Larkhill Medical Centre

Willoughby Road, Larkhill, Wiltshire SP4 8QY.

Defence Medical Services inspection

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

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

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Summary

About this inspection

We carried out this announced inspection on the 25 May 2022.

As a result of this inspection the practice is rated as good overall in accordance with CQC's inspection framework.

The key questions are rated as:

Are services safe? – good

Are services effective? – outstanding

Are services caring? – good

Are services responsive? – good

Are services well-led? – good

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 DMS.

At this inspection we found:

- The leadership team had a clear understanding of key issues and had developed plans to resolve or mitigate identified risks. However, there was scope for improvement by the full integration of governance with the PCRF.
- Measures were in place to identify patients who were considered vulnerable, coding was consistently applied to identify patients under the age of 18.
- An effective system was in place for managing significant events and staff knew how to report and record using this system. Reporting events was supported by an open door and no blame culture.
- Risks had been identified, assessed and actions recorded when completed.
- Arrangements were in place for managing medicines, including obtaining, prescribing, recording, handling and disposal in the practice.

- The practice had good lines of communication with the unit, the Primary Care Rehabilitation Facility (PCRF), the welfare team, the Padre and the Department of Community Mental Health to ensure the wellbeing of service personnel.
- Standard operating procedures (SOPs) had been developed to ensure that appropriate coding, outcomes and templates are consistently used by clinicians.
- The practice had developed an improvement programme to drive best practice.
- There was an effective and well-designed programme in place to managed patients with long term conditions.
- The practice had a system to ensure that staff completed the required mandated training and held the appropriate professional registrations.
- Information systems and processes were in place to deliver safe treatment and care including referral tracking.
- The building and equipment were sufficient to treat patients and meet their needs.
- Formal peer review arrangements were in place for all clinical staff to include effective auditing of notes.
- Staff understood and adhered to the duty of candour principles.
- The practice sought feedback from patients which it acted on. Feedback showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.

We identified the following notable practice, which had a positive impact on patient experience:

One member of staff had developed a 'Patients of Extra Interest' tracker. The tracker is a large spreadsheet workbook that allows staff to simply and easily manage their named populations, ensuring that patients who require monitoring, reviews and vaccinations are safely managed.

A culture of improvement was firmly embedded across the medical centre team and the Primary Care Rehabilitation Facility (PCRF). These improvements included;

- An early pregnancy loss audit has led to whole team learning and improved care for patients.
- A project was initiated to identify best practice in outcome measures for shoulder dislocation injuries and to identify how best to implement them. The aim was to standardise end-stage shoulder testing using evidence-based tests. Clinical research was reviewed and experts in the field consulted. Findings were presented at PCRF in service training where other staff provided feedback about the practicality of testing and this was then fed back to the regional team. A consultation began with the RRU to look at implementing this at other locations. An audit was planned for August 2022.
- PCRF staff were familiar with Department of Defence Rehabilitation Guidance and provided examples of treatment provided based on evidence-based guidelines and care pathways. The PCRF used the MSK-HQ (musculoskeletal health questionnaire)

as well as injury specific measures, such as the DASH questionnaire and the STarT Back tool (subgroups for targeted treatment back screening tool). The MSK-HQ was used via the DMICP template and this was seen in a notes audit.

- The senior physiotherapist was undertaking an MSc in pain science and management. A patient information leaflet on persistent pain had been produced. A spines course for patients was delivered over a three-week period aiming to promote self-management and accelerate return to optimal physical capability. Lessons in this were also delivered by Exercise Rehabilitation Instructors (ERIs) over a period of three weeks. A comprehensive exercise booklet was provided for patients which included information about spinal anatomy, cardiovascular and strength training.

The Chief Inspector recommends that the medical centre:

- Ensure that all patient waiting areas can be observed.
- Ensure all relevant clinicians have received up to date sexual health training.
- Ensure all significant events are well documented for all staff to access.
- Follow-up the impact of the work to enable improved telephone access for patients
- Supports full integration of governance with the PCRF.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

The inspection team comprised of two CQC inspectors and specialist advisors including a primary care doctor, a practice manager, a physiotherapist, a pharmacist and an exercise rehabilitation instructor.

Background to Larkhill Medical Centre

Larkhill Medical Centre provides primary and emergency care to a practice population of 4,467 comprising 3,165 service personnel and 1,302 registered dependents. Service personnel include phase 2 trainees. Primary care services include NHS screening, child immunisation, a midwifery service, Well Woman Clinic, health visitor service, minor operations and family planning. The practice also provides occupational health care to service personnel, including force preparation and travel health. Entitled civilian personnel working on the station can also access emergency care and occupational health services.

A Primary Care Rehabilitation Facility (PCRF) is located nearby with physiotherapy and rehabilitation staff integrated within the medical centre. Family planning advice is available with referral available to NHS community services. Maternity and midwifery are provided by NHS practices and community teams. There is a dispensary in the Medical Centre.

The practice is open from 08:00 to 16:30 hours Monday, Tuesday and Thursday, Wednesday 08:00 to 12:30 and Friday 08:00 to 16:30 From 16:30 until 18:30 access to emergency medical cover is provided by a regional team from Tidworth, Bulford, Larkhill and Warminster. Outside of these hours, including weekends and bank holidays, cover is provided by NHS 111.

