Wittering Medical Healthcare Facility

Quality report

RAF Wittering
Peterborough
PE8 6HB

Date of inspection visit:
20 January 2020 and 28 January 2020

Date of publication:
3 March 2020

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

Ratings

Overall rating for this service	Requires improvement
Are services safe?	Requires improvement
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

This practice is rated as requires improvement overall.

The key questions are rated as:

Are services safe? – requires improvement
Are services effective? – requires improvement
Are services caring? – good
Are services responsive? – good
Are services well-led? – requires improvement

We carried out an announced comprehensive inspection at Wittering Medical Healthcare Facility on 20 January 2020. We returned to inspect the PCRF (primary care rehabilitation facility) on 28 January as physiotherapy staff were not available on 20 January. Defence Medical Services (DMS) are not registered with the 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 learned from them.
- Risk was generally well managed, although there were some gaps.
- The practice fostered an ethos of patient centred care.
- Staff involved and treated patients with compassion, kindness, dignity and respect. However there had been occasions when patient choice had not been taken into account.
- The medical centre had identified inaccuracies around clinical searches within the patient records system and regularly reviewed patient registers to ensure that patients with long term conditions were monitored in an effective and timely way.
- We found instances where some care and treatment had not been delivered in accordance with evidence- based guidelines.
- Patients found the appointment system easy to use and experienced minimal waits to see clinicians, including rehabilitation services.
- A broad programme of quality improvement work was in place and achieved improved outcomes for some patients.
- Medicines management was in line with national guidelines.
- Complaints had been managed in line with DMS policy, although significant themes had not been dealt with adequately in order to improve the service delivered.

We saw areas of notable practice:

- The Musculoskeletal Health Questionnaire (MSK-HQ) had been used to assess outcomes in patients with a variety of musculoskeletal conditions. Results indicated 100% compliance with MSK-HQ at admission and discharge with an overall trend of improving outcomes. 75% of

patients had improved for one therapist and 100% for another, with those patients not improving being appropriately referred on.

- It was identified by PCRF staff that compliance with rehabilitation was an issue due to patients not engaging and line managers not releasing patients. An audit was conducted to confirm this. Changes were then made to place greater organisational commitment on patients' recovery. Alongside this, patients and line managers signed a rehabilitation contract agreeing to attend at least one session a week. A re-audit was completed identifying an improvement in compliance. Coupled with the MSK-HQ audit above, this demonstrated an approach which was truly focussed on delivering improved outcomes for patients.

The Chief Inspector recommends:

- Ensure that information of concern relating to the vulnerable patient is fully captured (including where this information is provided by another stakeholder) and place an alert on the patient's medical record.
- Ensure that PSDs are implemented and authorised in line with national guidelines.
- Cleaning arrangements for the gymnasium where patients attend exercise rehabilitation sessions require improvement. Gym equipment should be safety checked and the broken boiler addressed in order that rehabilitation sessions can be delivered in a safe and comfortable environment.
- Ensure that established lone working guidelines for staff are being used in practice.
- Widen peer review of medical records to ensure that national best practice guidance is adhered to.
- Ensure that themes emerging from complaints act as a driver to improve quality of care.

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 inspector**.** The team included a GP specialist adviser, a CQC national GP advisor, a practice nurse specialist adviser, a practice manager adviser, a medicines team inspector, a PCRF (primary care rehabilitation facility) advisor and an ERI (exercise rehabilitation instructor) advisor.

Background to Wittering Medical Healthcare Facility

Wittering Medical Healthcare Facility is located near Peterborough. The treatment facility offers care to forces personnel and also a number of dependants, including children. At the time of inspection, the patient list was approximately 1600 (including 583 dependants).

In addition to routine GP services, the treatment facility offers physiotherapy services and travel advice. The medical centre does not provide minor surgery. Family planning and sexual health advice is available, with referral onwards to NHS community services. Maternity and midwifery services are provided between the GPs, local NHS hospital and community teams.

The staff team

Position	Numbers
Senior Medical Officer (SMO)	One
Deputy Senior Medical Officer (DSMO)	One

Civilian medical practitioners (CMP)	One FT and one PT
Senior practice nurse	One in post and one deployed
Practice nurse Band 6	One
Practice manager (PM)	One
Deputy practice manager	One
Administrative staff	Four plus one gapped post
PCRF	Two physiotherapists One exercise rehabilitation instructor (ERI)
RAF Medics	Eleven
Pharmacy technicians	Two

Are services safe? | Requires improvement

We rated the practice as requires improvement for providing safe services.

