Hereford Medical Centre

Hereford Garrison

Defence Medical Services inspection report

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

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

Contents

Summary

About this inspection

We carried out this announced comprehensive inspection across two dates: 26 January and 4 February 2022.

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

Are services safe? – good

Are services effective? – outstanding

Are services caring? – good

Are services responsive to people's needs? – outstanding

Are services well-led? - outstanding

The CQC does not have the same statutory powers with regard to improvement action for the Defence Medical Services (DMS) under the Health and Social Care Act 2008, which also means that the DMS is not subject to CQC's enforcement powers. However, as the military healthcare regulator, the Defence Medical Services Regulator (DMSR) has regulatory and enforcement powers over the DMS. DMSR is committed to improving patient and staff safety and will ensure implementation of the CQC's observations and recommendations.

This inspection is one of a programme of inspections that the CQC will complete at the invitation of the DMSR in their role as the military healthcare regulator for the DMS.

At this inspection we found:

- Patient feedback about the service was positive. Patients we spoke with provided numerous examples of medical staff going the extra mile to provide exemplary care. They told us that care was highly accessible and that they were treated with compassion, confidentiality, dignity and respect. Patients valued the preventative and health promotion support made available to them.
- Patients found it easy to make an appointment and urgent and often routine appointments were available the same day.
- A programme of quality improvement activity (QIA) was in place and this was driving improvement in services for some patients. However there was scope to extend this to include areas that were relevant for the patient population.
- Arrangements were in place for managing medicines including high risk medicines.
- There was an effective programme in place to managed patients with long term conditions.

- The medical centre benefitted from a strong and inclusive leadership style, such that staff felt valued and able to contribute to improved ways of working.
- The practice had particularly positive lines of communication with the units they supported and the welfare team to ensure the wellbeing of service personnel.
- The medical centre team comprised two mental health clinicians whose contribution was delivering positive outcomes for patients.

We found the following areas of notable practice:

- The medical centre team included two mental health staff members who were qualified with a wide range of therapy skills including cognitive behavioural therapy (CBT), cognitive processing therapy (CPT), eye movement desensitization and reprocessing (EMDR) and psychodynamic and trauma focussed therapy. The mental health team members engaged in a range of welfare meetings including unit health committees for all units. They offered a wide range of mental health awareness training and promotion across the units and Chain of Command including pre and post-operative stress management sessions, 'consolidation', OP SMART, debriefs, mindfulness, TED talks, coping strategies and soft skills. Crisis plans and safety netting strategies were in place for all patients and shared with medical centre staff. Where mental health needs were identified for a patient, the unified care pathway was followed but, in addition, the mental health team members accepted self-referrals as well as referrals from doctors. Supportive management and prevention strategies as well as psychological intervention were offered to patients who could benefit from them. The mental health team members had developed a resource pack for patients. They also assisted medical centre staff to deliver step 1 interventions and provided wider guidance, advice and support, including diagnostics and how to deliver these interactions. The occupational therapist within the medical centre offered a variety of sessions including pain management and sleep management. We spoke with patients who had engaged and found these interventions useful. Access to mental health support was rapid. The national key performance indicator for a patient requiring mental health support to be seen for emergency assessment was one day and for routine referrals it was 10 days. The Hereford team usually saw emergency patients on the same day and routine referrals were available by the next day.
- Multi-disciplinary team work was enabling a holistic approach to patient care. The unit had its own health and wellbeing programme which was supplemented by the medical centre team. The health promotion lead within the practice kept the information up to date on the notice boards in line with national priorities when appropriate. As part of the targeted work around identifying and preventing hypertension, there was a blood pressure monitoring device in the waiting room for patients to use. The medical centre ran a Lifestyle Medicine Course for 15 to 20 personnel in conjunction with occupational therapy, mental health staff, gym staff and the nutritionist. This was a two or three day course open to all but aimed at those who needed more support. We interviewed seven patients whilst on site for this inspection and several outlined the value of health promotion advice provided by the integrated unit and medical team. One patient explained how they were supported to make healthy eating choices and a second spoke about support they had received to improve the quality of their sleep.

- Hereford Medical Centre held quarterly prescribing meetings where clinicians discussed the learning from medicines audits, national medicine safety alerts, emergency drug requirements, management of high risk drugs, medication reviews and regional prescribing reports. This provided an opportunity for clinicians to come together to share best practice, to discuss any medicine concerns or to request advice. This had contributed to the safe and effective management of medicines for patients.
- Following an injury, there was a strong emphasis on specific occupational requirements and ensuring that patients had the required functional ability to return to role. There was a clear evidence-based process to guide a patient's rehabilitation; closely aligned to their role requirements. An audit demonstrated that a very high percentage of patients returned to their pre-injury medical grading.

The Chief Inspector recommends to Hereford Medical Centre:

- Ensure that all patients receiving a medicine under a patient specific directive have been assessed by an appropriately qualified clinician.
- Ensure that all Medicines and Healthcare products Regulatory Agency (MHRA) have been received and actioned.

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

- Address functionality issues within the infection prevention and control audit tool
- Ensure that medical centre staff have rapid access to Control of Substances Hazardous to Health (COSHH) risk assessments (currently held by the Garrison).

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 inspection manager and comprised specialist advisors (SpAs) including a primary care doctor, nurse, physiotherapist, pharmacist, exercise rehabilitation instructor (ERI) and a CQC mental health inspection manager. The majority of the team were on site on 26 January. However, it was necessary for the ERI to conduct their interviews remotely and the physiotherapy SpA conducted their role on site on 4 February.

Background to Hereford Medical Centre

The medical centre provides primary care, occupational health, mental health and rehabilitation service to military personnel including reservists. Families and dependants of military personnel are not registered at the practice but at NHS practices local to them.

