Minley Medical Centre

Gibraltar Barracks, Blackwater, Camberley, Surrey, GU17 9LP

Defence Medical Services inspection report

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

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

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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 this announced inspection on 22 March 2022.

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 leadership team had a clear understanding of key issues and had developed formal links with Aldershot Garrison Medical Centre (AGMC) to strengthen governance arrangements and improve resilience.
- An effective system was in place for managing significant events and staff knew how to report and record using this system. This was supported by an open door culture.
- Risks had been identified and mitigated but there was scope to improve the record keeping and access. The exception was the lone-working arrangements in the Primary Care Rehabilitation Facility (PCRF) where gaps were identified.
- Arrangements were in place for infection prevention and control (IPC). These included steps taken to minimise the risks associated with COVID-19. The IPC lead expressed concern over time needed to complete the recently introduced Defence Primary Healthcare policy on audit.
- Arrangements were in place for managing medicines, including obtaining, prescribing, recording, handling and disposal in the practice.

- Standard operating procedures (SOPs) had been developed to ensure that appropriate coding, outcomes and templates are consistently used by clinicians. Formal processes were established to ensure ongoing monitoring of clinical staff.
- 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 a quality improvement programme to both monitor administrative tasks and to deliver the best possible outcome for patients.
- The practice had a system to ensure that staff completed the required mandated training and held the appropriate professional registrations. The practice were aware of and had made plans to catch up on overdue refresher training.
- Effective medical cover was in place to cover the times when the practice was closed. This was clearly communicated to patients.
- Staff understood the Mental Capacity Act (2005) and how it applied in the context of the service they provided.
- Staff and patients were able to give feedback (including anonymously) and the most recent survey showed a high level of patient satisfaction.
- Information systems and processes were in place or being developed to deliver safe treatment and care including referral tracking.
- The practice had good lines of communication with the units and welfare team to ensure the wellbeing of patients. Links had been developed both internally and externally to enhance the support provided to patients.
- The building and equipment was sufficient to treat patients and meet their needs.
- The practice made use of privacy screens and curtains in the clinical rooms. Arrangements in the PCRF were managed to ensure patient privacy and dignity was maintained.
- Staff understood and adhered to the duty of candour principles.

We identified the following area of notable practice:

- A stress fracture audit had been completed following identification of an injury trend among Phase 2 trainees. Conclusions included increased lifting during Phase 1 training, reduced vitamin D levels attributed to less exposure to sunlight during COVID-19 lockdown and patients not taking supplements provided during training. The audit was to be repeated annually and results had been fed back to unit and to Army Recruiting and Initial Training Command (ARITC).
- The practice had written a service-leavers guide they gave to patients with a list of all veteran’s accredited practices across the UK.

The Chief Inspector recommends to the practice:

- Ensure the chaperone service is clearly communicated to patients attending for treatment in the PCRF.
- Ensure protected time is allowed for completion of the mandatory IPC requirements.
- Strengthen processes to mitigate potential risk in the management of safety alerts.
- Complete planned training for staff including refresher training and peer review for all new exercise rehabilitation instructors.
- Review the position regarding direct access to physiotherapy to ensure patient choice is considered.
- Strengthen governance arrangements to further integrate the PCRF.

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, nurse, physiotherapist, practice manager and a pharmacist.

Background to Minley Medical Centre

Located in Gibraltar Barracks, Minley Medical Centre provides a primary healthcare, occupational health and force protection service to a patient population of 1,024 permanent staff and trainees, including 160 trainees under the age of 18, and 43 patients over the age of 40. The population comprises 970 men and 54 women. The practice also provides medical support for personnel on short courses at the camp.

A PCRF is located near to the medical centre and provides a physiotherapy and rehabilitation service. The medical centre is not a dispensing practice and medicines are dispensed from Aldershot Garrison Medical Centre (AGMC).

The practice is part of a regional hub that includes AGMC. There is a memorandum of understanding (MOU) with AGMC to define areas of responsibility and formalise the support provided.

The practice is open from 08:00 to 16:30 hours Monday, Tuesday and Thursday. Opening hours are 08:00 to 12:30 on Wednesday and until 13:00 on Friday. Emergency

appointments can be accommodated in the afternoons when it is closed. AGMC provides cover to Minley Medical Centre 13:00 to16:30 on Fridays. Sandhurst Medical Centre provides cover 16:30 to 18:30 Monday to Thursday. Outside of these hours, including weekends and bank holidays, cover is provided by NHS 111.

The staff team at the time of the inspection

Position	Numbers
Medical team	One Senior Medical Officer (SMO) who is a civilian medical practitioner (CMP) Part time locum CMP
Nursing team	One practice nurse Band 6
Practice management	One military practice manager
Administration team	Three administration staff (one post vacant)
PCRF team	One full-time physiotherapist and one part-time (0.5 whole time equivalent) physiotherapist One full-time exercise rehabilitation instructor (ERI) and two part-time locum ERIs (equivalent to one whole time equivalent)
Combat Medical Technician (CMT)*	Two

*In the army, a medic 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 practices but with a broader scope of practice.

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

The practice had safety policies in place including adult and child safeguarding policies. The local safeguarding standard operating procedure (SOP), reviewed in February 2022, referenced adults and children and included links to the local safeguarding team. Safeguarding arrangements were displayed on posters throughout the building and included essential contact details. Staff received safeguarding information as part of their induction and refresher training.

