RAF Leeming Medical Centre

RAF Leeming, North Yorkshire, DL7 9NJ

Defence Medical Services inspection report

This report describes our judgement of the quality of care at Leeming Medical Centre. It is based on a combination of what we found through information provided about the service, patient feedback and through interviews with staff and others connected with the service.

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

Published: 22 April 2024

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Summary

About this inspection

We carried out an announced comprehensive inspection at Leeming Medical Centre on 27 February 2024.

The Care Quality Commission (CQC) does not have the same statutory powers with regard to improvement action for the Defence Medical Services (DMS) under the Health and Social Care Act 2008, which also means that the DMS is not subject to CQC's enforcement powers. However, as the military healthcare regulator, the Defence Medical Services Regulator (DMSR) has regulatory and enforcement powers over the DMS. DMSR is committed to improving patient and staff safety and will ensure implementation of CQC's observations and recommendations.

This inspection is one of a programme of inspections that CQC will complete at the invitation of the DMSR in their role as the military healthcare regulator for the DMS.

At this inspection we found:

- A person centred culture was embedded to ensure patients received quality and compassionate care to meet their individual needs.
- Patients received effective care reflected in the review of screening and vaccination data. Although wait times for routine doctor's appointments were 4 weeks, there was same day access to urgent appointments. However, the backlog for summarising of patient notes meant there was a risk that some patients had conditions that the practice was unaware of.
- Measures were in place to identify patients who were considered vulnerable, coding was consistently applied to identify vulnerable patients. Staff had completed safeguarding training appropriate to their role.
- The practice had forged close working relationships within military healthcare, with NHS organisations and with the local community in planning how services were provided to ensure that they meet patients' needs.
- Multidisciplinary team meetings were held in the medical centre on a monthly basis, and care plans for complex patients drawn up jointly with other professionals to ensure the best care was provided.
- There was a safe system for the management of specimens and referrals.
- Arrangements were in place for managing medicines, including obtaining, prescribing, recording, handling and disposal in the practice.
- The practice had suitable health and safety arrangements in place to ensure a safe service could be delivered.
- Risks to the service were recognised by the leadership team. The main risks outside of the practice's control had been escalated and workarounds implemented. A range of risk assessments were in place for the practice.

- Facilities and equipment at the medical centre were sufficient to treat patients and meet their needs. However, the cleaning of the building could be improved to minimise the risk of infection being prevented or controlled.
- Staff were aware of the requirements of the duty of candour and monitored compliance. Examples we reviewed showed the practice complied with these requirements.
- The practice sought feedback from 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.

The Chief Inspector recommends that the medical centre:

- Review access arrangements to the dispensary accounting for the new guidance provided once the Defence Primary Healthcare policy has been updated and circulated.
- Ensure NEWS (National Early Warning Score) scoring cards and ATMIST (age, time of onset, medical complaint/injury, investigation, sign and treatment) cards are available on the crash trolley.
- Introduce a patient recall to screen those aged over 40.
- As a priority, continue with plans to address the backlog of the notes that require summarisation.
- Improve the processes around infection prevention and control and review the cleaning schedules to ensure they are sufficient.
- Complete annual auditing of minor surgery outcomes.
- Continue to monitor the recording of consent to ensure that further improvements of recording are achieved including when offering chaperones.
- Improve the coding for patients with caring responsibilities and further promote information for services provided to carers and signposting for translation services.

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Chief Inspector of Hospitals and Interim Chief Inspector of Primary Medical Services

Our inspection team

The inspection team was led by a CQC inspector. The team comprised specialist advisors including a primary care doctor, a practice manager, a primary care nurse, a pharmacist and a physiotherapist. Three specialist advisors new to the CQC were also in attendance as observers.

Background to Leeming Medical Centre

Located in North Yorkshire, RAF Leeming Medical Centre provides routine primary care and occupational health care service to a patient population of 2,290 (military personnel and their families). The station is a flying station and trains aircrew and air traffic controllers. A primary care rehabilitation Facility (PCRF) situated in building is an integral part of the medical centre and provides personnel with a physiotherapy and rehabilitation service. The medical centre also provides primary care to patients based at Fylingdales, a smaller station approximately 1 hour's drive away.

The medical centre is open from 08:00 to 18:30 hours Monday to Friday. Wednesday afternoons are protected for training, but patients can still access services by telephone and urgent patients can be seen. Outside of these hours, patients are signposted to the NHS111 or 999 service. Due to it being a flying station, medical cover is provided by a duty medic during flying hours, this being predominantly through the day but also during night periods when exercises take place. Medics triage calls and signpost patients or book them in for an appointment at the medical centre.

The staff team

Doctors	1 Senior Medical Officer (SMO) 1 Deputy Senior Medical Officer (DSMO) 1 Unit Medical Officer (UMO) 1 part time Civilian Medical Practitioner (CMP)
Nurses	1 Practice Nursing Officer (PNO) 1 Senior Nurse 2 civilian nurse's (Band 6 and Band 5, both part-time) 1 healthcare assistant (new post commencing March 2024)
RAF medics	11 (DPHC assets, not unit)
PCRF	2 physiotherapists (1 officer in command referred to as OC PCRF, 1 Band 6) 1 exercise rehabilitation instructor (ERI) locum
Pharmacy technicians	2
Warrant Officer in charge Practice manager	1 1

Deputy practice manager	1
Administrators	4 civilian administrators

Are services safe?

We rated the medical centre as requires improvement for providing safe services.

Safety systems and processes

The medical centre worked to the Defence Primary Care Healthcare (DPHC) Tri-Service safeguarding policies. These policies were accessible to staff and were in-date. The safeguarding polices included a clear process to guide on how concerns should be escalated. Contact addresses and telephone numbers for the local safeguarding teams (both in-hours and out-of-hours) were displayed in the waiting areas and clinical rooms. Staff interviewed during the inspection were fully aware of the policies and knew how to report a safeguarding concern.

The status of safeguarding and vulnerable patients was discussed regularly with the welfare team. Staff from the medical centre attended the monthly station welfare meetings and the welfare strategy group (the focus of the next meeting was safeguarding). The Deputy Senior Medical Officer (DSMO) attended local and some regional safeguarding meetings on behalf of the practice. We saw evidence of close working relationships with and regular referrals to SSAFA (the Armed Forces charity). In addition to informal discussion and the monthly clinical risk/vulnerable patient meeting, the needs of vulnerable patients were discussed at the monthly Service Personnel Support Committee (unit welfare meeting) attended by the safeguarding lead and colleagues from the multidisciplinary team.