The staff team

Medical team	One Senior Medical Officer (SMO) One Civilian Medical Practitioner (CMP) Two locum GPs
Nursing team	One Band 7 Practice Nurse Two Band 6 Practice Nurses One Band 5 Practice Nurse One Military Corporal Primary Healthcare Nurse
Practice management	One Band D Practice Manager
PCRF	One Military Major Physiotherapist One Band 7 Physiotherapist Three Band 6 Physiotherapists One Military Capt Physiotherapist One Military SSgt Exercise Rehabilitation Instructor Two Exercise Rehabilitation Instructors (ERI) One Occupational Therapist (Contractor)
Dispensary	Two Pharmacy Technicians
Administrators	Six Band E1 Medical Administrators
Mental Health team	One Staff Sergeant Community Psychiatric Nurse (CPN) One Band 7 Mental Health Practitioner

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

The lead nurse was the safeguarding lead at the medical centre and a CMP was the deputy lead. Both had completed level 3 safeguarding. All clinical and administrative staff were trained to the relevant level for their role.

The practice standard operating procedures (SOP) for both adult and child safeguarding had been reviewed and included contact details for local safeguarding teams. Staff interviewed during the inspection were aware of the policy, including how to report a safeguarding concern. Staff talked about examples of the practice's involvement with safeguarding concerns, including liaison with the welfare team, police and social services. Significant work has been done to identify and address the challenges surrounding children and partners of service personnel being registered at NHS practices.

Our review of DMICP (electronic patient records system) demonstrated that alerts were applied to the records of patients deemed to be vulnerable. The practice had effective links with welfare services. Each Monday a case conference meeting was held and provided an opportunity for medical officers and the mental health team to discuss the immediate needs of vulnerable patients. A comprehensive review was undertaken quarterly. A weekly meeting was also scheduled to discuss the rehabilitation troop (personnel who are injured or downgraded).

Clinical staff had received chaperone training and provided a chaperone service. The chaperone policy was displayed in the patient waiting area and the availability of a chaperone was detailed in the patient information leaflet.

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 checks to ensure staff, including locum staff, were suitable to work with vulnerable adults and young people. Recent staff to join the team had a current English Disclosure and Barring Service (DBS) check. A process was in place to monitor the professional registration of clinical staff. All staff had indemnity insurance. Vaccination status for staff was also maintained.

A nurse was the designated lead for infection prevention and control (IPC) and had received the appropriate training. The senior nurse was also a link practitioner and provided cover and support. Staff confirmed that the regional team provided IPC support as required. The annual IPC audit had been completed but we noted some omissions due to an issue with the DPHC audit tool functionality.

There was a cleaning contract in place. The practice manager oversaw the quality of cleaning and had not needed to report any concerns. Deep cleaning could be requested as needed. The medical centre was visually clean on the day of our inspection. A log of consignment notes was maintained by the practice. The nurse undertook an annual waste

audit and we saw that actions had been implemented, including bolting the lockable skips to the wall.

Arrangements to ensure safety of facilities and equipment were in place. Risk assessments had been undertaken and recommendations actioned covering fire risk, water safety, legionella, gas and electricity. Garrison staff maintained a log of portable appliance testing (PAT) undertaken.

Risks to patients

From a patient perspective, clinical staffing levels were sufficient as patients interviewed told us they had prompt access to a clinician at all times. The SMO and CMP were supported by two locum doctors. Staff appreciated the constraints faced by the regional team but confirmed their view that a third permanent CMP post would bring improved continuity of care and improved use of resource. The senior nurse was undertaking advanced nurse practitioner training, but arrangements to provide backfill for the senior nurse role were unclear. The PCRF team were adequately staffed with an appropriate skill mix. An administrator worked across two sites: in both the medical centre building and the PCRF building. They demonstrated a strong corporate knowledge and were instrumental in managing patient appointments, data tracking and conducting Caldicott audits.

All staff, including locums, completed the DPHC mandated induction which included locum and role specific elements. The practice retained copies of competed induction packs.

The emergency trolley was accessible, secure and regular checks were undertaken. We reviewed the medicines on the trolley and found them to be appropriate and in date. However, blood glucose test strips held on the trolley were out-of-date and there were no expiry dates on control solutions. These were replaced shortly after our inspection. Defibrillators were located in the medical centre and also in the gym. Oxygen was held and was accessible and appropriate signage was in place.

All staff had completed basic life support, sepsis, anaphylaxis and defibrillator training. Information about sepsis was displayed in various areas of the practice. Clinical staff had received training in climatic injury/illness. During the Covid-19 pandemic, medical officers cascaded training around the safe management of the virus to the staff team. The patient development plan included a requirement to ensure that all clinical and administrative staff are aware of how to manage emergencies. Any emergencies out of the medical centre resulted in a 999 call. A tabletop exercise or emergency response was completed annually, including involvement of the unit. The need to include management of medical emergencies of visitors/contractors in the plan was recognised.

Waiting patients could be observed at all times by staff working on the front desk through the use of a CCTV system. This included patients who had received vaccinations.

Information to deliver safe care and treatment

Staff confirmed that access to patient records was only occasionally a concern and did not pose a significant risk to continuity of patient care. However it was noted that the MODNET system was particularly slow. In accordance with DPHC policy, in the event of a DMICP outage, all routine work ceased and only emergencies were dealt with. These records were handwritten on FMed5s (paper forms) which were later scanned onto DMICP and coded appropriately. The medical centre had two SIM cards which could be used to access patient records on laptops.

Summarisation of notes for newly registered patients was undertaken by the nursing team who checked for any long term condition and vaccination requirements. There was no backlog at the time of this inspection.

The SMO undertook notes reviews of all clinicians' notes. An appropriate notes review template was in use. All staff were encouraged to use DMCIP templates as much as possible to capture all relevant information. The SMO and CMP reviewed each others' notes.

