Wyton Medical Centre

Quality report

Station Medical Centre
RAF Wyton
Huntingdon
Cambridgeshire
PE28 2EA

Date of inspection visit:
17 December 2019

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, 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?	Inadequate
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? – Inadequate
Are services caring? – Good
Are services responsive? – Requires improvement
Are services well-led? – Inadequate

We carried out an announced comprehensive inspection of Wyton Medical Centre on 17 December 2019. 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:

- A team approach was supported by staff who valued the opportunities available to them to be part of a patient-centred service.
- The arrangements for managing medicines, including obtaining, prescribing, recording, handling, storing, security and disposal minimised risks to patient safety. There was an effective approach to the monitoring of patients on high risk medicines.
- Staff were aware of current evidence based guidance.
- The practice shared best practice to promote better health outcomes for patients. However, there was no structured approach to patient recall.
- The practice proactively 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.
- Equipment at the practice was sufficient to treat patients and meet their needs.
- Staff were aware of the requirements of the duty of candour.

The Chief Inspector recommends:

- Ensure that alerts are in place for all vulnerable patients within their clinical records.
- Strengthen the arrangements for checks carried out on the emergency equipment and ensure staff have the knowledge on how they should be used.
- Further strengthen the specimen sample tracking system to ensure it is failsafe.

- Continue to improve the assessment and management of risks including shared learning from significant events.
- Implement a structured approach to manage and improve the recall of patients to include patients with long-term conditions, those who require vaccination and for those eligible for health screening.
- Implement a programme of quality improvement to drive improvements in patient outcomes.
- Strengthen the arrangements for continued professional development taking into account specific training needs for staff.
- Carry out an access audit as defined in the Equality Act 2010.
- Review the arrangements for direct access to physiotherapy.

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 doctor, practice nurse, practice manager and a physiotherapist.

Background to the Wyton Medical Centre

Wyton Medical Centre provides a routine primary care service to a patient population of 849 service personnel. Families and dependants are signposted to nearby NHS services. The centre is a tri-service base and provides medical cover to three small units in close proximity. The practice also provides occupational health to service personnel.

A Primary Care Rehabilitation Facility (PCRF) is located in a separate building to the medical centre and provides a physiotherapy and rehabilitation service for service personnel only.

The medical centre is open from 08:00 to 12:00 and 13:00 to 16:30 hours Monday to Thursday and until 16:00 hours on a Friday. The practice provides medical cover up until 18:30 each week day through a duty doctor. Patients can access the duty staff by contacting the guard room. Outside of these hours, including weekends and bank holidays, cover is provided by NHS 111.

The staff team

Position	Numbers
Civilian Senior Medical Officer (SMO)	One
Civilian medical practitioners (CMP)	One
Civilian senior practice nurse Band 6	One
Civilian practice nurse Band 5	One
Civilian practice manager (PM)	One (0.6 whole time equivalent)
Civilian deputy practice manager	One
Civilian administrative staff	Two
PCRF	One civilian physiotherapist Band 6 One military exercise rehabilitation instructor (ERI)

Regimental Medical Sergeant	One
Regimental Combat Medical Trainees	Two

Regimental Combat Medical Trainees are not part of the established staffing at the medical centre. They are phase two trainees who belong to the unit and complete a six week placement in the medical centre.

Are services safe? | Inadequate

We rated the practice as inadequate for providing safe services.

Safety systems and processes

Systems were established to keep patients safe and safeguarded from abuse.

