Leconfield Medical Centre

Normandy Barracks, Leconfield, HU17 7LX

Defence Medical Services inspection report

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

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

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Summary

About this inspection

We carried out this announced comprehensive inspection on 9,10,11 and 17 March 2022.

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

Are services safe? – good

Are services effective? – good

Are services caring? – good

Are services responsive to people's needs? – good

Are services well-led? - good

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

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

At this inspection we found:

- The practice sought feedback from patients which it acted on. Feedback showed patients received appointments at a time that suited them and from staff that treated them with compassion, dignity and respect. They were involved in care and decisions about their treatment.
- The practice was well-led and the leadership team demonstrated they had the capability and commitment to provide a patient-focused service and consistently sought ways to develop and improve. The capacity for clinical leadership was stretched as just one doctor worked at the practice.
- Effective safeguarding arrangements were in place and the practice had good lines of communication with the unit and welfare team to ensure the wellbeing of service personnel.
- 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. A controlled drugs audit had not been undertaken in the last 12 months.
- The practice was equipped to deal with emergencies, including medical emergencies. Some minor improvements were needed in this area.
- Arrangements were in place to ensure information to deliver safe and effective care was appropriate. However, the process for the summarisation of patient care was not clear.
- The healthcare governance workbook was detailed and captured a range of information to illustrate how the practice was performing. The Primary Care Rehabilitation Facility (PCRF) was not fully incorporated in the overall governance of the practice.
- Quality improvement activity in terms of clinical audit was underdeveloped. The leadership was aware of this and aimed to address this once governance structures were fully embedded.

The Chief Inspector recommends:

- All items of medical emergency equipment are checked to ensure they are fit for use.
- All rooms are included when checking the emergency alarm system. Ensure all staff are aware of the location of the alarms and how to use them.
- A review of all patients screened for high blood pressure to ensure that no requirement for active management has been missed. The practice should develop a system to ensure that follow up is arranged appropriately for abnormal blood pressure readings.
- A local protocol is developed for the summarisation of clinical records so there is a clear understanding of the process.
- A controlled drugs audit is completed each year.
- A review of governance arrangements, including risk management, to ensure a whole system approach that includes oversight of the PCRF.
- A process is established for the objective auditing of clinical records for all clinical staff.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

The inspection was led by a CQC inspector and a team of specialist advisors. The primary care doctor and practice manager advisors along with the lead inspector visited the practice on the 10 March 2022 and two specialist advisors shadowed as part of their induction. The nurse advisor participated in the inspection remotely on the 10 March. The physiotherapist advisor inspected the Primary Care Rehabilitation Facility (PCRF) face-to-face on the 9 March and was shadowed by a specialist advisor undergoing induction. The pharmacist advisor carried out the medicines management element of the inspection remotely on the 11 and 17 March 2022.

Background to Leconfield Medical Centre

Leconfield Medical Centre supports the Defence School of Transport and provides a routine primary care, occupational health and rehabilitation service to a patient population of 1,139 that includes students on driving courses and permanent staff. There is a transitory population of 500-800 students comprising 600 students on 38 different course types over 80 course instances with varied start and end dates. Not all students are registered at Leconfield Medical Centre due to the length of courses. Occupational health services are provided for reservists. Families and dependents of service personnel are not registered at the practice so are signposted to local NHS practices. Facilities within the medical centre include a dispensary and PCRF.

The practice is open from 08:00 to 16:30 hours Monday to Thursday and from 08:30 hours to 12:30 hours on Friday. Leeming Medical Centre provides cover from 16:30 to 18:30 Monday to Friday. Outside of these hours, including weekends and bank holidays, cover is provided by NHS 111.

The staff team

Doctors	Senior Medical Officer
Nurses	Civilian senior practice nurse Civilian practice nurse Military nursing officer (due to start)
PCRF	Civilian physiotherapist Civilian exercise rehabilitation instructor
Dispensary	Civilian pharmacy technician
Practice management and administration	Military practice manager Military deputy practice manager Two civilian administrators

Combat medical technicians (medics)	Two (one in role of deputy practice manager)

* In the army, a medic is a soldier who has received specialist training in field medicine. It is a unique role in the forces and the role is similar to that of a health care assistant in NHS GP practices but with a broader scope of practice.

