Brawdy Medical Centre

Cawdor Barracks, Brawdy, Haverfordwest, Pembrokeshire, SA62 6NN

Defence Medical Services inspection report

This report describes our judgement of the quality of care at Brawdy Medical Centre. It is based on a combination of what we found from information provided about the service, patient feedback and interviews with staff and others connected with the service. We gathered evidence virtually in line with COVID-19 restrictions and guidance and undertook a short visit to the practice.

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

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Summary

About this inspection

We carried out an announced comprehensive inspection of Brawdy Medical Centre on 22 March 2018. The practice received an inadequate rating overall, with a rating of inadequate for the safe, effective and well-led key questions. The caring key question was rated as requires improvement and the responsive key question rated good.

An announced comprehensive follow-up inspection took place on 8 February 2019 with the practice achieving a rating of requires improvement overall. The safe, effective and well-led key questions were rated as requires improvement with caring and responsive rated as good.

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

https://www.cqc.org.uk/what-we-do/services-we-regulate/defence-medical-services#medical

We carried out this announced follow up comprehensive inspection on 3 and 5 August 2021. The first day we gathered our evidence virtually and the lead inspector visited the service on the second day. The report covers our findings in relation to the recommendations made and any additional improvements made since our last inspection.

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? – requires improvement

Are services effective? – good

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, the military healthcare regulator, the Defence Medical Services Regulator (DMSR) has regulatory and enforcement powers over the DMS. The 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:

- Recruitment for a Civilian Medical Practitioner (CMP) had not been successful so for over a year the practice had relied on locum GPs to provide patient clinics. In addition, retention of staff had been a challenge in recent months and this risk was being managed through the regional General Practice Remote Support (GPRS) network led by the regional Senior Medical Officer (SMO).
- The practice was well-led with clinical leadership facilitated through the GPRS. The leadership team had a clear understanding of the issues and challenges the service was vulnerable to. They were considering options to secure a sustainable doctor presence for the practice.
- The practice pro-actively 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. However, patients indicated the change of doctors impacted continuity as they had to repeat their medical history.
- Despite the staffing challenges including the short term closure of the practice, patient feedback indicated staff responded promptly to ensure patients received timely and effective care.
- Since the appointment of a practice manager the governance of the practice had significantly improved, reflected in the development of a comprehensive health governance workbook. The workbook captured a wide-range of information which illustrated how the practice was performing.
- 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 approach to the monitoring of patients on high risk medicines.
- The practice worked collaboratively with internal and external stakeholders to promote better health outcomes for patients.
- Quality improvement activity was evident, including various approaches to monitor outputs and outcomes used to drive improvements in patient care. Clinical audit and re-audit had stalled due to COVID-19 and inconsistent staffing levels.

The Chief Inspector recommends:

- Defence Primary Healthcare (DPHC) should prioritise the recruitment of a permanent doctor for the practice to maximise consistency and continuity of clinical care for patients.
- The practice should ensure that clinical lead roles are undertaken by suitably experienced and competent staff.
- The re-audit of physiotherapist clinical records is completed without delay to ensure the areas for improvement from the initial audit and the findings from this inspection are addressed.
- A formal process of peer review for the physiotherapists should be established.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

The inspection team was led by a CQC inspector and comprised specialist advisors including a primary care doctor, physiotherapist and nurse.

Background to Brawdy Medical Centre

Rurally located and a short distance from the village of Brawdy, the medical centre provides a routine primary care, occupational health and rehabilitation service to a military service population of approximately 500 who are subject to operational deployment at any time.

A primary care rehabilitation facility (PCRF) is located within the medical centre and provides a physiotherapy and rehabilitation service. As there is no dispensary at the practice, medicines are dispensed from a local pharmacy.

The medical centre is open from 08:00 to 17:00 Monday to Thursday and is closed on a Friday. Medical cover is provided from Brecon Medical Centre when the practice is closed and before NHS 111 commences.

The staff team

Staffing	Numbers
Doctors	Locum Civilian Medical Practitioner (CMP)
Practice Manager	One (civilian)
Nurses	Civilian practice nurse Military nurse (post gapped) Locum nurse covering absence of civilian nurse
PCRF	Two physiotherapists – Band 6
Administrators	Locum administrator Recruitment in progress for two administrators
Combat Medical Technicians (CMT)*	Two gapped posts

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

Are services safe?

We rated the practice as requires improvement for providing safe services.

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

- infection prevention and control (IPC);
- medicines management, including high risk medicines (HRM);
- management of medical emergencies at the unit gym; and
- clinical record keeping, including clinical coding and use of standard review templates

We found the recommendations we made at the last inspection had been actioned. However, we identified a risk to patient safety systems due to insufficient and inconsistent clinical staffing levels.

