Middle Wallop Medical Centre

Stockbridge, Hampshire, SO20 8DY

Defence Medical Services inspection report

This report describes our judgement of the quality of care at Middle Wallop 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. We gathered evidence remotely in line with COVID-19 restrictions and guidance and undertook a short visit to the practice.

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

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Summary

About this inspection

As a result of this inspection the practice is rated as good overall

The key questions are rated as:

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

We carried out an announced comprehensive inspection of Middle Wallop Medical Centre on 5 November 2019. The practice was rated as requires improvement overall, with a rating of inadequate for the safe key question and requires improvement for the well-led key question. The practice was rated as good for the effective, caring and responsive key questions. A copy of the report from the previous inspection can be found at:

www.cqc.org.uk/dms

We carried out this announced follow up inspection on 6, 10 and 13 August 2021. The inspection was carried out remotely on 6 and 10 August and included a short visit by a CQC inspector on 13 August. This report covers our findings in relation to the recommendations made and any additional findings made during the inspection. The Primary Care Rehabilitation Facility (PCRF) did not form part of this inspection as it was no longer operational at Middle Wallop Medical Centre. Patients were signposted to the PCRF at Queen Elizabeth Memorial Health Centre (QEMHC), Tidworth.

The CQC does not have the same statutory powers with regard to improvement action for 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 the CQC's observations and recommendations.

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

At this inspection we found:

- The practice was well-led and the leadership team demonstrated they had the vision, capability and commitment to provide a patient-focused service and consistently sought ways to develop and improve.
- The leadership team had a clear understanding of the issues and had developed plans to resolve or mitigate identified risks.
- There was an open and transparent approach to safety. An effective system was in place for managing significant events and staff knew how to report and record using this system.
- The governance arrangements for infection prevention and control had been strengthened. Additionally, the practice had taken steps taken to minimise the risks associated with COVID-19.
- The arrangements for managing medicines, including obtaining, prescribing, recording, handling and disposal in the practice were now effective and minimised risks to patient safety.
- Standard operating procedures (SOPs) had been developed to ensure appropriate coding, outcomes and templates were consistently used by clinicians. A programme of ongoing audit of clinical records had been established to ensure standards of record keeping were monitored.
- Processes were in place for capturing and acting on patient feedback, results and actions taken in response to feedback were clearly displayed.
- Patient feedback about the service was positive. It showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.
- The practice had developed an audit programme to improve patient outcomes and the practice could demonstrate how quality improvement work was driving improvement.
- The practice had an system to ensure that staff completed the required mandated training.
- Effective medical cover was in place to cover the times when the practice was closed.
- Staff understood the Mental Capacity Act (2005) and how it applied in the context of the service they provided.
- Governance systems, activities and working practices had been strengthened. The healthcare governance workbook was well-developed and captured a wide-range of information to illustrate how the practice was performing. Integration had commenced in readiness for the move to being a group practice.
- Information systems and processes to deliver safe treatment and care were established and included referral tracking, notes summarising, audit of clinical record keeping and the management of referrals.
- The practice had good lines of communication with the units and welfare team to ensure the wellbeing of recruits. Links had been developed both internally and externally to enhance the support provided to patients.

- The building and equipment were sufficient to treat patients and meet their needs. However, potential improvements had been highlighted in the recent disability access audit (DDA).
- The privacy and dignity of patients was respected with clinicians using privacy screens and curtains when treating patients.
- Staff understood and adhered to the duty of candour principles.

The Chief Inspector recommends:

- Ensure a programme is implemented to address the backlog of patients eligible for an over 40s health check.
- Follow up on the potential need for improvements identified in the Disability Access Audit (DDA).

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

This inspection was undertaken by a CQC inspector and the inspection team comprised specialist advisors including a primary care doctor, a practice nurse, a practice manager and a pharmacist.

Background to Middle Wallop Medical Centre

Middle Wallop Medical Centre provides a routine primary care service to a patient population of approximately 660 service personnel. Families and dependants are signposted to nearby NHS services. At the time of the inspection there were 13 registered patients under the age of 18 and 335 patients aged 40 and over. The practice also provides occupational health to service personnel only. There was a higher number of patients aged 40 due to senior office based military personnel. In addition, the patient population included those belonging to the Army Chaplaincy Department.

In addition to routine GP services, the treatment facility offers minor surgical procedures, and travel advice. Family planning advice is available, with referral onwards to NHS community services. Maternity and midwifery services are provided by NHS practices and community teams. Medicals offered include fitness to fly and sports diving. The Primary Care Rehabilitation Facility (PCRF) had been transferred to QEMHC, Tidworth ahead of merger to become a group practice.

Opening hours are from 07:30 to 16:30 Monday, Tuesday, Wednesday and Thursday. On a Friday, the practice opens from 07:30 to 16:00. Outside of these hours including weekends and public holidays, cover is provided by NHS 111.