- 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 adult and child safeguarding policies. The safeguarding policy was last reviewed in May 2019. Staff, including Regimental medical staff working at the practice, had received safeguarding training and update training. However, the update training was overdue for one of the nursing team. Regimental medical staff are clinicians who are attached to units rather than employed to work directly at the medical centre.
- Doctors had completed level 3 training in adult and child safeguarding. A safeguarding lead was identified for the practice but there was no deputy in their absence. Nurses and the physiotherapist had completed level 2 training in line with DPHC policy, but there was no planned response to the new intercollegiate guidance for all clinicians to be level 3 trained. Safeguarding arrangements and local contact details were displayed in clinical rooms for staff to access.
- Coding and alerts were used to highlight vulnerable patients. A vulnerable patients register was held on the electronic patient record system (referred to as DMICP). However, one of the five patients from the register had no alert therefore staff would not easily be made aware of their status. Vulnerable patients were discussed monthly at the clinical meetings. Patient records were updated during the meeting. The needs of service personnel assessed as being vulnerable were discussed with the Welfare Officer at the monthly Unit Health Committee (UHC) and Station Welfare Casework Committee meetings.
- Chaperone training was provided to all staff and there was a chaperone policy last updated in December 2019. Notices advising patients of the chaperone service were displayed in patient areas. Staff had been subject to safety checks to ensure they were suitable to work with young people and vulnerable adults.
- The full range of recruitment records for permanent staff was held centrally. However, the practice could demonstrate that relevant safety checks had taken place at the point of recruitment, including a Disclosure and Barring Service (DBS) check to ensure staff, including locum staff, were suitable to work with vulnerable adults and young people. DBS checks were renewed every five years.
- Arrangements were in place to monitor the registration status of clinical staff with their regulatory body. All staff had professional indemnity cover. Information was in place to confirm staff had received all the relevant vaccinations required for their role at the practice.

- There were arrangements to manage infection prevention and control (IPC), including a lead who was appropriately trained for the role. The staff team was up-to-date with IPC training. An independent IPC audit had been undertaken in May 2019 and no significant concerns had been identified. There was scope to make the IPC processes more effective. For example, the daily check list sheets were not always completed and there was no cleaning schedule for the water cooler.
- Environmental cleaning was provided by an external contractor. Cleaning schedules and monitoring arrangements were established and displayed on the doors of each room. A deep clean of the premises took place biannually, the last one was completed in August 2019. We identified no concerns with the cleanliness of the premises.
- A member of staff had the lead for the safe management of healthcare waste. Consignment notes were retained at the practice and an annual waste audit was carried out in April 2019.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

- Staff we spoke with said staffing levels and skill mix was adequate to meet the needs of the patients. However, there had been a high level of staff absence in the previous 12 months meaning there was limited time for other tasks such as quality improvement work. This had been escalated to region and the practice had developed a business case for a healthcare assistant to improve clinical resilience.
- There was a mix of military and civilian staff. A locum induction programme was in place to familiarise temporary staff with systems and processes.
- The practice was equipped to deal with medical emergencies and staff had completed training in basic life support. An emergency kit, including a defibrillator, oxygen with masks and emergency medicines were accessible to staff in a secure area of the practice; all staff knew of its location but the basic life support training did not include the items on the trolley to ensure staff would be familiar on how they are to be used. Weekly and monthly checks were in place to ensure the required kit and medicines were available and in-date. However, these checks were not carried out in the absence of the nursing staff using the treatment room. Staff were not always able to demonstrate how checks should be conducted. For example, the nursing staff were unable to demonstrate the correct method for checking the Laerdal Suction Unit (LSU), a device used in emergency situations to clear the airways.
- A first aid kit and accident book was available.
- Staff were up-to-date with the required training for medical emergencies. They participated in regular training relevant to emergency situations. Staff had recently received training in how to manage patients presenting with heat illness. Staff were also trained in the recognition and management of sepsis. Posters about sepsis were displayed throughout the practice.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients. However the processes in place to check and act on the information needed strengthening.

- Individual care records were written and managed in a way that kept patients safe. The care records we looked at on DMICP showed information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- A process was established for scrutiny and summarising of patients' records and this was monitored by the receptionist. New patients completed a registration form, which was checked

by the receptionist and then passed to the doctors for further checks. Summarisation of service personnel was completed on DMICP. At the time of the inspection 96% of the patient records had been summarised.

- Staff described occasional loss of connectivity with DMICP, meaning clinics could be delayed. If this happened, the business resilience plan was followed and only emergency patients were treated.
- Referrals to other departments and external health care services, including urgent referrals, were managed by a dedicated staff member. They responded to requests from the doctors and booked patient appointments through the NHS e-Referral service (e-RS). If an appointment was not available based on patient availability then the administrator followed it up on behalf of the patient. Referrals were logged and monitored and for urgent two-week-wait referrals, patients left the practice with an appointment. The practice had a system to follow-up hospital appointments, the practice sent the patient a reminder close to the appointment day, or in cases where the patient had moved to another medical centre, a reminder was sent to the practice manager. Referrals made from the PCRF were integrated with the wider referral tracking system for the practice. Physiotherapists monitored the referrals they made to the Regional Rehabilitation Unit (RRU) and other services.
- The system that managed samples was not failsafe and the register of samples requested had not been completed since April 2019. There was a weekly check and a monthly audit of samples but we found one example of a sample not being processed correctly, and this had not been recorded as a significant event.

