Weeton Medical Centre

Weeton Barracks, Singleton Road, Preston, Lancashire PR4 3JQ

Defence Medical Services inspection report

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information given to us by the practice and patient feedback about 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

About this inspection

We carried out this announced comprehensive inspection on 16 June 2022.

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

Are services safe? – good

Are services effective? – good

Are services caring? – good

Are services responsive to people's needs? – 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 the CQC will complete at the invitation of the DMSR in its role as the military healthcare regulator for the DMS.

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

- Recognising that the practice had a higher than average patient population licensed as personal firearm holders, the practice developed a standard operating procedure (SOP) to ensure clinicians were timely and consistent in their response to police requests about medical concerns that may influence the granting of a firearm licence to an individual. The SOP took into account patients with an existing licence who had since developed medical issues, in particular mental health issues and concerns. This SOP was submitted as a regional quality improvement project (QIP).
- The practice nurse was the lead for health promotion (HP) for the region. To ensure consistency and efficiency, they held quarterly meetings with the HP leads in the other medical centres, which led to the development of a regional HP calendar with individual HP leads responsible for a specific campaign. The resources developed for each campaign was shared with the other HP leads in the region. This meant that only one person was investing time in researching and collating resources each month. This initiative had been identified as a regional QIP.

At this inspection we found:

- The practice was well-led and the leadership team demonstrated they had the vision, capability and commitment to provide a patient-focused service and consistently sought ways to develop and improve.
- An inclusive whole-team approach was supported by all staff who worked collaboratively to provide a consistent and sustainable patient-centred service.
- There was an open and transparent approach to safety. An effective system was in place for managing significant events and staff knew how to report and record using this system.
- The arrangements for managing medicines, including obtaining, prescribing, recording, handling, storing, security and disposal minimised risks to patient safety. There was an effective and holistic approach to the monitoring of patients on high risk medicines.
- The practice worked collaboratively with internal and external stakeholders.
- The healthcare governance workbook was well-developed and captured a wide-range of information to illustrate how the practice was performing.
- Quality improvement activity was embedded in practice and was used to drive improvements in patient care. Although measures were in place to monitor clinical record keeping, there were gaps in the application of clinical coding and the use of clinical templates.
- The practice sought ways to improve feedback from patients about the service. Feedback showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.

The Chief Inspector recommends to Defence Primary Healthcare (DPHC):

Review staffing levels to ensure the practice has sufficient capacity to provide timely occupational healthcare for patients.

The Chief Inspector recommends to the practice:

- Training in the application of clinical coding and use of clinical templates should be provided for the staff team to ensure all clinicians are working to the standard operating procedure for managing chronic conditions.
- The ‘well person’ clinics should be reinstated so that patients over the age of 40 have access to health screening checks.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

The inspection was led by a CQC inspector and a team of specialist advisors including a primary care doctor and a nurse. We were unable to secure a physiotherapist specialist advisor for the inspection, so the Primary Care Rehabilitation Facility (PCRF) was not inspected as part of the inspection.

Background to Weeton Medical Centre

Located in Weeton Barracks, Weeton Medical Centre provides a primary healthcare, occupational health and force protection service to a patient population of 958 from a range of units. The practice also provides an occupational health service for over 1,200 reservists within a wide catchment area in the North West of England.

A PCRF is situated in the medical centre and provides a physiotherapy and rehabilitation service. As there is no dispensary at the practice, medicines are dispensed from two local pharmacies.

The practice is open from 08:00 to 16:30 hours Monday to Thursday and 08:00 to 12:30 on a Friday. From 16:30 until 18:30 access to emergency medical cover is provided by Cosford Medical Centre. Outside of these hours, including weekends and bank holidays, cover is provided by NHS 111.

The staff team

Doctors	Civilian Senior Medical Officer (SMO) Their absence at the time of the inspection was covered by the SMO from Chester Medical Centre. Regimental Medical Officer (RMO) - 3 Medical Regiment. Position vacant at the time of the inspection. Part time (22 hours per week) civilian medical practitioner (CMP). Two locum CMPs (30 hours per week in total).
Practice Manager	One (37 hours per week).
Nurses	Band 7 practice nurse (full time). Band 6 practice nurse (30 hours per week).
PCRF	One full time physiotherapist One exercise rehabilitation instructor (18.5 hours per week). Position vacant at the time of the inspection.
Administrators	Receptionist (27 hours per week) One (37 hours per week) One position vacant.