There was an appointed lead and deputy for safeguarding, both had completed level 3 safeguarding training. All staff were in-date for safeguarding and safety training appropriate to their role and knew how to identify and report concerns. The safeguarding register was held in SharePoint with access limited to appropriate staff members.

Care leavers (identified and highlighted on the clinical operating system) in phase 1 of training were monitored monthly. In addition, individual case conferences were held when required (for example, when posted to another unit). Usually initiated by the Chain of Command, the Senior Medical Officer (SMO) and welfare team had appointments with patient (often held jointly). These were documented on the electronic clinical and patient record system, known as DMICP.

Vulnerable patients were identified during consultations, through the new patient registration process or on referral from another department such as the welfare team. All patients identified as vulnerable received were Read coded to highlight them on the clinical operating system. Read codes are a comprehensive list of clinical terms used by healthcare professionals to describe the care and treatment given to patients.

Consent was sought from the patient before information was shard with the Chain of Command and a RAG (traffic light) system prioritised the availability of appointments. There was a risk register of vulnerable patients and a system to highlight them on DMICP. The register was reviewed during monthly meetings with the welfare team. A note of any discussion was added to the patient record.

Staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. 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. Clinical staff were used to chaperone and training for military staff was planned for March 2022. An SOP was in place, last reviewed in March 2022, that included any patient under 18 to be provided with a chaperone. Posters advising patients about requesting a chaperone were clearly displayed in clinical rooms, the waiting room and in the practice leaflet. However, the policy did not extend to the Primary Care Rehabilitation Facility (PCRF) where chaperones were not offered routinely and no poster was on display.

The full range of recruitment records for permanent staff was held centrally. However, the practice could demonstrate that relevant safety checks had taken place at the point of recruitment, including a DBS check to ensure staff, including locum staff, were suitable to work with vulnerable adults and young people. DBS checks were renewed every three years for civilian staff and every five years for military staff.

Arrangements were in place to monitor the registration status of clinical staff with their regulatory body. All staff had crown professional indemnity cover. DBS and vaccination status were recorded on SharePoint in a folder with restricted access. This was extended during the inspection to include professional registrations. There was a checklist which recorded progress and completion of induction. All new staff had commenced the process and all permanent staff had completed an induction.

The regular locum doctor was shared with Aldershot Garrison Medical Centre (AGMC). The practice manager conducted pre-employment checks for locum staff on the online VMS (vendor management system). Evidence packs were checked on arrival and locum staff were asked to complete a specific induction pack.

The lead nurse led on infection prevention and control (IPC) and had completed role-specific training. The staff team was up-to-date with IPC training. An internal IPC audit had been undertaken in October 2021 and found the practice to be ‘overall good’ in compliance. Minor non-compliances had been acted on. For example, the floor covering in the toilets had been highlighted as an ongoing IPC concern, a business plan had been submitted and agreed. A date for the works to be carried out was to be advised. The IPC audit was scheduled to be repeated annually but the lead expressed concerns about having the time capacity and skills to use the new Defence Primary HealthCare (DPHC) template.

Environmental cleaning was provided by the contracted staff who carried out a twice daily clean of the practice. A deep clean of the premises took place three times each year during stand down periods (times such as Christmas holidays when operational activities temporarily cease). A cleaning register held at reception was signed daily by the cleaner and reviewed weekly by the practice manager and cleaning manager. There was a touch point and equipment cleaning register in each clinical room for staff to complete.

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 October 2021 found the practice was 100% compliant. Clinical waste was bagged and labelled before being logged and stored for collection by an external contractor. External storage was in a lockable waste skip held in a secure area.

The practice had recently taken steps to ensure that facilities and equipment were safe and that equipment was maintained according to manufacturers’ instructions. The servicing of the gymnasium equipment was managed by the full-time exercise rehabilitation instructor (ERI). There was a documented check of PCRF equipment and 10% of checks were being completed quarterly as per DPHC policy.

Risks to patients

Systems to assess, monitor and manage risks to patient safety were established to minimise any risk to patients.

The practice had developed cross cover arrangements with Aldershot Garrison Medical Centre (AGMC) to provide more resilience. These were detailed in a memorandum of understanding (MOU) which included the provision of clinical support to cover absence and any surge periods. The practice manager was developing two medics to cover essential tasks in their absence. The skill mix at the practice was sufficient to meet the needs of the patients.

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. Emergency kit, including a defibrillator, oxygen with masks and emergency medicines were accessible to staff in a secure area of the practice; all staff knew of its location. Equipment was checked daily and the crash trolley checked monthly.

Staff had completed training in basic life support training, anaphylaxis (severe allergic reaction) and instruction on how to use the automated external defibrillator (AED). A refresher update was due for six staff members. Clinicians knew how to identify and manage patients with severe infections including sepsis. A poster was displayed to guide patients and staff in recognising the symptoms and sepsis training was planned for March 2022. A support template with prompts to help identify potential sepsis was built into the DMICP. No specific training had been undertaken on how to deal with thermal injuries but a guide to treatment was displayed in the treatment room.

Temperature checking was not carried out in the gymnasium environment as an air conditioning system maintained safe conditions in which to train. PCRF staff were basic life support (BLS) trained and an AED was present in the gymnasium (checked daily). Due to the relative geographical isolation from the medical centre and the experience of a recent medical emergency (unrelated to the PCRF), a business case has been submitted for the acquisition of additional health monitoring equipment to be sited at the PCRF.