We contacted SSAFA, the welfare team and Padre as part of this inspection. They told us that they provided a welfare service to some vulnerable young individuals and praised the responsive approach and communication with both administrative and clinical staff from the medical centre. Informal communication took place daily and the medical centre team made valuable contributions to the monthly Station Personnel Support Committee. We were told that urgent appointment requests had always been accommodated. The practice had also established external links with the North Yorkshire Safeguarding Team with joint meetings held alongside Regional Headquarters (RHQ). Local NHS training sessions were made available to military staff with regularity these were advertised by RHQ. Close working with the midwives was also evident with a vulnerability assessment carried out on each pregnant woman referred with follow up appointments offered to any patient where there were concerns.

The DSMO was the safeguarding lead with the Senior Medical Officer (SMO) acting as deputy. Both were trained to safeguarding adults and children level 3. All other staff had completed safeguarding training appropriate for their role (all clinical staff were level 3 trained). Training was delivered through a combination of ‘eLearning for healthcare’ and live online training courses.

The team made regular contact with all patients considered vulnerable. The team had a network of contacts with internal and external services such as the health visitors and Padre. The medical centre worked closely with the Department of Community Mental Health (DCMH) and the welfare services. Communication within the medical centre and

with affiliated staff was excellent and we were informed that access to urgent appointments was always accommodated.

Vulnerable patients were identified during consultation, DMICP (clinical operating system) searches and on referral from another department such as the welfare team. Coding was applied to clinical records to identify patients considered vulnerable and urgent appointments were offered. A ‘vulnerable and long-term sick’ register (collated from searches on DMICP) was reviewed on the first Wednesday each month (the day before the monthly station welfare meeting). This included vulnerable patients and those with safeguarding or welfare concerns. Any new concerns raised were reviewed sooner and communicated to relevant personnel so information was shared in advance of the next meeting.

Chaperone training had been completed by all staff as part of induction. The leadership team monitored the healthcare governance (HcG) workbook and informed personnel when their refresher training was due to expire. Posters were displayed prominently throughout the building to advise patients on their rights to a chaperone (as well as the clinicians’ rights to a chaperone). Information was also included in the patient information leaflet. We noted that there was a good mix of male and female chaperones available. In addition, there was a chaperone policy that had been regularly reviewed and updated when required.

The full range of recruitment records for permanent staff was held centrally. However, the practice could demonstrate that relevant safety checks had taken place for the staff, at the point of recruitment, including a DBS check to ensure staff were suitable to work with vulnerable adults and young people. An electronic record identified when each member of staff was required to renew their registration.

Staff were up-to-date with their hepatitis B vaccination and there was a hepatitis B register available to view.

A process was in place to manage infection prevention and control (IPC). The current IPC lead had completed specific training for the role (the 2 day link practitioner course), accessed the DPHC IPC compendium for support and attended the quarterly IPC link forum led by the DPHC IPC lead. There was a named deputy lead who had completed role-specific training (the level 7 module). IPC training was included for all staff as part of induction. All staff were currently in-date with training.

Regular IPC audits were carried out including the DPHC mandated audits that were scheduled into a monthly rolling programme. Different sections were completed monthly by the IPC lead. Each of the 16 components was audited at 6 month or 12 month intervals in line with DPHC policy. The practice had an issues log where items that required action were listed. However, we found that remedial work had not been followed up and there was confusion regarding the responsibility for painting and flooring meaning that these issues had not been further investigated to achieve a solution. After the inspection, the practice submitted evidence to show that requests had been made to the contractor for floor repairs and re-decoration of areas where there was chipped paint.

A walk round the building (including the ambulance) carried out as part of the inspection visit highlighted further areas of concern. The practice IPC lead collated a table that

detailed each concern and prioritised them into a corrective action plan. Any actions that were not completed in a 'reasonable timescale' were escalated to the IPC regional lead. Examples of issues identified included out-of-date items, sharps bins that were not labelled correctly, a sluice drain that required de-odourising, ceiling light fittings that required cleaning and carpets (non-clinical rooms) that had no scheduled clean. Although there was an 'infections patient standard operating procedure (SOP), not all clinical staff were aware of which room to place a patient into should they present with an infectious disease

Environmental cleaning was provided by an external contractor. A written cleaning schedule was in place for each room although this needed updating. The practice did not have a copy of the cleaning contract although the Warrant Officer had put in a request. A walkaround on the day of inspection highlighted a number of areas that were not cleaned and/or in a poor state of repair. These included the kick boards at the bottom of each internal door (appeared to not have been recently cleaned), a number of storage rooms and stationery cupboards were not on the cleaning schedule (some of these rooms were locked on the day so we were unable to gain access) and some toilets did not have lids (meaning when the toilets were flushed, the contents would aerosol). There were unpleasant odours in both the sluice room and accessible toilet (next to the primary care rehabilitation facility or PCRF for short). Cleaning should be to NHS standards, and this means high use areas such as clinical rooms and toilets required a double clean each day. The practice started seeing patients from 08:00 hours so when the rooms were in use, these areas could not be cleaned until lunchtime (which suggested these areas were only getting one clean per day). Some rooms (the equipment store and stationery storerooms) were not listed on the cleaning schedule.

Healthcare waste was appropriately managed and disposed of with a responsible individual as the named lead. Clinical waste was monitored daily and when required, yellow bags containing waste were secured, labelled and locked in containers awaiting collection. Clinical waste was collected weekly. Waste transfer was recorded by email with paper copies held. Consignment notes were retained by the practice and an annual waste audit carried out in July 2023 showed full compliance. There was a lockable, external compound used to store the waste. However, the bin was very dirty and it was suggested that a request be submitted for a new one. Disposal certificates were retained to provide full traceability of clinical waste once removed from the station.

Risks to patients

The management team detailed how recent gaps in the established posts had resulted in capacity issues. The wait time to see a doctor for a routine appointment was approximately 4 weeks but urgent appointments could be accommodated on the same day. There was a backlog of patient notes (therefore a potential risk for patients whose health issues were yet to be identified and consequentially managed proactively). Gaps in the nursing team meant that they were not currently undertaking any medical for patients aged over 40 (there were 583 patients aged 40 and over). Filling vacant posts with locum staff had been challenging with a number of posts temporarily gapped whilst recruitment took place. The addition of new staff to fill gaps in the administration team was on hold due to the DPHC wide pause in recruitment.

We found that an appointment system was in place which facilitated same day face-to-face appointments with a doctor when needed. The nurse team offered same day appointments through a triage system.