The staff team at the time of the inspection

Position	Numbers
Senior Medical Officer (SMO)	one (shared with Tidworth Medical Centre)
Deputy Senior Medical Officer (DSMO)	one (currently gapped post being filled August 2021)
Civilian medical practitioners (CMP)	two (one full-time, one part-time)
Civilian practice nurse	one
Military practice manager	one
Administrative staff	one E1 one E2
Regimental clinical staff (medics)	eight

Are services safe?

We rated the practice as good for providing safe services.

Following our previous inspection, we rated the practice as inadequate for providing safe services. We found inconsistencies in processes to keep patients and staff safe including gaps in:

- the arrangements for infection prevention and control;
- the system to ensure timely reviews of sample testing results;
- systems and processes for medicines management; and
- management of risk.

At this inspection we found the recommendations we made had been actioned.

Safety systems and processes

Systems were established to keep patients safe, including processes to safeguard patients from abuse.

- The practice had safety policies including adult and child safeguarding policies which were reviewed, displayed in clinical rooms and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. Policies accessible to all staff (including locums) outlined clearly who to go to for further guidance, these safeguarding policies were reviewed annually. A quick reference guide was available in each clinical room. This included a flow chart with local contact details and a link to the 'NHS App'.
- There was a risk register of vulnerable patients and a system to highlight them on the clinical operating system (referred to as DMICP). Review meetings to discuss vulnerable patients were held every four weeks and additionally if required. There was a total of 13 patients under the age of 18 was at the time of inspection; all had been added to the vulnerable register. A doctor carried out monthly audits on vulnerable patients to see if they had been seen in the last 35 days and had their medication reviewed in the last 90 days and followed up when required.
- Staff took steps to protect trainees from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. Practice staff attended meetings with welfare teams and the Chain of Command to discuss the needs of this population group when required.
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns and safeguarding contact details were clearly displayed in all clinical rooms. Staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. A list of trained chaperones was displayed at reception. The chaperone policy was available to patients in a dedicated leaflet. In addition, advice on chaperones was provided in the

patient information leaflet. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. DBS checks were undertaken where required.
- There was now an effective system to manage infection prevention and control (IPC). Since the last inspection, the practice IPC link nurse had completed role specific training and was supported by an IPC lead for the region. Audits were carried out monthly and we saw a log that showed actions highlighted had been completed. We found that longstanding, minor issues highlighted at the last inspection had now been rectified. The IPC lead attended regional forums and produced a list of contacts for colleagues to refer to in her absence. All staff were required to complete an IPC course via e-learning. The practice manager conducted a monthly compliance check of the building, this was recorded on a register together with any follow up action required.
- The practice manager was the lead for cleaning and the contract was outsourced to an approved company. Systems in place included a process for reporting issues and monitoring the standard of cleaning. Annual deep cleaning took place and the audit programme included a six monthly check of compliance to cleaning standards.
- There were systems for safely managing healthcare waste supported by a policy. Clinical waste and pre-acceptance audits were carried out annually, the most recent in March 2021. The external bins used to store waste while awaiting collection were now secured and locked.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. The safety certificates for water, gas, electric and legionella were held by the unit and copies were made available to the practice.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed. There was an effective approach to managing staff absences and for responding to epidemics, sickness, holidays and busy periods. Staff had been upskilled to fulfil multiple roles and provide resilience and gaps were filled using staff from the Queen Elizabeth Memorial Health Centre (QEMHC) at Tidworth.
- An induction system was in place for temporary staff and this had role specific elements. All staff had completed a workplace induction and this has been recorded on the staff database. The practice also have a doctor and nurse handbook for reference which included details such as referral processes, prescribing information, standard operating procedures (SOPs) and mental health. Although there had been no new members of staff since the process was implemented, the practice manager planned to retain copies of completed induction checklists.

- Clinicians adhered to military guidance around sickness periods for personnel. They communicated effectively with Chain of Command so that line managers knew which tasks personnel could safely undertake.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. All items located on the emergency trolley had been uploaded onto the clinical operating system (DMCIP) which enabled stock expiry to be managed more efficiently. Face-to-face training had been delivered to staff on thermal injuries with cold injury training planned for later in the year. Sepsis guidelines were displayed throughout the practice.
- Staff were trained in how to respond to a medical emergency, for example, simulated training scenarios had been carried out on heat injuries. Clinicians knew how to identify and manage patients with severe infections including sepsis. Sepsis training was last done in July 2021 and was refreshed annually. There was a dedicated posters to inform patients about sepsis. Further training that was refreshed annually included cold injuries, heat injuries, basic life support and anaphylaxis.
- When there were changes to services or staff, the practice assessed and monitored the impact on safety using a comprehensive risk assessment template.
- A COVID-19 risk assessment had been completed. Clinics had been moved to telephone and/or Skype to reduce the need to visit the medical centre. Face-to-face appointments were offered when required, and appointment slots had been extended by five minutes to allow cleaning in between patients. Any patient with COVID-19 symptoms who required a face-to-face appointment was seen in the emergency treatment room, and cleaning was carried out between patients. Access to the room was direct from the outside to avoid entering any other part of the building. Seating in the waiting area hand been reduced to allow social distancing and signage throughout the medical centre promoted keeping a two metre distance. Staff were provided with personal protective equipment, touch points in the building were cleaned twice daily and sick parade had changed to a virtual clinic. The medics had been trained to telephone triage same day requests (triage is the prioritising of patients according to medical need). Staff worked from home where possible, there was clear signage throughout the practice and hand sanitiser was available at the main entrance and throughout the centre.