Within the PCRF, time was allocated for regular peer case review, in which clinicians discussed complex cases with another clinician within the PCRF team. Staff had received peer review training. PCRF notes were audited on an ongoing basis.

The process for managing specimens and test results was failsafe. Requests were made via the DMICP test request system. Each doctor was required to indicate on the template the date the test was due to be taken. The nursing team checked weekly that all pathology tests had been taken. At the time the sample was taken, two copies of the request form were printed. One copy accompanied the sample which was collected by a courier and taken to the local hospital every weekday. The results were returned on Pathlinks which was checked daily. A duty doctor had protected time every day to check the results and task the requesting doctor if action was required. The duty doctor could also action any abnormal results. The nursing team checked weekly that results were available for all tests sent to the laboratory.

There was a failsafe system in place to manage referrals. The majority of external referrals were made via the NHS electronic referral system (eRS) which was managed by one member of the administration team, with cover in place in the event of absence. A referrals tracker with limited access was maintained and included external and internal referrals, including radiology. Two week wait and urgent referrals were highlighted to be easily visible. Internal referrals to the regional rehabilitation unit, occupational health team and department of community mental health were also tracked to ensure that appointments were both secured and attended.

Safe and appropriate use of medicines

The CMP was the lead for medicines management at the practice and was also responsible for the dispensary. The pharmacy technician held terms of reference with accountability for medicines management. A suite of SOPs were in place and governed

ordering, receipt, assembly, labelling, controlled drugs, repeat prescribing, accuracy checking, transfer of items to patients and provision of medicines and information to patients. A near miss log was in place to record any departure from SOP and we saw that this had been used.

Patient Group Directions (PGD), which allow practice nurses to administer medicines in line with legislation, were in place and had been signed off. At the time of the inspection nurses had been authorised by a doctor to use PGDs. Annual competency assessments were carried out with both nurses. Medicines dispensed under a PGD were recorded both in DMICP and on a spreadsheet.

A PGD audit was undertaken every six months. The aim of the audit was to ensure that each PGD had been correctly authorised by an doctor, was within date and signed by the authorised nurses to use. We noted that the DPHC approved PDG audit was not being used so we checked a number of consultations and did not find any concerns.

Patient Specific Directions (PSD) were also being used and we saw that details of medicines and patients being administered within a PSD had been maintained and staff competency was up to date. However, we found instances where there was no record that the doctor had assessed the patients to ensure that administration of medicine within a PSD was appropriate.

A process was in place for the management of information about changes to a patient's medicines received from other services. Incoming correspondence, such as from out-of-hours services, hospital discharge letters and out-patient clinics was scanned and then tasked to doctors.

All blank prescriptions were stored safely. There was a logbook for receiving new blank prescriptions. When doctors took blank prescriptions from the dispensary they recorded the serial numbers.

A process for the safe processing of repeat prescriptions was in place. Where appropriate, medication reviews were taking place but were not always Read (clinically) coded. Prescriptions were authorised by doctors prior to dispensing.

Uncollected prescriptions were checked monthly by the pharmacy technician. A note was made on the patients record and the medicine destroyed including the prescription serial number. The pharmacy technician alerted the prescriber if the medicine was a high risk medicine.

Medicines held at the dispensary were stored securely including controlled drugs (medicines with a potential for misuse) (CD). The CD cabinet did not comply with Misuse of Drugs Regulations 1973 (whilst tight security is in place regarding who can access the garrison, it would be prudent to ensure compliance in case of an internal incident). Ordering processes and a CD register were in place and followed by staff. The identification of collecting patients or their representative was checked.

CDs were logged in on delivery and when handed out to the patients. Monthly CD stock checks were carried out by the pharmacy technician. Each quarter an additional stock check was undertaken by the regional pharmacist, although the requirement is for someone entirely independent to undertake this check. We carried out a check of a CD

and it matched the last stock check carried out. There were instances of obliteration of entries in the CD log. We gave verbal feedback that, going forward, these should be dated with a signed foot note.

There was an SOP to govern destruction of CDs. However, this had not been followed in that the witness was not external and independent. Out-of-date CDs were held in the CD cabinet and labelled ‘quarantined’. At the quarterly check these were destroyed using denaturing CD kits and recorded in the CD register.

The temperature checks of the medicine fridges and the ambient temperature of the dispensary were held electronically. An SOP was in place and we saw that recently recorded temperatures had remained within appropriate parameters.

The practice followed the DPHC protocol and local SOP for high risk medicines (HRMs). Regular searches to identify patients on HRMs were undertaken. An HRM audit had been undertaken in November 2021. We reviewed a sample of patients prescribed a high risk medicine and found that national guidance had been followed in most instances. Where required, shared care agreements were in place.

An antibiotic prescribing audit was last undertaken to assess prescribing across the last three months of 2021 and showed 100% compliance. A specific Co-Amoxiclav audit had been done.

Hereford Medical Centre held quarterly prescribing meetings where clinicians discussed the learning from medicines audits, national medicine safety alerts, emergency drug requirements, management of high risk drugs, medication reviews and regional prescribing reports. This provided an opportunity for clinicians to come together to share best practice, to discuss any medicine concerns or to request advice. This had contributed to the safe and effective management of medicines for patients.

Track record on safety

There was a comprehensive risk register on the healthcare governance workbook detailing all issues and barriers encountered by staff including mitigating escalation. The register was regularly reviewed and updated. There were a range of risk assessments in place including for both clinical and non-clinical risks. The assessments include lone working, sharps and health and safety. Control of Substances Hazardous to Health (COSHH) risk assessments were held by the garrison. It would be prudent for the medical centre to have direct access to these in the event of an incident. Both practice level and individual staff COVID-19 risk assessments were in place. The PCRF held specific risk assessments for exercise, thermal injury, heat packs, ultrasound and TheraBand (muscle strengthening elastic bands).