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.
- Staff we spoke with were aware of the system to highlight vulnerable patients in clinical records and clinical staff could point us to a risk register of vulnerable patients. Alerts were being used within the electronic patient records system to highlight the needs of patients. We noted that, in one instance, information provided by another agency had been noted but an alert had not been added to the patient's record. The risk was mitigated before we left the facility on the day of this inspection.
- The practice worked with other agencies to support both vulnerable adults and children 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. There were regular meetings with welfare teams, health visitors and Chain of Command to discuss the needs of the population group. We spoke with the Padre as part of this inspection, who described strong and effective communications across the medical facility and key stakeholders.
- All staff received up-to-date safeguarding and safety training appropriate to their role. All clinicians working with children 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 practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (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).
- There was an effective system to manage infection prevention and control. Cleaning services were provided by a contracted third party. Issues with regard to the standard of cleaning provided had been noted and discussed with the contractor and an issues log was in place. We particularly noted that standards of cleanliness within the gymnasium (The PCRF does not have

its own gym facility but uses a station gym facility which has a designated ERI room with DMICP access) were inadequate.

- There were systems for safely managing healthcare waste.
- The practice ensured that facilities and equipment were safe within the medical centre and that equipment was maintained according to manufacturers' instructions.
- The gym equipment belonged to the station gym and were not DPHC assets. The Physical Education Flight on station were responsible for maintaining the facility and equipment. However the equipment within the gymnasium (where patients undertook exercise rehabilitation work) had not been safety checked. Records were sent to us post inspection which showed that checks were overdue by a month. The service contract had expired and had not been renewed. The boiler was not working and so the gym felt cold. We saw evidence post inspection that medical centre staff had escalated this issue on several occasions to station infrastructure personnel. We were informed that after our inspection, the gymnasium had been closed to patients whilst equipment was safety checked and the boiler repaired.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed. There was an effective approach to managing staff absences and for responding to epidemics, sickness, holidays and busy periods.
- There was an induction system in place for temporary staff and this was tailored to their role. We looked at recently inducted staff records and noted that records had been completed to show that staff understood what was required of them.
- Clinicians adhered to military guidance around sickness periods for personnel. They communicated effectively with Chain of Command so that line managers knew which tasks personnel could safely undertake.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with thermal injury and severe infections including sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.
- The PCRF felt cold on the date of this inspection and staff reported that the room over heats in summer. Recently an air conditioning unit had been installed in order to manage this.

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. Staff had identified that Read coding inconsistencies meant that the medical centre could not easily search for cohorts of patients to ensure best delivery of care. They had therefore undertaken additional work and, using registers for cohorts of patients with ongoing needs, they ensured that monitoring and review was carried out effectively and in a timely way.
- The system to manage hospital letters was effective. Hospital letters were scanned and tasked to a clinician for their review. The system to manage pathology results was effective.

- There was no significant backlog in electronic summarising at the practice. Summarising was undertaken by clinicians.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. There was a documented approach to the management of test results.
- Referrals and hospital appointments were managed well by the administrative team and patients were well supported to obtain the most timely access to secondary care. A standard referral template letter was in use by clinicians and there had been a recent audit which concluded that there was scope for referrals letters to be written in a more effective way.
- Access to clinical records in DMICP was sometimes delayed due to connection issues or power outage. Most recently staff had been unable to access DMICP for several hours in December 2019. However, staff did not report any significant periods where they had had no ongoing access to the system. The medical centre had created a form to capture essential clinical information for patients which allowed consultations to go ahead in the event of no access to DMICP. This form had been adopted at other practices in the area.

Safe and appropriate use of medicines

The practice had systems which were appropriate and safe for handling of medicines.