Medical Sergeant*	One - 2 Mercian Regiment
Medics*	Unit medics were deployed at the time of the inspection.

*In the army, a Medical Sergeant and medics are soldiers who have 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

A range of policies, standard operating procedures (SOP) and local adult and child safeguarding contacts were in place and accessible to all staff. Practice safeguarding information was regularly audited to ensure it was up-to-date. The practice maintained a safeguarding and adults at risk register to monitor vulnerable patients. The Senior Medical Officer (SMO) was the practice lead for safeguarding and had met with the head teacher for the local primary school in 2022 to establish links. They had also met with the local NHS primary care practice, following which the practice was informed by one of the GPs of a safeguarding concern. Staff interviewed as part of the inspection were fully aware of the local safeguarding arrangements. All staff had completed safeguarding training at a level appropriate to their role.

The vulnerable adults SOP was reviewed in August 2021. A domestic violence SOP was also in place. The status of safeguarding and vulnerable patients was discussed at the monthly practice clinical register review meeting, which all clinicians attended. The Regimental Medical Officer, or another doctor in their absence, attended the unit health committee meetings, the forum at which the needs of vulnerable patients was discussed with unit commanders and the welfare service. The list of trained chaperones was reviewed and updated in December 2021.

Recognising that the practice had a higher than average patient population licensed as personal firearm holders, the health governance lead developed a SOP (January 2022) to ensure clinicians were timely and consistent in their response to police requests about medical concerns that may influence the granting of a firearm licence. In addition, the SOP took into account patients with an existing licence who had since developed medical issues, in particular mental health issues and concerns that may require safeguarding. This SOP was submitted as a regional quality improvement project (QIP) as the practice recognised that other Defence Primary Healthcare services may benefit from this adopting the SOP.

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 Disclosure and Barring Service (DBS) check to ensure staff, including locum and regimental staff, were suitable to work with vulnerable adults and young people. DBS checks were renewed in accordance with organisational policy. The DBS check for one of the clinical staff had expired. They had reapplied and, in the interim, were working under supervision. The matter had been added to the risk register. The practice manager monitored the professional registration of staff and the nursing team monitored the vaccination status of staff.

The infection prevention and control (IPC) lead had undertaken the required training for the role. An IPC audit for the practice was completed in January 2022. The audit and previous audits identified a range of IPC non-compliance with the infrastructure including flooring and taps. These issues were included in the risk register with clear evidence of

follow-up by the practice. The practice manager confirmed funding for improvements had been agreed and email evidence identified the work would be undertaken within the current financial year.

A contract was in place for environmental cleaning, which was monitored through meetings between the contract supervisor and IPC lead. The practice had enhanced cleaning hours which were used to deep clean one clinical room each month. The IPC lead carried out regular environmental checks to ensure the cleaning complied with IPC standards.

Arrangements were in place for the management of clinical waste including a waste log and consignment notes. Clinical waste was stored in a lockable unused shower room in the building. Waste from the co-located dental centre was also stored in this room. Storage of clinical waste was identified on the risk register. Funding had been agreed for the construction of an external storage compound to be completed within this financial year. An audit in September 2021 identified the practice was fully compliant with the management of clinical waste.

Risks to patients

Staff and patients we spoke with reported that staffing levels had improved and were adequate to meet the primary care needs of the patient population. Unit commanders highlighted significant delays with access to medical/grading reviews, indicating the shortage of doctors, in particular a Regimental Medical Officer (RMO), may have contributed to the delays. The RMO had recently moved and the post would not be filled until April 2023. Staff vacancies and gaps were being managed through the use of locum staff with a part time locum appointed recently. Through a memorandum of understanding, the SMO from Chester Medical Centre had recently taken on an acting SMO role and was spending two to three days at the practice.

The practice was equipped to deal with medical emergencies. The acting SMO had reviewed the medical emergency medicines and equipment since taking up post. All drugs held were now in line with regional guidance. Emergency medicines and equipment were monitored regularly, and records maintained of the checks. The staff team was up-to-date with training in emergency procedures, including basic life support, anaphylaxis and the use of an automated external defibrillator. Staff completed thermal/climatic injury training in October 2021 and online sepsis training. A sepsis training scenario was undertaken in 2021.