The staff team

Senior Medical officer (SMO)	one
Regimental Medical Officer (RMO)	five (one gapped)
Civilian medical practitioner (CMP)	three
Practice manager	one
Deputy practice manager	one
Nurses (civilian)	Four and a half (.5 gapped)
Health Care Assistants	Two and a half
Pharmacy technician	two (one post gapped)
Exercise rehabilitation instructors (ERI)	three (one deployed)
Physiotherapists	six
Administrators	five (two gapped)
Medical Sergeants	five (two gapped)
Combat medical technicians* (CMTs) (referred to as medics throughout this report)	twenty (two 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 practice as good for providing safe services.

Safety systems and processes

One of the doctors was the lead for safeguarding. All staff had received up-to-date safeguarding training at a level appropriate to their role, including staff working within the Primary Care Rehabilitation Facility (PCRF).

There was a risk register of vulnerable patients and a system to highlight them on DMICP (electronic patient record system). The practice manager ran monthly searches and all patients were discussed at the monthly vulnerable patients meeting. Doctors, nurses and a representative from the welfare team attended the meeting. The doctors had strong links with unit welfare teams and the commander's monthly health review (previously referred to as the unit health committee meeting).

The doctors, welfare officers, midwives, the practice nursing team and health visitors met monthly to discuss families linked to each welfare team. The safeguarding register separately identified children within categories, for example those in foster care. The register was comprehensive and was updated after each meeting.

The practice held a learning disabilities register, and they used the Royal College of General Practitioners 'health checks for people with a learning disability toolkit' to ensure they offered the support patients needed. Searches were completed for these patients with a future plan to invite them for annual health checks. There was no written SOP to support this at present, but this was to be implemented.

The practice held a register of all patients who were receiving treatment for cancer. These patients were discussed at every vulnerable patients meeting. Each patient had a cancer care plan developed from a recent primary care clinical update. A holistic needs assessment from McMillan Cancer Support was used to support patients with their needs.

Whilst the safeguarding of vulnerable patients was good, we noted that for vulnerable patients who were posted, currently there was no formal mechanism to know when these patients had left the practice or to provide a handover of their care needs to another medical practice. Following the inspection, the Senior Medical Officer (SMO) provided evidence to confirm they had contacted all the relevant clinicians with clear guidance as to what should be done to ensure this happened and included information to ensure vulnerable patients had the support they required.

We spoke with three Welfare Officers for the camp who told us they provided a welfare service to military personnel. They confirmed they had a good relationship with the practice and praised the responsiveness of the doctors when urgent intervention was required.

Notices advising patients of the chaperone service were displayed. Staff had conducted in house chaperone training in May 2022. Information was included about chaperones in the

practice leaflet. Staff who acted as chaperones 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.

The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. All clinical staff currently working in the practice had an up-to-date DBS certificate or a risk assessment in place in accordance with Defence Primary Healthcare (DPHC) policy.

The Band 6 nurse was the lead for infection prevention and control (IPC) within the medical centre and both the SNO and the band 6 nurse had completed the link practitioner training. The last IPC audit was undertaken in December 2021 resulting in a compliance score of 99%. Areas noted for improvement had been actioned.

The PCRF had their own lead for IPC and had conducted their own audits. One generic cleaning audit showed 99% compliance following engagement with cleaning staff to improve standard of cleanliness.

A contract was in place for environmental cleaning. Cleaning staff worked to cleaning schedules with non-clinical areas cleaned throughout the day and clinical areas in the evening. The practice manager and senior nurse carried out regular checks of the premises and reported any issues to the cleaning contractors. Within the PCRF the IPC lead conducted snap inspections to ensure continued high level of cleanliness. Evidence of weekly checks/signatures was in place in therapy rooms. 'Tidy Friday', was an initiative started at the medical centre and was embedded in the PCRF to maintain cleanliness of offices, desks and exercise areas frequented by patients.

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 August 2021. The PCRF undertook their waste audit in March 2022.

All equipment within the PCRF was maintained by the exercise rehabilitation instructor (ERI) under the Ministry of Defence service plan. Maintenance was carried out once a year and was in date. All gymnasium equipment was maintained by the unit physical training instructors (PTIs). There was a close working relationship between the PTIs and PCRF. Any rehabilitation equipment that was broken was quarantined and reported in accordance with defence rehabilitation processes.

The practice provided minor surgery and the related standard operating procedure (SOP) took account of IPC principles. For PCRF clinicians practising acupuncture, arrangements were in place for the safe provision of this treatment, including a SOP that referenced national guidance and a consent form signed prior to any treatment. A specific acupuncture patient information leaflet was provided for patients, so they understood the process and any risks. Patient consent was sought and recorded on DMICP. Sharps boxes in treatment room were in date and correctly stored.

Risks to patients

From a patient perspective, clinical staffing levels were sufficient as patients interviewed told us they had prompt access to a clinician. Waiting times for an appointment with a clinician confirmed this. However, there were potential risks with the capacity and consistency of clinical staffing levels moving forward.

The PCRF was fully staffed, having just recruited a locum ERI to fill a deployed position. Administrative staff rotated to work at both the medical centre and PCRF receptions.

There were appropriate risk assessments in place to ensure physical activity was conducted safely. Wet-bulb globe temperature (WBGT – a heat stress index) readings were taken in hot weather and activity managed accordingly. The building design of the cardiovascular, respiratory (treadmills, steppers, bikes) and class therapy area did not include air conditioning. The temperature in this area could increase as patients exercised. Portable air conditioning units were purchased to make patients comfortable during physical activity sessions.