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. However improvement was required in relation to the safe storage of controlled drugs. The practice had carried out an appropriate risk assessment to identify medicines that it should stock. The practice kept prescription stationery securely and monitored its use. The medical centre held controlled drugs on site, but the cabinet was not compliant with 'misuse of drugs' regulations. A new cabinet had been purchased which was compliant with requirements, but this had not yet been fixed to the wall. Access to the dispensary was restricted to authorised staff only and vaccines were stored in locked fridges.
- There was a named GP responsible for the dispensary. Arrangements for dispensing medicines at the practice kept patients safe. Written procedures (SOPs) were in place to support safe dispensing practice. There was a system for staff to record that they had read and understood them. Controlled drugs were checked by a second person when dispensed, although there was scope to record this in the BMED12. Controlled drugs were denatured and disposed of by the pharmacy staff. However there was no T28 exemption in place (The T28 exemption allows pharmacies and similar places to denature controlled drugs to comply with Misuse of Drugs Regulations 2001). Action was taken on the day of our inspection to address this oversight.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. There was a register of patients taking high risk drugs and alerts were in place in DMICP records. Staff we spoke with were aware of the Defence Primary Health Care (DPHC) DMARDs policy. Where appropriate, patients who took DMARDs (disease-modifying anti rheumatic drugs) had shared care protocols uploaded into their notes and recall dates had been set for blood testing.
- Prescriptions were signed before medicines were dispensed and handed out to patients. Requests for repeat prescriptions were only accepted in writing and never over the phone.
- Limited PGDs (Patient Group Directions) and PSDs (Patient Specific Directions) were in use to allow non- prescribing staff to carry out vaccinations in a safe way. A PGD we reviewed was appropriately managed as staff had received training and authorisation by the DMSO had been recorded. The DMSO had authorised the PGD under the delegation arrangement in the absence and of the SMO. Authorisation for the PSD in place was not in line with policy as the wrong form

had been used and there was no evidence to show that the prescriber had carried out the required clinical checks.

Track record on safety

- The practice manager was the lead for health and safety and had completed training relevant for the role. Risk assessments were in place including needle stick injury, lifting and handling, legionella management and lone working. Whilst a lone working arrangement was in place to ensure staff safety and this was being followed in practice for RAF medics, it was not being followed with regard to the ERI.
- The band 7 physiotherapist practiced acupuncture. The written consent form included a limited list of contraindicated conditions requesting patients are to notify the therapist if any applied. However there was no comprehensive screen for all contraindicated conditions or health screen completed as recommended by the AACP (Acupuncture Association of Chartered Physiotherapists). A standard operating procedure and risk assessment governing acupuncture were in place.
- Alarms were in place in treatment and consultation rooms and were tested on a weekly basis. One room did not have a fixed alarm and in this case, a personal alarm was in place. Staff told us about instances where they had successfully used the alarm to attract attention. There was no emergency alarm in the Collywestern gym (where the exercise rehabilitation instructor worked with patients). There was a phone in the gym but no emergency phone numbers on display by the phone.
- We reviewed the major incident plan in place to guide a response in the event of multiple casualties. This included guidance around who would be accountable for which tasks in the event of an incident and when to request NHS resource.
- The PCRF was located centrally within the medical centre within easy access of additional medical support and the crash trolley which was located in the hallway. The physiotherapist signed out an anaphylaxis kit from pharmacy whenever he performed an injection. Oxygen was located in the PCRF and an emergency alarm rang through to admin office which had been tested regularly.

Lessons learned and improvements made

There was a system for delivering learning and making improvements when things go wrong.

- There was a system and policy for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so. All staff (including locums) had a login for the ASER system and so could report incidents.
- There were systems for reviewing and investigating when things went wrong. There was evidence that the practice learned and shared lessons, identified themes and took action to improve safety in the practice. Staff could recall the learning from some recent significant events and they told us that issues were discussed on a weekly basis and then in more detail at monthly practice meetings. A log of significant events was maintained, although not all outcomes had been completed.
- There was a formal system for receiving and acting on patient safety alerts. CAS (Central Alerting System) alerts were routinely forwarded to clinicians for their review and action and read receipts were in place. Recording in relation to action taken was comprehensive. Staff confirmed that alerts and updates were discussed at clinical development meetings, although there was scope to specifically indicate what was discussed in meeting minutes.

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) best practice guidelines. Whilst staff had access to guidelines from NICE, we saw instances where these were not being followed to deliver care and treatment that met patients' needs. Clinical meetings had been held and minutes contained a record of discussion of best practice guidance. However concerns we found during our review of patient consultations indicated that these discussions were not always leading to improvements in clinical practice. Review of medical records had been undertaken recently by clinical leaders at the medical centre and this had uncovered some concerns. These concerns had been dealt with in line with DMS policy. However our review of records on the day of the inspection revealed similar concerns, meaning that patients were not always receiving the most appropriate or effective care.
- 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.