The practice was working to a COVID-19 risk assessment. The number of people accessing the building had been reduced, social distancing measures were in place, face coverings were mandated and the number of chairs in the waiting room had been reduced. There was a protective screen at reception and a one way entry and exit system had been introduced. Hand sanitiser was available for staff and patients.

There was a purpose built PCRF facility which was well provisioned to meet the specific needs of the patient population. A wide range of physical training, specialist rehabilitation and medical equipment had been procured and was well managed within servicing agreements. A faults register was in place and any work needed had been swiftly undertaken. Portable heaters were used during winter months and windows and doors kept open during hot weather. Wet-bulb globe temperature (WBGT – a heat stress index) readings were taken in hot weather and activity managed accordingly.

The PCRF facility included a swimming pool which was used to support recovery for patients unable to undertake full weight-bearing activity. Issues preventing its use had been escalated to the estates office on site, including water chemical levels and maintenance of temperature. As a result, microbe reports had been sent to PCRF staff in order that they could ensure parameters for the safe running of the pool were being adhered to. PCRF staff had completed their own pool evacuation training and all patients were risk assessed.

There was a fixed alarm system in two treatment rooms and other areas were covered by personal alarms. Weekly tests were carried out.

Lessons learned and improvements made

Significant events and incidents were reported through the electronic organisational-wide system (referred to as ASER) in line with the DPHC ASER policy. A local ASER SOP was in place. All staff had an ASER login.

ASERs were discussed at the practice meetings and identified in the minutes. It was clear from our discussions with staff that lessons learned were shared with the team.

The medical centre had a system in place to distribute Medicines and Healthcare products Regulatory Agency (MHRA). However, we noted that a number of alerts had not been received in October, November and December 2021. There were two medicines that were stocked by the medical centre on these recalls however, when we checked against the MHRA alert those within the medical centre were unaffected. The pharmacy technician was set up on the MHRA drug alerts subscription on the day of inspection to prevent drug alerts from being not actioned in the future. The CAS (Central Alerting System) alert log was held on health governance workbook including detail of action taken. Alerts were also discussed at the practice meeting as a standing agenda item.

Are services effective?

We rated the practice as outstanding for providing effective services.

Effective needs assessment, care and treatment

Processes were in place to support clinical staff to keep up to date with developments in clinical care including NICE (National Institute for Health and Care Excellence) guidance, clinical pathways, current legislation, standards and other practice guidance. Staff were kept informed of clinical and medicines updates through the DPHC newsletter circulated to staff each month. Updates were also discussed at multidisciplinary governance meetings. Clinicians also took turns to summarise the latest guidelines and present them at the monthly practice meetings.

Mental health (MH) staff were integrated and worked as part of the medical centre team. The military mental health nurse attended senior management team and clinical governance meetings and both MH staff attended DCMH meetings to keep up to date with MH practice and to gain peer support. The MH staff provided training and guidance to medical centre staff (and the wider services) on managing common mental health concerns, NICE and wider guidance.

PCRF staff were familiar with Department of Defence Rehabilitation Guidance and provided examples of treatment provided based on evidence-based guidelines and care pathways. The PCRF used Rehab Guru (software for rehabilitation exercise therapy) and, if appropriate, was documented in the clinical records we looked at. TrueCoach was used to provide feedback to the clinician and Limb ROM (range of movement) and limb symmetry parameters were used to ensure that patients' strength, balance and control progressed. The PCRF had a treatment room and gym. The space and equipment available was bespoke to meet patients' needs.

Hereford Medical Centre held monthly prescribing meetings where clinicians jointly discussed the learning from medicines audits, national medicine safety alerts, emergency drug requirements, management of high risk drugs, medication reviews and regional prescribing reports. This provided an opportunity for clinicians to come together to share best practice, to discuss any medicine concerns or to request advice. This had contributed to the effective management of medicines for patients.

Monitoring care and treatment

The CMP held the lead role for chronic disease management and was supported by the nursing team who ensured that patients with chronic disease were appropriately monitored. The medical centre held a detailed register of patients with chronic disease which included a traffic light system to highlight due dates for checks. There was limited access to this data base and DMCIP numbers were used to maintain confidentiality. We saw that substantial work (including the standardised use of Read codes) had been carried out to ensure effective management and recall of patients with chronic disease. DMICP searches were run monthly and patients were contacted when their review was due.

There were 30 patients recorded as having high blood pressure. Twenty-nine patients had a record for their blood pressure taken in the past nine months. Eleven patients had a blood pressure reading of 150/90 or less. The medical centre was targeting hypertension to promote preventative action in patients who could benefit.

There were eight patients on the diabetic register (two patients were very recently diagnosed and so have not yet commenced monitoring and two were currently deployed and were due for catch-up reviews upon their return). For four patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For seven patients, the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control. There was scope to better identify and monitor patients with pre-diabetes. The medical centre confirmed that this was planned for the future.

There were 19 patients with a diagnosis of asthma. Fourteen patients had an asthma review in the preceding 12 months which included an assessment of asthma control using the three RCP (Royal College of Physicians) questions. On review, five patients were out-of-date for review although only by a maximum of five weeks due to COVID-19 and the Christmas backlog. A consistent asthma review template was in use.

Sixty three percent of patients' audiometric assessments were in date (within the last two years). During COVID-19 routine audiometry had ceased in line the April 2020 DPHC directive. The practice had resumed audiometry as restrictions relaxed. We were advised the unit managed audiology recalls and prioritised those with a high readiness for deployment and those most at risk. We noted that the majority of the patients were on a 12 month audio cycle rather than 24 months. The percentage maintained was therefore to be expected given the higher proportion of deployable troops and post the COVID-19 reduction of services.