An automated external defibrillator (AED) was located in the PCRF reception area and all staff were clearly able to identify where it was located. No oxygen or other emergency drugs were stored on site, these were held in the medical centre. Staff advised that they followed the routine response process as well as placing a call to the practice to get support whilst waiting for an ambulance if required.

The arrangements in place to check and monitor the stock levels and expiry dates of emergency medicines were effective. The practice staff were fully trained in emergency procedures, including basic life support and the use of an AED and anaphylaxis training. On the day of the inspection we noted none of the staff had received sepsis training. However, shortly after the inspection we received evidence to show all staff had received comprehensive training.

We saw measures in place that had been introduced to minimise the risk of spreading infection during the COVID-19 pandemic. These included

- signs placed throughout to encourage social distancing,
- hand gel was readily available
- personal protective equipment was provided to staff when required. This included face masks that protect staff from airborne infection known as fluid resistant surgical masks 2 (FRSM2).
- The main waiting room could be seen by reception staff and a television was in the waiting area to try and ensure conversations were not overheard. However, patients that presented on the day with urgent needs were directed to a triage area and this waiting area could not be observed by staff

Information to deliver safe care and treatment

New patients registered at reception or electronically. Military patients' records were scrutinised by their medic attached to their regiment. Civilian patients' records were scrutinised by an administrator and then sent to the nurse for summary. There had been a backlog in summarising which had been addressed by allocating additional resources.

Recent minutes demonstrated that PCRF staff meetings took place fortnightly. In-service training (IST) occurred fortnightly. The IST log in the PCRF workbook included a good selection of topics and a list of attendees. A 'weekly round-up' email was sent to ensure all staff remained up-to-date with new or changing information. The senior physiotherapist attended the Heads of Department (HoDs) meeting at the medical centre fortnightly.

There was evidence of effective patient handovers between clinicians. There was regular communication between clinical staff to ensure clinical problems were highlighted and handed-over when required.

Staff reported that the IT outages could occur weekly, but usually only affected individual staff so clinic lists could be accessed/printed within the PCRF. If all PCRF terminals were affected, the medical centre would be contacted for a print-out of clinics. If required, appointments would be postponed.

In January 2021 a referral tracker was set up in order to record and track all referrals made by clinicians. A member of the administrative team was designated as responsible for the management of tracking referrals. In March 2022 it was identified that the referral tracker was out-of-date with some routine referrals from early 2021 still not tracked or closed. The practice worked hard to remedy this by identifying the issues and problems and by putting immediate improvement actions in place. We saw new processes and guidance in place for the management of external referrals with an administrator dedicated to monitoring the progress of referrals. The referrals spreadsheet clearly highlighted the two-week-wait referrals and all urgent referrals had been appropriately tracked.

PCRF staff were following routine DMICP processes specifically the use of the administration list which was used to track referrals and discharges to the department.

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

A doctor was the lead for medicines management at the practice and was also responsible for the dispensary. The pharmacy technicians were responsible for the day-to-day operation of the dispensary. Safe procedures were in place for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment.

We saw the dispensary had arrangements in place for general housekeeping. However, there was scope for improvement. There was excess stock that had not been returned. Patients 'owed' medicines were not followed up on a regular basis. If they did not collect

within a time frame agreed by the practice (normally 28 days), they should be removed and a consultation to that fact in DMICP. The prescriber should also be informed. Prescriptions for vaccines being administered by medics were not held in the dispensary (if the deployment was cancelled then so should the vaccines in their prescribing record.

Arrangements were established for the safe management of controlled drugs (CD), medicines with a potential for misuse, including destruction of unused CDs. We saw that monthly and quarterly checks were completed. All prescription pads were stored securely.

Medication requiring refrigeration was monitored twice a day to ensure it was stored within the correct temperature range.

We looked at the emergency trolley and all equipment and medicines required were present.

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. The pharmacy technician demonstrated good awareness of the requirements for monitoring and was clearly familiar with the patients on the register. They regularly checked when patients needed a review and arranged for these to be done before repeat medications were issued. An antibiotic prescribing audit had been undertaken to assess prescribing.

The practice followed DPHC protocol and local SOP for high risk medicines (HRM). The SNWO carried out regular searches to identify patients on HRMs. We reviewed four sets of records for patients prescribed HRMs and they were subject to a shared care agreement with secondary care, where necessary. The register of HRMs used at the practice was held on DMICP and all doctors and relevant clinicians had access to this.

The out-of-hours cover rotated between the medical centres in the area. Every three or four days Larkhill Medical Centre provided cover until 18:30 hours. The pharmacy technician worked until the duty doctor finished for the day, giving good access for patients.

Track record on safety

Health and safety was managed well within the practice. The practice manager was the designated health and safety lead had received training with the Institute of Occupational Safety and Health. All relevant risk assessments were in place. 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 2019. Taps were flushed through every week.

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.

We looked at the practice's arrangements for the provision of a safe service. A risk register was maintained that took account of the 'four T's' (transfer, tolerate, treat, terminate) to indicate where and how risks were being managed. Risk was discussed as part of the practice governance meeting which was held twice monthly. Evidence of good risk management was seen in the comprehensive document that had been developed by the SMO in clinical care delivery during periods of critical staffing, following risks that had been identified during the pandemic.

The practice had an integrated alarm system that was regularly tested.