Monitoring care and treatment

Management, monitoring and improving outcomes for people:

- 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.
- The practice provided the following patient outcomes data to us from their computer system on the day of the inspection:
- There were seven 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 six of these diabetic patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. The other patient was very recently diagnosed. For all diabetic patients, the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control. We noted that a pre-diabetic patient had not been Read coded as such and so there was potential that this patient would not be picked up for follow-up care. This issue was rectified the day after our inspection.
- There were 43 patients recorded as having high blood pressure and 42 patients had a record for their blood pressure taken in the past nine months. 42 of these patients had a blood pressure reading of 150/90 or less. We reviewed the treatment and care offered to these patients and found that current NICE guidance had been followed.
- There were 34 patients with a diagnosis of asthma. 28 of these asthmatic patients were showing as having had an asthma review in the preceding 12 months which included an assessment of asthma control using the three Royal College of Physicians questions. We reviewed the records for the six patients who had not attended a review and saw that the medical centre had made repeated efforts to actively engage with these patients. We looked at the clinical template in use

for asthmatic care and saw that this was used consistently and included prompts for immunisations.

- We reviewed three patients with anxiety and depression. In one case, the patient had not been fully assessed, downgraded or referred for additional assessment in line with DPHC guidelines.
- We reviewed a number of consultations which took place in the two weeks prior to this inspection. In several instances, we were concerned that appropriate examinations had not taken place and inadequate medical history had been taken. On two occasions referrals had not been made and on two occasions screening had not been pursued. We escalated these concerns to the SMO, RCD (Regional Clinical Director) and DMSR and were told that action was taken to re-review patients where appropriate.
- We spoke with 16 patients who had recently received care from the medical centre (including the PCRF). Most told us that they had received effective and appropriate care. However one patient told us that they were concerned that they had not received a physical examination when they attended a consultation with a clinician in the past.
- The Musculoskeletal Health Questionnaire (MSK-HQ) had been used to assess outcomes in patients with a variety of musculoskeletal conditions. Results indicated 100% compliance with MSK-HQ at admission and discharge with an overall trend of improving outcomes. 75% of patients had improved for one therapist and 100% for another, with those patients not improving being appropriately referred on.
- The patient survey asked patients using the PCRF to state whether they were content with the treatment received and clinical outcomes. 95% reported the PCRF was very good and 5% good.

Information from the Force Protection Dashboard, which uses statistics and data collected from military primary health care facilities, was also used to gauge performance. Data from the Force Protection Dashboard showed that instance of audiometric hearing assessment was slightly below average compared to DPHC practices nationally. 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). Data from May 2018 showed:

- 88% of patients' audiometric assessments were in date (as at December 2019). We conducted a search on the day of our inspection to ensure that recording within DMICP married with information held within JMES (Joint Medical Employment Standard: a means of communicating personnel's employability). We saw that where the JMES was complete for the HCP (Hearing Conservation Programme), this tallied with DMICP to show that an audiology test had actually been undertaken for the patient.
- There was evidence of a broad programme of quality improvement work including clinical audit, and this had led to improved outcomes for some patients:
- An internal quality assurance tool, the Defence Medical Services (DMS) Common Assurance Framework (CAF) was used to monitor safety and performance. The DMS CAF was formally introduced in September 2009 and since that time has been the standard healthcare governance assurance tool utilised by DMS practices to assure the standards of health care delivery within DMS. An HGAV (Healthcare Governance Assurance Visit) was undertaken in April 2019 and Wittering Healthcare Facility was given 'full assurance'.
- A broad programme of clinical audit work had been undertaken and was delivering improvements for some patients. A nurse lead had been appointed and audits covered both clinical and administrative concerns. PCRF staff were also involved and delivered their own audit work. Test results management audits had been delivered in a cyclical way across recent years and staff could demonstrate how they had identified and subsequently rectified an issue with communicating results to patients in a timely way. An NSAID (Nonsteroidal anti-inflammatory

drugs) audit in November 2019 identified the need for some patients to be called in for a blood test. Audits of diabetic and asthmatic care had led to improvements in Read coding and increased awareness around achievement of QOF indicators. Recently referral letters were audited to assess the quality of letters sent to hospital specialists by medical centre clinicians with regard to conveying essential clinical information effectively. The audit concluded improvements were required and that re-education of clinicians was recommended and was being planned at the time of this inspection.