Arrangements were in place to check and monitor the stock levels and expiry dates of emergency medicines. We saw evidence to show that an appropriately equipped medical emergency kit and trolley was in place and regularly checked. We identified a number of minor issues that did not present a risk to patients and were rectified on the day. There were no NEWS (National Early Warning Score) scoring cards nor ATMIST (age, time of onset, medical complaint/injury, investigation, sign and treatment) cards available on the crash trolley (NEWS cards were kept in a folder adjacent to the trolley but not all staff were aware). Therefore it was not clear how information would be handed over to an ambulance crew. There was also no paperwork in the doctor's grab bag. NEWS is an aggregate scoring system used to improve the detection and response to clinical deterioration in adult patients. ATMIST is a tool used for a rapid, accurate handover of a time critical patient.

There was a vehicle that could be used to transport patients from the airfield. A check of the vehicle identified a small number of items that had exceeded their expiry date. These were removed and disposed of on the day.

The staff team was suitably trained in emergency procedures, including basic life support (BLS), automated external defibrillator (AED) sepsis and anaphylaxis. Annual refresher training in BLS, AED and the use of emergency equipment was mandated for all staff. All RAF Medics were in-date for 3 yearly Immediate Emergency Care Provider (IECP) which included responding to medical emergencies, the management of thermal injuries and dealing with suspected spinal injuries. There had been limited simulation training to supplement courses completed by staff online except for BLS where face-to-face training had been delivered by the clinical team. However, we were informed that plans were in place to do more simulation training including the reintroduction of 6 meter ejection seat training (last undertaken in July 2023).

Clinical staff had completed hot/cold injury mandatory training. Sepsis training had been completed and was also last refreshed in December 2023. The Medical Officers were trained in aviation medicine. Doctors completed paediatric training as part of their advanced life support course and some of the nurses had completed paediatric intermediate life support training. Regional headquarters had provided a minor injuries and illness training workshop for the nurses and medics.

The layout of the building allowed patients to be observed whilst waiting.

Information to deliver safe care and treatment

The DPHC SOP was followed for the summarisation of patients' notes. The process for summarising and scrutinising notes was incorporated into the arrival process for patients. However, there was a backlog of notes awaiting summarisation. An audit from January 2024 showed that only 23% of patient notes had been completed. DMICP searches to provide oversight of notes that required summary or review had been amended (to include all clinical codes) and a repeat audit was planned for April 2024. Notes summarising identifies medical issues that may need intervention and therefore was a potential risk if

they were not reviewed. A plan to address the backlog had started with each clinician given 2 sets of notes to summarise each week. However, this had been temporarily put on hold until doctors had been trained on what was needed. The medical notes for families of serving personnel were transferred from NHS GP surgeries via LaSCA (an organisation that operates in partnership with the NHS to provide administrative support).

A peer review programme of doctors' DMICP consultation records was in place. The doctors all reviewed 10 sets of notes for an individual and graded them against a set criteria (included correct clinical coding, quality of note keeping and appropriate management). A doctor's meeting was then held to review the notes and discuss the findings. The peer review of notes for the nurses was carried out in the same way with 10 sets of notes being reviewed by a colleague. Medics did not undertake any routine consultations other than recording basic patient information onto templates. In the PCRF, the last annual notes audit was completed on the civilian physiotherapist and exercise rehabilitation instructor (ERI) in August 2023. Both reached minimum standards or above in all areas. Previous notes audits had shown lower standards and resulted in the use of synonyms (shortcuts used to standardise consultations) on DMICP (to prompt questioning) which had led to an improvement.

Co-ordinated by the administration team, a comprehensive and effective system was in place for the management of both internal and external referrals. Each referral was added to a tracker and this was reviewed monthly at the practice meeting. Urgent referrals were highlighted and prioritised. The administration team monitored the referral tracker daily and all staff granted access could view the document. We highlighted that best practice would be for referrals to remain on the tracker until the report had been returned and actioned and the patient discharged. Any appointment not attended by a patient was followed up. Internal referrals including those made by the PCRF were managed as part of the process.

An effective process was in place for the management of specimens and this was supported by an SOP. Specimens were tracked on an electronic register held on SharePoint. Results were emailed to patients by the requesting doctor. This method of communicating results had recently been discussed and there was plans to utilise DMICP (sending as 'tasks') to facilitate administrative support to clinical staff . We discussed how this could be further improved by using the text messaging service. Samples taken were recorded on a spreadsheet and results were returned via the PathLinks (electronic link between the pathology laboratory and healthcare services) inbox. These were then reviewed by the nursing team who updated the spreadsheet to confirm receipt before allocating to the requesting doctor for action. Nursing staff reported that not all results were returned so outstanding results were also reviewed by the duty nurse who then chased up any missing laboratory reports.

Staff reported regular DMICP outages and the slow speed of the system was seen to be wasting clinical time.

Safe and appropriate use of medicines

There were systems in place for the safe handling of medicines. A number of minor issues were raised during the inspection. Most of these were rectified on the day and did not create any risk to patients. A more significant issue we discussed related to the security

and access arrangements into the dispensary. It was apparent that there was an inconsistency in approach across DPHC regions so we sought advice and guidance from the command pharmacist at DPHC headquarters and from the CQC medicines management team.

The DSMO was the named lead for medicines management and this was reflected in their terms of reference (TORs). The day-to-day management was delegated to the pharmacy technicians and this was reflected in their TORs.

Arrangements were in place for the safe management of controlled drugs (CD), including destruction of unused CDs. We saw that monthly checks had been completed; the CD specimen signature list was complete. The CD cabinet was compliant and access controlled. Destruction certificates had been completed and witnessed by an appropriate individual external to the practice.

Emergency medicines were easily accessible to staff in a secure area of the medical centre and all staff knew of their location. The storage of oxygen and Entonox (an inhaled gas used for pain relief) cylinders was safe and the area was clear of clutter. Appropriate signage was displayed on the doors of rooms containing medical gases.

Medication requiring refrigeration was monitored twice a day to ensure it was stored within the correct temperature range. Storge arrangements for the vaccinations were secure and all stock was found to be in-date.

All staff who administered vaccines had received the immunisation training as well as the mandatory anaphylaxis training.

Prescription stationery was stored securely in the dispensary. There was a system to track their issue and usage to the individual prescriber.

Patient Group Directions (PGDs) had been signed off to allow appropriately trained staff to administer medicines in line with legislation. The PGDs were current and signed off by the authoriser. Medicines that had been supplied or administered under PGDs were in-date. Patient Specific Directions were not used at the practice.

