Bramcote Medical Centre

Gamecock Barracks, Nuneaton CV11 6QN

Defence Medical Services Follow Up inspection

This report describes our judgement of the quality of care at Bramcote 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 medical centre.

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**	

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Summary

About this follow up inspection

We carried out this announced comprehensive follow up inspection on 29 October and 2 November 2021. The report covers our findings in relation to the recommendations made and any additional improvements made since our last inspection.

We carried out a previous announced comprehensive inspection of Bramcote Medical Centre on 5 March 2020. The medical centre received a requires improvement rating overall, with a rating of requires improvement in the safe and effective domains. The caring, responsive and well led domains were rated as good.

A copy of the previous inspection reports can be found at:

https://www.cqc.org.uk/sites/default/files/20200416%20Bramcote%20Medical%20Centre%20Final%20report.pdf

The 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 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:

- 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 timeliness of access to appointments, reviews and screening/vaccination data.
- The practice had strong lines of communication with the units and welfare team to ensure the wellbeing of military personnel.
- Measures were in place to identify patients who were considered vulnerable, coding was consistently applied to identify patients under the age of 18.
- There was a safe system for the management of specimens and referrals.
- Medicines management systems were in place but there was scope to improve the implementation of safety alerts.

- To support assurance, the medical centre had full access to health and safety monitoring checks carried out by external partners. A range of risk assessments were in place for the medical centre.
- Risks to the service were recognised by the leadership team. The main risks were limited resilience to cover for staff absences.
- Facilities and equipment at the medical centre were appropriate to treat patients and meet their needs.
- Staff were aware of the requirements of the duty of candour. Examples we reviewed showed the medical centre complied with these requirements.
- The medical centre had effective leadership although this was hindered by acute staff shortages. The leadership team were aware there were some shortfalls and had plans to address these. Staff worked well as a team and said they were well supported and included in discussions about the development of the service.

The Chief Inspector recommends that the Medical Centre:

- Read Coding should be consistent and accurate.
- Improvement is needed to ensure the cleaning contract is fit for purpose.

The Chief Inspector recommends to DPHC:

- The regional team keeps staffing levels and additional staff roles under review to ensure there is clinical resilience in the system. Recruitment to vacant posts should be progressed in a timely way.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

The inspection team was led by a CQC inspector. The team comprised specialist advisors including a primary care doctor, a practice manager, a medical centre nurse and pharmacist.

Background to Bramcote Medical Centre

Bramcote Medical Centre provides a routine primary care, occupational health and rehabilitation service to a patient population of 832 including service personnel and

permanent staff for the camp. The practice supports the 30 Signal Regiment which has a high readiness for deployment. A small cohort of patients from the new Defence Medical Rehabilitation Centre (referred to as DMRC Stanford Hall) were also registered at the practice.

Most patients are aged between 18 and 44. At the time of the inspection, there were no registered patients under the age of 18.

A Primary Care Rehabilitation Facility (PCRF) is based in the medical centre and provides a physiotherapy and rehabilitation service for patients. As there is no dispensary at the practice, a contract in in place with a local pharmacy.

The medical centre is open from 08:00 to 16:30 hours Monday, Wednesday and Thursday, Tuesday 08:00 to 12:30 and on a Friday 0800:1300. Between 16:30 and 18:30 cover is provided by Lichfield or Cosford medical centres. Outside of these hours, including weekends and bank holidays, cover is provided by NHS 111.

The staff team

Doctors	one Senior Medical Officer (SMO)
Regimental Medical Officer (RMO)	none (currently gapped)
Practice manager	none (post currently gapped)
Nurses	three (two civilian, one military)
Exercise Rehabilitation Instructors (ERI)	one (currently on maternity leave)
Physiotherapists	one
Administrators	two
Medical Sergeant*	one (unit asset non DPHC)
Combat Medical Technicians* (CMTs)	three (unit assets non DPHC, one deployed)

*In the army, a medical Sergeant and CMT is a soldier who has received specialist training in field medicine. It is a unique role in the forces and their role is similar to that of a health care assistant in NHS GP medical centres but with a broader scope of medical centre.

Are services safe?