Where mental health needs were identified for a patient, the unified care pathway was followed but, in addition, the mental health team members accepted self-referrals as well as referrals from doctors, who were kept aware of all patients. Supportive management and prevention strategies as well as psychological intervention were offered to patients who could benefit from them. The mental health team members had developed a resource pack for patients. They also assisted medical centre staff to deliver step 1 interventions and provided wider guidance, advice and support, including diagnostics and how to deliver these interactions. The occupational therapist within the medical centre offered a variety of sessions including pain management and sleep management.

As is the case across DPHC, there was some inconsistency in Read coding patients with anxiety and depression and this in turn created a barrier to comprehensive audit work. A mental health audit had been conducted for all patients prescribed medication, but there was scope to also include patients in receipt of cognitive behavioural therapy.

Thirty-seven registered patients responded to the DMSR patient satisfaction survey which complemented this inspection. The survey included a question about whether the patient felt that their healthcare professional had recognised and/or understood their mental health needs. Of the 37 respondents, 24 stated that they had had a mental health need. Of these, 88% said that the healthcare professional had understood their mental health needs. Twelve percent stated that their needs were not well understood.

PCRF clinical records showed patients received appropriate treatment and care in line with their clinical need. A number of outcome measures were used by the PCRF to measure effectiveness of care including MSK-HQ (musculoskeletal health questionnaire). Force platforms (for soleus function) and the Nordbord (hamstring testing system) outcomes had been collected and used judiciously to establish normative data. There were also clearly defined objective measures linked to task analysis and SCR (Soldier Conditioning Review) requirements to aid the exit criteria on the High-Performance Programme (HPP).

An audit log was in place and there was scope to extend this work to comprise a quality improvement programme. Nine clinical audits were in place and more than one cycle had been undertaken for most. The review date for repeat audits was indicated using a traffic light colour system. Following a hypertension audit, the team developed a quality improvement process to identify patients with raised blood pressure who had not necessarily been diagnosed with hypertension.

- PCRF audit work was an integral part of the medical centre audit programme. Recent audits included infection prevention and control, disability access audit, clinical notes audit, waste management, consent, Pilates referral audit and ERI referral audit, hydrotherapy availability audit, 'Start Back Tool' and 'use of urgent slots audit'. We saw evidence that findings had been recorded in the healthcare governance workbook and was fed back at practice meetings – the work had led to clear improvements in patient care delivery.
- Following an injury, there was a strong emphasis on specific occupational requirements and ensuring that patients had the required functional ability to return to role. There was a clear evidence-based process to guide a patient's rehabilitation; closely aligned to their role requirements. The ERI DMICP synonym comprehensively covered indicators for occupational requirements. PCRF staff were able to refer patients to the occupational therapist (OT) and support from a nutritionist was also available. The OT had visited live firing ranges to work on patient's vestibular function. An audit demonstrated that a very high percentage of patients returned to their pre-injury medical grading.
- The PCRF contained a gait lab (helps determine if the way you are walking may be contributing to a current injury).

Effective staffing

All staff, including locums, completed the DPHC mandated induction which included locum and role specific elements. Copies of competed induction packs were retained. The PCRF had a standardised induction process for all new staff, including a tick list of all essential activity and mandatory training.

Performance appraisals were conducted by line managers for all staff and uploaded to HR systems. All doctors were in date for appraisal and all doctors and nurses had completed timely revalidation. Peer/notes review for PCRF staff had been undertaken. The peer reviews had been uploaded to the audit calendar on the healthcare governance workbook.

Mandatory training was recorded on the staff database. All staff had protected time for the completion of mandatory training and attendance at group training. All staff were encouraged to maximise use of the external training DPHC funds. The unit also funded some training. The SMO and lead nurse had undertaken clinical supervisor training and were looking at how to deliver elements of this to the rest of the medical centre team. Staff confirmed that clinical supervision was taking place on a weekly basis. There was scope to maintain a record of outcomes from these sessions for nurses.

All PCRF staff received regular appraisals, attended regular multi disciplinary team meetings and discussed specific patient. Physiotherapists completed peer review in which selected patients were reviewed with colleagues on a regular basis through review of DMICP notes.

Coordinating care and treatment

Medical centre staff had forged excellent links with all units on the base and welfare staff and we were told that a mutually supportive communication stream was in place. We interviewed the welfare officer as part of our inspection and they confirmed that regular meetings took place with the aim of supporting personnel. The medical centre had links with the local Sexually Transmitted Infections Foundation (STIF). There was access to a nutritionist on the garrison and also a local eating disorder clinic. The medical centre had forged links with local NHS practices, specifically to mitigate the identified safeguarding risks for partners and children registered with local NHS practices.

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 of the patient's health needs was provided. For patients with complex needs moving to another medical centre, a summary letter was given to the receiving medical officer. Patients were also made aware of the Veterans Health Service and, if appropriate, the Veterans Mental Health Transition, Intervention and Liaison Service (TILS). The practice had forged impactful links with local charities supporting the welfare of veterans and also carers. The mental health team remained open to veterans for six months after leaving military.

A mental health strategy for Hereford Medical Centre patients had been developed and formalised guidance around stepped care including a wide range of interventions for step 1. Going forward there were plans to meet with wider partners including Army Welfare Service (AWS), padres, occupational therapy and HPP to build on the strategy.

Helping patients to live healthier lives

A nurse was the lead for health promotion. The unit had its own health and wellbeing programme which was supplemented by the medical centre team. The health promotion lead within the practice kept the information uptodate on the notice boards in line with national priorities when appropriate. At the time of this inspection, alcohol consumption was the active health promotion campaign. We also saw a number of health promotion boards in the waiting area and corridors and these included information around sexual

health, being a carer and climatic injury. As part of the targeted work around identifying and preventing hypertension, there was a blood pressure monitoring device in the waiting room for patients to use. The medical centre ran a Lifestyle Medicine Course for 15 to 20 personnel in conjunction with occupational therapy, mental health staff, gym staff and the nutritionist. This was a two to three day course open to all but aimed at those who needed more support. We interviewed seven patients whilst on site for this inspection and several outlined the value of health promotion advice provided by the integrated unit and medical team. One patient explained how they were supported to make healthy eating choices and a second spoke about support they had received to improve the quality of their sleep.