Safety systems and processes

- A child and adult safeguarding policy was in place which included the contact details for local services. Information about safeguarding, including how to report a safeguarding concern, was displayed in clinical areas. Safeguarding was part of the induction for new staff, including locum staff.
- The clinician with the lead for safeguarding was absent from the service at the time of the inspection. The practice manager had completed level 3 safeguarding training and had assumed the role of safeguarding lead in the absence of another clinician to undertake the role. Although organisational expectation is that a clinician has the lead for safeguarding, the regional team had accepted this arrangement as an interim measure. The practice manager had access to advice from clinical safeguarding leads in the region should the need arise. The staff team had completed safeguarding training at a level appropriate to their role.
- A monthly search of DMICP (electronic patient record system) was undertaken to ensure the register of vulnerable patients was current. We reviewed clinical records for vulnerable patients and noted appropriate alerts and coding were used.
- Measures were in place to ensure vulnerable patients were supported, including through regular liaison with the Welfare Officer and the Chain of Command. Vulnerable patients and safeguarding concerns were discussed at the regular welfare meetings and Unit Health Committee meetings. These meetings also supported with identifying vulnerable service personnel who may not have been in contact with the medical centre. The Welfare Officer described close working relationships with the practice and provided examples of how they worked together to support vulnerable patients. Case conferences were held depending on individual need and the practice was represented at these meetings.

- All staff were trained chaperones. Information about the chaperoning service was displayed throughout the practice.
- 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 staff, were suitable to work with vulnerable adults and young people. DBS checks were renewed every five years. The practice manager carried out regular checks of professional registration. The vaccination status of staff had recently been reviewed and updated. Detailed checks of all locums were conducted when they started.
- In the absence of the clinical lead for IPC, the practice manager had assumed the lead role for the practice. It was planned that the locum nurse, who had started the week before the inspection, would take on this role once they had completed induction. They would be supported by the Senior Nursing Officer (SNO) from Brecon Medical Centre who had the link practitioner training for the role. An IPC audit for the medical centre and PCRF was completed in July 2021 and the practice achieved a compliance score of 96%. The actions identified had been addressed. The staff team was up-to-date with IPC training.
- One of the physiotherapists provided acupuncture and this practice was supported by an standard operating procedure (SOP). Guidance on the management of sharps and needle stick injuries was available in the PCRF.
- Cleaning schedules were established for the practice. The practice manager undertook a monthly review of the cleaning schedule with cleaning staff. These reviews were documented along with any issues identified and any required actions. A schedule was in place outlining the deep clean rota and the clinical curtain changes. All clinical areas were subject to a deep clean in June and July 2021. The environmental cleaning SOP had been updated in response to COVID-19.
- Arrangements were in place for the management of clinical waste including a waste log and consignment notes. A waste audit was carried out in July 2021. Clinical waste was stored in a secure compound outside of the building. The physiotherapist used the unit gym on the camp and transported bagged personal protective equipment (PPE) for disposal back to the medical centre. The PPE was just used face masks so did not pose a hazardous waste risk. The use of sharps bins and their disposal were safely managed.

Risks to patients

- Since the last inspection there had been a significant change in the staff composition. A full time practice manager post had been created and the practice manager had been in post since April 2020. The contract for the provision of GP clinics with a local NHS primary practice had ceased. Three episodes of recruitment for a Civilian Medical Practitioner (CMP) had failed to identify a suitable candidate. There was no post established at the practice for a Senior Medical Officer (SMO). GP provision had been provided by a series of locums; four in total since May 2020. Patients raised concern to us about the changeover of doctors in terms of continuity, particularly repetition of their medical history to various clinicians. The lack of a SMO and/or CMP to provide practice level clinical leadership was logged on the risk register.

- Since May 2021, the practice had lost two Combat Medical Technicians and its two administrators. The military nurse post was vacant, and a new military nurse was due to take up post in September 2021.
- Due to unforeseen circumstances, the practice had been without a locum GP and a civilian practice nurse for a short period in June 2021 resulting in the temporary closure of the practice. This had been reported as a significant event. In addition, two significant events were raised in relation to the need for patients during this time to access nursing care procedures at alternative health care facilities. Travel time by car to another defence primary medical care facility in the region was approximately two hours so local NHS services were used if appropriate.
- Since then, the practice has been heavily supported through the General Practice Remote Support (GPRS) South Wales group network, a strategy led by the regional SMO for six medical centres in the group. One of the objectives of the network was to strengthen service resilience during times of staff shortage. Brecon Medical Centre was identified as the hub practice for the network. The regional SMO and SNO at Brecon Medical Centre had provided patient clinics at Brawdy Medical Centre in the absence of clinical staff. Although we found the GPRS network was facilitating ongoing effective and safe clinical care for patients, sustaining adequate clinical staffing levels remained a key risk for the practice, including suitable clinicians to oversee clinical aspects of the practice.
- At the time of the inspection the locum GP had returned to work and a locum nurse had just started. We were advised that a Medical Officer was due to start working at the practice three mornings a week on a six month trial basis from 31 August 2021 (we confirmed this had happened). The role included routine clinics, medicals and occupational health. However, the Medical Officer did not have wider responsibilities, such as lead roles in key clinical areas.
- The PCRF was sufficiently staffed to meet the needs of the population. The two part time contracted physiotherapists had been in post for many years and worked in a dual role covering physiotherapy and exercise rehabilitation instructor (ERI) roles.
- Locum staff we spoke with said they were well prepared before they started seeing patients and received an induction specific to their role.
- The practice was equipped to deal with medical emergencies. The staff team was up to date in medical emergency procedures, including basic life support training, use of the automated external defibrillator (AED) and anaphylaxis. Spinal injuries training was undertaken in November 2020, thermal injuries training in May 2020 and sepsis training in July 2020.
- The PCRF gym was located in the unit gym and used for rehabilitation classes. Wet Bulb Globe Temperature (WBGT), which was used to indicate the likelihood of heat stress, was monitored every two hours by the Physical Training Instructors and the PCRF was informed of the temperatures every two hours by email. Access to the log of WGBT recordings were available from the Staff Sergeant Instructor if required. The physiotherapist facilitated running sessions on the airfield. This was undertaken in line with lesson plans and with the appropriate safety measures in place, including WGBT readings and provision of water.
- In winter, temperatures in the gym dropped and it was very cold. It was too hot for training when the central heating was on. Temperature control in the gym had been added to the issues register. The physiotherapist advised that fixed wall heaters were

available for use. By the time we visited the service on day two of the inspection arrangements had been put in place to routinely monitor the temperature of the gym.