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

Following our previous inspection, we rated the medical centre as requires improvement for providing safe services. We found inconsistencies in processes to keep patients and staff safe including:

- Improving the infrastructure to ensure sufficient space and equipment for clinical activity, and to ensure the premises meets the requirements of the Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'.
- The processes in place for the management of significant events needed review.
- Ensuring there is a safe and effective system in place to support staff who are working with patients in isolation of the wider staff team

At this inspection we found that recommendations we previously made had been actioned. However, low staffing levels throughout the medical centre meant that the small staff team met with daily challenges in delivering quality patient care.

Safety systems and processes

- 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. The safeguarding policies were reviewed annually.
- The senior nurse was the safeguarding lead for the practice. On the day of the inspection we noted that a staff members children's safeguarding training had lapsed. We have since received confirmation that this now has been completed. All other staff were up to date with safeguarding training at a level appropriate to their role.
- There was a risk register of vulnerable patients and a system to highlight them on the electronic patient record system (referred to as DMICP). All patients under the age of 18 had been added to the vulnerable register. All new patients were required to have an initial appointment with the medical centre and with the welfare team if they were under the age of 21. There was a local Standard Operating Procedure (SOP) that supported this.
- A monthly search of DMICP was undertaken to ensure the register of vulnerable patients was current. We reviewed clinical records for vulnerable patients and noted appropriate alerts and coding were used.
- The status of safeguarding and vulnerable patients was discussed at the monthly meetings with the welfare officer. In addition, the needs of vulnerable patients were discussed at monthly multi-disciplinary meetings. We spoke with the welfare officer for the camp who told us they provided a welfare service to military personnel and

dependents, they confirmed they had a good relationship with the medical centre and communication between them and outside agencies was good.

- Staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. We saw staff had last received chaperone training in May 2021. 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.
- Since the last inspection in March 2020 the medical centre had been completely refurbished. The building was large and light with plenty of space.
- The infection prevention and control (IPC) lead for the medical centre was the lead nurse, they had completed role specific training and was supported by an IPC lead for the region. Audits were carried out monthly and any issues completed.
- The senior nurse was the lead for cleaning and the contract was outsourced to an approved company. However, the cleaning contract in place was for the previous building which had less clinical areas to clean. The contract in place for cleaning was not sufficient for the new improved premises. Systems in place included a process for reporting issues and monitoring the standard of cleaning. Regular checks of compliance were made by the senior nurse to check on 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 May 2021.
- 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

- The current staffing levels were inadequate to meet the needs of the patient population. The civilian SMO had been in post for a year and was the only doctor at the medical centre. The SMO had not taken any annual leave in the past 12 months due in the main to the lack of cover for them. At the time of the inspection there was no locum in place although one was scheduled to start the following week. The Regimental Medical Officer (RMO) post had been vacant since February 2021 with a replacement not due until August 2022. There was no practice manager in post. The practice management was being undertaken by the Band 6 nurse, who was supported by another practice manager two days a week. The Band 6 nurse was unable to work clinically because of the practice management commitments.
- There were three medics in post. These individuals worked for the Regiment and were attached to the unit. One was deployed and would not be returning until next year. Another was due to be posted next month.

- 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.
- 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. The staff team was up to date in medical emergency procedures, including basic life support training, use of the automated external defibrillator (AED) and anaphylaxis. Thermal injuries training was undertaken in August 2021and sepsis training in July 2021. Sepsis guidelines were displayed throughout the practice.
- 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 were in place and were regularly checked.
- A COVID-19 risk assessment had been completed. Measures introduced to minimise the risk of spreading infection during the COVID-19 pandemic included:
    - signs placed throughout to encourage social distancing;
    - an automated hand sanitiser dispenser was placed at the main entrance and exit;
    - personal protective equipment (PPE) was provided to staff. This included face masks that protect staff from airborne infection (known as FP3 masks) when seeing patients.