Information to deliver safe care and treatment

In the event of an IT outage impacting DMICP access, staff referred to the business resilience plan. Only the practice manager had WIFI so staff experienced ongoing issues with connectivity, which was identified on the risk register. WIFI was due to be installed as part of the planned infrastructure improvements in this financial year.

A summarisation SOP (reviewed November 2021) was in place. Summarisation of patients' records was undertaken by the nursing team and minutes of the May 2022 practice meeting confirmed summarisation was up-to-date.

A programme was in place for the regular auditing/peer review of each clinician's DMICP (patient electronic record) consultation recordkeeping. All clinicians had received an audit in the last 12 months. A re-audit of clinical coding June 2022 showed the application of coding had significantly improved since an initial audit in June 2021. The nursing team developed guidance to support with accurate and consistent clinical coding following the initial audit. The use of chaperone coding was audited in March 2021 and the re-audit in January 2022 indicated there was scope for improvement. We reviewed a range of DMICP records and, whilst we had no concerns with the record keeping by nurses, we identified gaps and inaccuracies in record keeping by doctors. This predominantly related to the use of Read coding (clinical coding). For example, coding was either missing, inaccurate or used in an inappropriate area of the DMICP record.

Coordinated by the administration team, an effective central system was in place for the management of both internal and external referrals including a referrals SOP (reviewed November 2021). A referrals audit was undertaken for the time frame 16 – 27 May 2022 and all 15 referrals had been appropriately managed in a timely way.

A process was established for the management of samples and all samples were registered before they were sent to the laboratory. Results were triaged daily by senior practice nurse and a task sent to the clinician who requested the sample or to the duty doctor in their absence.

Safe and appropriate use of medicines

The SMO and one of the locum doctors were the leads for medicines management. Medicines were not stored at the practice except for vaccines and medicines held with the medical emergency kit. An SOP was in place for authorising Patient Group Directions (PGD) so the nursing team could treat patients and carry out vaccinations in a safe way. The nurses had received PGD training. Although PGD audits were no longer required by Defence Primary Healthcare, the senior practice nurse carried out an audit in April 2022.

The practice maintained a register of high risk medicines (HRM) that required monitoring (red/amber medicines such as those to lower cholesterol (statins), to lower blood pressure (ACE inhibitors) and to treat inflammatory conditions (DMARDs). We looked at a range of patient records where an HRM had been prescribed and it was evident appropriate alerts, and monitoring arrangements were in place. Shared care agreements (SCA) with secondary care services were in place if indicated. A SCA audit was undertaken in March 2022. A search was set up to identify female patients prescribed valproate (medicine to treat epilepsy and bipolar disorder).

The practice nurse carried out a 'sore throat prescribing audit'. Based on clinical data from January 2021 to February 2022, the audit concluded that antibiotics were being overprescribed. In addition, the audit found that clinicians were not following National Institute for Health and Care Excellence (NICE) anti-microbial prescribing in acute sore throat. For example, only 14% of patient records demonstrated that a diagnostic tool (FeverPAIN or Centor) had been used and there was limited evidence recorded to support

prescribing outside of the recommended guidance. All clinicians received a copy of the audit and a team discussion was scheduled at the healthcare governance meeting in July 2022. Since the audit, throat swabbing had increased, a practice antibiotic guardian identified and all clinicians issued with a flowchart detailing the management of an acute sore flowchart. A repeat audit was planned for August 2022.

Track record on safety

The practice was represented at the camp health and safety meetings (referred to as SHEF). Gas and electric safety checks were up-to-date for the building. A fire safety assessment was completed in February 2021 and the fire alarm and emergency lighting had been replaced. A fire emergency evacuation drill had been conducted in May 2022 to test the new system. Checks of the fire system were undertaken monthly. Through routine sampling, legionella had been found in the water system in October 2021. As a result, the medical centre was closed to patients for a week while further sampling was undertaken by a specialist team. A legionella SOP was developed in February 2022 to ensure the daily flushing of infrequently used water outlets was undertaken.

A system was established for the management of all clinical/non-clinical equipment including an equipment maintenance register, faults log and equipment inspection log. The equipment care policy was reviewed in January 2021 and an equipment assessment (referred to as a LEA) was undertaken in March 2022. Portable appliance testing was carried out in January 2022. A faults log was in place and the practice manager carried periodic checks of equipment. Clinical privacy curtains were changed every six months.