The lead nurse held the lead for sexual health and had completed the required training (referred to as STIF). There were established links with the local provider which was accessible 24 hours a day. Free condoms and chlamydia kits were available at the practice. Information about sexual health, contraception and pregnancy was displayed in the patient waiting area.

Health screening was proactively encouraged by the medical centre. Regular searches were undertaken for bowel (six patients identified), breast (one patient identified) and abdominal aortic aneurysm screening (no patients identified) in line with national programmes. One hundred percent of women who were eligible for a cervical smear had received one in the last five years which exceeded the NHS target of 80%.

Immunisations were regularly reviewed and administered to patients when they were required. Vaccination rates were high:

- 93% of patients were recorded as being up to date with vaccination against diphtheria.
- 93% of patients were recorded as being up to date with vaccination against polio.
- 99% of patients were recorded as being up to date with vaccination against hepatitis B.
- 99% of patients were recorded as being up to date with vaccination against hepatitis A.
- 93% of patients were recorded as being up to date with vaccination against tetanus.
- 90% of patients were recorded as being up to date with vaccination against typhoid.
- 97% of patients were recorded as being up to date with vaccination against MMR.
- 96% of patients were recorded as being up to date with vaccination against meningitis.
- 99.5% Yellow Fever

  The medical centre had worked with the NHS COVID-19 vaccine service to ensure that military patients could access their vaccine in the most convenient way. Medical centre staff had worked in local NHS practices to help deliver vaccines to the UK population.

Consent to care and treatment

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. They had a good understanding of the Mental Capacity Act (2005) and how it would apply to the patient population. Mental capacity training was incorporated into the safeguarding training.

Consent was appropriately recorded in the clinical records we looked at for physiotherapists, nurses, mental health staff and doctors. The offer and use of a chaperone was recorded in patient records. A consent audit was completed on an annual basis and results were satisfactory.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

We interviewed 11 patients as part of the inspection and feedback indicated staff treated patients with kindness, respect and compassion at all times. Most patients explained how medical staff centre routinely went the extra mile to ensure that the mental health and holistic needs of patients were met in a timely, respectful and compassionate way. This included extended appointments, out-of-hours support, and wellbeing and nutritional support. Several patients outlined care they had received from the medical centre team which they felt had been instrumental to their timely and successful recovery.

We reviewed the records for a number of patients who were experiencing poor mental health and noted that this was a large proportion of the doctors' workload. It was clear that clinicians were responding to patients with kindness and compassion, ensuring that patients had the space and time to talk when they needed to.

We interviewed the majority of staff working in the medical centre at the time of the inspection. All staff told us that Hereford Medical Centre was a happy place to work and that they could rely on their work team to discuss and mitigate any concerns they faced. They spoke about colleagues who were supportive, compassionate and caring.

Thirty-seven registered patients responded to the DMSR patient satisfaction survey which complemented this inspection. Patients had taken the time to enter comments into the free text box and spoke about the kind and compassionate support for patients with mental health needs and injury. Respondents described a medical centre staff team that proactively supported patients to live healthy lives and to return safely to work following illness or injury. All patients who responded to a question about how well clinicians listened to them, said that their experience was very good or good.

The PCRF had undertaken its own patient satisfaction survey in autumn 2021 and 24 patients had responded. All of the patients stated that clinicians were polite, professional and approachable.

Involvement in decisions about care and treatment

All 11 patients we spoke with said they were involved with decision making and planning their care. Several patients indicated that the healthy lifestyle and nutritional support information on offer had been instrumental in their decision making.

Of the 37 patients who responded to the DMSR patient satisfaction survey, 34 stated that they had been fully involved in decisions about their care and treatment. Two patients stated that they had not been involved in decision making and one patient reported that this did not apply to their situation.

Of the patients responding to the PCRF satisfaction survey, 88% definitely agreed that they had been involved in decisions about their care and the remainder stated that they had been involved to some extent.

The PCRF used a rehabilitation contract for patients who needed to be downgraded due to injury. This contract assisted with expectation management and incorporated the involvement of an occupational therapist (supplementary to the standard PCRF care pathway). The contract encouraged regular communication around expected rehabilitation milestones. The success of this approach was demonstrated by the high percentage (in excess of 80%) of personnel returning to pre-injury medical grading.

The PCRF used light duties chits and used downgrade maintenance physical therapy and reconditioning physical therapy prescriptions appropriately.

Patients with a caring responsibility were identified through the new patient registration process and a clinical code assigned to their records. There was a reminder for carers in the practice information leaflet and information in the waiting area. DMICP searches were undertaken to monitor carers.

An interpretation service was available for patients who did not have English as a first language.

Privacy and dignity

- All patients we spoke with stated that they were confident that the practice would keep information about them confidential. All stated that they felt that their dignity and privacy were upheld by medical centre staff. Consultations took place in clinic rooms with the door closed. Treatment room 3 had been sound proofed in 2021. Headphone sets were used for telephone consultations. Patient identity checks were completed prior to any information being disclosed. There were privacy curtains in all clinical rooms. There was a notice on reception advising patients they could speak with a member of staff in private if required. All staff had completed the Defence Information Management Passport training which incorporated the Caldicott principles. The radio was playing in the waiting area to help mask any conversations taking place with reception staff.
- The PCRF clinic area was composed primarily of curtained clinics, which presented some confidentiality issues. However, a private side room was available and utilised if greater levels of privacy were needed. Patients were advised that they could request to use the private room.
- Patients were able to see clinicians of either gender according to their preference. All patients who responded to the patient survey stated that they were able to see a clinician who suited their needs.