Information to deliver safe care and treatment

- Internet connectivity at Bramcote was often poor with staff using laptops and a dongle to provide extra functionality so that they are able to continue to access DMICP. With a more widespread outage staff referred to the business continuity plan and saw only emergency patients. Packs of paper forms were available to document consultations which would be later scanned onto DMICP. Paper forms for reporting significant events and ASER and safeguarding concerns were also available. Clinic lists were routinely printed for the following day.
- A SOP was in place to ensure summarisation of patients' records was undertaken in a safe and timely way. Patients registering at the practice completed a new patient questionnaire, which was submitted to the nursing team for scrutiny and summarising. This process identified any actions that required follow up.
- A peer review programme of doctors DMICP consultation records was recently undertaken with the SMO and a locum doctor, we saw a consistent methodology was used. We saw 20 sets of notes had been chosen and reviewed and gaps in recording had been identified. We saw a peer review programme of nursing notes had been completed. The SMO also regularly reviewed nurse and medic consultations.

- A failsafe process was in place for the management of specimens. A record was maintained of all samples sent so when results were returned, they could be tracked, and any missing results identified.

Safe and appropriate use of medicines

The medical centre had systems in place for the safe handling of medicines.

- Arrangements were established for the safe management of controlled drugs (CD), including destruction of unused CDs. We saw that monthly and quarterly checks were completed. Although the controlled drugs cabinet was in a safe location and locked, we noted the controlled drug cabinet did not meet the Misuse of Drugs (safe custody) regulations. The medical centre agreed to contact the regional pharmacist and obtain exemption from the local controlled drugs liaison officer.
- Emergency medicines were easily accessible to staff in a secure area of the medical centre and all staff knew of their location.
- Medication requiring refrigeration was monitored twice a day to ensure it was stored within the correct temperature range.
- All staff who administered vaccines had received the immunisation training as well as the mandatory anaphylaxis training.
- All prescription pads were stored securely.
- Patient Group Directions (PGD) had been signed off to allow appropriately trained staff to administer medicines in line with legislation. The PGDs were current and signed off correctly. Medicines that had been supplied or administered under PGDs were in date.
- Requests for repeat prescriptions were managed in person or by email, in line with policy. 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.
- We saw evidence to show that patients medicines were reviewed regularly. The doctor's notes in DMICP were comprehensive.
- Processes for the management of high-risk medicines were in place. We saw a process was established for the management of and monitoring of patients prescribed high risk medicines (HRM). The register of HRMs used at the medical centre was held on DMCIP and all doctors and relevant clinicians had access to this. We looked at a sample of patient records, we saw that all had been coded or had shared care agreements in place.

Track record on safety

At the last inspection we saw lone working was not well managed for members of the PCRF staff. At this inspection we saw improvements had been made.

- Measures to ensure the safety of facilities and equipment were in place. Electrical and gas safety checks were up to date. Water safety measures were regularly carried out

with a legionella inspection undertaken in February 2021. A fire risk assessment of the building was undertaken annually. Firefighting equipment tests were current. Staff were up to date with fire safety training and were aware of the evacuation plan.

- The medical centre staff had handheld portable alarms; these were tested monthly. There was a business case in place for an electronic alarm system to be installed. There was a Standard Operating Procedure (SOP) in place within the gym for those members of the PCRF lone working there. There was an alarm in both the gym and the PCRF.
- A COVID-19 risk assessment had been completed for the medical centre along with risk assessments for individual staff. The medical centre had developed an SOP in relation to COVID-19 and the use of personal protective equipment (PPE). The medical centre manager advised that this was regularly discussed with the staff team.

Lessons learned and improvements made

The processes in place for the management of significant events had improved. However, the management of patient safety alerts needed strengthening.

- All staff had access to the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events and incidents. The staff database showed that all staff had completed ASER training.
- From interviews with staff and evidence provided, it was clear there was a culture of reporting incidents from those staff able to access the system. 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 Healthcare Governance Workbook (HGW, a system that brings together a comprehensive range of governance activities) including any changes made.
- The system in place for managing patient safety alerts was adhoc and not all alerts were recorded. We discussed this with staff, who took immediate action and signed up to the Medicines and Healthcare Products Regulatory Agency (MHRA) and National Patient Safety Alerts so ensuring that all future alerts would be notified directly to them. There was a register on Sharepoint which detailed the alert and the action taken by the medical centre in response; the register was up to date.

Are services effective?

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

Following our previous inspection, we rated the medical centre as requires improvement for providing effective services. We found inconsistencies in processes for providing effective services including gaps in:

- Ensuring all clinical staff are supported to deliver effective patient care through peer review.
- Ensure a formal method was being used to measure clinical performance to assess patients undergoing physiotherapy and or rehabilitation.