A risk register, retired risk log and an issues log were in place. The practice used the ‘four T’s’ (transfer, tolerate, treat, terminate) approach to manage risks. A range of risk assessments were in place to support safe working practices including a lone working SOP. Control of Substances Hazardous to Health (COSHH) risk assessments and data sheets were in place. The risk assessments were reviewed annually or if there was a change of product. COSHH products were stored securely.

In the absence of an integrated alarm system, staff used personal portable alarms. A log of these alarms indicated they were tested regularly in line with the panic alarm SOP (November 2021).

A business resilience plan was in place and reviewed in January 2022. The plan was activated in October 2021 when Legionella was detected in the water system.

A COVID-19 risk assessment was in place for the practice along with risk assessments for individual staff. The practice had developed an SOP in relation to COVID-19 and the use of personal protective equipment (PPE).

Lessons learned and improvements made

All staff had access to the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events and incidents.

From interviews with staff and evidence provided, it was clear there was a culture of reporting incidents. Both clinical and non-clinical staff gave examples of incidents reported through the ASER system including the improvements made as a result of the outcome of investigations. An ASER log was maintained. A patient we interviewed raised a potential duty of candour issue. We noted it had been reported as a significant event and had been managed in line with duty of candour principles but was not recorded on the duty of candour log. The practice manager addressed this during the inspection. Duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.

An SOP and system was in place for managing patient safety alerts including a register and discussion of alerts at practice meetings.

Are services effective?

We rated the practice as good for providing effective services.

Effective needs assessment, care and treatment

Processes were in place to support staff to keep up-to-date with clinical developments including National Institute for Health and Care Excellence (NICE) guidance, clinical pathways, current legislation, standards and other practice guidance. A NICE guidelines notification was in place (November 2021). Minutes confirmed staff were kept informed of clinical and medicines updates at the monthly 'clinical updates' meetings. Staff also received updates through the Defence Primary Healthcare (DPHC) newsletter circulated each month.

Case discussions (referred to as ghost clinics) for patients with complex needs and/or vulnerabilities were discussed at the clinical register meeting, which all clinical staff were invited to attend each month.

Step one of the mental health intervention programme was undertaken at the practice although discretion was applied as to whether to refer patients to the Department of Community Mental Health (DCMH). Doctors were trained to assess risk in patients presenting with suicidal ideation or thoughts of self-harm. They liaised with key unit personnel to mitigate risk. The DCMH was based in Donnington. A satellite clinic held at Fulwood Barracks and included a full time community psychiatric nurse and social worker. The doctors had good links with the mental health team.

Monitoring care and treatment

The nursing team managed chronic conditions and had developed a detailed standard operating procedure (SOP) to support the process. This SOP was available to all clinicians. A comprehensive register for patients diagnosed with a chronic condition was in place. System searches were undertaken each month to ensure the register was current and included new patients diagnosed with a chronic condition. Chronic conditions, including case discussions, were discussed at both the 'clinical register review' and 'clinical updates' meetings each month.

The practice provided us with the following data:

Five patients were identified on the diabetic register, 10 patients were diagnosed with high blood pressure and 14 had a diagnosis of asthma. Patients were recalled and monitored in accordance with best practice guidance. Processes were in place to identify and monitor patients at risk of developing diabetes.

The 'well person' clinics stopped during the COVID-19 pandemic and had not yet recommenced. We spoke with a patient who shared concerns about their health. Although the patient was under the care of secondary care services, their concerns would likely have been identified at the practice through a 'well person' health check. With the patient's

consent, we fed back to the Senior Medical Officer (SMO) and the SMO agreed to follow the patient up as a matter of priority.

We looked at a wide range of patient records (17 in total), including records for patients with a mental health need. Although we identified deficiencies with the quality of record keeping, such as clinical coding and use of clinical templates, we concluded from a broad range of evidence that overall patients were receiving treatment and being monitored appropriate to their needs. The use of templates was audited in July 2021 and again in April 2022. A re-audit identified that nurses consistently used templates but this was not always the case for doctors.

Audiology statistics showed 84% of patients had received an audiometric assessment within the last two years. Joint Medical Employment Standards (JMES) were managed in an appropriate and timely way.

