# Woodbridge Medical Centre

## Quality report

Rock Barracks
Woodbridge
Suffolk
IP12 3TW

Date of inspection visit:
15 January 2020

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9 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, information given to us by the practice and patient feedback about the service.

## Ratings

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

# Chief Inspector's Summary

**This practice is rated as inadequate overall**

The key questions are rated as:

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

We carried out an announced comprehensive inspection of Woodbridge Medical Centre on 15 January 2020. 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. However, the Primary Care Rehabilitation Facility (PCRF) was not included as part of this inspection due to there being no specialist advisor available.

**At this inspection we found:**

- The practice leaders demonstrated they had the passion and integrity to provide a patient-focused service. However, staffing levels throughout the practice affected the capability to deliver safe and effective care.
- An inclusive team approach was supported by permanent staff who valued the opportunities available to them to be part of a patient-centred service. The service was impacted during periods of leave when there was no resilience in the system and staff belonging to the unit were unable to provide continuity.
- There was an open and transparent approach to safety. However, the systems were not fully effective and did not always extend to the locum and unit staff.
- The assessment and management of risks required strengthening to maximise the opportunity to promote a safe working environment.
- Most arrangements for managing medicines, including obtaining, prescribing, recording, handling, storing, security and disposal minimised risks to patient safety. However, there was no regular clinical oversight maintained over prescribers.
- Staff were aware of current evidence based guidance. They had received training so they were skilled and knowledgeable to deliver effective care and treatment.
- The practice worked to promote better health outcomes for patients but time limited the opportunities to adopt a more proactive approach.
- There was little evidence of quality improvement work to develop and deliver better patient outcomes.
- The practice sought feedback from staff and patients which it acted on. Feedback showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.

- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- The building and equipment were sufficient to treat patients and meet their needs. However, system outages affected the efficiency in the daily running of the practice.
- Staff were aware of the requirements of the duty of candour.

**The Chief Inspector recommends:**

- Ensure all staff have received safeguarding training appropriate to their role.
- Strengthen the arrangements for recruitment to ensure all staff have the appropriate checks carried out.
- Continue to improve the assessment and management of risks including staffing levels, training and shared learning from significant events.
- Challenges around timely access to accurate patient records occur due to outage periods in DMICP. DPHC should deliver solutions to improve access to up to date records.
- Implement a system for the summarising of patient notes.
- Further strengthen the referral tracking process to include internal referrals.
- Implement a programme of audit to drive improvements in patient outcomes.
- Strengthen the arrangements for formal supervision and continued professional development taking into account specific training needs for staff.
- Ensure that all patients are supported to identify risks that might lead them to develop poor long term health.
- Improve the provision of information and advice to support carers.
- Implement the arrangements for direct access to physiotherapy.
- Improve the arrangements in the waiting area advising patients on how to provide feedback.
- Improve the governance framework to provide an overarching framework that extends to all areas of the practice.

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

## Our inspection team

The inspection team was led by a CQC lead inspector**.** The team comprised specialist advisors including a GP, a specialist advisor from the Defence Medical Services Regulator (DMSR) and a practice manager.

## Background to the Woodbridge Medical Centre

Woodbridge Medical Centre provides a routine primary care service to a patient population of 600 service personnel. Families and dependants are signposted to nearby NHS services. There were no registered patients under the age of 18 at the time of the inspection and 69 patients aged 40 or above. The practice also provides occupational health to service personnel only.

The medical centre is not a dispensing practice and this service is outsourced to a community pharmacy in Ipswich. A Primary Care Rehabilitation Facility (PCRF) is co-located with the medical centre and provides a physiotherapy and rehabilitation service for service personnel only. However, the Primary Care Rehabilitation Facility (PCRF) was not included as part of this inspection due to there being no specialist advisor available.

The medical centre is open from 08:00 to 12:30 and 13:30 to 16:30 hours Monday to Thursday and until 12:30 on a Friday. Patients are able to attend Colchester Medical Centre up until 18:00 each week day. Outside of these hours, including weekends and bank holidays, cover is provided by NHS 111.