Safe and appropriate use of medicines

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

- A lead and deputy were identified as the subject matter experts for medicines management with the day-to-day management of medicines delegated to the nurses. 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) had been developed to allow appropriately trained nurses to administer medicines in line with legislation. The PGDs were signed but a PGD audit had not been carried out since February 2018 to ensure they were current.
- Requests for repeat prescriptions were safely managed and no telephone requests were accepted. A repeat prescription book was maintained and monitored by the nursing team. 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.
- A process was established for the management of and monitoring of patients prescribed high risk medicines (HRM). A register of HRM used at the practice was held on a spreadsheet and all doctors had access to this. Alerts, coding, diary dates and monthly searches were used to identify and manage patients on HRM. Shared Care Agreements were in place for those patients that required them.
- The management of medicines was subject to regular audit. For example, an antibiotic prescribing audit in February 2019 and identified that all prescriptions were appropriate. An

HRM spreadsheet was maintained and included required monitoring and next due date. An alert was Read coded to allow searches to be run and we found all patients on HRMs were in date with their monitoring.

Track record on safety

The processes for managing health and safety required strengthening.

- Measures to ensure the safety of facilities and equipment were not comprehensive. The practice manager was the lead for health and safety and there was support provided by the station lead. The COSSH (control of substances hazardous to health) assessments had been reviewed in June 2019 and arrangements were in place to check the safety of the water. However, there was no structured approach to identify risk assessments required. For example, there was no certificate for electrical safety.
- A fire risk assessment of the building was undertaken annually. The fire system was tested each week. Staff were up-to-date with fire safety training and were aware of the evacuation plan.
- Equipment checks, including the testing of portable electrical appliances were in-date. The PCRF provided evidence that the equipment held at the various gyms used to treat patients had been serviced.
- An alarm system was available in clinical areas to summon support in the event of an emergency. However there was no alarm in the dispensary and the waiting rooms were out of view from reception. A statement of need for CCTV had been submitted. Mobile phones were issued to PCRF staff to be used in the event of an emergency when working alone. However, this was not supported by an SoP.

Lessons learned and improvements made

The practice made improvements when things went wrong but there was scope to improve the management and monitoring of lessons identified.

- Staff used the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events, incidents and near misses. All staff with the exception of the ERI had electronic access to the system. The practice confirmed that the ERI had been added following the inspection. Staff provided several varied examples of significant events confirming there was a culture of effectively reporting incidents. Significant events were discussed as standing agenda items at the monthly healthcare governance and practice meetings, or sooner if required. However the process used for completing an ASER review was compromised as although the event was discussed before going onto the system, the information was not always entered onto the system by the individual who identified the event.
- Improvements were made as a result of investigations into significant events. For example, an urgent referral had not been received by the hospital as the DMICP internal referral system had been switched off and the referring clinician had not followed the correct process. As a result, additional staff had received training in the referral system. However there was no system in place for monitoring and managing lessons identified.
- There was a system and responsible individual for managing medicine and safety alerts. A group mail box was set up to receive alerts from region and the system required a daily check for alerts. All alerts should then be logged on a spreadsheet. However, a check of the spreadsheet found that two alerts from August 2019 were not included. Alerts were a standing agenda item at the clinical meetings.

Are services effective?	Inadequate

We rated the practice as inadequate 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 meetings for clinicians and, if relevant to the wider staff team, at the practice meetings and health care governance meetings. Staff were also kept informed of clinical and medicines updates through the Defence Primary Health Care (DPHC) newsletter circulated to staff each month.
- In addition to participating in the wider practice meetings, the PCRF team held their own formal meetings each month to discuss current practice, share updates and peer discussion.
- Our review of PCRF patient records showed Rehab Guru, software for rehabilitation plans and outcomes, was used for exercise programmes for some patients. Paper exercise sheets were also used depending on therapist preference.
- The PCRF team referred to the Defence Rehabilitation website for best practice guidance. For example, ERIs used it for guidance on equipment management, training and best practice guidance.