A COVID-19 risk assessment had been completed. Measures introduced to minimise the risk of spreading infection during the COVID-19 pandemic included:

- The majority of appointments were done via telephone with face-to-face appointments offered only when required.
- Personnel suffering from any underlying health condition must seek medical approval before returning to work.
- A one-way system was implemented into the building.
- Signs placed throughout on walls and floors to encourage social distancing.
- Hand sanitiser dispensers placed throughout the building.

- A ‘red room’ was used for patients presenting with COVID-19 symptoms. This room could be accessed without having to walk through the main part of the building.
- Personal protective equipment (PPE) was provided to staff. This included face masks and visors that protect staff from airborne infection when seeing patients.

Information to deliver safe care and treatment

The clinical records we reviewed were sufficiently detailed and managed in a way that kept patients safe. Doctor and nursing records were regularly audited by the Senior Medical Officer (SMO). The SMO had their clinical records reviewed by a doctor at AGMC. For PCRF staff, the last clinical notes audit was undertaken in June 2021. PCRF Minley were on the rota with PCRF Aldershot for a quarterly peer review. However, practice staff reported difficulty in coordinating with Aldershot and enabling the Aldershot team to travel to Minley for a shared patient evaluation. Consequently, their fallback position was a peer review of each other’s records.

Practice nurses completed the summarising of patient notes and ran regular searches on DMICP. Initial summarising was 92% completed with 74 sets of recently received notes that required summarising. The summarising of patient notes was reviewed every three years in accordance with DPHC policy.

Staff described occasional loss of connectivity with DMICP, meaning clinics could be delayed. If this happened, the business resilience plan was followed, and only urgent patients were seen. Consultation notes were recorded on to paper copies and scanned onto DMICP at a later date. The practice had Wi-Fi and new laptops with updated software that allowed for remote working and a contingency for times of power outage. Clinics could also be accessed from AGMC.

A system was in place for the management of external and internal referrals. The administration team monitored these referrals. Occupational health, Department of Community Mental Health (DCMH), physiotherapy and ERI referrals were recorded by the administrative staff and monitored on the referrals database. The SMO advised that a review of all internal referrals was undertaken every month to check they had been received. However, these were not included on the referral tracker document. PCRF referrals were discussed with the SMO at the two-weekly patient injury management meetings. Patient appointments were booked through the NHS e-Referral service (e-RS).

There was an effective system in place to ensure specimen samples were taken safely, appropriately recorded on DMICP and results reviewed and actioned by a clinician within seven days. This was supported by a SOP.

Safe and appropriate use of medicines

A lead and deputy were identified as the subject matter experts for medicines management. The lead was listed as the pharmacy technician from AGMC with the day-to-day management of medicines delegated to the SMO. Although staff were clear of their roles and those of colleagues, the SOP required updating to reflect these responsibilities

(the MOU did reflect the lead roles). Safe procedures were in place for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment. We found all items were within date and appropriately stored.

Dispensing was mainly carried out by dispensing staff from AGMC or outsourced to a local community pharmacy (for urgent prescriptions). The only stock held was dispensed items awaiting collection, vaccines, Patient Group Directions (PGDs) and medicines to be used in an emergency. Medication requiring refrigeration was monitored twice daily to ensure it was stored within the correct temperature range. The practice had used a data logger to record minimum and maximum temperatures in the fridge. Readings could be monitored by AGMC who provided a contingency for loss of power and provided an alternative stock location during stand down periods.

Appropriate arrangements were established for the safety of controlled drugs (CD), including destruction of unused CDs. A small number of dispensed CDs were held when awaiting collection. Monitoring and storage arrangements were in accordance with guidelines and policy. No other CDs were routinely held.

There was a process for the management of and monitoring of patients prescribed high risk medicines (HRMs). Monitoring was done by the SMO and the pharmacy technician at AGMC held the register. We reviewed the clinical records of all patients prescribed an HRM. We noted that alerts were in place and monitoring was carried out in accordance with the recommended frequency. Shared care agreements (SCA) were in place for the patients that required them. SCAs are important to provide clear responsibilities between clinicians involved in the patient's care. Staff did not have access to the HRM register held by AGMC. However, the SMO conducted searches to identify these patients on a monthly basis. Despite this duplication, there was clear evidence that patients on an HRM and those that required monitoring were being identified and appropriately managed within the practice.

Staff who were prescribers had signed the SOPs applicable to them.

Staff had access to British National Formulary and prescribing formulary. We saw that the prescribers were working to both local and national guidelines for prescribing. A structured programme of audit, including an audit of antibiotic prescribing, had been implemented. A review of the antibiotic audit showed 93% (13 out of 14 prescriptions for antibiotics) compliance with local guidelines produced by the Clinical Commissioning Group.

PGDs had been developed to allow nurses to administer medicines in line with legislation. The PGDs were current and signed, evidenced in the results of an audit carried out in January 2022. Patient Specific Directions (PSDs) were not used and medics administered medication from an individual patient prescription. PGDs are a written instruction allowing non-prescribing clinicians to administer or issue certain medicines to a group of patients. PSDs must be signed in advance of a medicine being administered to a named patient after the prescriber has assessed the patient on an individual basis.

The practice's arrangements for the access, storage and monitoring of prescription stationary were effective. Blank prescription pads and prescription paper were stored securely and an effective tracking system was followed.