- The patient waiting areas could always be observed as CCTV was installed. The crash trolley and automatic external defibrillator (AED) were in the corridor. Emergency medicines and equipment were checked regularly, and records maintained. The physiotherapist held rehabilitation classes in the gym and the nearest AED was in the guardroom approximately 400 meters away. PCRF staff had undertaken emergency scenario-based exercises along with the Physical Training Instructors from the unit, which including the time it took to access the AED.

Information to deliver safe care and treatment

- Staff advised that IT outages were infrequent. Three laptops were available in the event of an IT outage which meant staff could continue to access DMICP. Packs of printed forms were accessible in each clinical room as a backup and clinic lists were printed for the following day. Furthermore, the practice manager at St Athan Medical Centre had access to DMICP for Brawdy Medical Centre.
- An SOP was in place for the summarisation of patient records which clearly identified the actions to take. The SOP did not clearly articulate the process for checking records for new patients. This was a minor omission which would be addressed when the SOP was updated. The practice manager confirmed that patients new to the practice completed the new patients registration form which either the locum doctor or locum nurse processed.
- Our review of nursing records indicated they had been peer reviewed and identified no concerns with record keeping. A plan was in place for the SNO from Brecon to review the newly appointed locum nurse's records. Peer review of doctors records was facilitated through the GPRS network. The practice was subject to an organisational-led healthcare governance assurance visit (HGAV) in May 2021. Ten sets of doctors and nurses clinical records were reviewed as part of the visit and no concerns were identified with record keeping.
- An internal audit of physiotherapy records was conducted in November 2020. It was a new audit tool and highlighted areas for improvement. Evidence-based staff training in goal setting took place as a result of the audit. In addition, a process to record goal setting was designed. Our review of patient records showed some of the improvements had not yet been made. A further audit had started in May 2021 but had not been completed due to an increase in patient referrals and staff shortages. We were advised the audit would be completed in August 2021.
- A system was in place for the management of internal and external referrals. For external referrals, paper copy documentation was processed by the doctor and passed to the administrator who added them to the referrals register. Held on a shared electronic system, the status of referrals was regularly monitored and each referral remained active on the register until the patient received a clinic letter. Forty four referrals were active at the time of the inspection. There were no two-week-wait referrals. Referrals in Wales are submitted in paper form via the postal system and the practice ensured they were sent using recorded delivery. An internal referrals tracker was used by the administrative team to monitor and ensure referrals were actioned.

- A process was in place for the management of specimens. A regularly monitored specimen tracker was maintained which included the patient's DMICP number, date the sample was collected, date the result received and date actioned.

Safe and appropriate use of medicines

- The practice nurse was the lead for medicines management until such time as a CMP was appointed. In the absence of the practice nurse there was no lead identified. However, both the regional SMO and SNO from Brecon Medical Centre were supporting with medicines management. In addition, the pharmacy technician at St Athan Medical Centre had remote access to the registers for support and monitoring purposes. Medicines were outsourced to a local pharmacy and it was the responsibility of patients to collect their medicines from the pharmacy.
- In the absence of the practice nurse, the SNO from Brecon Medical Centre was overseeing the ordering of stock (vaccines, emergency trolley stock, medical gases), inputting pharmacy orders on DMICP and the removal of expired stock. The SNO was training the locum nurse in these processes.
- The regional SMO was overseeing red and amber drugs (high risk medicines) and shared care agreements. A search for high risk medicines (HRM) was undertaken each month and we noted a search took place at the beginning of July 2021. A register of HRMs was maintained which included the patient's DMICP number, clinical code, alert, prescriber, review date, monitoring required, and when an audit had taken place. A register of shared care agreements was also in place. Our review of clinical records for patients prescribed HRMs demonstrated safe clinical care.
- Medicines were stored in a temperature controlled locked medical store. Temperatures of the fridges were monitored and recorded each day. Controlled drugs (medicines with a potential for misuse) were not held at the practice. Patients collected prescriptions for CDs from the local designated pharmacy.
- Patient Group Directions (PGD) had been developed to allow the practice nurse to administer medicines in line with legislation. These were up-to-date and signed off. The SNO from Brecon Medical Centre carried out a PGD audit and it showed 100% compliance. Patient specific directions were not being used as no Combat Medical Technicians were in place to facilitate clinics.
- A pharmacy audit was completed by the regional pharmacist in April 2021. The prescribing audit from February 2021 and showed 90% compliance. The practice followed local guidance on antibiotic prescribing and this was confirmed through an antibiotic prescribing audit in February 2021.