- Audit work was conducted within the PCRF. This included audit of the documentation of injection therapy. Consent was found to be captured comprehensively, alongside documentation of injection and anaphylaxis risks. However the audit was conducted by the practitioner who administers the injections and so findings were not independent. A low back pain audit was completed in September 19 and prior to this in 2018. It compared performance against the best practice guidelines. However, the audit was comparing to old guidelines (as used in their 2018 audit) and not the updated guidance. An access audit was completed in order to review the demographics of the population treated in the PCRF as they believed it was changing. This identified 15% of patients accessed the PCRF via self-referral and 85% via referral. It also identified most common injuries treated and that the age group of patients treated was increasing. This helped to make them aware of changing pathologies and likelihood of increased timescales for treatment.
- The last antibiotic prescribing audit was undertaken in December 2019 and showed that 76% of antibiotics prescribing was appropriate (23/27 clinically justified). This shows that some improvement in this area was required. Staff told us that the results and action needed would be discussed at the next practice meeting.
- It was identified by PCRF staff that compliance with rehabilitation was an issue due to patients not engaging and line managers not releasing patients. An audit was conducted to confirm this. Changes were then made to ensure organisational support for patients. As part of this, patients and line managers signed a rehabilitation contract agreeing to attend at least one session a week. A re-audit was completed identifying an improvement in compliance and therefore potentially outcomes for patients.

Effective staffing

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

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff confirmed that all mandatory training was up to date.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, mentoring, clinical supervision and support for revalidation.
- Continuing professional development around acupuncture was maintained via update courses and the regional annual acupuncture group.
- Clinicians confirmed that periodic review of medical records took place with nurses, physiotherapists and medics reviewing one another's consultation records and Read coding and doctors doing the same. Given the concerns we found during our review of medical records, we were not reassured that this peer review of records was consistently delivering improvements for patients.

Coordinating care and treatment

Staff worked well together and with some other care professionals to deliver effective care and treatment. However, there were gaps.

- There are plans for the incoming SMO to attend Unit Healthcare and Welfare Meetings going forward. Units are accountable for sharing formal minutes but to date these had not been produced. The medical centre was arranging for these to be maintained in future. Consent forms have recently been issued to patients who welfare teams and line managers plan to discuss. Staff told us that they had forged some strong links with other stakeholders, including SAFFA, the Padre, Cambridgeshire and Peterborough Public Health Initiative, local sexual health services and local NHS Accident and Emergency departments (to facilitate protection plans when required). There was a nominated Link worker at DCMH for staff to liaise with. A psychologist and a health visitor regularly visited the medical centre.
- The Medical Centre is located within the same building as the PCRF service which provides physiotherapy assessment and treatment. An exercise rehabilitation service was also available for patients, a half mile walk from the medical centre. 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.
- PCRF staff reported good relationships within the medical centre and outlined regular daily communication. Formal meetings also took place where the PCRF team communicated regarding patients with the doctors. There were various team meetings to share medical centre business including practice meetings and trade training.
- The exercise rehabilitation instructor delivered graded exercise rehabilitation, progressing patients appropriately on a one to one basis. They used a walk run programme to return to running. Exercise sheets were used or Rehab guru depending on the injury and exercise given. When rehab guru was used the prescription code was entered on DMICP. This allowed good inter-operability between RRU and PCRF as they could view each other's programmes allowing for better continuity of care across the rehabilitation pathway.

Helping patients to live healthier lives

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

- Patients at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. The medical centre liaised with the Cambridgeshire and Peterborough Diabetes Prevention Programme and referred pre-diabetic patients to a tailored nine month programme for diet and exercise support.
- The PCRF team reported that they see a high proportion of patients with anxiety and depression which can impact on their injury and rehabilitation. The physiotherapist attended a mindfulness course which he had found useful to use with patients to ensure their wellbeing and mental health was also considered alongside physical injury. They also recommended the headspace app for use by patients. The PCRF used screening questionnaires such as GAD-7 and PHQ9 to screen for issues and they also had good links with the station Padre.
- The practice offered basic sexual health advice including the issue of free condoms and chlamydia test kits and referred on to local clinics in the community for more comprehensive services including family planning. Whilst no staff currently working in the Wittering medical centre were STIF (sexually transmitted infection foundation) trained, patients could access both

a GP and a nurse at nearby Cottesmore medical centre who had attended the training. 24 hour support was available, seven days a week. Referral and liaison with a military sexual health consultant in Birmingham was available.