Requests for repeat prescriptions were safely managed and no telephone requests were accepted. The process for repeat prescriptions was maintained and monitored by the SMO. A process was in place to update DMICP if changes to a patient's medication were made by secondary care or an out-of-hours service.

Track record on safety

Measures to ensure the safety of facilities and equipment were in place. Risk assessments included both clinical and non-clinical risks. For example, needle stick injury, lifting and handling, legionella management, lone working and Control of Substances Hazardous to Health. Data sheets were held for COSHH substances.

There were registers maintained of both active and retired risk. However, some of the risk assessments were difficult to locate as there was no index to list identified risks. One physiotherapist worked alone for approximately 30% of the time. There were arrangements with the medical centre and main security gate to advise them during these times. However, there had been occasions where communication had broken down, and unbeknown, the physiotherapist continued lone working without cover.

The practice manager was the lead for health and safety and was in the process of completing role-specific training. The safety certificates for water, electric and legionella were held by the station safety team and copies were made available or had been requested by the practice. We viewed those for fire, water and legionella on the inspection visit and found them to be in-date. There was no main gas supply into the building. A programme was in place to flush taps weekly in order to prevent the build-up of bacteria that can lead to legionella.

The station lead for health and safety carried out an annual assessment. Equipment checks, including the testing of portable electrical appliances were in-date.

There was no fixed alarm system in place and staff used hand-held alarms and whistles. These alarms were tested monthly and details recorded on the healthcare governance workbook (HGW). The practice manager has submitted a statement of need for a fixed alarm system and the matter was recorded on the issues register on the HGW.

Staff working on reception had full view of the waiting room so patients could continue to be observed whilst waiting to be seen.

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 and incidents (referred to as ASER). This was supported by an SOP and staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.

There was evidence that the practice learned and shared lessons and took action to improve safety in the practice. Staff we spoke with could recall the learning from a recent significant event when a category 1 ambulance had not arrived within the 15 minute response time. As a result, the practice reviewed their emergency medicines held routinely to ensure they could appropriately manage acutely unwell patients whilst waiting for an ambulance to arrive. ASERs were a standing agenda item at practice meetings and at the monthly healthcare governance meeting held jointly with AGMC.

The practice manager was responsible for managing medicine and safety alerts. In their absence, the responsibility fell to a medic. Alerts were sent from regional headquarters and the practice manager was also registered to receive alerts direct from the Medicines and Healthcare products Regulatory Agency website. We checked recent alerts and found they had been received. However, we highlighted that registering to receive alerts to the group inbox would improve the system. There was a register on the HGW where alerts considered relevant to the practice were recorded and discussed at the monthly practice meeting. It was not clear from the register what action has been taken, in what timeframe and by whom to implement any required changes.

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. Our review of patients' notes showed that NICE best practice guidelines were being followed. Staff we spoke with referred to and gave examples of updates they had acted on. Clinical guidelines was a standard agenda item at healthcare governance (HG) and practice meetings. For example, HG meeting minutes from April 2021 included evidence of discussion around updated guidelines for fertility medicines prescribed as part of an NHS England Armed Forces Health funded assisted conception cycle.

The Defence Primary Healthcare (DPHC) team produced a newsletter that was circulated to clinicians providing further information and a summary of relevant safety updates. The practice nurse dialled into the Aldershot Garrison Medical Centre (AGMC) 'journal club' each Monday and was invited to all nursing meetings where clinical guidelines formed part of the discussion.

We looked at a sample of clinical records from the Primary Care Rehabilitation Facility (PCRF). Templates that included the musculoskeletal health questionnaire (MSK-HQ) were used on all new patients. MSK-HQ is a tool developed to allow patients to report their symptoms and outcomes from treatment in a standardised way. Outcomes were used for individual patients and progress was reviewed though patient care committees. PCRF staff were aware of best practice guidelines but had not audited against them to determine their conformity.

Monitoring care and treatment

The Defence Medical Services (DMS) have a responsibility to deliver the same quality of care as patients expect in the NHS. Because the numbers of patients with long-term conditions (LTCs) are often significantly lower at DPHC practices, we are not using NHS data as a comparator. The practice nurse was the lead for the management of patients with LTCs. The population manager facility (referred to as 'popman') was used to identify and monitor patients with an LTC.

A total of 18 patients were recorded as having high blood pressure and 13 had a record of their blood pressure having been checked in the last 12 months. A total of five patients had a follow-up blood pressure reading of 150/90 or less (this is in an indicator for mild hypertension). All patients with high blood pressure had a treatment plan in place.

There were low patient numbers on the diabetic register and a review of clinical notes showed good management with regular recall and monitoring. All new patients were

offered at their nurse-led ‘New Patient Appointment’ screening (AUSDRISK) if over 25 and non-Caucasian or over 40 and Caucasian and offered an HbA1c blood test (blood glucose levels) if moderate risk or higher. All patients previously assessed as prediabetic (HbA1c >6.0) or diagnosed with gestational diabetes were offered an annual blood test. Opportunistic testing was done if patients were concerned about excessive weight gain or loss.

There were four patients on the asthma register and all had been reviewed in the last 12 months. A consistent template had been implemented and included the appropriate Read codes to be used. Read codes are a comprehensive list of clinical terms used by healthcare professionals to describe the care and treatment given to patients.

There was a formalised process in place for recall of other LTCs or for future recommended procedures. For example, post gestational diabetes and five yearly colonoscopy. The recall of these patients is important when the population is transient.