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 SMO and practice nurse led on long-term condition management but there was no structured approach to patient recall and monitoring.
- We were provided with the following patient outcomes data during the inspection:
    - There were six patients on the diabetic register. For four patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. One patient had been tested in August 2019 and blood results were found to be abnormal and although a letter of invite had been sent, no follow up had taken place.
    - For four patients with diabetes, the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.
    - There were 23 patients recorded as having high blood pressure. Thirteen patients had a blood pressure reading of 150/90 or less. However, the practice were unable to confirm how many had a record for their blood pressure taken in the past nine months.

    - There were 12 patients with a diagnosis of asthma. Five patients had an asthma review in the preceding 12 months which included an assessment of asthma control using the three Royal College of Physicians questions.

- The practice recognised that it was not meeting all the QOF targets, such as the recall target of 75% for diabetes, and were addressing this at the time of the inspection. Patients had been sent recall letters and further letters if no response was received.
- 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 79% of patients. No audit had been carried out to confirm the practice was compliant with completing the audiometry questionnaires prior to assessment.
- There was evidence of audit but no structured programme for the practice. Practice staff told us that opportunities for quality improvement work, including clinical audit, had been limited due to sub-optimal staffing levels. There was evidence of audits where the first cycle started in January 2019. These included hypothyroidism and diabetes audits. Second cycles were planned. The most recent infection prevention and control audit, undertaken in May 2019, showed no significant concerns had been identified.

Effective staffing

Continuous learning and development had been reduced due to insufficient staffing levels. The practice told us that opportunities had been limited due the prioritisation of patient care.

- A generic induction was in place for new staff to the practice. The practice manager had identified the need for a role-specific induction but this had not been implemented.
- Mandated training was monitored and the staff team was mostly in-date for all required training. Protected time was available to staff each week and all staff had completed most mandatory training and had planned completion where there were gaps.
- The ERI was recently qualified and joined the practice in July 2019 but there was no record of notes review or documentation of reflective practice having been reviewed by practice staff. The ERI spoke positively of the support provided by the post-graduate mentorship programme which provided external clinical supervision.
- Regional meetings and forums were established for staff to link with professional colleagues in order to share idea and good practice. However, staff expressed frustration with a lack of funding for training.

Coordinating care and treatment

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

- The clinical records we reviewed showed appropriate staff, including those in different teams, services and organisations were involved in assessing, planning and delivering care and treatment.
- The practice had developed good working relationships both internally and with health and social care organisations. For example, the SMO had attended local hospital meetings to develop links with consultants and referral staff. The SMO had tried to establish links with the local Commissioning Care Group (CCG) and had developed links with Local Medical Committees (LMC).
- A doctor represented the practice at s Unit Health Committee (UHC) 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. The PCRF was also represented at these meetings to provide performance data and advice on injury prevention.
- 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

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

- Clinical records showed that staff encouraged and supported patients to be involved in monitoring and managing their health. Staff also discussed changes to care or treatment with patients as necessary.
- The practice nurse 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 was a display to raise awareness about mental health and the associated support services available.
- Health fairs were held on the base and the practice was represented by the nurses and PCRF staff.
- A mental health information display was available for patients that took into account well-being and mindfulness. It included details about websites patients could access for further information.
- 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. Information about local sexual health pathways was displayed for patients.
- Patients had access to appropriate health assessments and checks. For example, a health check for patients aged 40 and over. However, the screening was done opportunistically and although the practice kept a record of how many patients were screened, there was no data to capture the eligible population.

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:

- 71% of patients were recorded as being up to date with vaccination against diphtheria.
- 71% of patients were recorded as being up to date with vaccination against polio.
- 23% of patients were recorded as being up to date with vaccination against hepatitis B.
- 16% of patients were recorded as being up to date with vaccination against hepatitis A.
- 71% of patients were recorded as being up to date with vaccination against tetanus.