**The staff team**

| Position | Numbers |
|---|---|
| Senior Medical Officer (SMO) | One deployed<br><br>The SMO has been on long-term deployment overseas since August 2019 and is not due to return until May 2020. In his absence, a doctor based at Colchester is covering the role, attending the centre 3.5 days each week. |
| Civilian medical practitioners (CMP) | One |
| Civilian practice nurse | One |
| Health care assistant | One |
| Civilian practice manager | One |
| Civilian practice administrator | One |
| PCRF staff | One physiotherapist<br>One locum exercise rehabilitation instructor (ERI) |
| | |
| Regimental Combat Medical Technician (CMT) | Three (deployed until February 2020) |

## Are services safe? | Inadequate

**We rated the practice as inadequate for providing safe services.**

**Safety systems and processes**

The systems to keep patients safe and safeguarded from abuse required strengthening.

- A framework of regularly reviewed safety policies was in place and accessible to staff, including locum staff. Staff received safety information about the practice as part of their induction and refresher training.
- Measures were in place to protect patients from abuse and neglect, including a safeguarding policy which referred to vulnerable patients, but this did not distinguish adults from children. The policy included the phone number for 'Customer first' which is the local Safeguarding team

within Suffolk Social Care services. The contact details were displayed in all clinical areas and throughout the building including the waiting area and on the main entrance door.

- Doctors, the nurse and the physiotherapist had completed level 3 training in adult and child safeguarding. A safeguarding lead and deputy were identified for the practice. However, Regimental Aid Post (RAP) staff working at the practice, had not received safeguarding training and update training at a level appropriate to their role. RAP staff are clinicians who are attached to units rather than employed to work directly at the medical centre.
- A vulnerable patients register was held on the electronic patient record system (referred to as DMICP). Coding and alerts were used to highlight vulnerable patients. There was no formal process to review the register, but practice staff told us that it was updated monthly and informal discussion took place between the practice manager, safeguarding lead and civilian medical practitioner (CMP). However we found an example on the register of a patient who was no longer being seen for primary care at the practice Patient records were updated during the meeting.
- Chaperones were always clinical staff and a list of trained chaperones was available. There was no record of chaperone training provided for medics but the practice confirmed that they would not be used in the role. Notices advising patients of the chaperone service were displayed in patient areas.
- The full range of recruitment records for permanent staff was held centrally. The practice policy was to complete relevant safety checks at the point of recruitment. However, there were gaps for two staff members, a combat medical technician (CMT) and the practice administrator, where no Disclosure and Barring Service (DBS) check had been carried out. Locum arrival checks had been conducted for the three locum staff currently working in the Practice
- Arrangements were in place to monitor the registration status of clinical staff with their regulatory body and all staff had professional indemnity cover. Information was in place to confirm staff had received all the relevant vaccinations required for their role. The staff database did not have complete records for all staff but we were able to review paper records and the online locum booking system during the inspection to verify that all clinical staff were in date for professional registrations
- There was an effective process to manage infection prevention and control (IPC), including a lead and deputy lead who demonstrated the experience despite not having completed role-specific training. The staff team was up-to-date with IPC training. An independent IPC audit had been undertaken in November 2019 and no significant concerns had been identified.
- Environmental cleaning was provided by an external contractor. Cleaning schedules and monitoring arrangements were established, including cleaning before the practice opened and at lunchtime. A deep clean of the premises took place on a rolling programme that extended to all rooms. We identified no concerns with the cleanliness of the premises.
- A member of staff had the lead for the safe management of healthcare waste and an annual waste audit was carried out in July 2019. Although we were assured that waste was disposed of correctly, the practice did not have copies of all consignment notes, there was no log of the waste removed by the contractor, and waste bags were not labelled appropriately.

**Risks to patients**

There were systems to assess, monitor and manage risks to patient safety. However, staffing levels did not allow adequate cover for unforeseen circumstances such as sickness absence and resulted in undue pressure on staff.