We looked at a range of patient records and were assured that the care of patients with a mental illness and/or depressive symptoms was being effectively and safely managed. Patients presenting with a mild to moderate anxiety or low mood were assessed in accordance with the pathway and treated initially at the practice (step 1) or referred to the Department of Community Mental Health (DCMH) team if their clinical need was assessed as greater than what step 1 could provide. The high number of trainees resulted in a demand for step 1 care

Information from the Force Protection Dashboard, which uses statistics and data collected from military primary health care facilities, was also used to gauge performance. Service personnel may encounter damaging noise sources throughout their career. It is therefore important that service personnel undertake an audiometric hearing assessment on a regular basis (every two years). Audiometric assessments were in date for 56% of patients. A catch up programme had commenced; medics contacted the units to recall all those out of date to attend for audio. They ran regular clinics to catch up on audiometric assessments and vaccinations.

The Senior Medical Officer (SMO) was the overall audit lead and the practice had implemented a calendar that included mandatory DPHC audits. The audit programme was established and consisted of repeat cycles. Audits completed included:

- hypothyroid medication
- treatment for depression
- treatment for gout and allopurinol prescribing
- infection prevention and control (IPC) and handwashing
- COVID-19 patient recall for at risk groups
- risk factors for stress fractures
- specimen handling
- pre-acceptance healthcare waste.

A stress fracture audit had been completed following an injury trend identified by the SMO who went on to audit risk factors for stress fractures. It explored potential reasons for the increased numbers of Phase 2 trainees who experienced a stress fracture. Conclusions included increased lifting during Phase 2 training, reduced vitamin D levels attributed to less exposure to sunlight during COVID-19 lockdown and patients not taking supplements provided during training. The audit was to be repeated annually and results had been fed back to unit and to Army Recruiting and Initial Training Command (ARITC).

There was scope to improve integration of the PCRF audits into the audit programme. IPC and clinical notes audits were done separately in the PCRF and were not integrated into the audit calendar. The IPC audit was carried out by PCRF staff who had not had the same level of training as the IPC lead.

An internal quality assurance tool, the Defence Medical Services (DMS) Common Assurance Framework (eCAF) was used to monitor safety and performance. The DMS eCAF was formally introduced in September 2009 and since that time has been the standard healthcare governance assurance tool utilised by DMS practices to assure the standards of health care delivery within DMS. The practice manager was able to describe how the eCAF was being developed, for example, to make reviews a constant cycle not a quarterly activity.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

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 had developed processes to provide staff with ongoing support through AGMC. These included one-to-one meetings, appraisals, mentoring, clinical supervision and support for revalidation. There was formal peer review in place for the nurses and rehabilitation staff. We were told that supervision was completed by the nurses quarterly but this had not been recorded.

The practice manager and a medic monitored mandatory training using the staff database and raised at the practice meeting when training courses were due to be renewed. All staff had protected time to complete mandatory training or take part in scheduled group training. The practice database showed 84% compliance for staff having completed mandatory training.

Combat Medical Technicians (CMTs) maintained their own portfolios and the SMO maintained oversight by regular review of their consultations.

The practice nurse linked in with peers through the regional nurse forum and inclusion in meetings held by the nursing team at AGMC. However, the nurse stated that a lack of available time was a limitation in completing training additional to the mandatory requirements.

Internal and external training sessions were available to staff. For example, the practice manager had funding secured to complete the DPHC practice manager course (currently suspended due to COVID-19) and the Institution of Occupational Safety and Health (IOSH) training course. The practice manager had completed the DMICP administrators course and first aid at work.

Physiotherapist appraisals were performed by a Band 7 physiotherapist from AGMC PCRF. PCRF staff were supported with revalidation and had a portfolio of evidence to present from the last two years to support professional development. The full-time ERI was currently studying for BSc Hons in strength training and conditioning. The practice employed two part time ERI agency staff who had not completed a peer review within six weeks of starting in line with DPHC guidance. However, the ERIs did provide evidence of completion of the post graduate mentoring programme or return to clinical practice (as appropriate).

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.

The practice had established links with local NHS services. These included connecting with the local mental health and safeguarding teams.

The practice had connected with the local sexual health clinic (Aldershot Centre for Health) and promoted their services within the practice as well as signposting patients to the internet for online support.

On leaving the military patients underwent a release medical and summary of their clinical notes. Signposting and information on civilian life was delivered by the unit. Links had been developed with a local GP who specialised in supporting patients on leaving the military. A debt counselling service (accessed via the welfare team) was promoted having identified a need for support among the practice population. A quality improvement project (QIP) had been undertaken for service leavers. The practice had written a service-leavers guide they gave to patients with a list of all veteran’s accredited practices across the UK.

There was good communication between the PCRF staff and unit physical training instructors and comprehensive programmes to follow for injury recovery and maintenance.

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 an LTC and those requiring advice on their diet, smoking and alcohol cessation. Patients identified as pre-diabetic (at risk of developing diabetes where intervention could result in prevention) were recalled for annual blood tests.

The practice nurse had the lead for health promotion and was supported by one of the CMTs as a deputy. The health promotion strategy had been formulated into a calendar for the next 12 months and was underpinned by national priorities and initiatives to improve the population's health. At the time of the inspection there was a campaign in place to encourage patients to quit smoking. Promotions were refreshed in line with seasonal and/or topical demand. Information leaflets and booklets were normally on display but had been removed due to COVID-19. 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.