Are services responsive to people's needs?

We rated the practice as outstanding for providing responsive services.

Responding to and meeting people's needs

- The PCRF facility was purpose built and equipment was well provisioned to meet the specific needs of the patient population. The separate Hereford Medical Centre building was spacious with dedicated rooms for staff to meet in large groups for meetings and training. We noted that there were issues in some rooms where ventilation was not optimal (to conserve patient confidentiality windows could not be opened) and blinds were not functional. An air conditioning unit had been purchased to support better thermal regulation in some areas. We walked around the building and did not note any issues with access. Patients we spoke with did not report any concerns with accessing the facility. An Equality Access Audit for the medical centre and PCRF had been carried out and no concerns had been noted. A hearing loop was available.
- The practice was constantly ready to respond at very short notice to the occupational needs of patients who needed to deploy. Additional clinics were arranged at short notice and during non-office hours in order to ensure that personnel could deploy at short notice. Patients and unit staff we spoke with confirmed how valuable this rapid response was to supporting operational capability.
- A policy was in place to guide staff in exploring the care pathway for patients transitioning gender. Medical centre staff had received training to support the appropriate and effective care of people who were transitioning gender.
- The medical staff team were aware of the need to quickly identify and treat patients with mental health needs in order to ensure the best possible outcome. Access to mental health support was exceptional at this medical centre with trained staff members available to offer face-to-face and also virtual 'attend anywhere' care. This enabled patients who remained operational to receive ongoing care and support. The national on call system (staffed by DCMHs on rotation) provided out-of-hours access to mental health beds.
- During the past 24 months, personnel on the base had tested positive for COVID-19 and the medical centre designed new ways to support people on site. The medical centre designed a 'red' back door entrance for patients who were thought to be positive and they were seen in a separate area. Staff wore appropriate protective personal equipment and additional infection control procedures were followed.
- Patient feedback was driving improvement. Feedback given to the PCRF had led to class therapy time changes, additional swimming pool sessions, additional PCRF equipment and the employment of an additional ERI. The medical centre had positive links with local charities supporting the units and could approach them with funding requests to aid patients' recovery.

Timely access to care and treatment

- Patients requiring occupational medicals could access one within three days. If there was an urgent need for a quicker medical turnaround, these could be turned around on the same day. Appropriately qualified doctors were available to provide oversight of patients with a specific occupational need.
- Arrangements were in place in order that patients could access a doctor at all times when the practice was closed and in an emergency. There were six military Regimental Medical Officers (RMOs) in post at any one time and they rotated the duty doctor rota which was a 24/7 service. Patients were aware that a doctor could be contacted out of hours.
- The medical centre was providing very responsive care for its patient population. Urgent and routine appointments with either a doctor or a nurse or physiotherapist could be accommodated on the same day if required. The patients we spoke with during the inspection confirmed they received an appointment promptly and at their preferred time. In the patient survey, 100% of respondents stated that their experience of making an appointment was very or fairly good.
- Where there was clinical need, home visits were triaged by the duty doctor and accommodated if appropriate. Military transport was also used to help patients who needed to attend appointments. Nurses provided post-operative care (dressing changes) on home visits if needed. Telephone consultations were available. This medical centre does not use eConsult.
- Daily walk-in gym clinics were available in the PCRF and were arranged at different times to meet the shifts and working patterns of the patient population. Direct Access Physio (DAP) clinics were also accessible for patients. Patients we spoke with reported using the direct access clinic and that they had found it beneficial to them.
- Rapid access to PCRF support was available with patients being seen well within the key performance indictors (within one day for acute referrals and within 10 days for routine referrals). Non-attendance of appointments was not an issue at the time of our inspection. A routine physiotherapy appointment was available within five days, a follow-up appointment within one day and an urgent appointment facilitated on the same day. For the ERI, a new patient appointment was available within one day and follow up appointment could be accommodated within one day. Patient access to a rehabilitation class was currently limited due to COVID-19. However, there was no waiting list for these classes at the time of our inspection.

Listening and learning from concerns and complaints

- The practice manager was the lead for complaints. There were 14 complaints on the practice log and, of these, 12 were verbal complaints that the medical centre had progressed and recorded appropriately. No trends had been noted, but staff told us that the investigation of a complaint had led to some improvements in rehabilitation consultation note taking.

- Patients were made aware of the complaints process through the practice information leaflet and a poster in the waiting room. Patients we interviewed were aware of how to complain but said they had no reason to make a complaint about the service.

Are services well-led?

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

Leadership, capacity and capability

- The staff team at the medical centre worked with determination and collaboratively to deliver the best possible care to patients. Mental health staff were integrated into the team and their work was pivotal to ensuring prompt access to assessment and care for patients with mental health requirements. All staff we spoke with described a committed and able leadership team with an SMO at the helm who demonstrated an inclusive and responsive leadership style. Staff owned terms of reference for their main role and separate terms of reference for any key lead roles that they undertook, although there was scope to improve these for the mental health team members.
- Throughout this inspection we met with patients and unit staff who described a medical centre team that frequently went the extra mile to ensure that patients' needs were met as quickly as possible in order to ensure their health and wellbeing, alongside their role in facilitating operational capability. The provision of 24/7 access to a doctor ensured that personnel needs could be met by someone with direct access to their medical records and clinical history.
- The medical centre team had the capacity and skills to provide care that extended well beyond the baseline at times, particularly mental health provision and health promotion support. The regional team had been available and proactive in supporting the medical centre and the shared resource library had proven very useful. Nevertheless, there was scope to provide even better continuity of care and to extend quality improvement work through a third permanent CMP post.