- Staff spoke of challenges in achieving the required staffing levels and skill mix to meet the needs of the patients. There was a mix of military and civilian staff but the high levels of deployment among the military staff often left the centre with little or no support from the CMTs. This had impacted patient care, for example, the nurse had been unable to do over 40s health checks due to time constraints.
- The practice was equipped to deal with medical emergencies and staff on the database were suitably trained in emergency procedures, including staff trained in life support. However, not all staff were in date for training. An emergency kit, including a defibrillator, oxygen with masks and emergency medicines were accessible to staff in a secure area of the practice; all staff knew of its location. A first aid kit and accident book was available. Weekly and monthly checks were in place to ensure the required kit and medicines were available and in-date.
- A sepsis training course in the recognition and management of sepsis had been held in June 2019 but records showed that key clinicians had not attended. We noted a display regarding the management of pain for non-freezing cold injury was displayed on one of the notice boards and posters about sepsis were displayed throughout the practice.

**Information to deliver safe care and treatment**

There were gaps in the information needed to deliver safe care and treatment to patients.

- The care records we reviewed on DMICP showed information needed to deliver safe care and treatment was available to relevant staff. A process was established for scrutiny of patients' records, the patient completed a registration form, which was checked by the receptionist and then passed to the nurses for further checks However, there was no routine summarisation of patient notes and no routine health checks for patients aged 40 and above.
- Staff described frequent loss of connectivity with DMICP, meaning clinics could be delayed. If this happened, the business resilience plan was followed and only emergency patients were treated. The practice reverted to using handwritten notes which were then scanned onto the system. If needed, patients could be seen at Colchester Medical Centre.
- Routine referrals to external health care services, including urgent referrals, were managed by the practice administrator. They responded to requests from the doctors and booked patient appointments through the NHS e-Referral service (e-RS). If an appointment was not available based on patient availability then the administrator followed it up on behalf of the patient. Referrals were logged and monitored by the administrator. However, internal referrals to other military health services were not included.
- A standard operating procedure (SoP) informed staff how samples were to be taken safely, recorded appropriately on DMICP and results reviewed and actioned by the requesting clinician within seven days. We found that samples and results were effectively managed in accordance with the SoP.

**Safe and appropriate use of medicines**

The practice had reliable systems for the appropriate and safe handling of medicines.

- The practice nurse was the lead for medicines management. Safe procedures were in place for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment.
- Dispensary stock was checked regularly. Appropriate arrangements were established for the safety of controlled drugs (CD), including destruction of unused CDs. Medication requiring

refrigeration was monitored twice a day to ensure it was stored within the correct temperature range. Prescription forms were securely stored and their use monitored.

- Patient Group Directions (PGD) were not required as the nurse was an independent prescriber. However, there was no formal process to maintain clinical oversight of the nurse's prescribing. Patient Specific Directions (PSD) were in place and signed by the prescriber to permit medics to vaccinate patients. Medics had completed vaccination training. A medic is trained to provide medical support on various operations and exercises. In a medical centre setting, their role is similar to that of a health care assistant in NHS GP practices but with a broader scope of practice.
- Requests for repeat prescriptions were safely managed and no telephone requests were accepted. A repeat prescription book was maintained and monitored by the practice administrator. A process was in place to update DMICP if changes to a patient's medication was made by secondary care or an out-of-hours service.
- There were no patients on high risk medicines (HRM) but the practice had a process to be used, when needed, for the management of and monitoring of patients.
- An antibiotic prescribing audit in November 2019 identified that out of the 20 patients reviewed, all had been prescribed appropriately.

**Track record on safety**

The practice had a good safety record but the systems required strengthening to become fully effective.

- The practice manager was the lead for health and safety and had received training for the role. Arrangements were in place to check the safety of the water. A fire risk assessment of the building was undertaken every five years. The fire system was tested each week and the fire evacuation drill was last carried out in November 2019. Staff were up-to-date with fire safety training and were aware of the evacuation plan. Confirmation of electrical and gas safety testing had been requested from the contractor but were not available on the day.
- Assessments including clinical and non-clinical risks to the practice were in place and they had been reviewed in July 2019. However, there were numerous risk registers in place and it was not clear which was the latest risk register and which was the issues log.
- Safety data sheets were in place for hazardous substances (COSHH) and the cleaning contractor carried out annual COSHH assessments of their products. Equipment checks, including the testing of portable electrical appliances were in-date.
- An alarm system was available in clinical areas to summon support in the event of an emergency. The waiting room was directly in front of reception so could be easily monitored from the desk.

