- Patients had access to appropriate health assessments and checks. 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. This included the practice nurse chasing up those patients deployed overseas to ascertain if they had attended for screening elsewhere. A quarterly search had been last run in September 2019 and there were no eligible patients to be screened.
- The percentage of eligible women whose notes recorded that a cervical smear had been performed in the last three to five years was 1,139 out of 1,254 which represented 96%, 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.

Children's immunisations were managed by the nurses. Data provided by the practice showed:

- Children under 12 months were 82% up to date with their immunisations.
- Children aged 24 months were 82% up to date with their immunisations.
- Children aged five years were 70% up to date with their immunisations.

The practice population included 939 patients aged 40 or above. A total of 137 health checks had been completed. The practice had prioritised the health checks for patients aged 50 or above, a total of 55 health checks had been completed out of an eligible population of 217.

It is important that military personnel have sufficient immunity against the risk of contracting certain diseases. The World Health Organisation sets a target of 95% for vaccination against diphtheria, tetanus, pertussis and polio and measles, mumps and rubella. Unit commanders were responsible for ensuring their personnel kept up-to-date with vaccinations. Based on clinical records, the following illustrates the current vaccination data for military patients:

- 89% of patients were recorded as being up to date with vaccination against diphtheria.
- 89% of patients were recorded as being up to date with vaccination against polio.
- 87% of patients were recorded as being up to date with vaccination against Hepatitis B.
- 92% of patients were recorded as being up to date with vaccination against Hepatitis A.
- 89% of patients were recorded as being up to date with vaccination against Tetanus.
- 84% of patients were recorded as being up to date with vaccination against Meningitis (92% of service personnel had been vaccinated).
- 81% of patients were recorded as being up to date with vaccination against Measles, Mumps and Rubella (MMR) (87% of service personnel and 70% of pre-school children had been vaccinated).

The practice were catching up on the immunisation programme following the large influx of new patients.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance. Templates were used to record consent; for example, minor operations and blood tests. Verbal consent was recorded on the consultation notes. The last audit of consent for minor surgery was carried out in November 2019 and all consultations had consent recorded appropriately.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Staff had not received specific training but the SMO sent information electronically to all clinicians, for example, the assessment of mental capacity and the code of practice.

Are services caring?	Good

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs. For example, the women's health clinic was held outside core work hours and the emergency cover after 16:30 each day (16:00 on Fridays) was used to facilitate appointments for children outside of school hours.
- The practice gave patients timely support and information. This included participation in charity events to increase staff health awareness and raise money, for example, Macmillan coffee mornings and breast cancer awareness coffee mornings.
- A sign at the reception desk advised patients that a room was available to discuss sensitive issues. There was a slip that patients could hand to a receptionist to ask for a private conversation.
- We received 94 patient Care Quality Commission comment cards in total. Of these, 79 were entirely positive about the service experienced, thirteen of the cards were mixed and two negative. Positive comments were in relation to the helpfulness and friendliness of staff. Four of the negative comments related to the attitude of doctors.
- The practice had an information network available to all members of the service community, known as HIVE. Information about the service was not displayed in the waiting area but staff told us they would advise patients about the service. HIVE provided a range of information to patients who had relocated to the base and surrounding area. Information included resources at the unit, civilian services, including healthcare facilities.

Involvement in decisions about care and treatment

- The clinicians and staff at the practice demonstrated that they recognised when people attending the medical centre required extra guidance in making decisions about their care. 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.
- Interpretation services were available for patients who did not have English as a first language and staff knew how to access them. Staff told us that the practice leaflet had been translated into Nepalese as there was a number of Ghurkhas on camp.
- The NHS eReferral System had been integrated and was used to support patient choice as appropriate. (The NHS eReferral system is a national electronic referral service which gives patients the choice of date and time for their first outpatient appointment in a hospital).
- Data received from the patient experience survey (211 responses from 300 questionnaires distributed in August 2019) showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example:
    - 98% said that they felt involved in decisions regarding their care (1% said that this question did not apply to them).
    - 95% said that they felt listened to (4% said that this question did not apply to them).