Patients could access sexual health services from a nearby clinic in Aldershot. Contact information for the local genitourinary clinic was detailed in reception and a permanent sexual health notice board was sited in the patient waiting area. Condoms were not available but we were told were on order to be given out on request. Patients were encouraged to order sexually transmitted infection (STI) screening kits from the 'letstalkaboutit' website which offered free STI postal test kits. STI screening could be done within the practice after review by a clinician.

Medical centre staff attended unit health fairs held twice a year to give advice and health promotion information to personnel. The most recent fair was held in November 2021 was attended by the practice nurse and a CMT who provided stands to promote smoking cessation and sexual health.

We saw that the ERI included questions about lifestyle as part of their assessment and used wellness measures on Rehab Guru (software for rehabilitation exercise therapy) to monitor lifestyle and wellness activity. The ERI had formed close relationship with the unit physical training team and had volunteered health lectures focussed on the promotion of movement quality in injury prevention.

The practice offered preventative health checks to identify any conditions that patients may be at risk of and could be avoided by treatment and lifestyle choices. There was a structured approach to patient recall; of a total of 118 patients eligible for the over 40s health check, 67 had been completed.

A monthly 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 screening programs. At the time of the inspection there were no eligible patients for screening.

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 27 out of 30 eligible women. This represented an achievement of 90%. The NHS target was 80%. Invite letters were sent out and followed up if not responded to, the nurses contacted patients by telephone.

It is important that 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 March 2022 provides vaccination data for patients using this

practice (regional and national comparisons were not available): military personnel have sufficient immunity against the risk of contracting certain diseases.

- 96% of patients were recorded as being up-to-date with vaccination against diphtheria.
- 96% of patients were recorded as being up-to-date with vaccination against polio.
- 86% of patients were recorded as being up-to-date with vaccination against Hepatitis B.
- 98% of patients were recorded as being up-to-date with vaccination against Hepatitis A.
- 96% of patients were recorded as being up to date with vaccination against Tetanus.
- 100% of patients were recorded as in date for vaccination against MMR.
- 99% of patients were recorded as in date for vaccination against meningitis.

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.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance. For example, verbal consent was recorded in DMICP. Acupuncture was administered by the physiotherapist. There was an standard operating procedure which included a written consent form.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

When providing care and treatment for young patients aged between 16 and 18 years, staff carried out assessments of capacity to consent in line with relevant guidance. There were very few patients under 18 but clinical staff were aware of the protocols and were supported by DMICP templates. The unit had a policy on accompanying under-18 patients if sent to hospital. The practice sought consent from the patient for a named, appropriate individual to travel to hospital with them.

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.

From our interviews, we established the practice, Primary Care Rehabilitation Facility (PCRF), Welfare Officer and the unit had developed an effective relationship that was underpinned by a person-centred approach. They worked closely to ensure the best care for each individual taking account of their occupational and health requirements.

The practice gave patients timely support and information. We were provided with examples of compassionate care where clinicians supported patients beyond what was required on their role. A translation service was available and promoted at reception and in the patient waiting area. Staff told us that there had been no requirement to use the service.

The practice had an information network available to all members of the service provided through the Army Welfare Service. This provided a range of information to patients who had relocated to the base and surrounding area. Information included what was available from the Unit and from civilian facilities, including healthcare facilities. The contact details for the welfare team were included in the patient information leaflet and there was a poster at reception.

Involvement in decisions about care and treatment

The clinicians and staff at the practice recognised that the personnel they provided care and treatment for could be making decisions about treatment that could have a major impact on their military career. Staff demonstrated how they gauged the level of understanding of patients, gave clear explanations of diagnoses and treatment, and encouraged and empowered patients to make decisions based on sound guidance and clinical facts.

The e-referral service 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 conducted by the Defence Medical Services Regulator in the weeks before this inspection (42 responses were collated) indicated:

- 76% described their overall experience as good (13% did not respond).
- The 13 patients who responded to the question said that they were treated with care and concerns.

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

Notices were displayed in the patient waiting area which told patients how to access a number of organisations. Information was prominently displayed and accessible and we saw that it was age appropriate and relevant to the patient demographic. Mental health support services were promoted and campaigns were run during the year to give greater emphasis.

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 them to personnel within the military who could guide them through the exit process and transition to NHS care and other support functions. Links had been developed with a local GP who specialised in supporting people when leaving the military.

The practice maintained a register of patients who were also carers and provided extra support as required. Carers were identified as part of the new patient registration process. Carers and cared for patients were Read coded and recalled for annual flu immunisations and had been 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. There was a notice for carers in the practice leaflet and relevant information displayed in the waiting room. Staff were given guidance in a carer's standard operating procedure (SOP) last reviewed in December 2021.

Privacy and dignity

The practice respected patients' privacy and dignity.

Privacy screening was provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. Clinic room doors were closed during consultations and conversations could not be overheard.

Physiotherapists used two separate rooms to offer privacy during consultations and treatment. Exercise rehabilitation instructors (ERIs) used a curtained off area in the main gymnasium area, background music reduced the likelihood of conversations being overheard. If requested when seeing an ERI for treatment, privacy was provided by using one of the clinical rooms.

Privacy for patients when speaking with receptionists was supported by the layout with the waiting area set away from the desk. Signage asked patients to stand back while waiting to be seen and background noise (television) had been introduced to assist with privacy. Staff at the reception desk advised patients that a private room would be offered should they wish to discuss sensitive issues.