**Lessons learned and improvements made**

The practice evidenced some learning and improvement when things went wrong although the recording process and sharing of lessons learnt did not always extend to the full team.

- Staff used the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events, incidents and near misses. All permanent staff had electronic access to the system, but locum staff (including a long-term doctor) did not. Staff provided several varied examples of significant events but the healthcare governance workbook, that provided an audit trail as well as a reference for other staff, did not include details of what actions had been taken. Significant events were discussed at the practice meetings but

minutes did not contain sufficient detail of discussion, required actions and lessons learnt. The ASER system was also used to report good practice and quality improvement initiatives.

- Improvements were made as a result of investigations into significant events. For example, an ASER referred to an incident when a patient with mental health concerns was found to have firearms at their home address. One of the actions was to recommend that a question regarding firearms license be added to the DPHC new patient questionnaire. However, it was not clear from the ASER system and supporting documents if the practice had completed all actions suggested by the regional healthcare governance lead, and the minutes of the meeting in which the incident was discussed did not clarify what the learning points were.
- The practice manager was responsible for managing medicine and safety alerts. Alerts were received into a group email box which was checked daily. Any alerts were placed in a folder and logged onto a register, reviewed with the practice nurse and marked as actioned once completed.

| Are services effective? | Requires improvement |
|---|---|

**We rated the practice as requires improvement for providing effective services.**

**Effective needs assessment, care and treatment**

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

- Patient records informed us that clinicians carried out assessments and provided care and treatment in line with national standards and guidance, supported by clear clinical pathways and protocols. Arrangements were established to ensure staff were up-to-date with current legislation, research and guidance, including NICE (National Institute for Health and Care Excellence) and the Scottish Intercollegiate Guidelines Network (SIGN). These were discussed at the weekly practice meetings. Staff were also kept informed of clinical and medicines updates through the Defence Primary Health Care (DPHC) newsletter circulated to staff each month.

**Monitoring care and treatment**

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

- The practice nurse was the chronic condition lead overseeing the management, including recall, of patients with long term conditions.
- Data provided during the inspection showed the practice was meeting all the QOF targets for asthma, diabetes and high blood pressure.
- We looked at a range of patient records and were assured that the care of patients with a mental illness and/or depressive symptoms was being effectively and safely managed, often in conjunction with the Department of Community Mental Health (DCMH). Appropriate templates were used to assess patients and plan their care.

- 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 71% of patients. This included those patients who required a re-test (where the result was lower than the previous test). In total, 92% of patients had been tested in the last two years. The practice were reviewing coding issues used to identify patients who required a recall to be assessed. All assessments required completion of the audiometry questionnaires prior to assessment.
- There was no structured programme of quality improvement work. Some first cycle clinical audits had been completed; for example, an audit of the prescribing of medicines used in the treatment of sleep problems, but there were no repeat audits undertaken to evidence improvement.

**Effective staffing**

The staff database was monitored by the practice manager to ensure staff were up-to-date with training and development. Continuous learning and development opportunity was limited by time and the availability of funding.

- A generic and role-specific induction was in place for new staff to the practice. All staff, including a recently inducted member of staff, had completed the programme.
- Mandated training was monitored and the staff team had protected time each week to complete online training modules. Permanent staff were in-date for all required training. The nurse attended quarterly meetings in Colchester for support with revalidation. However, there was no formal supervision for clinical staff, and no regular, formal meeting to maintain oversight of their work (including prescribing).
- The practice had two Regimental Aid Post (RAP) staff working at the practice. These were medics that belonged to the unit but supported the practice when not on exercise or deployed. We found that the three CMTs were not on the staff database. They were added to the database during the inspection but there were gaps in required training.
- Regional meetings and forums were established for staff to link with professional colleagues in order to share idea and good practice. For example, nurses were supported to attend the regional nurse's forum to link with their colleagues.

**Coordinating care and treatment**

Staff worked together and with other military health and social care professionals to deliver effective care and treatment but there was no evidence of engagement with external health and social care organisations.