Information to deliver safe care and treatment

At our previous inspection we identified that staff did not always have the information they needed to deliver safe care and treatment to patients because the system to process pathology results was not failsafe.

- The system to manage pathology results was now effective. The practice nurse had reviewed the process and implemented a new SOP. Several individuals had been trained to cover any period of absence. There were clear lines of responsibility and a tracker that was checked daily (the tracker was a list of all outstanding sample test requests). There was an electronic system that had a record of received test results awaiting review, this was checked daily.

- The practice had an effective process for the electronic summarising of patient notes. The practice had adapted the Defence Primary Healthcare (DPHC) new patient registration form and used a template that identified any chronic disease or outstanding health needs. The practice nurse summarised new patient notes at the point of registration and set up and tasked the administration team with any patient recall required. All patient notes had been summarised at the time of this inspection. However, we found a gap where pre-diabetic patients had not always been identified. This was actioned the day after the inspection.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. There was a documented approach to the management of test results with named staff responsible.
- Referrals and hospital appointments were managed by the administrative team and patients were well supported to obtain the timeliest access to secondary care. A standard referral template letter was in use by clinicians and each was entered onto a register. Internal referrals (to other healthcare services within the military) were included on the same register. The register was reviewed weekly and any referrals that had not been completed within the month were moved forward to the next month's register. The register was split into two sections; referrals and scans/imaging. The referral entry was only closed after the secondary appointment date. The referral was opened again if the patient did not attend their appointment. The referral tracker was reviewed during the visit and found to be well managed with some waiting times for non-urgent referrals due to delays in secondary care. The doctors maintained oversight of the tracker.
- Staff told us that access to clinical records in DMICP was generally reliable but sometimes delayed due to connection issues. In such an event, patients were redirected to the QEMHC at Tidworth (approximately nine miles away). Outages would be managed by reverting to emergency appointments only and using packs of paper forms which would be uploaded to DMICP when available. Clinics were not printed routinely as QEMHC staff could access the Middle Wallop DMICP system to provide support.

Safe and appropriate use of medicines

The practice had updated an overarching SOP for medicines management. Systems for appropriate and safe handling of medicines had improved following the previous inspection:

- Regular checks were routinely carried out on medicines, including vaccines, and emergency medicines and equipment. We found all items were within date and appropriately stored.
- The practice's arrangements for the access, storage and monitoring of prescription stationary had been improved since the previous inspection. Blank prescription pads and prescription paper were stored securely and an effective tracking system had been implemented. Controlled access arrangements to the storage area had been introduced.

- Controlled drugs (CDs) were not held on the premises. Prescriptions of controlled drugs were dispensed and patients collected from QEMHC, Tidworth.
- Staff had access to British National Formulary (BNF) and prescribing formulary. An antibiotic prescribing audit ensured that prescribing practice was in line with local guidelines.
- Prescriptions were signed before medicines were dispensed and handed out to patients.
- At the last inspection we found patients taking high risk medicines (HRMs) were not always monitored within recommended timescales. At this inspection, we found an effective system had been introduced and patients on HRMs were well managed and the relevant monitoring checks were checked as completed before their repeat prescription was issued. A doctor led on the monitoring of HRMs and completed monthly searches that included a cross check (searches were run by both Read code and medicine list) and any new patients were referred to the prescriber if any concerns were found.
- PGDs (Patient Group Directions) were in use to allow non-prescribing staff to carry out vaccinations in a safe way. PGDs were appropriately managed, staff had received training and authorisation by the SMO had been recorded. The practice stated that PSDs (Patient Specific Directions) were not currently used. All patients requiring medication were referred to a prescriber. PGD audits were carried out annually by the doctors.

Track record on safety

The practice had strengthened processes governing around health and safety and had a good safety record since the last inspection:

- The practice manager was the lead for health and safety within the medical centre and was supported by the Safety, Health, Environment and Fire (SHEF) lead for the station. The practice had registers for both current and retired risks; similarly, there were current and retired issues logs. These are all held on the Healthcare Governance (HG) workbook. The practice had a number of risk assessments with each one covering a number of areas including control of substances hazardous to health (COSHH), lone working, slips trips & falls and management of sharps. The practice manager reviewed the risk register monthly.
- There was a fixed alarm system in the clinical rooms. However, the practice had entered the potential of alarms not being heard onto the risk register. In response and since the last inspection, all staff had been issued with handheld personal alarms which were checked periodically for audibility and staff response.
- A monthly audit documented checks on the building and surrounding environment, first aid equipment and updates from the SHEF team on station.