Lessons learned and improvements made

Significant events and incidents were reported through the electronic organisational-wide system (referred to as ASER) in line with the DPHC ASER policy. A local ASER SOP was in place. All staff had access to the ASER system for recording and acting on significant events and incidents. The staff training database showed that all staff had received up-to-date training.

The practice used a 'brief analysis template' that had been implemented by the regional team to analyse significant events, identify trends and minimise reoccurrence. We saw numerous examples where this had been used and a full and comprehensive analysis undertaken. ASERS were discussed at practice meetings but little information was documented. We discussed this with the practice team and they agreed they would do so moving forward. It was clear from discussion with the staff that lessons learnt were discussed as a team.

The medical centre had a system in place to distribute Medicines and Healthcare products Regulatory Agency (MHRA) alerts. The CAS (Central Alerting System) alert log was held on health governance workbook including detail of action taken. Alerts were also discussed at the practice meeting as a standing agenda item.

Are services effective?

We rated the practice as outstanding for providing effective services.

Effective needs assessment, care and treatment

Processes were in place to support clinical staff to keep up to date with developments in clinical care including National Institute for Health and Care Excellence (NICE) guidance, clinical pathways, current legislation, standards and other practice guidance. Staff were kept informed of clinical and medicines updates through the Defence Primary Healthcare (DPHC) newsletter circulated to staff each month. Updates were also discussed at multi-disciplinary clinical governance meetings which dispensary staff also attended.

Consultants regularly gave clinical updates to the practice doctors as well as clinicians from Department of Community Mental Health (DCMH). All clinicians were supported to undertake continued professional development courses in practice.

Doctors regularly held case discussions and were supportive of each other. The practice used ‘Red Whale’ (an online medical educational site) to keep further updated. The Clinical Commissioning Group also linked in with ‘Cinapsis’ (a clinical communications platform that gives clinicians access to specialist advice and guidance when they needed it).

PCRF staff were familiar with Department of Defence Rehabilitation Guidance and provided examples of treatment provided based on evidence-based guidelines and care pathways. The PCRF used the MSK-HQ (musculoskeletal health questionnaire) as well as injury specific measures, such as the DASH questionnaire and the STarT Back tool (subgroups for targeted treatment back screening tool). The MSK-HQ was used via the DMICP template and this was seen in a notes audit.

The exercise rehabilitation instructor (ERI) made effective use of objective outcome measures when planning and progressing patient care. This was measured at the start of treatment, reviewed every four to six weeks and measured again on completion of rehabilitation. There was clear evidence of using objective markers from best practice guidelines.

The senior physiotherapist was undertaking an MSc in pain science and management. A patient information leaflet on persistent pain had been produced. A spines course for patients was delivered over a three-week period aiming to promote self-management and accelerate return to optimal physical capability. Lessons in this were also delivered by ERIs over a period of three weeks. A comprehensive exercise booklet was provided for patients which included information about spinal anatomy, cardiovascular and strength training.

A project was initiated to identify best practice in shoulder outcome measures for dislocation injuries and to identify how best to implement them. The aim was to standardise end-stage shoulder testing using evidence-based tests. Clinical research was reviewed and experts in the field consulted. Findings were presented at PCRF in-service

training where other staff provided feedback about the practicality of testing; this was then fed back to the regional team. A consultation began with the Regional Rehabilitation Unit (RRU) to look at implementing this at other locations. An audit was planned for August 2022.

A patient document was attached to patients' DMICP notes to record prescribed exercises. It included a Rehab Guru (a comprehensive exercise programme) clinical code that can be used to access full details of the programme. This was seen in most audited notes.

Monitoring care and treatment

We found that chronic conditions were managed well. A standard operating procedure (SOP) outlining the management and monitoring arrangements for chronic conditions was in place. Monthly searches were run by the nurse to ensure recalls were not missed. Patients were recalled by letter or text and followed up by a telephone call if needed.

One member of staff had developed a 'Patients of Extra Interest' tracker. The tracker was a large spreadsheet workbook that allowed specific lead clinicians to simply and easily manage their named populations. The reasoning behind the tracker was to:

- provide an automated one-page review for the Senior Medical Officer (SMO) so they can appropriately focus resources in areas where they are most needed.
- to improve care of patients on medications that required monitoring. Prior to its initiation medication reviews were approximately 50%; this has now improved to 89%.
- hosts a centralised DMICP search log for screening, medications.
- improve efficiency allowing clinicians to focus on clinical support to patients instead of compiling lists.
- allows easy integration with the on-mass text system (Caldicott sensitive) meaning texts could be sent for annual reviews, COVID-19 vaccinations, flu campaigns and so on, a task that DMICP currently does not support.

The introduction of the tracker has meant clinicians can spend more time seeing patients and less time completing administrative tasks. Benefits for patients included reviews that were easily planned so patients received timely and professional input. Text messages were a beneficial communication method and were proving to be successful in reducing the numbers of patients with out-of-date reviews.

All patients over the age of 40 were 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 three to five years unless identified as a risk when patients were recalled annually for blood testing. All patients with a chronic disease 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 not currently identified as part of the chronic conditions

monitoring. We discussed this with the doctors who agreed to develop this further. Following the inspection, we were provided with evidence to demonstrate this search had now been built into the tracking tool, so all pre-diabetic patients were identified and were offered appropriate monitoring reviews. The tracker also separated the gestational diabetic patients off from the general diabetes list in order that they could more accurately track their requirements for repeat bloods tests 13 weeks post-partum.