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

Effective needs assessment, care and treatment

- Clinical staff had a forum to keep up to date with current medical centre and guidance. These included the monthly healthcare governance meeting and two weekly clinical meetings between the doctor and the nurses. These forums included an agenda item to discuss national clinical guidance, including NICE (National Institute for Health and Care Excellence) and the Scottish Intercollegiate Guidelines Network (SIGN). We saw these discussions were not recorded in the medical centre meetings for all staff to refer to.
- At the last inspection we saw some action was needed to be taken by the PCRF to improve effective needs led assessment. At this inspection we saw evidence to show the musculoskeletal health questionnaire (MSK-HQ) to assess outcomes for patients was being used. Rehab Guru, software for rehabilitation plans and outcomes, was being used.
- Staff were kept abreast of clinical and medicines updates through the 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 although this had been temporarily halted due to Covid restrictions.

Monitoring care and treatment

- We found that chronic conditions were managed well. The SOPs outlining the management and monitoring arrangements for long term conditions were in place. Monthly searches were run by the nursing team, patients were recalled by letter or email and followed up by a telephone call if needed.
- All patients over the age of 40 are invited to a full health check including bloods and identifying risk factors. Lifestyle and health advice were provided as appropriate both verbally and written. This check was repeated every 3-5 years unless identified as at risk when patients were recalled annually for blood testing. All chronic disease patients had an annual screening including blood tests or more frequently if required.

- There were very low numbers of patients on the diabetic register and their care indicated positive control of both cholesterol control and blood pressure. Patients at risk of developing diabetes were identified through the over 40's screening, which included relevant testing (HbA1c). There were low numbers of patients recorded as having high blood pressure. All were recorded as having blood pressure check in the past nine months. There were low numbers of patients with a diagnosis of asthma and all had an asthma review in the preceding 12 months.
- Audiology statistics showed 88% of patients had received an audiometric assessment within the last two years. This number was reduced due to the impact of the pandemic and in line with DPHC policy.
- Through 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).
- A programme of clinical audit work had been established. For example, we saw audits including medicines audits, infection control, obesity and chronic disease. The PCRF also undertook audits including electronic referrals and notes audits. The senior nurse had been established as the audit lead and an audit calendar was in place showing planned audit work continuing throughout the upcoming year.
- The range of patient records we looked at confirmed that coding needed to be improved to ensure accuracy and in turn facilitate improved clinical searches. For example, we saw two male patients that had been coded as pregnant. This presented a risk to both clinical care and governance activity.

Effective staffing

- The medical centre has implemented the DPHC induction programme. Where possible all new staff were aligned to a mentor.
- The medical centre had a training calendar. We saw there was a record of mandatory training and compliance was good across the medical centre team. Compliance was monitored and required training was discussed at the practice meetings. Time was available to staff every Wednesday afternoon to complete mandatory training.
- The SMO and nurses had the appropriate skills for their role and were working within their scope of practice. Opportunities were in place to support clinical staff with continual professional development and revalidation, including peer review, we noted there was no formal clinical supervision for the nursing staff, instead informal frequent meetings to discuss good practice. Medics received clinical supervision from the nurses. A process of peer review for the doctor and physiotherapist was established.
- The medical centre could demonstrate how it ensured role-specific training and updating for relevant staff. For example, for nurses and doctors on consent and Gillick competence (Gillick is a term used in medical law to decide whether a child under 16 years of age is able to consent to his or her own medical treatment, without the need for parental permission or knowledge).

- Staff administering vaccines had received specific training which included an assessment of competence. Staff who administered vaccines 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

Staff worked well 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. Staff told us that they had forged some strong links with other stakeholders, including the local NHS surgery.
- PCRF staff fostered close working relationships, meeting with the doctor and nurse when required to ensure individual patients were discussed and care planned appropriately to support good recovery. There were good examples seen of regular meetings arranged between the medical centre staff, the rehabilitation staff and the chain of command.
- 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 structured mental health questionnaire was also completed.
- 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.