Track record on safety

- The practice manager was the lead for health and safety. A risk register, policies and risk assessments pertinent to the practice were in place, including lone working and risk assessments for products hazardous to health. The risk assessments had recently been reviewed and signed off by the area manager. A range of risk assessments specific to the PCRF were in place, including for outdoor running, class therapy, acupuncture, use of the unit gym and manual therapy.

- A COVID-19 risk assessment had been completed to reflect changes in working practices. The changes made included chairs spaced out in the waiting area, signage indicating regarding distancing and a dedicated area to see patients presenting with potential symptoms of the virus. Risk assessments and checks were undertaken for patients entering the building. A separate COVID-19 risk assessment was in place for PCRF gym.
- Systems were in place and up-to-date for the safe management of utilities, including electricity, equipment and gas. A legionella risk assessment was undertaken in July 2020. Records were maintained of the weekly flushing of water outlets. A fire risk assessment took place in October 2018 and. The practice manager checked the fire extinguisher each month. Staff were up-to-date with fire safety training undertaken as part of the DPHC mandated training policy.
- The annual land equipment audit carried out externally was out of date because of COVID-19 restrictions. It was due to take place in September 2021. Snap inspections of equipment were carried out by the area manager each month and periodic management checks undertaken by the practice manager each month. Portable appliances had been tested in October 2020. We noted that one TENS machine (device to help reduce pain and muscle spasm) was out of date for servicing. The practice machine confirmed it had been taken out of service. Staff had completed equipment care training in February 2021.
- An integrated emergency alarm system was in place. It was tested monthly and records maintained. There was no alarm in the PCRF gym. The physiotherapist advised they carried a mobile phone to summon support in the event of an emergency while working at the unit gym. Physical Training Instructors (PTI) worked from the unit gym so the physiotherapists were rarely there alone.

Lessons learned and improvements made

- All staff, including locums, had access to the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events and incidents. The dates staff completed ASER training was recorded on the staff database.
- A significant event analysis was undertaken for 2020. The HGAV report in May 2021 identified under reporting of incidents and significant events. We noted reporting had improved since then with an increase in ASER submission.
- Historically, ASERs had been discussed at governance meetings and this was recorded appropriately. Meetings had temporarily ceased due to the limited number of staff available to attend meetings. The meetings had recommenced shortly before this inspection as the SNO from Brecon Medical Centre was overseeing and monitoring ASERs for the practice.
- Both clinical and non-clinical staff gave examples of incidents reported through the ASER system including improvements made as a result of the outcome of investigations. An ASER log was maintained on the health governance workbook including any changes made. The health governance workbook is the system used to bring together a range of governance activities, including the risk register, significant events tracker, lessons learnt log, training register, policies, meetings, quality improvement and audit.

- The practice manager was the lead for the management of medical and patient safety alerts. They received alerts from the government website which were forwarded to the practice nurse for review and action. The practice manager reviewed the alerts register each week. Recommendations from the HGAV report about how to develop the register had been actioned. Alerts were discussed at the healthcare governance meetings and documented.

Are services effective?

We rated the practice as good for providing effective services.

Following our previous inspection, we rated the practice as requires improvement for providing effective services. We found inconsistencies in processes to ensure effective services for patients including gaps in staff training, the quality of clinical records and quality improvement activity.

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

Effective needs assessment, care and treatment

- Processes were in place to support clinical staff to keep up-to-date with NICE (National Institute for Health and Care Excellence), the Scottish Intercollegiate Guidelines Network (SIGN), clinical pathways, current legislation, standards and other practice guidance. The main forums for this was through the healthcare governance meetings. Updated guidance was also circulated via the monthly DPHC Newsletter.
- PCRF staff were familiar with Department of Defence Rehabilitation Guidance. Best practice guidance training had been delivered and further training sessions were planned. Printed copies of best practice guidance was available in a folder in the PCRF for quick reference.
- The physiotherapist advised us that Rehab Guru (software for rehabilitation exercise therapy) was used and coded but that the detail was not always referenced in clinical records. Our review of records confirmed this which meant it was unclear what exercises had been prescribed and the frequency of the exercise programme. Inclusion of this detail was important for continuity of care particularly if the patient was deployed or referred to the Regional Rehabilitation Unit (RRU). We noted this issue was also identified in the May 2021 HGAV report. A recommendation was made and was yet to be actioned.
- The PCRF was sufficient in size for the patient population, including the PCRF gym located in the unit gym.
- The PCRF held weekly meetings with the Regional Rehabilitation Unit (RRU) to discuss patients who may require referring to the RRU, caseload support and for regional clinical governance support. A good practice ASER (referred to as a purple ASER) was raised for this activity as it had improved patient management and ensured appropriate patients were referred to the RRU or local services in a timely way.

Monitoring care and treatment

- In the absence of the civilian practice nurse and whilst the military nurse post was gapped, the SNO from Brecon Medical Centre had taken the lead with the management of chronic conditions. Monthly searches were undertaken using both the population management process (referred to as POPMAN) and DMICP. The searches complemented each other and ensured no patients were missed. At the time of the inspection the chronic disease register was being updated to move to a birthday recall

system. It was anticipated this would provide a better appointment booking system for the patient and the practice.