The practice were unable to provide data for patients being up to date with vaccinations against MMR and meningitis.

Consent to care and treatment

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

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making. This included written consent for treatments such as minor surgery. Advance discussion with the patient around treatment was documented together with a record of consent.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. Training regarding mental capacity had been completed by practice staff in October 2019. Staff we spoke with were aware of the Mental Capacity Act (2005) and how it could apply to their practice.
- Monitoring the process for seeking consent had not been undertaken through an annual audit.

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 October 2019 Patient Experience Survey (40 respondents) showed patients were happy with how they were treated. The 12 CQC comment cards completed prior to the inspection were complimentary about the friendly, considerate and caring attitude of staff.
- The practice had an information network available to all members of the service community, through the 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 booklet to ensure patients were clear about the facilities available including key members of the practice team, contact numbers, opening times and clinics provided.

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. There had been no requirement for the past five years but a guidance note had been completed for staff to refer to.
- The Patient Experience Survey showed 93% of patients were involved in decisions about their care and 98% considered their needs were met. Feedback on the CQC patient feedback cards highlighted that patients received information about their treatment to support them with making informed decisions about their treatment and care.
- The practice had a register of carers and highlighted them on DMICP. However the new patient form used by the practice did not ask if individuals had caring responsibilities and there was no information for carers in the practice booklet or in the patient waiting area. A register of carers was maintained by the senior nurse and it identified 13 patients with a caring responsibility.

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 PCRF infrastructure supported patient confidentiality as there was a dedicated clinical area and a private gym separate to the main gymnasium. PCRF staff could accommodate same gender appointment requests through an alternative base approximately one hour away.
- The practice could facilitate patients who wished to see a clinician of a specific gender. All the doctors were male and the nurses female so a patient requesting a clinician of specific gender that could not be accommodated were referred to Chicksands Medical Centre, approximately 45 minutes by car. The same arrangement was in place for the PCRF where both the physiotherapist and ERI were male.

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, afternoon clinics had been extended to accommodate shift workers and remote patients based at one of the nearby stations.
- Specific clinics were in place including vaccination and chronic disease.
- The Patient Experience Survey indicated that 78% of respondents would recommend the practice to family and friends.
- An access audit as defined in the Equality Act 2010 had not been completed for the premises. The building did not lend itself to ease of access for patients with a disability. The practice had made as much reasonable adjustment as possible and had submitted a statement of need and scoped out the work required to make the building compliant. Clinic rooms were available on

the ground floor. Notices in both waiting areas advised patients of where the accessible WC facilities were available on site.

- The PCRF were not offering Direct Access to Physiotherapy (DAP) to patients in accordance with DPHC standard operating procedure. DAP allows patients to make an appointment directly with the PCRF and without referral from a doctor. The practice was achieving the key performance indicator of appointments for the PCRF being available within10 days.

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 one day. There was a one week wait for specialist medicals.
- Non-attendance at appointments was monitored for the practice, including the PCRF. The number of non-attendances for November 2019 was eight hours twenty minutes. An audit of waiting times had been completed for a week timeframe in July 2019 and was displayed for patients.
- Arrangements were in place for patients to access NHS 111 when the practice was closed, including emergency care.
- Telephone consultations were available to patients remote to Wyton and those with an infectious condition. Home visits were not offered and the patient booklet advised patients to call for a telephone consultation and offered military transport if necessary.
- The PCRF provided a same day or next day appointment to those with an initial consultation and patients prioritised as urgent. Routine appointments were available within 10 working days.

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. The complaints procedure and a complaints form was included in an information pack placed on chairs in the patient waiting area.
- The practice manager was the designated responsible person who handled all complaints. The practice managed complaints in accordance with the DPHC complaints standard operating procedure. Both written and verbal complaints were recorded and linked to the health governance workbook.
- Any complaints were discussed at the clinical and/or practice meetings and lessons identified. Changes to practice were made if appropriate and used to improve the patient experience. For example, a complaint about the amount of information left in a message to a patient resulted in training for staff on their responsibilities and procedures for the management of clinical information.
- Patients' medicines were only available to be collected between the hours of 15:30 and 16:30 Monday to Thursday and 14:00 and 15:00 on Fridays. This had resulted in a written complaint in July 2019 and was negative feedback on one of the 12 CQC comment cards. After discussion in a practice meeting, it was decided to not make any change due to the impact on nursing capacity.