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, these included an information leaflet for 'Combat Stress' (a 24 hour mental health helpline) and an information leaflet on women's health. We saw that information that was age appropriate and relevant to the patient demographic, prominently displayed and accessible.
- The practice acted in a compassionate way toward any patient that had to be discharged on health grounds. We saw that the practice reassured 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.
- The practice had a GP and nurse lead for carers. There was a bespoke form for patients to register as a carer and staff told us that they used the new patient registration form to identify patients who were cared for or had caring responsibilities. A code was added to their records in order to make them identifiable so that extra support or healthcare could be offered as required. The practice used different codes to highlight those patients with caring responsibilities, those who are cared for and young carers.
- The practice had produced a pack to support carers that included an emergency card and key ring for Wiltshire support services, a 'what's on' guide to events and a 'courage to care' card. Carers were recalled for the annual flu immunisation and given flexibility of appointment times. There were four patients on the carers' register. Practice staff attended monthly 'carer's café' and 'Courage to Care' meetings. Courage to Care is a programme delivered by Carer Support Wiltshire to support military carers and their families.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect. For example, a slip was available at the reception desk to request an appointment for a potentially sensitive reason such as a sexual health concern or a concern about mental health. This slip included a box that could be ticked to request a private conversation with a clinician.
- The layout of the reception area promoted confidentiality of conversations at the reception desk. Telephone calls were answered away from the front desk and seating areas were separate to the reception area and out of earshot.
- Privacy curtains in treatment rooms provided screening.

Are services responsive to people's needs? | Good

We rated the practice as good for providing responsive services

Responding to and meeting people's needs

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. For example, the patient information leaflet and sexual health information leaflets had been translated into Nepali as there was a large number of Gurkhas on the camp.

- An access audit as defined in the Equality Act 2010 had been completed in June 2019 on return to the refurbished premises. The audit reported good access and facilities and this was evident when walking round the building during the inspection; for example, there was an automatic door at the main entrance and adapted toilets. The audit identified that there was no hearing induction loop, this had been approved as an addition as part of the refurbishment.
- The practice stated that they provided a home visiting service at the discretion of the SMO. In the event of a patient being too ill to attend the surgery, the request would be assessed by a doctor to grade the urgency. This was not detailed in the practice leaflet.
- Where military personnel were signed off from work for health reasons, the medical centre ensured that line managers were informed about any downgraded activities for safety reasons. This ensured that Chain of Command had a clear idea of which tasks personnel could safely undertake.

Timely access to care and treatment

- Access to routine appointments was good. A patient who rang in on the day of our inspection could have accessed a same day appointment with a GP or a nurse if their need was urgent. The number of patients not attending for appointments was monitored by the regimental aid post (RAP) sergeants and reported to the chain of command. Specialist medicals (such as boxing and sports diving) were conducted on request and were available within three working days. Increased medical appointments were made available to accommodate a larger influx of patients; for example, in the run up to the annual regimental boxing championship.
- Patients needing to access the PCRF could self-refer through the direct access physiotherapy service (DAPS). The wait time was within the key performance indicator (KPI) of 10 days.
- Outside of routine clinic hours, a duty nurse provided emergency cover on week days up until 18:30. From 18:30 hours, patients were diverted to the NHS 111 service. In this way, the practice ensured that patients could directly access a GP between the hours of 08:00 and 18:30, in line with DPHC's arrangement with NHS England.
- To reduce the need to travel, patients were offered a telephone consultation. This was used for specific requirements; for example, to advise patients who may have an infectious disease and to follow up patients recently discharged from hospital.
- There was clear instruction in the entrance area and in the practice leaflet advising patients of the opening hours and the numbers to call outside opening hours. This included contact numbers for the local accident and emergency (A&E) department and for the nearest walk-in centre. The nearest A&E department was located in Salisbury District Hospital (approximately 35 minutes by car).
- The telephone system at the practice was not fit for purpose. There was only one incoming telephone line for approximately 10,000 patients to speak to a receptionist. A business case for a new system had been submitted to regional headquarters and a generic reception email address created for patients.
- Results from the practice's patient experience survey showed that patient satisfaction levels with access to care and treatment were generally high. For example, results from August 2019 showed:
    - 97% of patients said that they could access an appointment at a convenient time.
    - 98% of patients said that their appointment was in a convenient location.