There were low numbers of patients recorded as having high blood pressure. All were recorded as having a 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 72% of patients had received an audiometric assessment within the last two years. During COVID-19 routine audiometry had ceased in line the April 2020 DPHC directive. The medical centre had resumed audiometry as restrictions relaxed. We were advised the unit managed audiology recalls and prioritised those with a high readiness for deployment and those most at risk.

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.

A quality improvement programme was in place which had been designed for optimal relevance to the patient population. We saw audits were in place spanning clinical, administrative and managerial topics. More than one cycle had been undertaken in some instances and there was evidence of positive outcomes. One audit was initiated following an email sent to all DPHC practices in August 2021 highlighting that care of people who had experienced pregnancy loss could be improved. The medical centre undertook a search covering two years using a variety of codes including miscarriage, termination and ectopic pregnancy. There were 29 patients identified as relevant to the search criteria. These patients' notes were scrutinised against a set criteria. The results showed the practice were correctly referring to the Early Pregnancy Unit but that the patients were not routinely offered sick leave. The correct coding was also considered. This audit was shared with all clinical staff for future learning.

The PCRF had its own audit programme. Some examples we saw included:

An Exercise Induced Leg Pain (EILP) audit was undertaken in the use of EILP questionnaires to check if physios were using the EILP questionnaire (suggested criteria from the Best Practice Guidelines). This was for patients with leg pain related to exercise and to check if physiotherapists were referring these patients to the Regional Rehabilitation Unit (RRU) within three months if they weren't improving as expected. Only three out of 11 patients had completed questionnaires and one out of six were referred to the Regional Rehabilitation Unit (RRU). An action plan to improve compliance was included. A planned re-audit was overdue from December 2021.

In March 2022 an audit was undertaken to check if referrals from the physiotherapist to the ERI included whether the correct template was being used and if there was a recording of

a clear diagnosis. Compliance with completing the template was 100% and was 93% for recording a clear diagnosis.

There was a graded programme of rehabilitation delivery, with exercise sheets for patients to work with. Rehab Guru was being used for consistency and continuity.

Effective staffing

We looked at the induction process for new and existing staff. There was a role specific induction in place for permanent staff. Mandated training was monitored by the practice manager and was recorded on the staff database. All staff had protected time for the completion of mandatory training and attendance at group training.

Mandatory training was recorded on the staff database. All staff had protected time for the completion of mandatory training and attendance at group training. Regular clinical supervision and reflection took place for doctors and nurses and medics. Physiotherapy staff received regular appraisals, attended regular multi-disciplinary team meetings and had clinical supervision. Peer review was well established through all clinical groups. Physiotherapists received peer reviews in the form of watched patient consultations at least annually. A peer review plan was seen in the PCRF workbook. Two records of peer reviews from one physiotherapist were seen, which included comprehensive feedback and an action plan. A programme of peer review and clinical supervision had been instigated for ERIs with good evidence and feedback seen.

Clinicians 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. There were arrangements for the auditing/peer review of nursing records. The last peer review audit was in December 2021 conducted by Senior Nursing Officer (SNO) and the results found 100% compliance in 35 nursing consultations.

Staff administering vaccines had received specific training which included an assessment of competence. Staff who administered vaccines could demonstrate how they were 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

The medical centre met with welfare teams and line managers to discuss vulnerable patients. Staff told us that they had forged some good links with other stakeholders, including the local NHS, social services and voluntary organisations.

The midwives met regularly with practice staff when they held weekly clinics at the medical centre. The school nurse and the health visitor attended the safeguarding meetings.

Medical centre staff had forged good links with all units on the base and welfare staff and we were told that a mutually supportive communication stream was in place. We

interviewed the welfare officers as part of our inspection, and they confirmed that regular meetings took place with the aim of supporting personnel.

The practice was at the early stages with developing relationships with the NHS practice who shared the building, they were hopeful this would grow moving forward.

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. Whilst there was a process for release medicals for service personnel, there was no defined process for the dependent population. Following the inspection the SMO requested that all clinicians responsible for civilian patients with complex needs who were moving to an NHS practice were offered a 'release style medical appointment' to confirm that there was sufficient medical records to provide to their new GP and, where appropriate a plan for transition of secondary care.

Referrals from the PCRF were sent to Regional Rehabilitation Unit (RRU) or local NHS as required. Waiting times for the RRU were within the key performance indicators.

Helping patients to live healthier lives

One of the nursing team was the lead for health promotion and had the appropriate experience for the role. We saw information leaflets were available in the treatment rooms.

There were notice boards located in various places around the medical centre, some example topics covered included smoking and alcohol.

There was a planned Unit Health Fair for June 2022 and medical centre staff, including the PCRF, were involved. There was a health promotion board in PCRF, with topics changed every month.

The nurses had the appropriate sexual health training, although this required updating, and provided sexual health support and advice. Patients were signposted to local sexual health services for procedures not undertaken at the medical centre.

There were chlamydia self-test kits available in each toilet so that patients could manage their own healthcare, condoms were also available.

All eligible female patients were on the national cervical screening database and were recalled by the nurse. The latest data confirmed an 85% uptake. Regular searches were undertaken to identify patients who required screening for bowel, breast and abdominal aortic aneurysm in line with national programmes. Alerts were added to their DMICP record which allowed for opportunistic discussion with a health professional. DMICP searches had been created for all national screening.