There was an effective process to manage requests for repeat prescriptions. Requests were managed in person, email or by e-Consult, in line with policy. Re-issuing of repeat prescriptions only happened if the medication review was in-date and there were available repeat counts on the patient’s prescribing record. Pharmacy technicians showed good awareness of their responsibilities and when requests should be tasked to a senior clinician. A spot check of the dispensed repeat prescriptions found that all had been dispensed within 8 weeks. This showed that the pharmacy technicians were effectively informing patients that their prescriptions were ready for collection and were efficiently returning uncollected medicines to stock if they were not collected within 8 weeks (the prescriber was informed). 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. The repeat prescription process was detailed in the practice leaflet and in a poster displayed at the dispensary hatch.

The 5 patients on repeat medication we checked had all been managed appropriately. We saw evidence to show that patients' medicines were reviewed regularly and the doctor's notes in DMICP around medication changes were comprehensive.

Reviews of patients prescribed antibiotics were carried out 6 monthly. The most recent conducted in September 2023 raised no concerns. All but 1 of the antibiotics prescribed were in line with guidance. For the exception, there was no primary care antibiotic prescribing guidelines but the consensus among clinicians was that the right antibiotic, dose and duration was given.

A process was established for the management and monitoring of patients prescribed high risk medicines (HRM). We saw that this was a collaborative approach between the prescribing clinicians and the pharmacy technicians. The register of HRMs used at the medical centre was held on DMICP and all doctors and relevant clinicians had access to this. We looked at a sample of patient records and saw that all had been coded, monitored within recommended timescales and had shared care agreements in place. An HRM audit was conducted in February 2024, the overall compliance was 42% and evidence was seen that an action plan had been created and communicated to the team to improve the timely monitoring of patients prescribed HRMs. In addition, assurance of HRM management was supported by a quarterly regional audit.

Track record on safety

Measures to ensure the safety of facilities and equipment were in place. Electrical safety checks were in-date. Water safety measures were carried out weekly with the water tested by the environmental health technicians (based on the station but not medical centre staff). A legionella inspection had reportedly been conducted but the medical centre had not been provided with a copy so were not aware of the date. A fire risk assessment of the building was undertaken annually and firefighting equipment tests were current. Staff were up-to-date with fire safety training and were aware of the evacuation plan. A land equipment audit completed in November 2023 highlighted 9 areas of non-conformance and 3 minor observations. The practice sent evidence to show that the areas of non-conformance had been actioned.

A system for monitoring and recording the servicing of all clinical/non-clinical equipment was established, including equipment in the PCRF.

Staff had adopted the current risk template as per DPHC guideline and used the 4Ts (treat, tolerate, transfer or terminate) to manage risk. The Warrant Officer had completed the necessary courses to conduct risk assessments and all risk assessments were in-date at the time of the inspection.

The HcG workbook contained active and retired risk registers. The active risk register was reviewed regularly with risk management being a standing agenda item at the monthly practice and HcG meetings.

A business continuity plan (BCP) was in place for the medical centre, this had last been updated in November 2023. The BCP was held on the medical centre SharePoint so could be accessed remotely if required. The plan was comprehensive in covering the most likely

causes of a major incident and included a list of key personnel together with their contact details. These included the utilities providers, 'facilities and plans' team and neighbouring military medical centres. A major incident plan was also in place and this covered the station as a whole. A station crash exercise involving the medics had taken place in June 2023.

The medical centre had a fixed alarm system that was tested regularly for both serviceability and response.

Staff had the information they needed to deliver safe care and treatment to patients. If there was an unplanned DMICP outage, the medical centre would undertake urgent care only as per DPHC direction. Clinic lists were printed at the end of each day so appointments could be reviewed and rescheduled in the event of an unplanned outage. The BCP detailed workaround steps should problems with connectivity continue. Paper records would be used and scanned onto DMICP once access had been reestablished.

Lessons learned and improvements made

All staff had access to the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events and incidents. There was a designated ASER lead and deputy, this was reflected in their TORs. The staff database showed that all staff had completed ASER training and discussion around learning took place at the monthly practice management and HcG meetings. A record of ASERs was maintained by the Warrant Officer. We saw these had been completed in a timely manner and included a completion date, whether or not the ASER had been added to the risk/issues log and a note of any lessons learnt. The originator of an ASER was invited to the HcG meeting (if not a regular attendee) so that information could be discussed face-to-face.

From interviews with staff and evidence provided, it was clear there was a culture of reporting incidents for all staff. Both clinical and non-clinical staff gave examples of incidents reported through the ASER system including the improvements made as a result of the outcome of investigations. An ASER log was maintained on the HcG workbook and this included any resultant changes made.

ASER audits were completed twice a year. Recent audits highlighted the main trend as being where information had been sent out to the wrong patient in error. As a result, additional training was delivered to the medics to reinforce the importance of and refresh the processes around data protection.

An electronic near miss log was in place in the dispensary. The pharmacy technicians understood the importance of using a near miss log and shared the learning with all medics working in the dispensary. Near misses had been recorded in 2023 and 2024 which evidenced that the system was used appropriately.

A system was in place for managing patient safety alerts. The pharmacy technicians checked the Central Alerting System spreadsheet and distributed alerts in-house. All clinicians were signed up to receive Medicines and Healthcare products Regulatory Agency alerts and the website was checked daily. We were given a recent example of an alert on the dispensing of sodium valproate as full packs only.

Are services effective?

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

Effective needs assessment, care and treatment

Arrangements were in place to ensure staff had a forum to keep up-to-date with developments in clinical care and guidance included in the monthly governance or continuing professional development (CPD) meetings. The nursing team also referred to clinical guidelines in their monthly meetings. The CPD meetings incorporated an agenda item to discuss national clinical guidance, including National Institute for Health and Care Excellence (NICE) and the Scottish Intercollegiate Guidelines Network (SIGN). Guidelines relevant to primary health care and those that required a more thorough discussion/review were discussed at subsequent meetings and reported as acted on or not. Adherence to clinical guidelines formed part of the peer review for doctors and nurses. Issues with staffing levels had resulted in auditing against current NICE guidelines not having been carried out since September 2023 (although any new guidance was discussed at the weekly clinical meetings). The practice were looking at a new meeting structure to facilitate discussion and review actions taken in response to updates on clinical guidance.

Our review of clinical records demonstrated that clinicians carried out assessments and provided care and treatment in line with national standards and guidance, supported by clear clinical pathways and protocols.