- A doctor, the practice manager and the physiotherapist represented the practice at monthly UHCs and welfare meetings to discuss the occupational health needs of the units, the needs of patients who were medically downgraded and those who were vulnerable.
- An SoP was in place outlining the process to follow for patients leaving the military. Doctors provided patients transitioning from the military with a release medical. They also referred patients to the welfare team for support with the transition, and if appropriate to the Department of Community Mental Health (DCMH). Patients were signposted to SSAFA, a UK charity providing welfare and support for serving personnel in the British armed forces, veterans and military families.

**Helping patients to live healthier lives**

There was some evidence of health promotion work, but there was opportunity to adopt a more proactive approach.

- 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 medic had the lead for health promotion. The health promotion strategy was underpinned by national priorities and initiatives to improve the population's health including, stop smoking campaigns and tackling obesity. It also took account of the patient population need and seasonal variation impacting health.
- Health promotion displays were available in patient areas. These were dated and refreshed in line with the strategy. At the time of the inspection there were displays about climatic injury and a promotion by the PCRF on core strength.
- Health fairs were held on the base unit gymnasiums and the practice was represented by representatives from the practice but medics led..
- A mental health information display was available for patients that took into account wellbeing and mindfulness. It included details about websites patients could access for further information.
- Although there was no appointed lead for sexual health, this did not impact the service provided. Information was available for patients requiring sexual health advice, including sign-posting to other services. Where appropriate patients were referred to local genitourinary clinic for screening. Condoms were available at the practice. In the foyer, information about local sexual health pathways was displayed for patients.
- Patients had access to health assessments and checks. Regular searches were undertaken for patients eligible for bowel and breast screening and appropriate action taken if patients met the criteria. DMICP checks alongside Open Exeter checks were undertaken to ensure patients meeting the national screening programme for cytology were recalled. Open Exeter is a national screening recall system that gives access to patient data so eligible patients can be invited to participate in the screening programme.
- The practice had not recalled patients for preventative health checks. Health checks can help to identify any conditions that patients may be at-risk of and could be avoided by preventative treatment and lifestyle choices.

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

- 96% of patients were recorded as being up to date with vaccination against diphtheria.
- 96% of patients were recorded as being up to date with vaccination against polio.
- 91% of patients were recorded as being up to date with vaccination against hepatitis B.
- 96% of patients were recorded as being up to date with vaccination against hepatitis A.
- 96% of patients were recorded as being up to date with vaccination against tetanus.
- 92% of patients were recorded as being up to date with vaccination against typhoid.

- 93% of patients were recorded as being up to date with vaccination against MMR.
- 92% of patients were recorded as being up to date with vaccination against meningitis.

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

**Consent to care and treatment**

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. Staff we spoke with were aware of the Mental Capacity Act (2005) and how it could apply to their practice. A training session regarding mental capacity took place in November 2019.
- There was no process in place for monitoring the process for seeking consent. However, the practice did not perform minor surgery and templates for vaccination and cytology included a record of consent.

| **Are services caring?** | Good |
|---|---|

**We rated the practice as good for caring.**

**Kindness, respect and compassion**

Staff supported patients in a kind and respectful way.

- Throughout the inspection we observed staff were courteous and respectful to patients arriving for their appointments.
- Results and comments from the February 2019 Patient Experience Survey (40 respondents) showed patients were happy with how they were treated. The 13 CQC comment cards completed prior to the inspection were very complimentary about the friendly, considerate and caring attitude of staff.
- The practice had an information network available to all members of the service community, known as HIVE. This provided a range of information to patients who had relocated to the base and surrounding area. Information included what was available from the local unit and from civilian facilities, including healthcare facilities.
- The practice had a concise information leaflet to ensure patients were clear about the facilities available including key members of the practice team, contact numbers, opening times and clinics provided. At the time of the inspection the leaflet was being updated and was not available unless requested at reception.

**Involvement in decisions about care and treatment**

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

- Interpretation services were available for patients who did not have English as a first language and staff provided an example of when they recently used the service.

- The Patient Experience Survey showed 81% of patients felt involved in decisions about their care. The practice had identified this as an outlier and had discussed the patient feedback with the doctors and asked that choices of treatment were fully discussed.
- The practice proactively identified patients who were also carers. The practice maintained a register of patients with a caring responsibility and recalled them annually for flu immunisation. However, there was no visible information available to support carers, no reference in the practice leaflet and practice staff were not aware of any local support services other that the HIVE.