A register of quality improvement activity (QIA) was in place. We looked at the QIA log from 2019 onwards and it showed a balanced range of clinical and non-clinical audits. All members of the team contributed to QIA. Although not all audits identified for a repeat had been followed up, many had, including cervical cytology, smoking cessation and clinical coding. The range of audits we looked at in detail had been based on criteria measured against evidence based standards and followed a recognised structure for audit planning. Further audits were scheduled up until December 2022.

Effective staffing

Staff had received an appropriate induction and appraisal. Their mandated training was monitored by the practice manager and all staff were up-to-date with their training. Role specific training was provided for staff with lead roles and those who were undertaking specialist practice.

A log of in-service training was maintained which supported professionally registered clinicians with their continual professional development (CPD) and revalidation. Staff told us there was plenty of opportunities for CPD. In addition, clinicians had links with regional forums such as the quarterly regional health promotion meeting, monthly regional nurses' peer review. The practice was represented at the biannual regional nurse forum and the practice nurse attended the regional nurse informal meeting on Wednesday afternoon.

Coordinating care and treatment

Discussions with staff, supported by clinical records, confirmed the practice had a range of established links with internal teams and services, including with the welfare team and the Department of Community Mental Health. The practice was represented at the unit health committee meetings at which the care of vulnerable and downgraded patients was reviewed.

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. Patients were also made aware of

the Veterans Health Service and, if appropriate, the Veterans Mental Health Transition, Intervention and Liaison Service (TILS).

Helping patients to live healthier lives

The practice nurse was the lead for health promotion (HP) for both the practice and the region. To reduce the amount of time health promotion takes across region, the practice nurse had established quarterly meetings with the HP leads in other medical centres. This led to the development of a regional HP calendar with individual HP leads responsible for a specific campaign. Each lead developed the resources for their campaign which they shared with the other HP leads in the region. This meant that only one person was investing time in researching and collating resources each month. This initiative had been identified as a regional quality improvement project.

A yearly plan for HP was in place with two new topics each month. At the time of the inspection there were displays in relation sun exposure, men's health and diabetes. The practice participated in the camp health promotion fairs; the most recent was held in October 2021.

Both practice nurses were appropriately trained and experienced to deliver sexual HP. The senior practice nurse was the lead for sexually transmitted infections. The practice nurse had completed the Royal College of Nursing sexual and reproductive health skills course (including family planning). Condoms were provided at the practice. Patients were signposted to local sexual health services for procedures not undertaken at the practice.

The nursing team undertook monthly searches to identify patients who met the criteria for the national screening programmes. Data at the time of the inspection showed the practice had an uptake of 99% for cervical cytology screening. The NHS target is 80%. A small number of patients were identified that met the criteria for breast screening.

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

- 97% of patients were in-date for vaccination against diphtheria.
- 97% of patients were in-date for vaccination against polio.
- 97% of patients were in-date for vaccination against hepatitis B.
- 95% of patients were in-date for vaccination against hepatitis A.
- 97% of patients were in-date for vaccination against tetanus.
- 91% of patients were in-date for vaccination against meningitis.
- 98% of patients were in-date for vaccination against mumps, measles and rubella (MMR).

Consent to care and treatment

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. A range of consent audits had been undertaken some of which identified gaps in the application and accuracy of clinical coding.

Clinicians had a good understanding of the Mental Capacity Act (2005) and how it would apply to the population group. They had received training in mental capacity.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

We interviewed 12 patients as part of the inspection and all indicated the staff team treated them with kindness, respect and compassion. There was no response to the satisfaction survey circulated to patients by the Defence Medical Services Regulator which complemented this inspection.

The clinicians and commanders we spoke with provided examples of how they had worked together to provide compassionate, supportive and patient-centred care to individual patients. The practice developed an ‘end of life’ standard operating procedure (SOP) in August 2021 as a result of caring for a patient.

Involvement in decisions about care and treatment

The patients we spoke with described how they were included in proposed plans about their treatment and care. They said medical issues were explained to them in a way they clearly understood, included medicines and any potential side effects.

A process was in place to capture, monitor and support patients with a caring responsibility, including a DMICP register and SOP (September 2021). The register was reviewed at the ‘clinical register review’ meetings. We were advised patients usually identified themselves as a carer through the new patient registration form or when the units shared this information with the practice. Alerts were added to clinical records to identify carers so they could be offered flexibility with appointments. In addition, carers were screened for mental health issues and offered the flu vaccine. Information was displayed for carers including the services available and the contact details for the local carers service.