- There were very low numbers of patients on the diabetic register and their care indicated positive control of both cholesterol control and blood pressure. Patients at risk of developing diabetes were identified through the over 40's screening, which included relevant testing (HbA1c). There were low numbers of patients recorded as having high blood pressure. All but one were recorded as having high blood pressure in the past nine months. All but one patient had a blood pressure reading of 150/90 or less. There were low numbers of patients with a diagnosis of asthma and all had an asthma review in the preceding 12 months.
- Our review of the chronic disease management documentation and a sample of patient records showed the clinical management of chronic disease was good. Patients were recalled for reviews as required. Relevant templates were used and clinical coding was appropriate.
- Physiotherapy and rehabilitation records showed patients received appropriate treatment and care in line with their clinical need. However, we found inconsistencies in areas, such as the use of rehabilitation templates and exercise rehabilitation instructor coding. Patient Reported Outcome Measures (PROMs) were used and the physiotherapists had created guidance notes for the use and scoring of PROMs. Our review of clinical records showed PROMs was not always evident in patient records or a reason for this omission recorded. The musculoskeletal Health Questionnaire (MSK-HQ) was not always used at six week intervals to monitor progress. There could be an acceptable reason for this but it was not evident in the records.
- In line with the April 2020 DPHC directive, routine audiometry had ceased. The practice was awaiting further guidance as to when routine audiometry could be resumed. Sixty nine per cent of patients' audiometric assessments were in date (within the last two years). The clinical records we looked at showed audiometric assessments were recorded in accordance with the Hearing Conservation Programme.
- In relation to mental health, the practice provided step 1 of the mental health pathway. The Welfare Officer advised us that mental health issues, exacerbated by the isolation of the location, were the main reasons people sought support from the service. The Welfare Officer worked closely with the medical centre and provided recent examples of how they worked together to safely and effectively support individual patients. Occupational activity for patients with mental health needs was managed with oversight and input from the Regional Occupational Health Team (ROHT) as appropriate. There was a process for managing personnel unfit to use live arms. Our review of patient records showed patients were effectively supported, safeguarded and referred to the Department of Community Mental Health (DCMH) as appropriate to their assessed risk. Standardised clinical codes were applied with depression the most commonly used code (until a diagnosis confirmed). Patients with mental health needs were routinely coded as vulnerable.
- A quality improvement activity (QIA) planner was established for 2021 along with a log of QIA from 2018 to 2021. QIA comprised both clinical and non-clinical audits, service evaluation, mandated audits and data searches. Re-audit was limited at the time of the inspection due to low staffing levels, including the re-audit of cytology and chronic disease template usage. Locum doctors had carried out audits despite not being contractually required to do so. The practice was waiting for the audit SOP which was being developed by the DPHC to ensure that all mandatory and recommended audits were completed to schedule.

- The PCRF had completed a service evaluation in 2020 to review the rehabilitation time for various injuries. The evaluation also explored the difference between injuries and the length of treatment for different injuries. This was a valuable piece of work that provided scope for further audit and focussed training in injury prevention. The PCRF had plans to expand on this work and were capturing initial and discharge MSK-HQ data alongside injury information to analyse improvement in the outcome measure score from initial assessment to discharge.

- The GPRS network provided opportunities for practice staff to engage with peer support, shared learning and clinical development within the region. Time was dedicated each Friday for this activity.

Effective staffing

- An induction programme was in place for permanent staff. It took account of DPHC requirements, local expectations and the role of the staff member appointed. Mandated training was monitored by the practice manager who confirmed training was up-to-date for all staff. In-service and external training was also scheduled for key topics relevant to the practice and patient population. For example, both physiotherapists had completed a running course and one of the physiotherapists had completed strength and conditioning for therapists. Role specific training could be accommodated for staff with lead roles. Staff appraisals were up-to-date for permanent staff.
- Ensuring doctors and nurses had the appropriate skills for their role and were working within their scope of practice was considered as part of the GPRS network. Opportunities were in place to support staff with continual professional development and revalidation, including peer review and collaborative work with other practices in the region through the network. Clinical supervision for nursing staff was facilitated by the SNO at Brecon Medical Centre. A process of formal peer review for the physiotherapists was not established and this had been identified in the HGAV report. However, the physiotherapists had direct access to the RRU at St Athan for support and attended weekly meetings with the team.

Coordinating care and treatment

- The regional SMO attended all the Unit Health Committee (UHC) meetings at which the health and care of vulnerable and downgraded patients were reviewed. Multi-disciplinary patient injury management meetings were held each month to discuss patients ahead of the UHC meetings.
- Due to nursing staff shortages to provide essential treatment and care, the practice had referred patients to either other medical centres within the regional group or to local NHS facilities.
- PCRF staff reported good access and an effective service from the RRU at St Athan, including timely access to the multi-disciplinary injury assessment clinic (MIAC), podiatry and rehabilitation courses. They had the facility to refer patients to Withybush General Hospital in Haverfordwest for specialist physiotherapy services such as hand therapy.