Helping patients to live healthier lives

- One of the nurses was the lead for health promotion and had had the appropriate training and experience in this field. We saw information leaflets were available in the treatment rooms. During the Covid pandemic health promotion had been delivered remotely by the nurses. Presentations were delivered via Microsoft Teams on weight, smoking, alcohol, and sexual health – these had been well supported by the unit.
- There were notice boards located in various places around the medical centre, some example topics covered were, accessing 111, antibiotic guardian, sepsis, smoking, alcohol, veterans and safeguarding.
- The lead nurse for sexual health had the appropriate sexual health training and provided sexual health support and advise. Patients were signposted to local sexual health services for procedures not undertaken at the medical centre.

- Cervical smears were not currently carried out by the nurses at Bramcote Medical Centre. Patients are asked to go to Lichfield medical centre or to Stanford Hall. One of the nurses is due to undertake the training in January 2022 meaning patients would not have to travel.
- 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 no patients identified that met the criteria for bowel screening.
- An effective process was in place to recall patients for their vaccinations. As a result of the COVID-19 pandemic and in accordance with DPHC FragO, routine immunisations were ceased, and remain so to date. Only operationally essential vaccinations were administered. This will have had an effect on the vaccination statistics, and figures should be considered with this in mind.

Vaccination statistics were identified as follows:

- 98% of patients were in-date for vaccination against polio.
- 95% of patients were in-date for vaccination against hepatitis B.
- 96% of patients were in-date for vaccination against hepatitis A.
- 98% of patients were in-date for vaccination against tetanus.
- 92% of patients were in-date for vaccination against MMR.
- 99% of patients were recorded as being up to date with vaccination against diphtheria.

Consent to care and treatment

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making. They had a good understanding of the Mental Capacity Act (2005) and how it would apply to the population group.
- Clinicians advised us that implied consent was accepted for basic procedures such as the taking of blood pressure. Written consent was taken for more intimate examinations.

Are services caring?

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- We were unable to collate responses from patients using Care Quality Commission paper comment cards in order to comply with COVID-19 restrictions.
- An information network known as HIVE was available to patients this was located at Kineton base located 36 miles away. This provided a range of information to patients who had relocated to the base and surrounding area. HIVE provided information about facilities available on the station and locally including civilian healthcare facilities.

Involvement in decisions about care and treatment

- Patients identified with a caring responsibility were captured on a DMICP register, it included what had been discussed at the monthly practice/clinical meeting and any actions identified.
- We were advised patients usually identified themselves as a carer through the new patient registration form or when the Unit Welfare Officer shared this information with the medical centre. Alerts were added to all registered carers and they were offered flexibility with appointments.
- Staff explained that they occasionally saw patients who spoke English as a second language. They could access a translation service if they needed it. Staff told us about a recent instance where ‘The Big Word’ was used to provide a translation service during consultation.

Privacy and dignity

- The layout of the reception area and waiting area meant 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.
- The area around the reception desk had a picture board of staff members, a notice to say that patients could request a private conversation and a notice to advise that chaperones could be requested. There was a CCTV system that both monitored the front door and allowed conversations via an intercom. This was used to promote privacy but also during COVID-19 to minimise people entering the building and to maintain just one in the reception area at any time. There was also a CCTV system that monitored the waiting room. The waiting room was separate to the reception desk and behind a closed door so conversations could not be overheard.

- The clinical rooms all had privacy curtains that were replaced every six months. The practice was waiting for blinds for each room to stop the glare from the sun. These were for the top panes and did not compromise privacy. Clinic room doors were closed during consultations.
- The medical centre could not always facilitate patients who wished to see a clinician of a specific gender so patients could be directed to an alternative medical centre if needed.

Are services responsive to people's needs?

Responding to and meeting people's needs

- The practice was committed to meeting the principles of the Equality Act 2010, including safeguarding people with protected characteristics. For example, the practice information leaflet had been translated for the Nepali population.
- An equality access audit had been reviewed in October 2021. The front doors were automatic, there was parking for disabled drivers, and an accessible toilet. A hearing loop installed. The practice trained staff in equality and diversity and there was a 'diversity and inclusion' lead within the medical centre.
- In response to restrictions associated with COVID-19, a remote triage model, including the use of eConsult and telephone consultation was implemented by the practice. Face-to-face consultations were facilitated if clinically required.
- All clinicians worked together to make sure clinics ran smoothly and to time and would often help out others. This allowed clinicians to know they could spend more time with those patients should they need it.
- The practice responded to feedback from patients. For example, in response to requests for more comfortable chairs new higher chairs were purchased. A water cooler was also sourced for patients to use following feedback.