Lessons learned and improvements made

The practice shared learning and made improvements when things went wrong.

- There was a system and policy for recording and acting on significant events (referred to as ASERs) and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were systems for reviewing and investigating when things went wrong. There was evidence that the practice learned and shared lessons, identified themes and took action to improve safety in the practice. Staff we spoke with could recall the learning from recent significant events and minutes of meetings showed lessons learnt were discussed at the practice meeting. For example;
    - A recent ASER was raised when a staff member at QEMHC, Tidworth printed off a subject access request to a printer at Middle Wallop. The practice manager at Middle Wallop raised an ASER, and as a result, all printers not in use were removed and ‘think before you print’ stickers were placed on each monitor.
    - The practice nurse had submitted an ASER as 20 patients had blood tests rejected due to incorrect labelling by medics. Inhouse training was completed, the patients recalled and the tests repeated. Patients were informed of what had happened in accordance with the duty of candour.
- There was a system for receiving and acting on patient safety alerts. The practice manager was the lead for Medicines and Healthcare products Regulatory Agency (MHRA) and Central Alerting System (CAS) alerts and had created a register which included hyperlinks to the alert where possible. Alerts were a standing agenda item on the practice meeting agenda. However, the register was often completed with ’not applicable’ in the action column so it is not clear what action or review had taken place to determine why no further action was required.

Are services effective?

We rated the practice as good for providing effective services.

Effective needs assessment, care and treatment

Clinicians were aware of relevant and current evidence-based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. Clinical meetings had been held and minutes contained a record of discussion of best practice guidance.

- Our review of patients' notes showed that NICE best practice guidelines were being followed.
- Staff we spoke with could refer to this and gave examples of updates they had acted on and discussed within the practice.
- The Defence Primary Health Care (DPHC) Team produced a newsletter that was circulated to clinicians providing further information and a summary of relevant safety updates.
- Guidelines were communicated visa the DPHC newsletter and discussed in Healthcare Governance meetings.

Monitoring care and treatment

The practice undertook quality improvement work to review the effectiveness and appropriateness of the care provided.

- The Defence Medical Services (DMS) have a responsibility to deliver the same quality of care as patients expect in the National Health Service (NHS). Because the numbers of patients with long term conditions are often significantly lower at Defence Primary Healthcare Services (DPHC) practices, we are not using NHS data as a comparator.
- The practice nurse and medical officer shared the lead for management of patients with long-term conditions (LTC). The population manager facility (referred to as 'popman') was used to identify and monitor patients with an LTC. A total of 27 patients were recorded as having high blood pressure and all had a record of their blood pressure having been recorded in the last nine months. There were as small number of patients on the diabetic register, all had a total cholesterol of 5mmol/or less, an indicator of positive cholesterol control. There were 15 patients on the asthma register, all had been reviewed in the last 12 months.
- The practice had low numbers of patients with an LTC so the nurse provided us with an overview of the current status for each patient, including the action taken if patients failed to respond to recall letters.
- Those patients categorised as at risk of diabetes were added to a 'pre-diabetes register' and reviewed monthly. We ran a search on DMICP that identified 14 pre-

diabetes patients. However, this did not correspond with the six patients on the chronic disease register. The practice established that when they started conducting the pre-diabetes searches and created the pre-diabetes register in late 2020, the search criteria failed to identify those patients at risk who were not monitored either by previous medical centres or prior to the implementation of the prediabetes search and register being created. The practice took appropriate action the day after the inspection and sent evidence to show that patients had been added to the register and recalled where required.

- 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 46% of patients. This was low as guidance had been issued from strategic command during the COVID-19 pandemic to reduce face-to-face appointments.
- The practice had implemented a structured programme of audits to monitor and systematically review clinical and non-clinical outcomes to ensure treatment and care was being provided in accordance national and local standards. A doctor led on clinical audit; this was included in the terms of reference (TORs). Audits undertaken in 2020/21 included:
    - antibiotic prescribing;
    - diazepam (started due to high levels of prescribing);
    - pre-acceptance healthcare waste;
    - environment;
- An internal quality assurance tool, the Defence Medical Services (DMS) Common Assurance Framework (CAF) was used to monitor safety and performance. The DMS CAF was formally introduced in September 2009 and since that time has been the standard healthcare governance assurance tool utilised by DMS practices to assure the standards of health care delivery within DMS.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and chronic disease management. The cervical screening programme was run from QEMHC, Tidworth but a new nurse was due in September who was trained to undertake cervical screening.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, mentoring, clinical supervision and support for

revalidation. The induction process had a separate annex for each professional group with an additional reference manual for locums.