An interpretation service was available for patients who did not have English as a first language. We were advised it had not needed to be used.

Privacy and dignity

Consultations took place in clinic rooms with the doors closed. Privacy curtains were used when patients were being examined. Telephone consultations were undertaken using headsets to maximise patient confidentiality. Staff advised us that the screen at reception and the radio playing minimised conversations being overheard. A SOP (January 2022) was in place detailing the action staff should take if a patient presented at the practice distressed. In these circumstances patients would be supported by a member of staff in a private area. The primary care rehabilitation facility (PCRF) had been reconfigured to ensure privacy and confidentiality as previously conversations in an adjoining clinical room

could be overheard. To ensure awareness of handling personal information, the staff team had completed the Defence Information Management Passport training.

An ‘absence of a female doctor’ SOP (January 2022) was in place. In the event that a clinician of a preferred gender was not available then patients could be referred to an alternative local service. In the case of physiotherapy, there was an arrangement with Chester Medical Centre for patients to attend the PCRF there.

Are services responsive to people's needs?

We rated the practice as good for providing caring services.

Responding to and meeting people's needs

The practice was responsive to the individual patient needs. Some of the patients we spoke with had complex health care needs and said the practice responded promptly to any concerns they had often facilitating an appointment at short notice. The practice also accommodated patients who wished to see a clinician out of the area. The commanders we spoke with described how practice staff were responsive to the needs of patients considered vulnerable, including seeing a patient out-of-hours. Patients with mental health needs were given an extended appointment.

In addition, the practice was responsive and demonstrated effective staff teamwork to ensure medical force protection for 400 soldiers deploying at very short notice. The deployment was during the pandemic when unit medical staff were both running the camp and participating in COVID-19 testing. Medical centre staff stepped in to support with vaccinating and worked over and above their hours to ensure a timely and successful delivery of the force protection programme. This successful response was highlighted as an area of good practice (purple ASER).

An Equality Access Audit for the premises was completed in November 2021. The building was accessible for people with mobility needs including an accessible toilet. A hearing loop was not required based on the current needs of people who used or accessed the building. A diversity and inclusion standard operating procedure (SOP) was in place and reviewed in November 2021. The practice worked to the Ministry of Defence policy for the recruitment and management of transgender personnel in the armed forces.

Timely access to care and treatment

Patients had the option of using eConsult. Face-to-face appointments were available as COVID-19 restrictions had relaxed. Urgent appointments with a doctor could be facilitated on the same day and a routine appointment within six days. Nurses could accommodate patients with an urgent need on the same day and a routine appointment within one day. Feedback, including the patients we spoke with, confirmed they received an appointment promptly and at their preferred time.

Unit commanders we spoke with indicated there have been delays of 60 to 90 days for access to medical/grading reviews at the practice and also delays with access to regional occupational health. These delays meant downgraded service personnel could not return to work until they had been reviewed and signed off as fit. The practice confirmed the reasons for the delays was a combination of the impact of COVID-19, mobilisation of reservist medical examinations and a shortage of doctors. To manage this, a prioritised waiting list had been created. As a result, all patients due for a review had an appointment booked on DMICP. In addition, service personnel requiring an initial downgrading were seen within a couple of weeks.

Emergency out-of-hours cover midweek was provided by Weeton Medical Centre from 16:30 hours until NHS 111 commenced at 18:30. Patients had access to NHS 111 at weekends and on public holidays.

Listening and learning from concerns and complaints

The practice manager and senior practice nurse had the lead for complaints. Complaints were managed in accordance with Defence Primary Healthcare policy complaints policy and local procedure (November 2021). Written and verbal complaints were recorded logged and discussed at the health care governance meetings.

Are services well-led?

We rated the practice as good for providing caring services.

Leadership, capacity and capability

In February 2021 the practice had a remote quality assurance audit led by the Defence Medical Services Regulator. Staff interviewed as part of the audit expressed concern about the effectiveness of the clinical leadership of the practice. Areas highlighted included uncertainty about overall leadership, team engagement, delegation, decision making and adapting to change. There had been further leadership changes since the audit, notably the departure of the Regimental Medical Officer and the Senior Medical Officer (SMO) from Chester Medical Centre providing clinical leadership in the absence of the practice SMO.