Vision and strategy

- Staff we spoke with were clear that their remit was to support patients to benefit from the best possible healthcare outcomes which, in turn, supported operational capability. This included a preventative approach which involved proactive health promotion support, lifestyle advice and prompt barrier-less access to mental health provision. Care was delivered to patients through an integrated multi-disciplinary approach. With the patient truly at the centre of this shared care approach, the benefits and positive outcomes for patients were not accidental.
- The medical centre had forged close links with all the units it supported and tailored the service to their specific needs to support deployments such as force protection clinics. Duty doctors, nurses and medics were routinely on hand to facilitate urgent access to care.

Culture

- Staff we spoke with described a strong team ethic across the medical centre whereby the patient's requirements were held at the centre of all decision making. We observed staff going the extra mile to provide a 24/7 service to their patients, often accommodating short notice requests to meet occupational health requirements for personnel about to be deployed.
- The practice team operated an open and honest meeting culture where all staff were encouraged to attend and offer suggestions or raise concerns. Leaders operated an open door policy for staff to use.
- Staff were aware of the whistleblowing policy and were also aware of the Freedom to Speak Up (FTSU) process within the region.
- Processes were established to ensure compliance with the requirements of the duty of candour, including giving those affected reasonable support, information and a verbal and written apology. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. We were given examples of when duty of candour had been applied appropriately.

Governance arrangements

- The healthcare governance workbook (HGW) was the overarching system used to bring together a range of governance activities, including the risk register, ASER tracker, training register, SOPs, QIA and complaints.
- Communication across the practice was strong and an appropriate meeting structure and healthcare governance approach was in place. This included regular clinical, practice, healthcare governance and unit healthcare committee meetings, chronic disease, safeguarding, PCRF meetings and monthly prescribing meetings.
- The PCRF contributed to the medical centre's eCAF (Common Assurance Framework) document which was reviewed with the PCRF regularly. The PCRF were involved in all key relevant meetings. The PCRF also attended the Regional Rehabilitation Unit (RRU) regional training sessions and the lead physiotherapist attended the regional rehabilitation meetings. The PCRF had recently provided training to the medical centre team around acute musculoskeletal injuries (MSKI) management.
- Mental health staff were integrated within the staff team and were engaged in governance activity. They had worked with the SMO to create a mental health strategy for the safe and effective delivery of mental health care to the patients at Hereford. This was resulting in particularly accessible mental health care for this patient cohort. Safety netting and risk management arrangements afforded strong protection for patients with a mental health need.

Managing risks, issues and performance

- There was a current and retired risk register on the HGW along with current and retired issues. The register articulated the main risks identified by the practice team including. The registers were regularly reviewed. There were a range of risk assessments in place including both clinical and non-clinical risks. The assessments included lone working, sharps safety and health and safety. There were processes were in place to monitor national and local safety alerts, incidents, and complaints.
- The Business Continuity Plan (BCP) had been reviewed and was exercised to ensure that staff knew what to do in an emergency. The BCP covered all the main risks to the service. The practice had a major incident plan which supported all units and had been agreed by unit commanders.
- Staff who were not performing would be supported initially to identify any underlying cause and implement support structures. If performance did not improve then formal performance management processes, military or civilian, would be followed.

Appropriate and accurate information

- The eCAF (Common Assurance Framework) commonly used in DPHC services to monitor performance is an internal quality assurance governance assurance tool to assure standards of health care delivery within defence healthcare. The eCAF was used by the medical centre as the agenda template for the healthcare governance (HG) meetings to identify areas for improvement although there have been no specific HG meetings for some months due to staff shortages. The medical centre had received an HGAV recently and this had resulted in a management action plan which was being implemented.
- 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.

Engagement with patients, the public, staff and external partners

- There were various options in place to encourage patients to provide feedback on the service and contribute to the development of the service. These included a patient experience survey and a suggestions box was available in the waiting room. Lunch time and later appointments had been provided as a result of feedback received.
- The practice team stated that they felt well supported and had excellent communication streams with all Units they supported. Welfare staff told us that their relationship with the MC team was positive and trusted. Communication channels with local NHS services, including NHS GP practices, local sexual health services and secondary care providers had been established and meant that patients could access the care that they needed locally.

Continuous improvement and innovation

- Recent cardiac incidents had led to a step up in identification measures for hypertension. This included the introduction of a blood pressure monitoring device in the waiting area and increased checks during medicals.
- The team had implemented a mental health strategy for the safe and effective delivery of mental health care to the patients at Hereford Medical Centre. This was resulting in particularly accessible mental health care for this patient cohort as the best possible safety netting and risk management arrangements were in place.
- Patients registered at Hereford Medical Centre benefitted from access to an occupational health service as required, this gave them optimal opportunities to recover from illness and injury with the best possible outcome. The occupational therapist role was initially piloted in 2018: supporting 55 patients initially and growing to 133 patients in 2021. The OT service provided local treatment including scar management, vestibular training, and mood, sleep and mindfulness support.
- Patients benefitted from a multi-disciplinary approach to health promotion which included advice around lifestyle, healthy sleep patterns, alcohol consumption, promoting good mental health and diet. The delivery of three day courses run by qualified nutritionist, mental health, physiotherapy and clinical staff equipped patients with a useful toolbox for healthy living and sound wellbeing.
- A PCRF development plan had been developed in October 2021 and had led to Increased dedicated time for clinical supervision and the development of a ‘High Performance’ booklet.
- In 2020 staff identified shoulder and back injuries which commonly occurred in a specific regiment. They delivered training (including mobility sessions) to optimise conditioning and so targeted improvement in an occupational group that went from long static periods to high intensity exercise.
- The PCRF had explored and engaged in the use of unscaled equipment which has supported better outcomes of patients. Bio-dex Interactive (neuromuscular testing and rehabilitation technology) has been used to treat nerve injury. The NordBord hamstring testing approach has been used to improve lower-limb function.
- Patient feedback has led to the employment of an additional ERI to support patient recovery from injury.