An effective process was in place to recall patients for their vaccinations. Vaccination statistics were identified as follows:

- 90% of patients were in-date for vaccination against polio.
- 84% of patients were in-date for vaccination against hepatitis B.
- 93% of patients were in-date for vaccination against hepatitis A.
- 90% of patients were in-date for vaccination against tetanus.
- 97% of patients were in-date for vaccination against MMR
- 90% of patients were recorded as being up to date with vaccination against diphtheria.
- 71% of patients were recorded as being up to date with meningitis.

Previously the children's immunisations were co-ordinated by Virgin Healthcare, who had access to the national database of all eligible children. Virgin Healthcare then notified the parents of the day and time of their appointment at the medical centre. Virgin Care then shared that clinic list with the medical centre.

There were problems with communication using this system, particularly with children who had arrived from overseas. From May 2022 onwards the medical centre co-ordinated delivery of the childhood vaccination programme independently.

Out of 1,302 eligible civilians/dependants:

- 78% of patients were in-date for vaccination against diphtheria.
- 78% of patients were in-date for vaccination against polio.
- 78% of patients were in-date for vaccination against tetanus.
- 53% of patients were in-date for vaccination against MMR.

Based on a population of children under two years old and under five years old

- Data for Measles Mumps Rubella (MMR) for under two years
- Of a population of 178 children, 163 (92%) had been vaccinated
- Data for MMR for under five years

Of a population of 95 children, 81 (85%) had been vaccinated

Searches were undertaken each month to check the status of immunisations.

Consent to care and treatment

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. They understood the Mental Capacity Act (2005) and how it would apply to the population group. There was guidance on the walls of the clinical rooms.

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?

We rated the practice as good providing caring services.

Kindness, respect and compassion

An information network known as HIVE was available to patients on the camp. Situated in the community centre, 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.

We spoke with four patients as part of the inspection and feedback indicated staff treated patients with kindness, respect and compassion at all times. This included extended appointments, and wellbeing support. Two of the patients we spoke with described how staff and gone ‘over and above’ to ensure their needs were met. We also spoke with the Welfare Officers who described the care and compassion given to patients as excellent and highlighted the dispensary for providing an exemplary service.

We reviewed the records for a number of patients who were experiencing poor mental health. It was clear that clinicians were responding to patients with kindness and compassion, ensuring that patients had the space and time to talk when they needed to. However, Welfare Officers voiced concerns of wait times for the Department of Community Mental Health. We fed this back to the Defence Medical Services Regulator (DMSR).

Sixty-six registered patients responded to the DMSR patient satisfaction survey which complemented this inspection. All patients who responded to the question about how well clinicians listened to them, said that their experience was very good or good.

Involvement in decisions about care and treatment

The clinicians and staff at the medical centre 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.

Of the 66 patients who responded to the DMSR patient satisfaction survey, 55 stated that they had been fully involved in decisions about their care and treatment. Five patients stated that they had not been involved in decision making and six patients reported that this did not apply to their situation.

The last patient feedback for the Primary Care Rehabilitation Facility (PCRF) showed 18 responses between September and December 2021. All respondents rated their healthcare provider as good or excellent at addressing their healthcare needs, giving clear information, respecting privacy and dignity and treating with kindness and compassion.

Patients identified with a caring responsibility were captured on a DMICP register and identified as part of the new patient registration process. Support for carers included recall for annual flu jabs and health assessment. Carers had been prioritised for COVID-19 vaccinations. The practice leaflet mentioned that support for carers was available from the medical centre

Staff explained that they regularly saw patients who spoke English as a second language. They could access a translation service if they needed it and a laminated sign at reception advising patients of the service had been translated into the main languages encountered.

There was a comprehensive practice information leaflet available in both English and Nepalese.

Privacy and dignity

Patients who provided feedback about the service said their privacy and dignity was upheld at all times. All consultations were conducted in clinic rooms with the door closed. All clinical rooms had a separate screened area for intimate examinations.

Arrangements were in place to maintain patient privacy when arriving at the medical centre. A room in the reception was available should patients request confidential conversation away from the desk. Chairs in the waiting area were set back sufficiently to prevent conversations from being overheard. The reception desk was shared with an NHS GP practice situated in the same building, a plastic screen was used to form a partition and provide confidentiality.

All physiotherapists had separate and private clinical rooms for assessment and treatment.

We spoke with one patient who said they had experienced good support and sensitivity when attending the practice whilst they were breastfeeding.

The medical centre had doctors and nurses of both genders so patients could choose if they wanted to see a specific doctor. patients were offered a chaperone routinely.

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 medical centre staff understood the needs of its patient population and tailored services in response to those needs. Appointments slots were organised to meet the needs of specific population groups. For example, appointment for made available for patients requiring cervical screening so they could attend without their children, giving them more time and improving their experience.

The medical centre re-introduced a 'sick parade' (emergency clinic) every day for military patients requiring to be seen urgently on the day (this was stopped at the being of the COVID-19 pandemic). This was run by the medics supported by a supervising doctor who worked in the clinic alongside the medics to support and advise as required. As this service was run by the medics, they had been instrumental in devising the protocols for this.

The e-referral service had been implemented and was used to support patient choice as appropriate. E-referral is a national electronic referral service which gives patients the choice of date and time for their first outpatient appointment in a hospital.

Medical centre staff had received training to support the appropriate and effective care of people who were transitioning gender. There had also been a talk arranged with a patient who had transitioned, so that staff could listen to their experiences and of the challenges the patient faced, all to further understand how to provide the best care.