- Medical centre staff attended unit open days and manned stalls to provide health promotion information to personnel.
- 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 screening programme. Abdominal aortic aneurysm (AAA) screening was not routinely promoted based on the age of a patient, but patients with increased risk were offered screening.
- 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 235 out of 259 eligible women. This represented an achievement of 91%. 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.

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It is important that military personnel have sufficient immunity against the risk of contracting certain diseases. The World Health Organisation sets a target of 95% for vaccination against diphtheria, tetanus, pertussis and polio and measles, mumps and rubella. The data below from December 2019 provides vaccination data for patients using this practice:

- 98% of patients were recorded as being up to date with vaccination against diphtheria
- 98% of patients were recorded as being up to date with vaccination against polio
- 97% of patients were recorded as being up to date with vaccination against Hepatitis B
- 97% of patients were recorded as being up to date with vaccination against Hepatitis A
- 98% of patients were recorded as being up to date with vaccination against Tetanus
- 74% of patients were recorded as being up to date for the MMR vaccination

Child Immunisation

The practice had a system in place to contact the parents or guardians of children who were due to have childhood immunisations. The practice has exceeded the WHO based national target of 95% (the recommended standard for achieving herd immunity) for three childhood immunisation uptake indicators. For the one indicator where the national target was unmet, the practice could explain that this was down to awaiting essential information about two children's vaccination history. Results are below:

Child Immunisation	**Practice %**	**Comparison to WHO target of 95%**
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB)	92%	WHO target not met. Practice taking appropriate action.
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster)	100%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster)	100%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR)	100%	Met 95% WHO based target

Consent to care and treatment

- Staff sought patients' consent to care and treatment in line with legislation and guidance. Verbal consent was recorded in DMICP in a free text box. PCRF staff took written consent for acupuncture procedures.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Training was last provided to staff in June 2019.
- When providing care and treatment for children, staff carried out assessments of capacity to consent in line with relevant guidance.

Are services caring? | Good

We rated the practice as requires improvement for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff explained that they sometime saw patients who spoke English as a second language. They could access a translation service if they needed it. Staff told us about a recent instance where 'The Big Word' was used to provide a translation service during consultation.
- 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.
- We received 81 patient Care Quality Commission comment cards in total. These were almost entirely positive about the service experienced. Patients praised the demeanour and attitude of several clinicians and stated that their needs had been met and, at times, exceeded.
- 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

- Staff supported younger people to access the treatment they required in an appropriate way. Children were only seen by GPs for examination and assessment and told us how they presented information to them in a way that they could understand. We spoke with patients who were attending for physiotherapy appointments and they told us that they were well supported to understand their injury, to set realistic personal goals and to commit to their care plan in order to achieve best results in terms of their recovery.
- The Choose and Book service had been implemented and was used to support patient choice as appropriate. (Choose and Book is a national electronic referral service which gives patients the choice of date and time for their first outpatient appointment in a hospital).
- Results from the practice's Patient Experience Survey (50 responses were collated) showed patients felt they were involved in their treatment:
- 100% of patients said they felt involved in decisions about their care.
- 92% of patients said they would recommend the medical centre to others. Four patients did not answer this question.

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

- 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 spot 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. Leaders explained how they took care to ensure that the healthcare records for these patients were shared promptly and comprehensively to NHS services.
- Practice staff identified patients who were also carers. The practice sent letters to all patients who were cared for and attached a carer referral form. They also sent letters to patients who could be undertaking a caring role to invite them to consider benefits they might be entitled to and to access additional support. Codes were added to their records in order to make them identifiable and so that extra support or healthcare could be offered as required.

Privacy and dignity

Patients' privacy and dignity and was not always respected.

- We reviewed the care record for a patient who had requested not to see a specific clinician. An alert popped up to state the patient's preference when we viewed the record. We saw that the patient had been given an appointment with that clinician. Staff informed us that the patient had agreed to see the clinician. We noted that the clinician had then annotated in the notes that when they consulted with the patient, they had spoken with the patient about their request not to be seen by them. This did not protect the rights of the patient to make choices about their care provision and also breached their privacy rights. A protocol was in place to guide reception staff to add patient requests, should they not wish to see a certain clinician. The patient was not obliged to give a reason and the protocol requested that patients should be signposted to the complaints policy. However in this instance the practice had been unable to deliver an appointment in line with the patient's wishes.
- The practice had identified the fact that conversations with receptionists could be overheard by patients in the waiting room, due to the open plan nature of the waiting area. Reception staff could take patients to a separate area if they were upset or requested a private conversation.
- In the PCRF space, curtains separated patients who were being assessed and treated. This meant that conversations could be overheard. A private treatment room was available and was offered for more sensitive issues or on request by the patient. A radio was used to partially screen conversations. This risk was recorded on the risk register. The PCRF conducted a patient survey between April and October 2019 and 90% of respondents stated that were content with the privacy arrangements. 10% were happy to some extent.