Staff were kept abreast of clinical and medicines updates through the Defence Primary Healthcare (DPHC) newsletter circulated to individual staff and to the medical centre each month. Participation with regional events and forums also provided an opportunity for clinicians to keep up-to-date.

Monitoring care and treatment

Long-term conditions (LTCs) were managed by the nursing team with the main LTCs divided between the team so that there was a named lead for each. The nurses managed their own monthly searches and any issues. For example, non-compliant patients diagnosed with epilepsy were flagged to a doctor. Most of the patient recall was carried out by the nurses who managed diary dates for reviews. A document was used to detail what tests were needed including blood tests required for annual reviews. Staff had completed specific training in some of the LTCs including the advanced nurse practitioner (ANP) asthma update. We looked at a sample of patients' notes; they were comprehensive and in good order. The medical centre provided us with the following data:

- The small number of patients on the diabetic register were regularly monitored in accordance with best medical practice guidance. Processes were in place to identify and monitor patients at risk of developing diabetes.
- There were 49 patients on the hypertension register who were regularly monitored in accordance with best medical practice guidance. All 49 patients had a record of their

blood pressure taken in the past 12 months and 36 had a blood pressure reading of 150/90 or less.

- There were a total of 55 patients with a diagnosis of asthma, 41 had received an asthma review in the preceding 12 months using the asthma review template. Reviews on the remaining 14 patients were planned.
- Audiology statistics showed 65% of patients had received an audiometric assessment within the last 2 years. The nursing team and medics had an effective recall process in place, completed the appropriate templates and applied the correct Read codes.

Through a review of clinical records and discussions with the doctors, we were assured that the care of patients with a mental illness and/or depressive symptoms was being effectively and safely managed, often in conjunction with the Department of Community Mental Health (DCMH). The practice followed the DPHC guidance and provided step 1 interventions and immediate referral for appropriate diagnoses. We noted that there was a good welfare setting for families and RAF personnel. This included signposting patients via self-referral to the RAF Benevolent Fund, local talking therapy for families and some cognitive behavioural therapy.

Wait times for mental health referrals were generally good. However, staff reported long wait times for first appointments with the DCMH. Those patents waiting were assessed by DCMH to prioritise when deemed necessary and monitored by the doctors whilst awaiting the appointment.

We saw that referrals to the Regional Rehabilitation Units and minor injury assessment clinics were made promptly with manageable wait times for the patients.

An audit lead and audit calendar were in place and this extended to and integrated with the primary care rehabilitation facility (PCRF). The practice was engaged with the DPHC regional headquarters audit programme and this was tracked in the healthcare governance (HcG) workbook. Due to staffing levels, there was a focus on completing the mandatory DPHC audits. Some clinical audits had been completed and these included epilepsy, diabetes and antibiotic prescribing. However, there had not been any annual audit on minor surgery in the past 12 months. The Unit Medical Officer (who was the governance lead) had a practice -wide general change and improvement plan scheduled for March and April 2024.

Effective staffing

There was an induction pack for all new staff that included role specific sections. All inductions were held on the HcG workbook. The induction processes had recently been improved to be more specific to the departments (RAF medics, nurses, doctors and civilian staff) following a review of ASERs. During the induction, new staff members were provided with shadowing opportunities and a booklet for individuals to sign off when elements had been completed. Peer review of notes was also completed as part of the induction process for clinicians

On arrival, locum staff completed the DPHC mandated locum induction programme which had been amended accordingly to include role-specific elements and information relevant

to the unit and geographical area. According to the staff database, all locums had completed their induction programme and evidence of this was shown at the time of the visit.

There was a training calendar and a record of mandatory training. The training lead monitored the status for staff and discussed required training activity in the practice meetings. A hard copy of mandatory training was displayed in the training room. Protected time was afforded to staff every Wednesday afternoon to complete training. Compliance levels for training were high across the team and all clinicians were encouraged to engage in CPD and were supported in taking study leave. This was monitored via the appraisal system for doctors and nurses.

The meeting schedule supported CPD and revalidation requirements through clinical updates, guideline reviews, safeguarding updates and RAF/Defence Medical Services (DMS) specific training.

There was role-specific training for relevant staff. For example, the doctors received training to provide aviation and diving medicals. CPD included a course for doctors on domestic abuse and one doctor who had signed up to complete a dermatoscopy course. The RAF medics were signed up to compete the DMS apprenticeship scheme with allocated study and clinical time with doctors and nurses. The Warrant Officer and practice manager had attended a risk management training course at RAF Halton.

Staff administering vaccines had received specific training which included an assessment of competence. Vaccinators could demonstrate how they stayed up to date with changes to the immunisation programmes, for example, by access to online resources and discussion at nurses' meetings.

Coordinating care and treatment

Practice staff attended the Personnel Support Committee meetings (held monthly) at which the health and care of vulnerable and downgraded patients was reviewed (consent from the patient was gained in advance). A doctor attended the welfare meetings when requested or if clinical capacity allowed. Case conferences were also attended by a doctor and consent was gained in advance to enable the doctor to discuss the case prior to the meeting. Handovers were arranged with the receiving practice when vulnerable patients moved between services. There was no specific handover for civilian patients unless there was serious concerns.

It was clear that the PCRF was an integral part of the practice. The practice communicated well with staff in the PCRF, meetings were inclusive and governance structures integrated.

For patients leaving the military, pre-release and final medicals were offered. During the pre-release phase, the patient received an examination and a medication review. A summary print-out was provided for the patient to give to the receiving doctor, and a letter if the patient was mid-way through an episode of care. A few month's supply of medicine was given to those on repeat prescriptions to ensure that the transfer did not make gaps.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred or after they were discharged from hospital. Information was shared between services and we saw that a full copy of findings from investigations and any further treatment requirements were sent to the medical centre to update the patient's records.

The PCRF staff referred to the Regional Rehabilitation Unit (RRU) at Catterick (or to an alternative RRU if courses were available sooner). There was no significant wait times and a recent change to fortnightly courses provided easier access.

Helping patients to live healthier lives

The practice had a named lead for health promotion and there was a structured programme of health promotion activity with a yearly planner and calendar on the HcG workbook. The health promotion displays were comprehensive, clear and positioned strategically to target the most relevant cohort of patients. There was a campaign on recognising the symptoms of measles at the time of the inspection visit. Staff has been involved in supporting health fairs and linked in with station health promotion work. Information had been pushed out around the station using electronic scrolling boards. Posters had been placed in the messes, gymnasium, shop as well as posts made on the Facebook community page. The health promotion lead sat on the health and wellbeing committee alongside the environmental health technician and exercise rehabilitation instructor.