- Mandated training was monitored by the practice manager. Staff were sent an email each month reminding them of training they needed to complete and a link to the training. Compliance in mandatory training was at 99%.
- The nurses were given protected time to complete continued professional development (CPD) work. Formal supervision was in place to maintain oversight of the work carried out by the nursing team. The practice nurse was line managed by an advanced nurse practitioner (ANP) and the deputy senior nursing officer at QEMHC, Tidworth. The ANP carried out an annual notes review (or more regular reviews would be carried out if there were any concerns), mid-year and annual appraisals were carried out. The ANP or senior nursing officer (SNO) visited monthly to do case reflection and discuss any complex patients. The nurse was very positive about the support provided.
- Internal and external training sessions were available to staff. For example, the practice manager had completed the equipment care training. The practice nurse had completed 'IPC Link' training since the previous inspection. The practice manager was new to the role and had been assigned a mentor for the initial months. The nurse had been approved to do a sexual health (STIF) course in October 2021.
- The medics had SOPs and terms of reference (TOR) to set out their duties. They completed mandatory training and competency checks as part of their induction refreshed annually thereafter.

Coordinating care and treatment

Staff worked together and with other care professionals to deliver effective care and treatment. The practice met with welfare teams and line managers to discuss vulnerable patients who were both trainees and permanent staff.

- The practice had established links with local NHS services, these included connections with the local diabetic retinopathy service and Andover Sexual Health Clinic.
- The practice had developed better links with military practices to improve the handover of patients. For example, the practice had developed a leaving pack for patients exiting the military to help transition into civilian life. The pack included advice on what needs to be done when leaving the military in order to register with an NHS practice, information on services available to support military veterans and what people's entitlements are once they had left the military.
- The PCRF service which provided physiotherapy assessment and treatment and an exercise rehabilitation service was delivered by QEMHC, Tidworth. Referral into the PCRF service was via a primary care clinician or through direct access to physiotherapy (DAP).

Helping patients to live healthier lives

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

- Patients at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.
- The 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, a drink aware promotion, women's health and tackling obesity. It also took account of the patient population need and seasonal variation impacting health. For example, female health screening had been added to the health promotion calendar in response to patient feedback.
- The practice offered basic sexual health advice with new recruits during the welcome brief. Patients would then be signposted to a sexual health clinic in Andover for further advice. The clinic provided a walk in service to patients aged under 18. Information was available for patients requiring sexual health advice (on toilet doors), including signposting to other services. Where appropriate patients were referred to local genitourinary clinic for screening.
- Medical centre staff attended unit open days and manned stalls to provide health promotion information to personnel. Notice boards were used in the waiting area for health promotion campaigns. These were dated and refreshed in line with the strategy. At the time of the inspection there were displays about mental health and heat injury. There was a monthly programme whereby promotions were refreshed in line with seasonal and/or topical demand. There had not been a health fair since the previous inspection due to COVID-19 but one was planned before Christmas 2021 if risks could be mitigated.
- All of the medics and the practice manager had been seconded to support COVID-19 vaccinations in the community.
- A mental health information display was available for patients that took into account wellbeing and mindfulness. It provided details about websites patients could access for further information.
- The practice recalled patients for preventative health checks. Health checks can help to identify any conditions that patients may be at-risk of and could be avoided by preventative treatment and lifestyle choices. A total of 287 patients were eligible for an over 40s health check, 137 had a health check completed in the past five years. Letters were sent out to the 150 due a check; but uptake was low and the practice had established this was due to COVID-19. The practice nurse ran the search quarterly and sent second invite letters to those who had been invited but had not attended. The practice planned to catch up the programme when more human resource was available (a second nurse was due to start in September 2021 and the pending merger would add more resource to catch up).
- A quarterly search was undertaken for all patients aged 50 to 64 years who were entitled to breast screening. The practice also engaged with all national screening programmes and had a mechanism to ensure that eligible patients were referred into the bowel cancer or abdominal aortic aneurysm (AAA) screening programs.

- The number of women aged 25 to 49 (there were no women patients aged 50 to 64) whose notes recorded that a cervical smear had been performed in the last three to five years was 58 out of 62 eligible women. This represented an achievement of 94%. The NHS target was 80%. Invite letters were sent out and followed up if not responded to. The nurse contacted patients by telephone or email and invited them into the practice to discuss the smear test and if required, to show them the kit and equipment which then could help the patient decide if they wish to go ahead. If the patient decided she would like a test, then this was completed immediately to prevent any further delay.

It is important that military personnel have sufficient immunity against the risk of contracting certain diseases. The World Health Organisation sets a target of 95% for vaccination against diphtheria, tetanus, pertussis and polio and measles, mumps and rubella. The data below from August 2021 provides vaccination data for patients using this practice (regional and national comparisons were not available):

- 86% of patients were recorded as being up to date with vaccination against diphtheria.
- 86% of patients were recorded as being up to date with vaccination against polio.
- 83% of patients were recorded as being up to date with vaccination against Hepatitis B.
- 78% of patients were recorded as being up to date with vaccination against Hepatitis A.
- 86% of patients were recorded as being up to date with vaccination against Tetanus.
- 75% of patients were recorded as in date for vaccination against MMR
- 94% of patients were recorded as in date for vaccination against meningitis.