**Privacy and dignity**

The practice respected patients' privacy and dignity.

- Screening was provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. Clinic room doors were closed during consultations.
- The layout of the reception area and waiting area meant that conversations between patients and reception staff would unlikely be overheard. If patients wished to discuss sensitive issues or appeared distressed at reception, they were offered a private room to discuss their needs.
- The practice could facilitate patients who wished to see a clinician of a specific gender. The doctors were male, the nurse and physiotherapist were female and the so a patient requesting a clinician of specific gender that could not be accommodated were referred to another medical centre in the region.

## Are services responsive to people's needs? | Requires improvement

**We rated the practice as requires improvement for providing responsive services.**

**Responding to and meeting people's needs**

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

- Staff understood the needs of its population and tailored services in response to those needs. Appointments slots were organised to meet the needs of specific population groups. For example, dedicated vaccination clinics were held when vaccinations were required in readiness for short-notice deployment.
- The Patient Experience Survey indicated that 100% of respondents would recommend the practice to family and friends. Comments submitted by patients included: "staff did everything in their power to help" and "friendly and approachable".
- An access audit as defined in the Equality Act 2010 was completed for the premises in June 2019 and no issues had been identified. The building provided ease of access for patients with a disability. The practice had clinic rooms available on the ground floor and accessible toilet facilities were available.

**Timely access to care and treatment**

Patients' needs were met in a timely way.

- The practice accommodated patients with an emergency need and staff advised us that no patients were turned away and would be seen on the same day. Routine appointments could be accommodated within two days. There was a one week wait for medicals.

- Non-attendance at appointments was monitored for the practice, including the PCRF. The non-attendance rate was 3.5% for December 2019. A weekly audit of waiting times was completed to review clinical capacity.
- Arrangements were in place for patients to access NHS 111 when the practice was closed, including emergency care.
- Home visits were not provided but telephone consultations were available with clinicians.
- A direct access physiotherapy (DAP) service was not in place for patients.

**Listening and learning from concerns and complaints**

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information was displayed in the waiting area, outlined in the practice leaflet to help patients understand the complaints process. However, there was no forms to complete and the suggestions/complaints box was not labelled to make it clear to patients how feedback could be left anonymously.
- The civilian practice manager was the designated responsible person who handled all complaints. The practice managed complaints in accordance with the DPHC complaints policy and procedure. Both Written and verbal complaints were recorded and linked to the health governance workbook.
- Any complaints were discussed at the practice meetings and lessons identified. Changes to practice were made if appropriate and used to improve the patient experience. We reviewed the one complaint made in the last 12 months. This was a verbal complaint about a clinician's attitude and lack of explanation around treatment and care. The feedback was discussed with the clinician and a full explanation of the treatment and care given to the patient.

| **Are services well-led?** | Inadequate |
|---|---|

**We rated the practice as inadequate for providing a well-led service.**

**Leadership capacity and capability**

The practice team were experienced and trained in their roles but faced a workload beyond their capacity which was exacerbated by the lack of consistent clinical leadership and regular unit RAP medics.

- On the day of inspection, it was clear that practice staff had a focus on providing the best possible service for their patients. However, the capacity of the permanent staff was overstretched.
- The clinical leadership arrangements were not sufficient to achieve complete oversight. The practice, supported by region, had been unable to recruit into the civilian medical practitioner (CMP) role over the last four years. The practice manager was filling gaps where clinical input was required, for example; management of clinical events on the ASER system.
- Allocated roles such as clinical lead and healthcare governance were not supported by signed terms of reference.

**Vision and strategy**

Throughout the inspection it was clear that staff put patients best interests first, but there was limited forward planning and the capacity of the team was fully engaged with the day to day running of the practice.

- The practice worked to the DPHC mission statement of:

  "Provide and commission safe and effective healthcare which meets the needs of the patient and the chain of command."

- There was no practice development plan but the practice used the management action plan to develop processes and procedures.
- We spoke with the regional operations manager who provided a detailed account of the vision and plans for the future. Central to this was to increase the number of permanent staff to create stability and resilience.