- Most comments related to access made in the CQC comments cards were positive.

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.
- The practice manager was the designated responsible person who handled all complaints in the practice. Verbal complaints were recorded and managed through the same process as written complaints. A complaints tracker was maintained to record each stage of the process.
- We saw that information was available to help patients understand the complaints system. A prominent poster that detailed the policy was displayed in the practice waiting area alongside a complaint form.
- We reviewed the three complaints that had been submitted by patients in the past 12 months. We saw that there were processes in place to share learning from complaints. There was a theme identified of complaints about staff attitude identified through a recent audit (November 2019) and actions to address the issues were planned for discussion.

Are services well-led?	Requires improvement

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

Leadership capacity and capability

The practice had been through a period of time in which patient numbers had increased significantly through rebasing of serving personnel and the closure of a local NHS GP practice (in July 2019) where some military families were registered. The leadership team, that included the regional clinical director, told us how the practice had recently been through a difficult period with a significant increase in patients and delayed recruitment to meet the new demand. Most of the difficulties experienced had been actioned and plans to make further improvement were in place although some were dependent on a major refurbishment of the building scheduled for 2020.

- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. It was clear that the practice team enjoyed working together and staff told us that their team ethos was supportive and inclusive.
- The practice had forged links with local NHS services and worked collaboratively with nearby military medical centres.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values built around the mission statement, ‘DPHC will deliver a unified, safe, efficient and accountable primary healthcare and dental care services for entitled personnel to maximise their health and to deliver personnel medically fit for operations.’ The practice had a realistic strategy and supporting business plans to achieve their priorities.
- The practice had their own practice ethos:

- ‘Our practice is committed to providing a high quality, comprehensive, cost effective and continuing service to patients, including the use of effective and economic prescribing methods and referrals to secondary care and diagnostic tests.’
- ‘To achieve this aim we must undertake self-assessments that encourage the whole primary care team to reflect on performance and encourage a positive learning culture within the practice.’

- The medical centre planned its services to meet the needs of the practice population. For example, the practice used links with local NHS services to arrange outreach clinics at the base.
- The medical centre produced management action plans and monitored progress against delivery of the strategy.

Culture

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

- Both formal and informal opportunities were in place so staff could contribute their views and ideas about how to develop the practice.
- 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 could do this anonymously if they wished, but all staff we spoke with said that they were happy to raise issues directly with manager and leaders. They had confidence that these would be addressed and spoke of a no-blame culture within the practice.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. Staff annual appraisals had been completed or were planned. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were given protected time for professional development and evaluation of their clinical work.
- The practice had sought staff feedback through a survey. From the 16 responses, eight staff reported that they felt valued at work and six mostly felt supported.
- The practice actively promoted equality and diversity and staff had received training in this area.
- The practice demonstrated a patient-centred focus and staff understood the specific needs of the population. For example, appointments were available for families and children outside of core school hours.

Governance arrangements

There was an overarching governance framework in place which supported the delivery of good quality care. The increase in personnel to manage the increased patient list meant that the governance arrangements were being finalised but there were some gaps around the medicines management, referral tracking and management of alerts.

- There was a clear staffing structure in place and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. Terms of reference were

in place to support job roles, including staff who had lead roles for specific areas. Most were current but a small number required updating.