At the time of inspection, vaccinations had been postponed due to COVID-19. They were only given to those patients due to be deployed. The practice had identified that vaccinations had stopped for phase one trainees so the practice was receiving phase two trainees who had not been vaccinated. A catch up clinic had been planned for the end of August 2021.

- Units were responsible for ensuring their personnel kept up-to-date with vaccinations. The practice worked collaboratively with Chain of Command to ensure all personnel requiring additional immunisations in line with operational requirements were identified and vaccinated within an appropriate timeframe. Monthly searches were undertaken to recall patients for vaccinations.
- On leaving the Armed Forces, personnel underwent a release medical with the approach tailored to individual patient's needs. The welfare team were engaged throughout the process to ensure all issues were adequately addressed. Transition to NHS services was managed to ensure continuity of care.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance. We saw that consent was sought and documented on DMICP. The annual audit of notes included a check to ensure consent had been recorded when appropriate.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (MCA) 2005. All staff had been given a toolkit to assist in decision making and posters were displayed in clinical rooms. A bespoke in house training session on MCA had been delivered in June 2021.

- When providing care and treatment for young recruits aged between 16 and 18 years, staff carried out assessments of capacity to consent in line with relevant guidance.

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.

- The medical centre had taken account of patients' personal, cultural, social and religious needs; for example, practice staff we asked could explain how they would support patients if going through gender reassignment. This was supported by a transgender policy which included information on treatment.
- The practice gave patients timely support and information. Translation services were available. For example, information leaflets on long-term conditions could be printed off in different languages. Staff knew of a 'Big Word' print off that extended to 27 languages. There were plans to have the practice leaflet translated into multiple languages
- A notice on the reception desk informed patients that if they wanted to discuss sensitive issues or appeared distressed, they could offer them a private room to discuss their needs.
- The practice had an information network available to all members of the service community, known as HIVE. This provided a range of information to patients who had relocated to the base and surrounding area. Information included what was available from the local unit and from civilian facilities, including healthcare facilities.
- The station welfare team staff kept a register of patients who were also carers and provided extra support as required. There was a note for carers in the practice leaflet and posters in reception. The practice had a guidance note for staff on how to support carers. Patients were primarily identified during the arrivals process or via the vulnerable patients meeting, coded and included on a register held on DMICP. There was a self-help folder in the waiting room signposting carers to external support services. Carers and cared for patients were Read coded and recalled for annual flu immunisations and were prioritised for COVID-19 vaccinations. There was an open door policy for support to be provided and staff knew of services that carers could be signposted to.

Involvement in decisions about care and treatment

- The clinicians and staff at the practice recognised that the trainee personnel they provided care and treatment for, could be making decisions about treatment for the first time. Staff demonstrated how they gauged the level of understanding of patients, avoided overly technical explanations of diagnoses and treatment, and encouraged and empowered young patients to make decisions based on sound guidance and clinical facts.

- The e-referral service had been implemented and was used to support patient choice as appropriate. (e-referral is a national electronic referral service which gives patients the choice of date and time for their first outpatient appointment in a hospital).
- Results from the practice's Patient Experience Survey for January 2021 to July 2021 (62 responses were collated);
    - 95% said they felt they had been given clear information regarding their treatment and care.
    - 100% of patients who responded said that they would recommend the practice to civilian friends, family and colleagues if they were able to use the facility.

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

- Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of organisations. We saw information that was age appropriate and relevant to the patient demographic which was prominently displayed and accessible. For example, we saw dedicated notice boards to promote nutrition and mental health.
- The practice acted in a compassionate way toward any patient that had to be discharged on health grounds. We saw that the practice reassured these patients and signposted to personnel within the military who could guide them through the exit process and transition to NHS care and other support functions.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Privacy screening was provided in doctors', nurses' and medics' consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. Clinic room doors were closed during consultations.
- There was a clearly marked box to ensure patients are required to stand back at reception until called forward, and a radio in the waiting room to provide background noise. The practice also had privacy cards available, patients could hand to reception staff to identify that they would like to discuss a matter in private.
- The practice could facilitate patients who wished to see a clinician of a specific gender (patients could be signposted to QEMHC, Tidworth).

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 understood the needs of its population and organised and delivered services to meet patients' needs. It took account of patient needs and preferences. For example, the urgent walk in appointments known as 'sick parades' were staggered to ensure trainees could be seen at the earliest opportunity to minimise the impact on planned training.