**Culture**

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

- An inclusive culture underpinned the approach of the practice. All staff had an equal voice, regardless of rank or grade.
- Staff described an open and transparent leadership style and said they would feel comfortable raising issues. They felt respected, supported and valued. Both formal and informal opportunities were in place so staff could contribute their views and ideas about how to develop the practice.
- The practice clearly demonstrated a patient-centred focus. Staff understood the specific needs population and tailored the service to meet those needs. For example, the practice force protection statistics were a priority and performance was high in readiness for short notice deployment.
- Openness, honesty and transparency were demonstrated when things went wrong. A no-blame culture was evident; complaints and incidents were seen as opportunities to improve the service.
- The practice had systems to ensure compliance with the requirements of the duty of candour, including giving those affected reasonable support, information and a verbal and written apology. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.
- The practice promoted equality and diversity and staff had received training in this area. However, no record of training was available for the CMTs and locum staff.

**Governance arrangements**

Governance arrangements needed strengthening to provide an overarching framework that extended to all areas of the practice.

- 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. However, terms of reference were generic and had not been adapted to be practice specific.
- The lead roles and deputies were shared across the practice team appropriately. However, many posts were single-handed and temporary staff were not routinely arranged to cover

annual leave. Patient care was facilitated as required with some staff arranging annual leave around unit stand down periods to minimise the effect of their absence. This meant that there was potential for clinical work to remain unactioned until the clinician returned from leave.

- The practice worked to the health governance (HG) workbook, a system that brings together a comprehensive range of governance activities, including the risk register, significant events tracker, lessons learnt log, training register, policies, meetings, quality improvement and audit. The HG workbook was basic and in need of development to be effective. The areas included in the workbook were more of a register with actions completed rather than detailed learning points. The HG workbook was used predominantly by the practice manager and was not shared with the practice team as a central repository for information.
- Practice meetings were held weekly but the minutes recorded were not detailed enough for staff unable to attend to understand what was discussed. Clinical meetings were ad hoc and were not documented.
- The audit programme was limited and needed to be developed throughout the practice and added to the HG workbook; there were no links on the HG workbook to the completed audits.
- The practice used DPHC handbooks but needed to develop local SOPs to demonstrate the practice specific processes.

**Managing risks, issues and performance**

The processes for managing risks, issues and performance required strengthening.

- There were risk assessments in place, last reviewed in July 2019, but these had not been updated using the latest DPHC guidance note. There were a number of risk registers in place but it was not clear which was the current version and which was the issues log. Risks had not been reviewed to establish if any required transfer to regional headquarters.
- A system was in place to monitor performance target indicators. In particular the system took account of medicals, vaccinations, cytology, and non-attendance rates. However, the practice were not summarising patient notes so essential information could be missed.
- A business continuity plan was in place and could be accessed electronically should access to the building be restricted.
- Procedures were in place for managing poor performance. Civilian staff who were not performing would be managed in accordance with Ministry of Defence (MOD) policy, rules and guidance or through the appraisal process. All other staff concerns would be raised to their line manager or to regional headquarters staff to address.

**Appropriate and accurate information**

The practice was hampered by system outages. Although contingency plans were in place, the outages compounded the capacity issues by causing lengthy delays in processing and reviewing essential information.

- An internal quality assurance tool, the DMS Common Assurance Framework (CAF) was used to monitor safety and performance for the practice and included the PCRF. 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. However, the practice manager stated that time limitations prevented regular review of domains and progress of management action plans.

- The nurse had been unable to recall patients for preventative health checks due to time constraints.

**Engagement with patients, the public, staff and external partners**

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

- There were various options in place to encourage patients to provide feedback on the service and contribute to the development of the service. A patient experience survey was undertaken throughout the year. In addition, patients could leave feedback using the suggestion box.
- The practice was exploring options to develop a patient focus group.
- Good and effective internal links had been established with the welfare team, the Regional Rehabilitation Unit (RRU) and the Department of Community Mental Health (DCMH). Staff felt well supported by the Regional Occupational Health team. However, there was no evidence of links with external organisations such as local NHS services and social services.

**Continuous improvement and innovation**

There was little evidence of continuous improvement in the practice. We saw one example of innovation by way of screening by the physiotherapist prior to 'pre para' training (to identify injuries and prevent them worsening), but this has not been documented on the workbook and had not continued.