The practice could facilitate patients who wished to see a clinician of a specific gender. Patients were signposted to another military medical centre if wanting to see a clinician of the same gender (a standing agreement was in place with Aldershot Garrison Medical Centre). Male patients could be signposted to the local sexual health clinic to be seen by a male clinician for sexual health screening.

The practice had produced a transgender SOP written after caring for a transgender patient in a phase 2 training establishment. The procedure clearly demonstrated and acted on lessons learned and included collaboration with the Chain of Command. Examples included consideration of how patient toilets are labelled.

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 organised and delivered services to meet patients' needs and to account for preferences.

The practice understood the needs of its population and tailored services in response to those needs. Appointments slots were organised to meet the needs of specific population groups. For example, eConsult could be accessed 24 hours a day, aimed to provide particular support to those patients in training who had difficulty contacting the practice during opening hours. Telephone consultations and eConsult appointments were alternative options for patients who required an appointment. Specific clinics were in place including vaccination and chronic disease.

An Equality Access Audit as defined in the Equality Act 2010 was completed for the premises in February 2022 and no significant concerns were identified. The audit identified that lighting outside the facility was inadequate, this has been added to the practice issues log and a business case was being completed for additional lighting.

There was no hearing loop but the practice stated that they had no requirement as no patients on their register, visitors or staff with visual or hearing impairment.

The practice had a policy available to staff or patients that stated home visits would not normally be provided. We discussed the rationale for this and it had been decided that any patient unable to attend in person would be in need of more urgent treatment from the emergency services. If clinically appropriate, a home visit would be conducted as per Defence Primary Healthcare (DPHC) policy.

Direct access to physiotherapy had been used in the past but was stopped during the first COVID-19 lockdown and not reinstated as it was deemed ineffective due to the good availability of appointments. However, in not reinstating, patients were unable to see a physiotherapist without referral from a doctor, which limited their choice.

There was a lead and deputy appointed for equality and diversity. All staff had completed training as part of their mandatory requirements.

Timely access to care and treatment

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 proactively managed and slots were available each week. Nurses had capacity to see a patient within two days. Appointments for new patients with a physiotherapist and follow up appointments were available within one day.

Outside of routine clinic hours, cover was provided up until 18:30 by Sandhurst Medical Centre. On Fridays, Aldershot Garrison Medical Centre provided cover between 13:00 and 16:00 and Sandhurst Medical Centre from 16:00 until 18:30. From 18.30 hours, patients were diverted to the NHS 111 service and/or eConsult (a message could be left for the practice to follow up on the following working day if not urgent). If the practice closed in the 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 hours and 18.30 hours, in line with DPHC's arrangement with NHS England.

The nearest accident and emergency department and minor injuries was located at the Frimley Park Hospital (approximately 10 minutes away).

Results from the practice's patient experience survey (compiled between September 2021 and February 2022, 33 responses were received) showed that patient satisfaction levels with access to routine care and treatment were high;

- 100% of patients said their appointment was at a convenient time.

Electronic consultations with a clinician could be organised and details on how to arrange this was outlined in the practice information leaflet.

The practice leaflet provided comprehensive 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.

The practice manager was the designated responsible person who handled all complaints in the practice. The practice had implemented a process to manage complaints in accordance with the DPHC complaints policy and procedure. Both verbal and written complaints were recorded.

There had been three complaints recorded in the last 12 months. We reviewed these to find appropriate process had been followed. For example, the wrong prescription was dispensed to a patient by the outsourced pharmacy. An ASER was raised and duty of candour applied, with both logs updated accordingly.

Information was available to help patients understand the complaints system, including in the patient information leaflet. A 'you said, we did' section displayed in the patient waiting area informed patients of changes made as a result of patient feedback.

Are services well-led?

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

Leadership, capacity and capability

The leaders at the medical centre were meeting the challenges of having low staff numbers whilst providing a consistent and timely service to the patients. Resilience had been developed through a memorandum of understanding with Aldershot Garrison Medical Centre (AGMC) that covered key areas of responsibility and support for any periods of absence or surges in demand. The Senior Medical Officer (SMO) was well supported when undertaking the majority of the healthcare governance (HCG) activities, such as searches, audits and the development of standard operating procedures (SOPs). The practice manager post was protected from deployment to provide stability and continuity.

Leadership roles had been established for key responsibilities and staff were clear of their own role and those of colleagues. Staff felt that they could raise concerns if they had them and forums had been established where all staff could get together to share and learn from key messages. Staff spoke highly of internal communication. Leaders were knowledgeable about issues and priorities relating to the quality of services. As a result, key risks were being addressed. For example, a management plan had been produced following the last Healthcare Governance Assurance Visit (HGAV), carried out remotely in December 2020.

The rehabilitation team spoke of good support and a close working relationship with the SMO.

Terms of reference were in place and reflected the key responsibilities given to individuals.

Vision and strategy

The practice had developed the working relationship with AGMC in line with the strategy to be part of a regional hub. The strategy extended beyond the provision of resilience and included integration of both the patients and staff. In addition to a management action plan, there was a practice development plan

The practice followed the Defence Primary Healthcare (DPHC) mission statement to “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 team had produced their own mission statement stating, ”we are committed to the provision of high-quality patient centred care and best practice, through the delivery of services which are timely, considerate and responsive to the needs of our patient population and supported by a clear focus on information management excellence and information systems innovation”.