- The practice provided rapid access for aircrew and staff were trained to provide specialist support.
- The facilities and premises were bespoke and appropriate for the services delivered. An access audit had been completed in July 2021 and some actions that included installing a bell at the main entrance had been actioned. We noted that the audit highlighted a number of areas for improvement. These included a review/update of all posters to ensure the font was size 16 and at a suitable height, the assessment of need for a hearing loop and a workaround for areas too narrow for people to pass a wheelchair. These actions had not yet been summarised into a plan so no statements of need had been submitted. However, the practice planned to do this soon after the inspection.
- The practice had a policy available to staff or patients around when a home visit might be necessary and appropriate.
- The practice trained staff in equality and diversity and there was a 'diversity and inclusion' lead. Staff could access the lead on station and a dedicated board detailed all qualified leads on station and the point of contact in the medical centre. The lead also attended diversity and inclusion meetings at unit and national level. A transgender SOP had recently been implemented which included links and treatments.

Timely access to care and treatment

Patients' needs were met in a timely way.

- The practice accommodated patients with an emergency need on the day they presented at the practice. Routine appointments with a doctor could be facilitated within two days and gradings were available within five working days. Nurses had capacity to see a patient within five working days but medics could provide earlier appointments to do blood tests. Staff told us that the access was normally same day but had been impacted by the inspection and annual leave. This was supported by the patient questionnaire which provided positive feedback on access to appointments.
- Outside of routine clinic hours, telephone cover up until 18:30 was provided by a doctor at QEMHC, Tidworth. From 18.30 hours, patients were diverted to the NHS 111 service

and/or e-consult (a message could be left for the practice to follow up on the following working day if not urgent). If the practice closed on an afternoon for training purposes, patients could still access a doctor in an emergency. In this way, the practice ensured that patients could directly access a doctor between the hours of 08.00 and 18.30, in line with DPHC's arrangement with NHS England.

- The nearest accident and emergency department was located at the Salisbury District Hospital and the Royal Hampshire County Hospital in Winchester (approximately 13 miles away). However, these were not detailed in the practice leaflet.
- Results from the practice's patient experience survey (62 responses were received) showed that patient satisfaction levels with access to routine care and treatment were high;
    - 97% of patients said they were able to access healthcare easily (same day if requested).
    - 97% of patients felt satisfied with the time of their appointment.
- Outlined in the practice information leaflet, electronic consultations with a clinician could be organised. The practice leaflet confirmed home visits were available and provided details for out of hours services.

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.

- DPHC had an established policy and the practice adhered to this.
- The practice manager was the designated responsible person who handled all complaints in the practice. Verbal complaints were recorded and managed through the same process as written complaints. A complaints tracker was maintained to record each stage of the process.
- We reviewed the complaints log for the past 12 months. There was no theme identified and complaint levels were below the threshold to undertake an audit (the practice manager was aware of the parameters to audit if required).
- We saw that there were processes in place to share learning from complaints. Complaints management was comprehensive and included an audit to identify any trends. We reviewed a recent complaint to find that it was managed appropriately and to the satisfaction of the complainant. The feedback was used to make improvement in the patient experience.
- Information was available to help patients understand the complaints system.

Are services well-led?

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

At our previous inspection, we rated the practice as requires improvement for providing well-led services. We identified shortfalls in governance arrangements around medicines management and infection prevention and control (IPC).

At this inspection we found the recommendations we made had been actioned.

Leadership, capacity and capability

The leaders at the medical centre had been working hard to address areas they had identified as requiring improvement as well as building resilience and continuity in readiness for the move towards becoming part of a group practice. Significant work had been undertaken and it was evident that a cohesive and comprehensive plan had been implemented by the practice management team. The impact of COVID-19 was seen to have been well managed.

- Staff felt that they could raise concerns if they had them. A practice-wide meeting had been established where all staff could get together to share and learn from key messages.
- The practice was well supported by the regional management team and in particular, the practice nurse spoke positively about the support provided by colleagues at QEMHC, Tidworth.
- Leaders were knowledgeable about issues and priorities relating to the quality of services. As a result, key risks had been addressed.
- There was flexibility within leadership roles to ensure continuity in each department. The practice manager had worked hard to ensure key roles had at least one second point of contact. This had been supported and facilitated with the move towards becoming a group practice. The imminent arrival of a Deputy Senior Medical Officer (DSMO) provided further stability for the team.

Vision and strategy

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

- There was a clear vision and set of values built around the mission statement, ‘DPHC will deliver a unified, safe, efficient and accountable primary healthcare and dental care services for entitled personnel to maximise their health and to deliver personnel medically fit for operations.’ The practice had developed a simple but effective mission statement ‘one practice, one team’ which focussed on the imminent merge into a group practice.

- Staff were aware of and understood the vision, values and strategy and their role in achieving them. The leadership team were working on the transition into becoming a group practice and had adopted a phased approach that strengthened the position prior to the merging of patient lists.
- The practice planned its services to meet the needs of the practice population.