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 facilities and premises were bespoke and appropriate for the services delivered.
- A duty clinic was in place which provided after school appointments for school children. Appointment slots for aircrew were available and well woman clinics were provided flexibly as required. The Facebook Patient Participation Group (PPG) had been used to inform changes to clinics.
- The nursing team had produced a Facebook VLOG (Video log) to support patients with healthy alcohol intake.
- An access audit (as defined in the Equality Act 2010) had been completed in August 2019. It was identified that the disabled WC did not have a panic/safety alarm installed and this was added to the action plan.
- The medical centre had carried out a diversity audit in October 2019 which sought to ensure that services provided were fair and equally accessible to everyone. A transgender policy was 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.
- 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. No recent home visits had been undertaken.
- The physiotherapist reported that a patient made a comment that equipment was lacking in the gym including a bosu board and mats. The PCRF ordered the additional equipment following the feedback. The equipment was viewed in the gym on the inspection.

Timely access to care and treatment

- Routine appointments are usually available within two weeks. We checked on the day of our inspection and the next available routine appointment was in eight days. Urgent appointments are available on the same day. The wait to see a physiotherapist on the day of our inspection was nine days and patients could see a nurse the following day. Patients requiring an Annual Aircrew Medical with an Aviation Medical Officer could secure one within two weeks. Administrative staff had audited patients who failed to attend for their appointments (which averaged 35 per month). There was an improvement in performance where text reminders had been sent.
- Outside of routine clinic hours, patients were signposted to the 111 OOH service. If the practice closed for an afternoon for training purposes, patients were diverted to a local medical centre. 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 NHSE.
- The practice leaflet gave clear directions on local accident and emergency unit access. The nearest accident and emergency department was located at Peterborough City Hospital.
- On the inspection day, the wait to see a physiotherapist for a routine appointment was seven working days. Follow-up and urgent appointments were available in five working days. The wait for a new patient to see an ERI was five working days and for a follow-up appointment, just one day. These waits were well within the key performance indicators set centrally.

- Results from the practice's patient experience survey (50 responses were received) showed that patient satisfaction levels with access to care and treatment were generally high. For example:
    - 96% of patients who responded said that the medical centre listened to their comments, compliments or complaints. Two patients said that this was not the case.
    - 100% of patients said that their appointment was available at a convenient time in a convenient location.
- We spoke with 16 patients who had recently received care from the medical centre (including the PCRF). They all told us that they could secure appointments when they needed them and were confident that they would be seen quickly if they had an urgent concern.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to individuals appropriately. However prompt action had not always been taken to ensure optimal care.

- Staff told us that patients had identified that they did not know how to make a complaint. In response A3 posters had been placed in the reception area and a complaints form had been attached to the registration form handed out to all new patients. Complaints cards were also available in the waiting area.
- 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.
- We spoke with sixteen patients who told us that they felt comfortable and knew how to complain if the need arose. They confirmed that military rank would not be a barrier to them raising issues with the practice.
- We reviewed complaints that had been submitted by patients in the past 12 months. We identified a common theme across a significant number of complaints which stretched back over three years. Whilst each complaint had been reviewed and a response provided to the patient, it was not clear that adequate action had been taken, given the number of complaints and particularly as similar complaints had been submitted over a three year period.

Are services well-led?	Requires improvement

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

Leadership capacity and capability

- The SMO at the medical centre had come into post a few weeks prior to the inspection and was already working hard to address some areas they had identified as requiring improvement. Some systems required additional work in order to ensure that care for patients was safe and effective. On the day of our inspection we met with a staff team who were open and transparent about the issues they needed to address. They listened to the feedback we gave and offered reassurance that risks and concerns would be addressed as a priority.
- Staff we spoke with referred to a 'good team approach' and told us that they enjoyed coming to work. All staff felt that they could raise concerns if they had them.