- For patients leaving the military, pre-release and final medicals were undertaken. 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. 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 SNO for Brecon Medical Centre had engaged with the unit regarding COVID-19 and COVID-19 information was displayed around the camp. Restrictions associated with the pandemic meant the regular unit-led health fairs had not taken place. Similarly, the injury prevention brief delivered by the PCRF team to the unit when personnel were due to attend arduous courses was on hold. The PCRF team had provided training for the Physical Training Instructors in running and injury prevention. An injury prevention display was in the main gym for patients to access.
- Health promotion information was available in patient areas within the medical centre including information about sexual health, skin cancer, mental health and cold injuries. Our review of patient records showed clinicians provided information about health improvement to patients based on individual need.
- In the absence of the practice nurse, the SNO for Brecon Medical Centre had assumed the lead for sexual health and was suitably trained for the role (STIF foundation course). Sexual health was identified as a key need for the population. The findings from a cytology audit led to the practice promoting awareness about sexual health with the patient population. For complex sexual related conditions, patients were signposted to sexual health services in the local area. Local sexual health services were advertised within the practice and condoms were available along with sexual health displays and leaflets. Patients could also be referred to the military sexual health service in Birmingham.
- The practice had set up a display outside the canteen which included information on sexual health, smoking cessation, use of alcohol and drugs.
- Monthly searches were undertaken to identify patients who required screening for bowel, breast of abdominal aortic aneurysm in line with national programmes. At the time of the inspection no patients were identified that met the criteria for this screening. Data at the time of the inspection for cervical screening showed the practice had an uptake of 100%. The NHS target is 80%.
- Searches using DMICP were undertaken to identify when vaccinations were due. The vaccination statistics for the population were identified as:
    - 94% of patients were in-date for vaccination against diphtheria.
    - 94% of patients were in-date for vaccination against polio.
    - 90% of patients were in-date for vaccination against hepatitis B.
    - 97% of patients were in-date for vaccination against hepatitis A.
    - 94% of patients were in-date for vaccination against tetanus.
    - 88.4% of patients were in-date for vaccination against MMR.
    - 88% of patients were in-date for vaccination against meningitis.

Consent to care and treatment

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making. They had received in-service training and had a good understanding of the Mental Capacity Act (2005) and how it would apply to the patient population.
- Doctors records showed that consent was appropriately taken and recorded. The physiotherapists recorded consent for acupuncture and took patient consent to share information with the Chain of Command. Our review of nursing records showed consent was routinely documented but appropriate clinical coding was not consistently recorded. We highlighted this to the locum nurse and were assured this would be completed. A consent audit had not been completed and one was scheduled to take place later in the year.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

- We took into account a variety of methods to determine patients' views of the service offered at Brawdy Medical Centre. These included direct interviews with patients, the 2020 PCRF patient satisfaction survey, the 2020 patient experience audit, the regional-wide patient survey (referred to as GPAQ) conducted between June and December 2020 and the DMSR patient satisfaction survey circulated ahead of this inspection. All sources of feedback indicated staff treated patients with kindness, respect and compassion.
- Staff and patients provided us with numerous examples of when the practice had gone the extra mile to ensure patients received individualised and compassionate care.
- There was no Hive network (network providing a range of information to service personnel who had relocated to the camp and surrounding area) available at Cawdor Barracks but posters were available in the medical centre signposting patients to welfare services.

Involvement in decisions about care and treatment

- Patient feedback suggested the health care needs of patients were effectively addressed and they received appropriate information to make decisions about care and treatment. Although there was no evidence this had happened, some patients raised concern about the potential of the regular change in civilian locum doctors to miss things as they may not understand military healthcare processes.
- Our review of patient records showed the PCRF team appropriately used physical training recovery, maintenance and light duties prescriptions to guide patient's return to fitness.
- We were advised patients usually identified themselves as having a caring responsibility, often through the new patient registration form or when the welfare team shared this information with the practice. A carers SOP had recently been developed and one of the physiotherapists was identified as the carers champion. A carers register was in place and it was managed within the nursing team. Carers were reviewed at the monthly review meeting.
- 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

- Patient feedback indicated that practice staff ensured the privacy and dignity of patients was maintained.

- Patient consultations were conducted in clinic rooms with the door closed. The two treatment areas within the PCRF were well distanced and curtains were used to maintain privacy. A low playing radio was used to minimise conversations being overheard.
- Headphone sets were used for telephone consultations. All clinical rooms had a separate curtained area for intimate examinations. If a patient presenting at reception was distressed or wished to discuss a sensitive issue, they had the option to talk with a member of staff in a private area.
- In the event that a clinician of a preferred gender was not available then patients could be referred to an alternative defence medical or rehabilitation service.

Are services responsive to people's needs?

We rated the practice as good for providing responsive services.

Responding to and meeting people's needs

- The practice took account of the Equality Act 2010 in responding to the needs of individual patients. For example, transgender patients had access to extended appointments, were provided with information and encouraged to access clinical services appropriate to their clinical needs, such as screening.
- The practice manager had completed an equality access audit for the medical centre and PCRF. Accessible facilities were limited including no disabled access to the building or accessible toilet. This deficit was identified on the risk register and statements of need (SON) had been submitted for accessibility to be improved. Although a very low risk for the current patient population, staff and others who used the building, it was evident from the risk register that the practice manager routinely monitored the status of the SONs. A hearing loop was due to be installed. The PCRF gym had not been included in the audit and accessibility was assessed based on individual need. The practice manager advised us that the PCRF gym would be included when the equality access audit was reviewed in October 2021.
- In response to restrictions associated with COVID-19, a remote triage model including, the use of eConsult and telephone consultation was implemented by the practice. Face-to-face consultations were facilitated if clinically required.
- The practice responded to feedback from patients with the aim to improve the service. For example, the PCRF secured additional strength and conditioning equipment for the gym and introduced informal therapy sessions based on feedback received.
- A home visit SOP and register was in place. No home visits had been undertaken. The practicality of delivering home visits was identified at the HGAV in May 2021 so the policy was currently under review.