Timely access to care and treatment

- Details of how patients could access the doctor when the medical centre was closed were available through the base helpline. Details of the NHS 111 out of hours service was in the medical centre leaflet.
- Urgent doctors' appointments were available on the day. Routine doctor appointments were available within five working days.
- Appointments to see a nurse were available the same day.
- The practice leaflet gave clear directions on local accident and emergency unit access. Outside of routine clinic hours, patients were signposted to the 111 out of hours (OOH) service
- We spoke with five patients who had recently received care from the medical centre. They all told us that they could secure appointments when they needed them and were confident that they would be seen quickly if they had an urgent concern.

Listening and learning from concerns and complaints

- The nurse was the lead for complaints which were managed in accordance with the DPHC complaints policy and procedure. Written and verbal complaints were recorded

and discussed at the medical centre meetings. A complaints audit had not been undertaken as there was only one complaint recorded.

Are services well-led?

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

Vision and strategy

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

- The practice worked to the DPHC mission statement: '"To provide and commission safe and effective healthcare which meets the needs of the patient and the Chain of Command in order to contribute to Fighting Power."
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The medical centre planned its services to meet the needs of the practice population.

Leadership, capacity and capability

- The SMO and the senior nurse were the leaders for the medical centre, both being civilian staff members gave consistent leadership. They clearly understood the medical centre priorities and demonstrated they had capability to drive service change for the benefit of patients. However, the practice manager post was vacant, the senior nurse was acting up as practice manager and had no formal training in practice management. These staffing constraints were highlighted in the risk register.

Culture

- Staff were consistent in their view that the medical centre was patient-centred in its focus.
- A responsive and patient-centred focus was clearly evident with this ethos embedded in practice. Staff continually looked at ways to improve the service for patients.
- Both civilian and military staff described an approachable and supportive leadership team that was committed to ensuring cohesion, equality and inclusion. It was clear from discussions with staff that their contributions to the development of the service were valued. All staff attended the practice meetings where they could put forward suggestions or raise concerns.
- 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
- 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

- There was an overarching governance framework in place to support the delivery of good quality care.
- 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 in place to support job roles, including staff who had lead roles for specific areas. However, we found that due to the lack of staff this often fell to the nurse acting up as practice manager.
- The medical centre worked to the health governance workbook (HGW), a system that brings together a comprehensive range of governance activities, including significant events tracker, lessons learnt log, training register, policies, meetings, quality improvement and audit. Staff had access to the workbook which provided links to meeting minutes, policies and other information. A programme of clinical and internal audit was in place.
- A schedule of regular practice meetings was in place, within this meeting clinical and governance issues were discussed. All staff attended the meetings and minutes were maintained.
- 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.

Managing risks, issues and performance

- Recruitment and retention of staff was the main risk for the practice. The practice managed to put some strategies in place to ensure enough clinical cover was available, for example, the nurses coordinated their annual leave around the availability of nurses at Kineton. All efforts were made to fill vacant posts so patient care was not compromised.
- The medical centre had a business continuity plan and major incident plan in place that was is located on SharePoint. This was also displayed on a board for ease of access. All staff were required to read and sign they had understood all action plans in the event of an incident as part of the induction process.
- Processes were in place to monitor national and local safety alerts and incidents, but these were underdeveloped and needed further work to ensure patient safety.
- Processes were in place for managing staff under-performance including external support for clinicians.

Appropriate and accurate information

- Quality and operational information was used to ensure and improve performance.
- 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

- There were systems in place to encourage patients to provide feedback on the service and contribute to the development of the service. Due to COVID-19, options for patients to provide feedback while visiting the medical centre were limited. Patient experience surveys were uploaded directly to Governance Assurance Performance and Quality (GPAQ). There were only 28 responses received in October 2021, all were satisfied with the care they received.
- Good and effective links were established with internal and external organisations including the Welfare Officer, Regional Rehabilitation Unit (RRU), DCMH and local health services.

Continuous improvement and innovation

- We identified that the medical centre had worked hard to continue to provide a good service over the last year despite many challenges, with staff clearly motivated to develop the service.