Culture

The practice had a culture of high-quality sustainable care and where gaps had been identified, systems had been reviewed to make them more effective:

- Staff stated they felt respected, supported and valued. Discussion with staff members indicated that morale was high and in particular staff were positive about the moves towards becoming part of a group practice.
- The practice manager described a 'no rank' ethos within the practice and an open door policy amongst the management team where staff could raise concerns to any member of staff, either in person or during meetings. The practice ran an anonymous staff survey which was mostly positive with only minor concerns raised which the management acted on immediately (staff were not putting out of office notes on their email accounts).
- Leaders and managers had taken action to address gaps in the performance of the practice, specifically in response to those issues highlighted at the previous inspection and in particular the strengthening of processes around medicines management.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed. Opportunities for staff to have positive influence on the practice had been extended to ensure they were not impacted by the establishment of a group practice.
- There were processes for providing staff with professional development. This included appraisal and career development conversations. All staff received annual appraisals and were supported to meet the requirements of professional revalidation where necessary. Staff were encouraged to complete courses aimed at their professional development.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training.

Governance arrangements

There were consolidated and clarified responsibilities and systems of accountability to support good governance and management. The practice had built in more resilience with leads, deputies and cross working, in particular using the pending merger between

practices to share roles cross practice. Since the last inspection, improvements had been made in the governance framework around medicines management and infection prevention and control.

- Joint working with the welfare team, pastoral support and Chain of Command was in place with a view to safeguarding vulnerable personnel and ensuring co-ordinated person-centred care for these individuals.
- Shared care protocols were in place for patients taking high risk drugs and an effective system implemented for the controlled storage and tracking of prescription stationary.
- Practice leaders had established a number of policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. The practice had revised procedures and implemented an overarching SOP for medicines management. Clinical waste procedures had been strengthened after gaps had been highlighted at the last inspection.
- There was a programme of regular meetings that extended to include all staff. These included a heads of department and multidisciplinary team meeting (held weekly), practice governance and practice team meetings (held monthly). Minutes of meetings were recorded and made available to those unable to attend.

Managing risks, issues and performance

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

- Practice leaders had established a governance structure that provided oversight of risk and the quality of service.
- The practice maintained a risk register a record of short-term issues and had plans in place for major incidents. We saw that these were reviewed regularly, acted on and staff had been trained. A record of retired risks was also held for refence.
- Regularly reviews risk assessments and audit was having a positive impact on safety. These covered a number of areas including COSHH, lone working, slips trips & falls and management of sharps.
- The practice manager was able to describe processes that could be used to manage poor performance. These included welfare support, re-training, appraisal or, if required, disciplinary processes.
- All staff were in date for ‘defence information passport’ and ‘data security awareness’ training.
- There was a business resilience plan and a station major incident plan that were reviewed regularly.

Appropriate and accurate information

- An understanding of the performance of the practice was maintained. The practice manager used the Common Assessment Framework (CAF) as an effective governance tool. A number of different meetings were held regularly and extended to the whole team. Cross-practice meetings had been established and provided a forum for effective discussion and shared learning. Minutes from meetings we reviewed demonstrated that key agenda items had been discussed including safeguarding, NICE guidance and CAS alerts.
- There were robust arrangements at the medical centre in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

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. Patient feedback was requested monthly, and a patient experience survey was undertaken throughout the year.
- Patients could leave feedback via a complaints and compliments slip that could be posted anonymously. A notice board in the waiting area provided a summary of feedback for patients. This included the results from the most recent questionnaire. A record of compliments was kept in the healthcare governance (HCG) workbook; a total of 13 had been recorded in the last 12 months.
- There was evidence that the practice acted on feedback from patients. For example, in if the wait time for their appointment was to be longer than expected due to a clinic running behind, the practice would make the patient aware.
- Good and effective links with internal and external organisations were established, including with the welfare team, Regional rehabilitation Unit (RRU) and with Department of Community Mental Health (DCMH).

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation. The practice maintained a quality improvement log on the health governance workbook. The practice had completed a number of quality improvement projects (QIPs) which were detailed on the quality improvement log. QIPs were also communicated to DPHC Regional Headquarters. There was a good examples of quality improvement that included:

- A chronic disease register had been created by the practice nurse due to Read codes on DMICP not recalling all patients correctly. By having a chronic disease register the nurse could track patients who may have been Read coded incorrectly. The register improved patient recall by providing visibility on upcoming reviews. It also allowed the practice nurse to delete those patients who had been excepted but remained on the monthly DMICP searches.
- A screening register was created to aid in the monitoring and recall of patients that were not identified by Read codes. The register ensured that patients due for NHS screening were reviewed quarterly. The screening register was used by the practice nurse to track patients who may have been referred but had not responded.
- A ‘veteran’s support’ QIP was created to improve the information provided at release medicals and to enable service leavers to engage with NHS providers and the services available to support this transition. A pack was made available for leavers to support the transition period. The leaflet could be shared with local NHS practices to help them become aware of what services were available to military veterans.
- A ‘notify.gov’ QIP was created to ensure easily accessible signposting and patient information leaflets during Covid-19 restrictions. ‘Notify.gov’ was an electronic tool that enabled the practice to continue to provide signposting and patient information when the patient was given a remote appointment.