The medical staff team were aware of the need to quickly identify and treat patients with mental health needs in order to ensure the best possible outcome. Access to mental health support was swift with trained staff members available to offer face-to-face care. The welfare service could refer patients for a same day appointment and medics were trained and supported by a questionnaire to identify those in need of urgent referral for a same day appointment with the supervising doctor or duty doctor.

An Equality Access Audit as defined in the Equality Act 2010 was completed for the medical centre in May 2022 and for the PCRF in December 2021 and no significant concerns were identified.

The lead for diversity and inclusion (D&I) was the practice manager. D&I training formed part of the mandatory requirements for all staff.

Timely access to care and treatment

Details of how patients could access the doctor when the medical centre was closed were clearly displayed at the front entrance so could be easily seen when the practice was

closed. In addition, the information was relayed through the answering machine message and included in the patient information leaflet.

Urgent doctor and nurse appointments were available on the day. Routine doctor appointments were available within two weeks. Routine appointments to see a nurse were available within a few days.

The Primary Care Rehabilitation Facility (PCRF) offered direct access to appointments. A new patient or routine physiotherapy appointment was available within one week. There was capacity to see patients urgently on the same day if required. Appointments to see the exercise rehabilitation instructor (ERI) or a new or routine appointment were available within three days. There was no waiting list for rehabilitation classes.

Outside of routine clinic hours, cover was provided by the doctors up until 16:30 hours and then by Queen Elizabeth Medical Health Centre, Tidworth up 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). In this way, the practice ensured that patients could directly access a doctor between the hours of 08:00 and 18:30, in line with Defence Primary Healthcare's (DPHC) arrangement with NHS England.

We spoke with four patients who had recently received care from the staff at the practice. 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. However, the DMSR patient survey highlighted that access by telephone was an issue with 34 of 66 patients that responded reporting it was not easy to get through to the practice by telephone. The practice was aware of this issue as they only have one telephone line. They have taken measures to try and resolve this by encouraging the use of eConsult for non-urgent questions and queries. Originally eConsult was used for clinical problems and acute presentations only but the practice encouraged patients to use it for administrative questions as well as requesting appointments or repeat prescriptions. They were then filtered so that they can be passed to the relevant other person, whereas previously this would only have been duty nurse, duty doctor or dispensary, it could now include RAP medics and the practice manager.

Whilst the practice had only one telephone line, they did have phones on each of the Regimental Aid Post (RAP) unit desks. The practice gave these telephone numbers to patients so that individuals wishing to contact their own medical desks to organise routine appointments, grading reviews, audiograms and to ask general questions had other options. They also created business cards for each of the units which contained their contact details of the RAP desks. This will also be done for new patients at the point of registering. Next to reception there was a notice board with these business cards expanded to A4 size and laminated which individuals can take a picture of on their phone in order that they always have their RAP desk number available.

The practice was awaiting the introduction of a 'smart' phone line which will allow queueing and options.

The PCRF Patient Experience Survey (21 responses) showed100% of patients had been able to book an appointment easily. They said there was sufficient space and resources

for appropriate care, felt listened to and received clear information. Patients were satisfied with the outcome, felt treated with dignity and respect, and found the Rehab Guru programmes useful for understanding their exercises.

Listening and learning from concerns and complaints

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 DPHC's complaints policy and procedure. The process included the recording of both written and verbal complaints.

There had been 12 complaints received within the past 12 months. Information was available to help patients understand the complaints system, including in the patient information leaflet and in the waiting room. Each complainant was invited in by the Senior Medical Officer (SMO) to discuss their complaint. In addition, a dedicated patient leaflet outlined the complaints procedure.

Are services well-led?

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

Vision and strategy

The medical centre had a clear vision and credible strategy to deliver high quality, sustainable care. Their mission statement was:

“Larkhill Medical Centre will provide a safe and effective healthcare service to the military and civilian population of Larkhill, responding to the changing needs of our patients and local units and, through compassionate leadership at all levels, will create a kind and caring environment for all staff and patients using our facility.” The Primary Care Rehabilitation Facility (PCRF) whilst identifying with the overall vision did not have their own mission statement.

Staff we spoke with were clear that their remit was to support patients to benefit from the best possible healthcare outcomes which, in turn, supported operational capability. This included a preventative approach which involved proactive health promotion support, lifestyle advice and prompt barrier-less access to mental health support.

The medical centre had forged close links with all the units it supported and tailored the service to their specific needs to support deployments such as force protection clinics. Duty doctors, nurses and medics were routinely on hand to facilitate urgent access to care.

The medical centre had hopes to become ‘Veteran Friendly’ to provide extra help and support for those leaving the service. There were also plans for Larkhill Medical Centre to be the minor surgery referral centre offering a clinic once a week for patients from surrounding practices.

Leadership, capacity and capability

The staff team at the medical centre worked with determination and collaboratively to deliver the best possible care to patients. All staff we spoke with described a committed and able leadership team with a Senior Medical Officer (SMO) that led with an inclusive and responsive leadership style. Staff had terms of reference for their main role and separate terms of reference for any key lead roles that they undertook.

Throughout this inspection we met with patients and unit staff who described a medical centre team that frequently went the ‘extra mile’ to ensure that patients’ needs were met as quickly as possible in order to ensure their health and wellbeing, alongside their role in facilitating operational capability.

The support from the regional team was described as good. The practice was linked into the regional meetings and engaged about matters related to the practice e.g. staffing and recruiting.