Timely access to care and treatment

- We used patient feedback to determine the impact of access to timely and effective care when the practice closed temporarily in June 2021 as no clinical staff were available. Practice staff acted promptly to source alternative care either at other medical centres in the region or at local NHS facilities. Although patients received satisfactory and timely care, they described having to travel as inconvenient and disruptive to their operational duties. Military transport was provided for those without transport. At the time of the inspection the practice had re-opened and clinical staffing deficits were being addressed through the GMRS network and the appointment of a locum nurse.
- Urgent appointments were available daily with a doctor or nurse with routine appointments usually available the same day they were requested. Access for vulnerable patients was prioritised.
- A routine physiotherapy appointment was available within six working days, a follow-up appointment within three working days and an urgent appointment facilitated within five

working days. Rehabilitation appointments could be facilitated within five working days for new patients and three days for follow up appointments. Rehabilitation classes were accommodated within the same week.

- A self-referral SOP was in place for PCRF access. An electronic questionnaire was completed and sent though to physiotherapist's email address. These were triaged in the morning and then offered an appointment slot. Although the PCRF received a large proportion of self-referrals, an evaluation of the self-referral service had yet to be completed to determine its effectiveness.
- Patient feedback indicated patients were aware of how to access a doctor out of hours (OOH). The patient information leaflet included these details. OOH cover was provided by the duty medic and Friday afternoon was covered by Brecon Medical Centre. Through the GPRS network a doctor was on call for the region OOH and until the NHS 111 service commenced.

Listening and learning from concerns and complaints

- The practice manager had the lead for complaints which were managed in accordance with the DPHC complaints policy and procedure. A local process for managing written and verbal complaints was in place. The practice had received no complaints in the last 12 months.
- Patients were made aware of the complaints process through the practice information leaflet and information in waiting room.

Are services well-led?

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

Governance arrangements at the practice had significantly improved since the initial inspection in March 2018. This was due to the appointment of a locum practice manager. However, the locum practice manager's contract was due to end in March 2019 with no plans in place for sustainable leadership and governance of the practice. For this reason, we rated the well-led domain as requires improvement.

In April 2020 a full time permanent practice manager was appointed for the practice.

Vision and strategy

- The challenges associated with clinical delivery at Brawdy Medical Centre were well known. The main challenge has been the rural and isolated location which has impacted staff recruitment in general but particularly for a Civilian Medical Practitioner (CMP). There was also a lack of resilience to cover staff absence, including when military staff deployed.
- The region (South Wales and neighbouring English counties) had experienced similar challenges, characterised by a widely distributed patient population shared amongst isolated medical centres with small establishments. The loss of even one member of staff has had a significant impact at local level, driving the need for mutual support to deliver resilience.
- To maximise resilience, the regional SMO, along with key staff from each practice and Regional Headquarters (RHQ) developed the General Practice Remote Support (GPRS) South Wales group network, a communication strategy for six medical centres in the region. Objectives of the network included strengthening service resilience during times of staff shortage, sharing best practice and the use of collaboration to promote collective development. This initiative has been recognised as a regional quality improvement project (QIP).
- Brecon and St Athan medical centres were designated as hub medical centres. St Athan Medical Centre concentrated on its remit as a families practice while Brecon Medical Centre was given the role of supporting the smaller practices, particularly Brawdy and Chepstow medical centres. The SOP was refined through wide circulation and review by the South Wales Group management team and was regularly discussed at the weekly South Wales Group meetings. The regional pharmacist was actively involved to ensure the receipt of email prescriptions and prescriber signatures were logged at each pharmacy. In addition, the RHQ IT lead put systems in place to ensure eConsult inboxes could be monitored remotely.
- The GPRS SOP went live during Christmas 2020 and a review was carried out to see how effective the patients from Brawdy and Chepstow medical centres (both closed over Christmas) were supported. All the patient contacts recorded were dealt with appropriately and safely.
- At the time of our inspection Brawdy Medical Centre was being effectively supported through the GPRS network. The greatest need for the patient population was ensuring deployability of the unit, including at short notice. At the time of the inspection 415 service personnel were medically fit to deploy.

Leadership, capacity and capability

- Staff described how the service had significantly improved since the practice manager took up a permanent post in April 2020, including strong leadership and direction. Clinical leadership had been facilitated by the locum GPs. During the recent absence of clinicians, the regional SMO and SNO from Brawdy Medical Centre had stepped in to ensure continuity with clinical leadership. The regional SMO planned to continue this level of clinical oversight until permanent clinical leadership arrangements had been secured for the practice.
- To maximise consistency and continuity of clinical care for patients, a range of options had been considered. The most viable option of posting a Medical Officer to the practice was supported by regional DPHC, DPHC HQ and the Defence Advisor General Practice. However, not all stakeholders supported the proposal and the matter had progressed to arbitration.
- A regional HGAV took place in May 2021. The practice received positive feedback about the leadership of the service and the changes made since the last CQC inspection.