Vision and strategy

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

- The practice worked to the DPHC mission statement: 'To provide and commission safe and effective healthcare which meets the needs of the patient and the chain of command in order to contribute to Fighting Power'. The medical facility staff also worked to their achieve their own mission statement which was 'To support A4 Operations and provide a confidential and integrated service that is responsive to the health and welfare needs of permanent staff and entitled patients'.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The medical centre planned its services to meet the needs of the practice population.

Culture

The practice had a culture of high-quality sustainable care, but there were some gaps in the provision of safe and effective care:

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients, but more timely action was required to address themes emerging from complaints and to ensure that the personal preferences of patients were both respected and adhered to.
- We noted an ongoing concern where leaders and managers had not been successful over a significant time period in taking action to address gaps in the performance of the practice. Medical staff told us that leaders were confident and supported (both by regional teams and DPHC Headquarters) to performance manage staff, but that concerns remained. We saw that additional action had been taken very recently by the incoming SMO to escalate concerns with a view to improving service delivery.
- 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.
- There was a strong emphasis on the safety and well-being of all staff, although lone working arrangements for the ERI were not being followed.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training.

Governance arrangements

With the arrival of the new SMO, the medical centre was in the process of consolidating and clarifying responsibilities, roles and systems of accountability to support good governance and management.

- Joint working with the welfare team, pastoral support and Chain of Command was in place and there were well established systems to safeguard vulnerable personnel and to ensure co-ordinated person-centred care for these individuals.
- The PCRF delivers rehabilitation services from a building within the medical centre. The service enables patients to access timely, holistic care. Staff working within the PCRF felt integrated within the medical centre team and they contributed to improvement work to deliver the best outcomes for patients.

- Practice leaders had established a number of policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. Any gaps were mostly known and action was being taken to address them.
- A programme of clinical improvement work was in place and was driving improvements for patients.

Managing risks, issues and performance

There were clear and effective processes for managing many risks, issues and performance. Where improvement was required, staff were mostly aware and already working towards implementing solutions.

- 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 largely aware of the risks facing its staff and patients.
- Complaints were comprehensively managed and individuals were given responses when they complained. However a significant number of complaints over a prolonged period indicated a theme in performance. Staff provided evidence of action that had been taken over a three year period to address concerns raised by patients. However, on the day of our inspection, our review of care records demonstrated that this action had failed to act as a catalyst in providing patients with the most effective care.

Appropriate and accurate information

The practice held mostly appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. The views of patients were routinely sought in line with DMS policy and staff provided examples of changes this feedback had triggered.
- An understanding of the performance of the practice was maintained. The practice manager used the Common Assessment Framework (CAF) as an effective governance tool. A number of different meetings were held regularly. We saw that meetings were used for forward planning, for example, to ensure that patient needs were met during busy clinic times and periods of staff sickness. Staff regularly met together to learn from one another, discuss recent guidance changes and to review their approach in clinical settings.
- The information used to monitor performance and the delivery of quality care was accurate and useful. Staff had identified inconsistent use of Read codes and they understood how this could lead to inconsistent delivery of care for patients. Staff had received training in the use of ‘Population Manager’ which is a clinical search facility. Staff reported issues with using this search facility as they found it to be unreliable. In mitigation, staff had adopted corroborative ways of working by using patient registers which they routinely updated and cross checked.
- There were robust arrangements at the medical centre in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. This extended to the PCRF.

Continuous improvement and innovation

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

- The PCRF team reported that they saw a high proportion of patients with anxiety and depression which can impact on their injury and rehabilitation. The physiotherapist attended a mindfulness course which he had found useful to use with patients to ensure their wellbeing and mental health was also considered alongside physical injury. They also recommended the headspace app for use by patients. The PCRF used screening questionnaires such as GAD-7 and PHQ9 to screen for issues and they also had good links with the station Padre.
- It was identified by PCRF staff that compliance with rehabilitation was an issue due to patients not engaging and line managers not releasing patients. An audit was conducted to confirm this. Changes were then made to create compulsory rehabilitation sessions. Alongside this, patients and line managers signed a rehabilitation contract agreeing to attend at least one session a week. A re-audit was completed identifying an improvement in compliance and increase in attendance showing the effectiveness of the new system.
- Displays of health promotion information within the patient waiting area were particularly broad to meet the needs of different patients. This included advice and signposting to services around mental health, sexual health, health screening, immunisations, well woman and children's services.