Despite being in separate locations there was clearly a good working practice between the PCRF and practice. There were frequent meetings to support close working.

Culture

'Be Kind' was the focus of the presentation given on the day of the inspection. We saw this thread of care and compassion throughout practice systems for example with ASERs and complaints.

Staff we spoke with described a strong team ethic across the medical centre whereby the patient's requirements were held at the centre of all decision making. The SMO

and the whole staff team operated an open and honest meeting culture where all staff were encouraged to attend and offer suggestions or raise concerns. Leaders operated an open-door policy for staff to use. Staff were aware of the whistleblowing policy and were also aware of the Freedom to Speak Up process within the region.

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 given examples of when duty of candour had been applied appropriately.

Governance arrangements

The leadership team had defined responsibilities, roles and systems of accountability to support good governance and management. The practice had built in more resilience with leads and deputies in most areas. The healthcare governance workbook (HGW) was the overarching system used to bring together a range of governance activities, including the risk register, ASER tracker, training register, quality improvement projects and complaints.

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.

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.

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 a wide range of standard operating procedures (SOPs) in place and available on the HGW. The SOPs were separated into administrative, clinical and PCRF and included a review date. The medical centre used unified mental health codes as an aide memoire these were on every desktop.

The PCRF worked independently to the medical centre. The PCRF completed their own separate audit programme. There was no evidence of any real integration. Joint

meetings/forums were for the whole practice but were attended by a limited number of PCRF staff. Governance and assurance information was not yet consolidated into one central workbook. Moving forward there will be one consolidated workbook and eHAF.

A meeting schedule was established, and this included daily coordination meetings, weekly clinical meetings and monthly healthcare governance, safeguarding, practice and Unit Health Committee meetings. Quarterly meetings were held with Defence Primary Healthcare (DPHC) Headquarters. Discussion at each meeting was recorded and made available to those unable to attend.

Managing risks, issues and performance

The leadership team was mindful of risks to the service. The main risks identified were a shortage of doctors from July 2022 at Larkhill Medical Centre and Warminster Medical centre putting significant strain on the workforce and risking the delivery of safe and effective healthcare. A comprehensive 'Manning Pressures Plan' was put in place by the SMO to try and lessen the impact and plan ahead.

A system was in place to monitor performance target indicators. The system took account of medicals, vaccinations, cytology, summarising and non-attendance. Risk to the service were recognised and logged on the risk register. The PCRF recorded all risks on the medical centre HGW.

Processes were in place to monitor national and local safety alerts and incidents.

Processes were in place for managing staff under-performance including external support for clinicians.

There was a business resilience plan and a major incident plan that were reviewed regularly and tested through simulation. All staff were informed of updates to the business continuity plan.

Appropriate and accurate information

The eHAF (electronic health assurance framework) commonly used in DPHC services to monitor performance is an internal quality assurance governance assurance tool to assure standards of health care delivery within defence healthcare. The practice manager referred to the eHAF to monitor the practice.

National quality and operational information were used to ensure and improve performance. Quality and operational information was used to ensure and improve performance.

There were arrangements at the practice 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 various options in place to encourage patients to provide feedback on the service and contribute to the development of the service. These included a patient experience survey via a QR (quick reference) code available in the waiting room. A patient experience survey was undertaken throughout the year and the results used to make improvements.

The medical centre had 'tea and toast' every Friday morning which provided an opportunity for staff to catch up with one another. 'Tidy Friday' was also in place, all staff had their own responsibilities to ensure their workplaces were clutter free and tidy in readiness for the following week.

The medical centre had introduced other QR codes for patients ease to register at the medical centre electronically, submit an eConsult or to follow the Facebook page. There were plans to organise a patient participation group with the first meeting planned for early July 2022.

The practice team stated that they felt well supported and had good communication streams with all units they supported. Welfare staff told us that their relationship with the practice team was positive. Communication channels with local NHS services, including the adjacent NHS GP practices were good.

Continuous improvement and innovation

We identified that the practice 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. Some examples included;

- The implementation of the 'Patients of Extra Interest' tracker.
- QR codes used for different patient interactions and ease.
- The implementation of the 'sick parade' with protocols written by the medics and a supervising doctor for support
- The introduction of the ASER tool used for analysis and to ensure improvement.
- The holistic care plan devised using Best Practice Guidelines for cancer patients.

Examples of quality improvement activity for the PCRF

A project was initiated to identify best practice in shoulder outcome measures for dislocation injuries and to identify how best to implement them. The aim was to standardise end-stage shoulder testing using evidence-based tests. Clinical research was reviewed and experts in the field consulted. Findings were presented at PCRF in-service training where other staff provided feedback about the practicality of testing; this was then fed back to the regional team. A consultation began with the Regional Rehabilitation Unit

(RRU) to look at implementing this at other locations. An audit was planned for August 2022.

Physiotherapist to ERI referral template to improve clinical information sharing with ERIs. An audit of this in March 2022 showed excellent compliance with use of the template.

A patient information leaflet on persistent pain had been produced. A spines course was delivered over a three-week period aiming to promote self-management and accelerate return to optimal physical capability, lessons in this were also delivered by ERIs over a period of three weeks. A comprehensive exercise booklet was provided for patients which included information about spinal anatomy, cardiovascular and strength training.

Sick parade with physiotherapy involvement. This is in the early stages of development. Further work is needed to agree on how best physiotherapists can support the needs of patients and other clinicians involved in sick parade, but this is work in progress.