- There was a programme of regular meetings that extended to include all staff. These included a heads of department team meeting (held weekly), practice governance and practice team meetings (held monthly). Minutes of meetings were recorded and made available to those unable to attend. The practice did not routinely hold multidisciplinary team meetings as they considered the practice too large and the staffing levels insufficient partly due to the frequency of military clinicians being away and therefore unable to attend. The practice had written a SOP that allowed clinicians to request a meeting when a coordinated approach was required to further manage a patient.
- The practice worked to regional health governance (HG) workbook, a system that brings together a comprehensive range of governance activities, including the risk register, significant events tracker, lessons learnt log, training register, policies, meetings, quality improvement and audit. The practice was subject to a regional health governance visit in 2016, there was no record of the report. The PCRF had been visited in July 2018 and was graded overall as substantial assurance (minor weaknesses identified). An action plan had been completed.
- The PCRF delivered rehabilitation services within the same building. Discussions with staff and minutes of meetings highlighted that governance systems were integrated with the wider practice.
- Practice leaders had established a number of policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

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

- There were effective processes to identify, understand, monitor and address current and future risks including risks to patient safety. Risk to the service were well recognised, logged on the risk register and kept under scrutiny through regular review at the governance meetings.
- Processes were in place to monitor national and local safety alerts, incidents, and complaints. However, the system required strengthening to ensure timely action was taken to establish and mitigate any risk of harm.
- Practice leaders had oversight of national and local safety alerts, incidents, and complaints.
- A programme of clinical audit resulted in a positive impact on quality of care and outcomes for patients. However, repeat cycle audits were not always identical making them unclear when compared to the benchmark.
- The practice had plans in place and had trained staff for major incidents.

Appropriate and accurate information

Information was used to monitor performance and the delivery of quality care. The practice used information from the Common Assessment Framework (CAF) and Health Governance Assurance Visit (HGAV) to formulate an extensive action plan to address areas of improvement.

- An understanding of the performance of the practice was maintained. The practice manager used the CAF as an effective governance tool. Practice meetings were held regularly and were used as an additional governance communication tool. Learning needs were discussed at practice meetings and appropriate training was requested and delivered through this forum.

This provided an opportunity for staff to learn about how the performance of the practice could be improved and how each staff member could contribute to those improvements.

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

Engagement with patients, the public, staff and external partners

The practice involved patients, staff and internal partners to influence its services.

- Patients were encouraged to feed back their views on the way care was delivered to them. We saw that quarterly patient surveys had led to improved delivery of care to patients and a suggestion box located in the patient waiting area enabled feedback to be made anonymously.
- The practice produced a 'you said, we did' board to inform patients of actions that resulted from feedback. For example, patients fed back that they experienced problems when contacting the practice by telephone. In response, a business case had been submitted for a new telephone system. In the interim, the first line call answering had been moved to the rear of the reception area to improve confidentiality and allow reception staff to provide a better service at the front desk.
- Six staff members attended a CAMEO (come and meet everyone) event in September 2019. These events were arranged by the Army Welfare Service (AWS) as part of their community engagement. The practice used the opportunity to meet new patients and provide information on the medical services provided.
- The practice had developed strong links with local NHS services. For example, the Salisbury sexual health team provided clinics from the medical centre and a collaboration with Public Health Wiltshire gave patients direct access to the diabetes service.
- Effective engagement with unit command, welfare support services, local military services and DPHC.
- The practice had sought staff feedback through a survey. However, only 16 responses were gained, 50% of staff reported that they felt valued at work and 38% mostly felt supported. An away day had been planned to develop team building and identify solutions.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

- A domestic violence and abuse policy had been drawn up by the safeguarding lead. This included risk factors, management of suspected abuse and contact numbers. Barcode stickers were available throughout the practice to be used as a discrete method of providing the 24 hour domestic abuse helpline number to patients.
- In February 2019, the practice implemented a diabetes prevention programme to proactively manage those patients identified at high risk of developing type two diabetes.
- A confidentiality card was used at the reception desk to allow sensitive information to be communicated with discretion and privacy.
- A 'Transgender Healthcare Protocol' introduced in October 2019 provided education and guidance to practice staff on referral pathways, long-term prescribing of hormones, updating of

medical records to reflect a change in gender (including acceptable terminology) and screening recommendations.

- The practice made use of internal and external reviews of incidents and complaints. Learning was used to make improvements.
- The PCRF had their own programme of quality improvement work that included patient experience surveys, evaluations on specific clinical cohorts such as patients who presented exercise induced leg pain, and a project to review if best practice guidelines had been following when referring patients to the PCRF.