Staff were aware of and felt fully engaged in the vision, values and strategy and their role in achieving them. Key responsibilities had been and continued to be assigned throughout the team and all staff spoke positively about the improvements being made.

The practice planned its services to meet the needs of the practice population and liaised with unit personnel to promote their vision and values. The practice staff were aware of specific medical requirements for trainees and we found strong links with the Welfare Officer and with the station executives.

Culture

Through discussion with practice staff, it was clear that the practice had fostered a ‘no blame’ culture. Key systems had been reviewed to make them more effective and staff we spoke with were aware of the whistle-blowing policy and freedom to speak up champion.

Discussion with staff members indicated that morale was high and in particular staff were complimentary about the leadership in the practice. They felt respected, supported and valued.

The practice focused on the needs of patients. Examples included a stress fracture audit which resulted from identifying injury trends among trainees.

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. There was information displayed to advise staff on the freedom to speak up process and this included signposting to ‘Speak Out’ a confidential helpline to support those who felt bullied , harassed or discriminated against. The management team had an open door policy and the meeting structure was inclusive in providing all staff the opportunity to offer their opinion.

Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They spoke of how the culture was one where both suggestions and concerns would be both listened to and acted on.

Processes were being implemented to provide staff with professional development. This included appraisal and peer review. All staff were scheduled to receive 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. However, opportunities for the practice nurse to complete courses such as training in sexual health had been limited due to time constraints.

Staff had completed equality and diversity training.

Governance arrangements

The leadership team had worked to consolidate and clarify responsibilities, roles and systems of accountability to support good governance and management. The practice had built in more resilience with leads, deputies and cross centre working, in particular utilising

colleagues from nearby medical centres to provide both resilience and continuity. The HCG workbook was the overarching system used to bring together a range of governance activities, including the risk register, training register, policies, quality improvement activity and complaints. A monthly HCG meeting was held. We queried whether the level of integration between the medical centre and Primary Care rehabilitation Facility (PCRF) could be improved to further strengthen governance arrangements.

Through engagement, the practice had developed strong links with the welfare team, pastoral support and Chain of Command. Systems were in place to safeguard vulnerable personnel and ensure co-ordinated person-centred care for these individuals.

Practice leaders had reviewed, introduced and implemented a suite of policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. There were links to DPHC polices and some had been adapted to local policies.

An audit calendar was detailed on the HCG workbook. It included both mandated and opportunistic audits and had led to positive outcomes. Repeat cycles were planned to provide visibility on quality improvement.

The practice had a system to monitor all patients on high risk medicines (HRMs). Shared care protocols were in place for patients taking high risk drugs. Regular clinical searches were carried out to monitor patients on HRMs.

A meeting schedule was established and this included monthly healthcare governance, practice and welfare meetings. Weekly meetings held in conjunction with AGMC included a working group and a practice update meeting. Discussion at each meeting was recorded and made available to those unable to attend. Quarterly meetings were held with DPHC Headquarters.

Managing risks, issues and performance

Practice leaders had established a governance structure that provided oversight of risk and the quality of service. A risk register was maintained and discussed at the monthly practice meeting. There were clear and effective processes in place for managing risks, issues and performance. The ‘four T’s’ (transfer, tolerate, treat, terminate) DPHC Guidance Note on managing risk was referenced on the risk register. The way in which identified risks were filed would benefit from an index as some were not easily located when requested. We highlighted that further integration with the PCRF would further strengthen the processed in place. For example, lone working arrangements in the PCRF required review as they were in a separate building and working arrangements lacked detail.

Although there had been no performance issues with staff, leaders were aware of policies to be followed and where to access support if advice was needed. All staff were in date for ‘defence information passport’ and ‘data security awareness’ training.

There was a business continuity plan which had last been reviewed in February 2022 and included agreed minimum staffing levels, directions to follow in the event of extreme

weather and interruption of power supply. All staff were recorded as having read the policy and a hard copy was kept on the staff notice board.

Appropriate and accurate information

A number of different meetings were held regularly and extended to the whole team. A practice wide meeting was held monthly 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, national guidance and alerts. Meetings were used to keep staff updated on and included in the implementation of ongoing improvements.

The leadership team was aware of the Common Assessment Framework (CAF), an effective governance tool used in military practices to monitor performance.

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. A patient experience survey was undertaken throughout the year. Actions taken were communicated via a ‘you said, we did’ display in the patient waiting area. Attempts had been made to establish a patient group; however, meetings had been poorly attended.

Patients could leave feedback anonymously via a suggestion box and could record feedback in a complaints and compliments book. A notice board in the waiting area provided a summary of the complaint process and duty of candour principles.

Good and effective links with internal and external organisations were established, including with the welfare team, Quartermaster’s department, Regional Rehabilitation Unit and with the local safeguarding team.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation. The practice developed a plan of improvement following the last HGAV inspection and had addressed the majority of gaps found. The practice had completed a number of quality improvement projects that were detailed in the quality improvement folder. Good examples of quality improvement included:

- A quick guide for doctors to use for referrals in particular to assist locum doctors who may not be familiar with the system. The guide was reviewed and updated annually.
- A list of local GP practices that were veteran friendly accredited was collated and placed in all doctor's rooms. This was given to patients who are about to be discharged from the Armed Forces as part of a guide to healthcare services.
- Use of QR (Quick Review) codes to capture patient feedback and maintain confidentiality and anonymity.
- Aimed at reducing wastage of medication and improve patient care, a text reminder was used to inform patients when their medication had arrived.