Two of the nurses had completed specific sexual health training (referred to as STIF) and provided sexual health screening, support and advice. Patients were signposted to a local NHS sexual health clinic for procedures not undertaken at the medical centre. There was also an outreach clinic in Catterick for under 18 year olds. Many patients did not drive and the station was not well served with public transport so the local sexual health services had been invited into the practice. In addition to appointments offered during the day, a recent evening walk in clinic was provided for smears. There were plans to repeat this in the future. Chlamydia testing kits, sanitary products and condoms were available at the practice. These were provided free of charge and placed in the toilets meaning patients had access without having to ask a member of staff. Heath fairs were used to target sexual health screening and provide educational help and advice although the next one planned for May 2024 was to provide a focus on mental health.

The number of eligible women whose notes recorded that a cervical smear had been performed in the last 3-5 years was 333 which represented an achievement of 87%. The NHS target was 80%.

Regular searches were undertaken to identify patients who required screening for bowel, breast and abdominal aortic aneurysm in line with national programmes. At the time of the inspection there were a small number of patients identified that met the criteria for screening. A recall system was in place that monitored uptake and those eligible were in-date for screening.

Patients due a vaccination were identified when summarising patient notes. The units were responsible for ensuring their personnel booked in for their own vaccines. Force protection performance was high with vaccination statistics identified as follows:

- 88% of patients were in-date for vaccination against polio.
- 92% of patients were in-date for vaccination against hepatitis B.
- 91% of patients were in-date for vaccination against hepatitis A.
- 88% of patients were in-date for vaccination against tetanus.
- 99% of patients were in-date for vaccination against MMR.
- 99% of patients were in-date for vaccination against meningitis. *
- 88% of patients were in-date with vaccination against diphtheria.

  * there was no requirement for the medical centre to undertake a pro-active catch up programme for permanent staff. However, they did a periodic vaccine recall and push in line with NHS guidance.

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 World Health Organisation (WHO) based national target of 95% (the recommended standard for achieving herd immunity) for all childhood immunisation uptake indicators. 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)	98%	WHO target met.
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received	100%	WHO target met.

Pneumococcal booster) (PCV booster)		
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%	As above.
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR)	100%	As above
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR)	96%	Met 95% WHO based target

Consent to care and treatment

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. Consent recording formed part of peer review and audits were carried out. The chaperone training module included a section on obtaining and recording consent. However, a review of the consent audit and re-audit (both carried out in December 2023) showed that despite further training, clinicians were not asking for and coding consent (although some were asking and writing consent). Records suggested that a chaperone was not always offered for more intimate examinations, were not coded correctly and were written within the text from the consultation (this means that searches when auditing would not identify these consultation records). All patients seen in the PCRF were sent a consent for assessment and treatment form prior to their first appointment. This included the definition of informed consent, the right to refuse treatment and the right to request a chaperone. Completed forms were Read coded correctly and added to DMICP.

Clinicians had a good understanding of the Mental Capacity Act (2005) and how it would apply to the population group. All staff received training as part of their in-house programme. In addition, the Senior Medical Officer had delivered face-to-face training in July 2023. As part of their CPD, the clinicians had discussed a recent example of seeing a patient who lacked capacity. Capacity was assessed for all patients when consulting to ensure they had the capacity to make their own decisions and participate in discussion around their treatment and care.

Clinicians were aware of ‘Gillick competence’ and ‘Fraser guidelines’ (used to assess whether a child is mature enough to consent to treatment). One of the nurses had recently completed a contraception module where competence and guidelines were discussed.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

In advance of the inspection, patients were invited to give feedback using comments cards. A total of 38 patients responded and feedback was positive. We also observed staff being courteous and respectful to patients in person and on the telephone. The overriding theme was that staff were friendly, professional and willing to listen.

Patients could access the welfare team and various support networks for assistance and guidance. Information regarding these services was available in the waiting areas and the clinical staff were fully aware of these services to signpost patients if required.

A continuous patient questionnaire had been in place but the number of returns in 2023 was very low. A new, revised questionnaire was released in January 2024 and electronic tablet devices were positioned in the patient waiting area. A review of the comments from the new questionnaire had yet to be conducted but the practice reported an increase in returns.

Involvement in decisions about care and treatment

Patients with caring responsibilities and cared for patients were identified through the new patient registration form and at new patient medicals. Patients identified as having a caring responsibility had an alert on their notes and were captured on a DMICP register. Priority appointments were given to patients with caring responsibilities when required. However, a review of the records showed that 2 out of 5 carers did not have an alert in place.

There was a carer’s lead and deputy for the practice. Staff had access to a carers’ policy and carers’ register standard operating procedure. These included how to identify a carer, Read codes and support measures such as annual flu vaccinations.

A carer’s poster was situated in the waiting area. QR (quick response) codes allowed patients to access forms to notify the practice that they had carer responsibilities and to download a carer’s questionnaire. Although not named on the poster, there was an appointed lead and deputy for coordinating support to carers. There were contact details for support staff and services including local support services and national helplines. However, there was no information for carers on the patient information leaflet.

Staff could access ‘The Big Word’ translation service if they needed it. There was an accessible information pack for staff kept in the main office that provided clear instruction and telephone numbers needed to use the service. Staff told us that there had been a recent requirement to use the service and this was done successfully. Although there was

no clear signage at the reception desk to inform patients of the translation service, there were posters in all of the consulting rooms.

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 primary care rehabilitation facility (PCRF) occupied rooms within the same building to the main medical centre. Clinical rooms provided privacy for patients.

The reception area was well laid out with the waiting area set back from the desk meaning that conversations between patients and reception would unlikely be overheard. If patients wished to discuss sensitive issues or appeared distressed at reception, they were offered a private room to discuss their needs. This was supported by clear signage on the reception desk. Telephone consultations were undertaken in private to maximise patient confidentiality (calls were fielded in the main office that was separate to the reception desk area). There was a television in the waiting area that provided background noise to promote privacy. The dispensary hatch could only accommodate one patient at a time and the door was closed when a patient was in attendance.

The staff team were in-date with their Defence Information Management Passport to ensure awareness when handling personal information.

The mix of male and female staff allowed the medical centre to facilitate patients who wished to see a clinician of a specific gender. If requests could not be met by the medical centre, they would be accommodated by signposting patients to an alternative military medical centre in the region.