Are services well-led?	Inadequate

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

Leadership capacity and capability

The leadership team had the experience, skills and drive to deliver high-quality sustainable care. However, the staffing levels had been sub-optimal for large parts of the year resulting in a reduced capacity and prioritisation of workload. In 2019, there had been no practice manager for four months and one practice nurse post was gapped for six months.

- The administrative management team was not effective in delivering a collaborative approach to leading the practice and supporting staff. There was clear division which impacted the efficient administration of the practice.
- The regional management team worked with the practice but the staff team felt further support could be provided in some areas.

Vision and strategy

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

- The practice had developed their own mission statement:

  "We will develop and maintain safe and effective, occupationally focused primary health care to meet the needs of all entitled patients and the Chain of Command."

- On the day of the inspection, we found the practice was working to its aims with a practice development plan produced by the SMO.

Culture

The culture at the practice was inclusive in that staff felt comfortable in raising any 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.

- An inclusive culture underpinned the approach of the practice. Staff told us that they felt confident to raise concerns and were encouraged to promote their ideas during meetings.
- The PCRF was integrated with the wider practice, including an integration of governance systems.
- 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 maintained a record of future follow up appointments both at the practice and secondary care. Reminders were sent prior to the appointment date. This included patients who had since relocated to another military medical centre.
- 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.

- Staff were encouraged and supported to be the best they could be through training and developing their skills. Supervision and appraisal was in place for all staff and in-house awards were used to show recognition and appreciation.
- The practice promoted equality and diversity and staff had received training in this area.

Governance arrangements

There was a governance framework in place but it required strengthening to improve its effectiveness.

- 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 required updating, the role and governance of the Medical Sergeant required clarification, and the administrative management lacked clarity and cohesion due to a disconnect of responsibilities between the practice manager and deputy practice manager.
- 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. All staff had access to the workbook which provided links to meeting minutes, policies and other information.
- An effective range of communication streams were used at the practice. A schedule of regular practice, healthcare governance and team specific meetings were well established.
- There was no structured audit programme to measure the effectiveness and success of clinical and administrative practice. The practice explained that this was an area that had been impacted by the low staffing levels.
- The PCRF were supported from the Regional Rehabilitation Unit (RRU) with the last visit having been made in September 2019.

Managing risks, issues and performance

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

- Risk to the service were well recognised, logged on the risk register and kept under scrutiny through regular review. There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety. Processes were in place to monitor national and local safety alerts, incidents, and complaints.
- The practice had a system in place to monitor performance target indicators. However, staff required training in order to make effective use of the system.
- A business continuity plan and a major incident plan were in place.
- Procedures were in place for managing poor performance. We were given an example of a formal process for a staff member under supervision who was being supported and monitored to improve their individual performance.

Appropriate and accurate information

The practice acted on appropriate and accurate information. However, there were gaps in staff knowledge on how to obtain necessary 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.

- The administrative management team was unable to locate the CAF and was unable to identify the updating process used to ensure the information contained was current and accurate.

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 via through the suggestion box. Patients were informed of the response to their feedback through a 'You said we did' display. For example, the practice agreed to conduct a review on the potential to use emails to deliver test results following patient feedback on postal problems with delayed and missing items.
- In addition to leaflets and posters, clipboards were placed on chairs in the waiting room to provide information for patients on the services provided. The clipboard included information on repeat prescribing procedures and comment cards for compliments, complaints and suggestions.
- Good and effective links with internal and external organisations including the welfare team, Regional Rehabilitation Unit (RRU), the Department of Community Mental Health (DCMH), local NHS services and social services.

Continuous improvement and innovation

The low staffing levels had limited the amount of continuous improvement work in the last 12 months. We found that improvements were implemented based on the outcome of feedback about the service, complaints, audits and significant events.

Quality improvement activity we identified included:

- Development of a health promotion programme with a dedicated lead staff member.
- The PCRF had shortened the patient care pathway with the implementation of a joined up care approach with all new patients seen by both the physiotherapist and the ERI.