Staff we spoke with were satisfied with the current leadership arrangements and said structure and consistency had improved since the quality assurance audit including clearer direction, decision making and structure. Since joining the team, the acting SMO had reviewed policies and the arrangements for medical emergencies.

Staff spoke highly of the support they received from the regional team and valued the weekly input and responsiveness of the regional manager.

Vision and strategy

The practice worked to the Defence Primary Healthcare (DPHC) mission statement defined as:

> "To provide and commission safe and effective healthcare which meets the needs of the patient and the Chain of Command in order to contribute to Fighting Power."

The vision statement for the practice was outlined as:

> "MTF Weeton Barracks aims to provide patients with high quality personal health care and to seek continuous improvement in the health status of the whole practice. We aim to achieve this by developing and maintaining a cohesive team-based approach which is responsive to people's needs and expectations and reflects, wherever possible, the latest advances in primary care."

The practice team were considering how planned changes to the units would impact the size and demography of the patient population.

Culture

It was clear from patient feedback, interviews with staff and unit commanders there was a patient-centred culture at the practice. Staff described how strengthening the leadership

team had promoted an inclusive and open-door culture with everyone having an equal voice, regardless of rank or grade.

All staff said they would feel comfortable raising any concerns and were familiar with the whistleblowing policy. Staff were given the opportunity to speak out at meetings or had the option to approach one of the practice leaders or the area manager.

The practice had systems to ensure compliance with the requirements of the duty of candour, including giving those affected reasonable support, information and a verbal and written apology. We were given examples of when duty of candour had been applied.

Governance arrangements

Following the quality assurance audit, the practice developed a management action plan (MAP) and the majority of the recommendations had been addressed. Recommendations included a review of the use clinical coding and the use of clinical templates. Although internal auditing of record keeping regularly took place, we found that further improvement in relation to clinical coding and clinical templates was needed.

There was a staffing structure in place and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. One of the doctors was the lead for healthcare governance and had one day a week to dedicate to this role.

The practice had a well-developed healthcare governance workbook; the overarching system used to bring together a range of governance activities, including the risk register, MAP, training register, policies, quality improvement activity (QIA) and complaints. The provision of care was monitored through an ongoing programme of QIA.

A range of meetings with defined topics for discussion were held to ensure a communication flow within the team. The monthly meeting schedule included:

- Practice meeting
- Clinical register review
- Healthcare governance
- Clinical updates

Managing risks, issues and performance

An effective process to identify, understand, monitor and address current and future risks including risks to patient safety was in place. Risk to the service were well recognised, logged on the risk register and kept under scrutiny through review at the practice meetings. The business resilience plan was reviewed in June 2022 and was a standing agenda item at the practice meetings.

Processes were in place to monitor national and local safety alerts, incidents, and complaints. This information was used to improve performance.

Appraisal was in date for all staff. Staff performance was dealt with by individual line managers with input from the regional team if required. The leadership team was familiar with the policy and processes for managing under-performance and ensured staff were

supported in an inclusive and sensitive way taking account of their wellbeing. The priority had been to maintain patient safety whilst supporting individual members of staff with improving their performance.

Appropriate and accurate information

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

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

Although there were various options in place to encourage patients to provide feedback on the service, the practice had recognised that feedback was low. Since introducing sending patients who recently used the service a link to the 'My Healthcare Hub', feedback had significantly increased; 33 (out of 40) returns from 6-19 June 2022.

Good and effective links were established with internal and external organisations including the Welfare Officer, Regional Rehabilitation Unit (RRU), Department of Community Mental Health and local health services.

An anonymous staff survey was undertaken in June 2021 with a 70% response. All respondents indicated they were satisfied with the overall management of the practice. No concerning trends were identified.

Continuous improvement and innovation

It was clear the team had acted promptly to address the recommendations made from the quality assurance audit in February 2021. In addition, the team continually explored ways to improve the quality and safety of the practice including:

- Audit to monitor anti-microbial prescribing for acute sore throat.
- Development of a firearms standard operating procedure (SOP).
- Initiated the development of a regional health promotion calendar and the sharing of regional health promotion material.
- Development of an end-of-life SOP.
- Development of a chronic conditions SOP.