Are services responsive to people's needs?

We rated the practice as good for providing responsive services.

Responding to and meeting people's needs

The practice used an appointment system where patients could be seen in person or have a consultation by telephone. Home visits were not routinely offered but had been provided in rare circumstances when a patient was house bound through ill health or unable to attend the practice in person. Requests for a home visit were assessed by a doctor on a case-to-case basis. The eConsult service was used to provide more convenient access to information and advice whilst prioritised patients in need of urgent care could be seen in person.

An Access Audit as defined in the Equality Act 2010 had been completed for the premises in January 2024. Actions identified in the audit had been completed. These included allowing extra time for patients who required the translation service. The building and surrounding area including the car park supported access for those with reduced mobility. There were disabled parking spaces close to the entrance, a dropped kerb and automatic opening front doors. Inside the building, there was an accessible toilet and baby changing facilities.

A hearing induction loop was available at reception. Crutches and a wheelchair were available for any patient that may need support due to limited mobility.

Dependant on the patient's clinical need, the option of a telephone or face-to-face appointment or e-mail reply could be offered. The practice found this system to be effective for patients to gain access to appointments so had continued once COVID-19 restrictions relaxed. Telephone consultations had become commonplace and a doctor's routine daily clinic was a mix of face-to-face and telephone conversations. Aircrew specific medicals were provided.

The practice had a diversity and inclusion (D&I) lead role and this was vacant at the time while a member of staff completed training for the role. There was a dedicated noticeboard situated on the first-floor corridor. The noticeboard included the D&I network representatives contact details. Staff were aware of the new Defence Primary Healthcare (DPHC) transgender standard operating procedure and accommodated cultural requirements such as the implications of fasting on physical training and rehabilitation appointments. A transgender policy was in place and we were given an example of a patient who had been well managed.

The practice had taken a number of measures to have a positive impact on the environment. Recycling bins were used throughout the practice. The practice had linked into ecology and conservation. As part of the health and wellbeing support, patients were signposted to 'ECO therapy' designed at getting people outdoors for ecological conservation and developing a series of polytunnels.

Timely access to care and treatment

The practice opened Monday to Friday 08:00-18:30 hours although Wednesday afternoons were protected for training with only urgent appointments available. A duty doctor was available each day and saw any urgent patients as well as working through the eConsult correspondence. Due to it being a flying station, medical cover was provided 24/7 by a duty medic. Medics would triage any call and signpost patients or book them in for an appointment at the practice. The duty phone number was also held in the guard room that was staffed 24/7. The dispensary opened each weekday from 08:00 to 18:30 hours except for on Wednesday (from midday due to training) and Friday (from 15:00) afternoons.

Details of how patients could access the doctor when the practice was closed were available through the patient information leaflet, on the main entrance to the building and on the recorded message relayed when the practice was closed. Details of the NHS 111 out-of-hours service was in the patient information leaflet and instructions were displayed on the doors at the main entrance so could be seen when the practice was closed.

There was good availability of urgent appointments for all clinicians. For example, urgent slots with a doctor were available on the day. However, there was an approximate wait of 4 weeks for a routine appointment (although this is longer than what we normally find in Defence Medical Services, it is comparable to NHS services which we benchmark against). An appointment with the nurse could be secured the same day and a routine appointment within 1 day. Routine and follow up appointments were available with a physiotherapist within 5 days and urgent appointments could be accommodated on the day. The Primary Care Rehabilitation facility was meeting all of its key performance indicators for access. New patient appointments were available with an exercise rehabilitation instructor (ERI) within 2 days. Follow up ERI appointments were available the following day.

Evening appointments for cervical smear testing had been introduced to give more flexibility to those patients unable to attend in core working hours. To help with audiometry assessments, there was a proposal for an audio booth to be relocated to Fylingdales with staff attending on a regular basis to undertake audios for pre-arranged appointments.

Listening and learning from concerns and complaints

There was a named lead and deputy for the management of complaints. The process followed was in accordance with the DPHC complaints policy and procedure. Written and verbal complaints were recorded and discussed at the monthly practice meetings together with any compliments that had been received. There had been an insufficient number of complaints to trigger an audit but the lead was aware of the threshold. A total of 4 complaints had been received in the preceding 12 months and no trends were identified. We reviewed 1 of the 4 complaints in detail. This had been managed appropriately and in accordance with policy. The complainant had praised the practice manager for their efforts and timeliness of responses.

Information was displayed in the patient waiting area and included a flow chart to detail the process when making a complaint. The complaints process was also detailed in the patient information leaflet and on interactive boards around the station.

Are services well-led?

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

Vision and strategy

The medical centre worked to the Defence Primary Healthcare (DPHC) mission statement which was: ”DPHC is to provide safe, effective healthcare to meet the needs of our patients and the chain of command to support force generation and sustain the physical and moral components of fighting power”.

Leeming Medical Centre had written their own mission statement which was specific to their role on station. This was ”to provide appropriate levels of medical to all service personnel and their families registered at RAF Leeming in co-operation with local health care agencies.”

The Senior Medical Officer (SMO) had joined the practice in November 2023 and had set a list of priorities. One was to focus on staff welfare and bring the whole team together for social events, physical training and informal gatherings that included ‘fishfinger Tuesday’ where all staff were welcome to gather in the crew room for fishfinger sandwiches. The SMO provided protected time for doctors to complete essential administrative work to relive some of the time pressures. Although this has resulted in a longer wait time for patients to see a doctor for a routine appointment, urgent requests were well-manged with same day appointments available.

Strong links had also been re-established with the station by attending unit executive meetings and sending representation to the unit health committee. It was clear that the strategy was having a positive impact with more correspondence being sent to the SMO from units to raise any concerns around the individuals under their command.

Leadership, capacity and capability

A key feature for Leeming Medical Centre was that they were a training practice. There had been a reduction in the number of trainee doctors (there had not been any since November 2023) and this had impacted service delivery.

The practice had been through a time when a number of positions in the established team were not filled. This had impacted service delivery in the preceding 12 months and although there had been some improvement, a number of resultant issues presented a challenge. However, we found a team who were measured in their approach and had the experience to prioritise and provide good clinical care. The SMO stated that there was a shortage of doctors and was in discussion with regional headquarters to escalate the challenges and impact. In particular, occupational medicine had increased and carried an administrative burden. The SMO had taken steps to protect the doctors from ‘burn out’ and train the medics on reception to filter demand to reduce the workload on clinicians. In addition, the planned introduction of ‘total triage’ was aimed at reducing the clinical workload by assessing the necessity to be seen by a nurse or doctor. Medicals were

prioritised with those less operational such as sports medicals being a lower priority than those required to deploy and fly. The primary care rehabilitation facility (PCRF) had benefited from an experienced physiotherapist who although not part of their job, had provided leadership through a period when the senior post was vacant.