Culture

- Staff demonstrated a patient-centred focus. Despite the challenges associated with staffing levels, it was clear staff made every effort to respond to the needs of patients in a safe, effective and timely way.
- Equality and inclusion of all staff was evident, including locum staff. At the previous CQC inspections some staff told us they did not feel included or part of a team. This had changed and staff told us their contributions to the service were listened to and that they felt valued. Team building meetings were held regularly.
- Staff said there was an open-door policy with everyone having an equal voice, regardless of rank or grade. All were familiar with the whistleblowing policy and said they were comfortable raising any concerns.
- Processes were established to ensure compliance with the requirements of the duty of candour, including giving those affected reasonable support, information and a verbal and written apology. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. There was a duty of candour register within the healthcare governance workbook with examples of when the duty had been applied. Staff had received training in the subject.

Governance arrangements

- The leadership team had revised and/or developed systems and processes in accordance with DPHC expectations and the needs of the patient population. In particular, the practice manager had developed a comprehensive healthcare governance workbook which provided a detailed overview of how the service was being monitored. The practice effectively used the healthcare governance workbook to capture and monitor governance activity. All staff had access to the workbook which provided links to meeting minutes, policies and other information.

- The staff team had acted promptly to address the recommendations identified in the HGAV report and were working on the remaining recommendations. Based on staff need, the physiotherapists maintained a PCRF specific workbook and the HGAV report recommended that the practice and PCRF healthcare governance workbooks were merged. Because the PCRF workbook was linked with the practice workbook, we identified no risk with this approach.
- The last annual Regional Rehabilitation Unit (RRU) governance advisory visit took place in February 2020. The 2021 visit did not take place due to COVID-19.
- Communication and information sharing structures were in place including a schedule of regular practice, governance, clinical and training meetings. The regional SMO and SNO from Brecon Medical Centre participated in these meetings where appropriate. The practice manager attended the weekly South Wales group meeting which was chaired by the regional SMO.
- Although a quality improvement activity programme was established to monitor the clinical and administrative practices, population-based clinical audit and re-audit had stalled due to depleted clinical staffing levels and the impact of COVID-19. However, our review of individual patients' records showed care was safe, effective and timely.
- The unit held regular meetings facilitated by the Regimental Sergeant Major (RSM) which the nurse and physiotherapist attended. The aim of these meetings was to ensure communication and provide updates in relation to travel health and force protection.

Managing risks, issues and performance

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety. Risks to the service were well recognised, logged on the risk register and kept under scrutiny.
- The business continuity plan was reviewed in April 2021. It included the action to take in the event of no access to DMICP, loss of staff and how to respond to a pandemic. The practice had access to the major incident plan for the unit. There were no specific actions identified for the practice.
- Recruitment and retention of staff was the main risk for the practice. A series of locum GPs had provided patient clinics for over a year. However, the contract for locums meant they were not required to take on additional duties for clinical areas. This meant nurses took the burden of clinical lead roles, such as medicines management, clinical audit and safeguarding. At the time of our inspection, a locum nurse was providing cover in the absence of the practice nurse. The clinical lead role gaps and risks were being effectively managed through the GPRS network. However, reliance on the GPRS was not a feasible long term solution.
- Processes were in place to monitor national and local safety alerts, incidents, and complaints.
- The practice manager was familiar with the policy and processes for managing under-performance and ensuring staff were supported in an inclusive and sensitive way.
- The two physiotherapists were employed under contract. The contract was managed by the regional operations manager. Annual contract monitoring meetings were held which and were attended by the practice manager. The next meeting was due in September 2021.

Appropriate and accurate information

- National quality and operational information were used to ensure and improve performance.
- Systems were in place that took account of data security standards to ensure the integrity and confidentiality of patient identifiable data, records and data management. Patients could refer directly to the PCRF using electronic Microsoft (MS) forms. The patient's service number was used on the forms. Although the practice was granted approval by the DPHC for the use of MS forms, we identified a potential data protection risk as data cannot be permanently deleted and is stored on servers in the USA. At the time of processing this report, further guidance was being sought from DPHC headquarters as to whether continued use of MS forms was appropriate.

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. Due to COVID-19, options for patients to provide feedback while visiting the practice were limited. The outcome of patient feedback was displayed, including how the practice had responded.
- Good and effective links were established with internal and external organisations including the welfare services, RRU, DCMH and local NHS services.

Continuous improvement and innovation

- Whilst it was clearly evident the practice had made improvements since the last CQC inspection and acted on the recommendations of the HGAV, quality improvement projects (QIP) were underdeveloped mainly due to a lack of continuity with clinical staffing levels.
- A recently reported QIP was in relation to improving communication with the Chain of Command. Processes had been put in place to improve communication but evaluation had not yet taken place. The PCRF team had plans for future QIPs. For example, an injury prevention QIP involving the delivery of an injury prevention brief to patients and to measure if those who received the brief needed any PCRF input. In addition, a QIP was planned to determine if goal setting improved patient adherence to exercise.
- A COVID-19 working pattern survey which included a patient questionnaire looked at how many referrals were received and how many patients discharged. The survey identified 55% of patients seen remotely were discharged with 30% fully fit indicating some effectiveness of remote consultations. The survey suggested new patients preferred to be seen face-to-face while ongoing assessments worked well with phone and video calls. From this, the plan was to continue remote follow up for subjective assessment and to prioritise face-to-face initial objective assessment.