Leaders within the medical centre provided direction, decision making and structure. There was a comprehensive meeting structure that underpinned the governance structure and promoted an inclusive leadership approach. Staff we spoke with praised the leadership and this was echoed in the feedback from affiliated staff and patients.

The SMO and the Deputy Senior Medical Officer (DSMO) covered each other as the clinical leads during periods of leave, deployments, and other absences. The Warrant Officer, practice manager and deputy managed their leave to ensure there was always a constant managerial presence within the practice.

Job descriptions and terms of reference were mostly in place for all members of staff. There was a list of roles and responsibilities which involved a wide range of staff and each lead had an appointed deputy.

Staff felt well supported by the regional team and commented that this strong working relationship proved a very useful resource for help and guidance.

Culture

Staff were consistent in their view that the practice was patient-centred in its focus.

We heard from staff that the culture was inclusive with an open-door policy and everyone having an equal voice, regardless of rank or grade. All were familiar with the whistleblowing policy and said they would feel comfortable raising any concerns.

Meetings were inclusive with all staff encouraged to attend. Staff felt involved in decisions made and were comfortable in raising any concerns or issues within their department. Group team building exercises were held regularly. Staff welfare was seen as a priority. Medical centre staff physical training was done as a group and ‘fishfinger Tuesday’ and ‘bake-off’ events proved popular with the team.

Processes were established 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. We were provided with examples of when duty of candour had been applied.

Governance arrangements

A comprehensive understanding of the performance of the practice was maintained. The system took account of medicals, vaccinations, cytology, summarising and non-attendance. The last Healthcare Governance Assurance audit took place in 2022 and an overall grading of ‘substantial assurance’ was achieved. The HAF (electronic health

assurance framework) was used to document and evidence governance activity and had been extensively populated by the practice management and other key staff members.

There was a clear staffing structure in place and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. Terms of reference (ToR) were mostly in place to support job roles, including staff who had lead roles for specific areas. Resilience was provided by appointed leads having named deputies who were sufficiently trained to deputise.

All staff had access to the healthcare governance (HcG) workbook which included various registers and links such as the risk register, ASER tracker, duty of candour log, IT faults and cleaning issues log. A range of information was accessible though quick links from the HcG workbook. These included risk assessments, TORs and the standard operating procedure index. The workbook was continually being developed and was managed by the Warrant Officer, practice manager and deputy practice manager.

An audit programme was in place and we saw examples of both clinical and administrative audits where repeat cycles were carried out to monitor standards and quality. There was no forecast of audit activity for the PCRF but there was some records of past activity with minimal input.

A range of meetings with defined topics for discussion were held to ensure a communication flow within the team. The practice had a designated meeting matrix in place which included the following:

- Monday morning brief for all staff.
- Healthcare governance meetings held weekly.
- Monthly nursing meetings.
- Weekly clinical meetings.
- PCRF staff attended the practice, healthcare governance and practice meetings.
- Station Personnel Support Committee (unit welfare meeting) held monthly.
- In-house training held (protected time allocated weekly).

Staff told us that these formal meetings were supplemented by regular ad hoc conversations to share information.

Managing risks, issues and performance

Processes were in place to monitor national and local safety alerts and incidents. The practice had continued to use their own system in addition to the regional system in order to ensure there was a record of action.

An effective process to identify, understand, monitor and address current and future risks including risks to patient safety was in place. Risks were actively monitored and managed in line with DPHC policy and through the ongoing review and revision of a risk register. Risks were escalated as appropriate to DPHC and beyond. Where relevant/applicable, risks were raised by the SMO with the Station Commander/executives and if needed, were added to the station’s risk register. The PCRF managed their own risk assessments and

these were held centrally in the practice risk register. The risk register was held on the HcG workbook and discussed at the monthly HcG and practice meetings. Clinical risks were discussed at the monthly clinical meetings.

Appraisal was in-date for all staff. The leadership team was familiar with the policy and processes for managing under-performance and ensured staff were supported in an inclusive and sensitive way taking account of their wellbeing.

A business continuity and major incident plan was in place and reviewed annually as a minimum. The plan was available for remote access and to all staff through inclusion on the HcG workbook. Tabletop exercises were carried out every 6 months by the station to test the response to a major incident.

Appropriate and accurate information

Quality and operational information was used to ensure and improve performance. The DPHC electronic health assurance framework (referred to as HAF) was used to monitor performance. The HAF is an internal quality assurance governance tool to assure standards of health care delivery within defence healthcare.

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

Engagement with patients, the public, staff and external partners

The practice had been utilising their patient feedback to produce actions that were documented on a noticeboard in the waiting area. The results of an audit on patient satisfaction with pharmacy services were displayed and showed a high level of satisfaction (88% for 2023, an improvement from 63% when the same audit was carried out in 2020). Efforts had been made to establish a patient participation group but there had been a lack of interest among patients.

The practice had developed their own questionnaire to gather patient feedback and positioned touchscreen tablets in the waiting area together with quick review (QR) codes that we displayed on the ‘have your say’ poster. Feedback from the new survey was yet to be collated as it had been introduced in January 2024.

The PCRF provided a questionnaire to all discharged patients after their final appointment using a QR code or tablet in the waiting area. There was the aspiration to also do targeted ‘all patient’ surveys for short periods. The feedback captured praised staff and the treatments provided so no changes had been made as a result of comments or requests from patients.

Good and effective links were established with internal and external organisations including the Regional Rehabilitation Unit, Department of Community Mental Health and

local health services. Safeguarding links were in place with the local area team. Of note, we saw that successful steps had been taken to forge close working relationships with colleagues in the welfare team, padre and SSAFA (the Armed Forces charity).

Continuous improvement and innovation

We identified that the medical centre had an audit programme improvement and a quality improvement project (QIP) programme that were driving improvement. Examples included:

- The change of the pathology form to an electronic DMICP template that saved clinical administration time.
- Evening cervical cytology clinics.
- The planned introduction of the ‘total triage’ system.
- A ‘patient agreement’ scheme to encourage better attendance at rehabilitation classes.
- The development of a ‘gestational diabetic pathway’ and ‘pre-diabetic pathway’ that included education and diet programmes.