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

The Senior Medical Officer (SMO) was the safeguarding lead and the senior practice nurse the safeguarding champion. All staff were in-date for safeguarding training at a level appropriate to their role. Reviewed in April 2021, the local safeguarding standard operating procedure (SOP) referenced adults and children and included links to the local safeguarding team. Safeguarding arrangements and contact details were displayed in all clinical rooms.

A vulnerable patients register was maintained by the senior nurse. A DMICP (electronic patient record system) search was established that took account of vulnerable patients, patients with a caring responsibility and patients under the age of 18. A search was last undertaken in March 2022. Codes and alerts were applied to patients under 18 during the new patient registration process. Our review of clinical records identified that most, but not all, of these young patients had an alert on their record as a reminder to offer a chaperone. Measures were in place so that under 18s had direct access to clinicians. For example, this cohort of patients were required to have a face-to-face consultation rather than using the eConsult system (remote consultations). Led by the SMO, a vulnerable patients meeting was held each month.

The welfare team described an effective relationship with the practice and particularly welcomed the enhanced structures and lines of communication put in place by the practice leadership team. The practice was represented at the Commanders Monthly Heath Review (previously referred to as a Unit Health Committee meeting). A case conference was held for all service personnel identified as vulnerable. We were provided with examples of when the welfare team and practice worked well together to support vulnerable patients.

A register of trained chaperones was in place. Both clinical and administrative staff had completed the training. The patient information leaflet included details about how to access a chaperone. The chaperone policy was displayed in various areas throughout the building.

The full range of recruitment records for permanent staff was held centrally. The practice could demonstrate that relevant safety checks had taken place at the point of recruitment, including Disclosure and Barring Service (DBS) checks to ensure staff, including locum staff, were suitable to work with vulnerable adults and young people. A process was in place to monitor the professional registration and vaccination status of staff All relevant staff had indemnity insurance.

The senior nurse was the lead for infection prevention and control (IPC) and had completed link practitioner training. IPC audits in key areas were completed throughout 2021 and resulted in a high level of compliance, although the unit gym used by the Primary Care Rehabilitation Facility (PCRF) was not included in the audit. Records were in place to demonstrate several staff training sessions had been held over the last 12 months in

response to COVID-19. Sharps were managed appropriately in accordance with the regulations. Disposable privacy curtains in clinical areas were last changed in February 2022.

The premises was cleaned twice a day. The practice manager monitored the standard of environmental cleaning and undertook a recorded weekly check. A copy of the contractual cleaning requirement checklist was held in the cleaner's room. An environmental audit was completed in March 2020 and the premises achieved a 94% compliance score. The audit was next due in March 2022.

No deep clean was included in the contract. However, there was evidence in place to confirm the practice manager was liaising with the Defence Infrastructure Organisation (DIO) who managed the contract to secure a deep clean. We identified no concerns with the cleanliness of the practice.

The clinical waste SOP was last reviewed in June 2021. The duty medic collected the clinical waste at the end of each week ensuring it was bagged, tagged and labelled. Clinical waste was stored in a locked outdoor compound that included two locked skips; one for sharps and one for clinical waste. A clinical waste log and consignment notes were in place. All medicines were disposed of in the appropriate clinical or pharmaceutical waste bins. The last annual waste audit was undertaken October 2021 resulting in a compliance score of 98%. A score of 92% was achieved for the 2021 sharps audit. It identified that the contractor was not removing sharps waste and this had since been rectified.

Risks to patients

From a patient perspective, clinical staffing levels were sufficient as patient feedback indicated they had access to a clinician when they needed it. Overall, the team suggested there was sufficient clinical staffing capacity to meet patient need, particularly as a military nursing officer was due to start at the practice. The SMO was the only doctor at the practice and had an informal arrangement with York Medical Centre to provide clinical cover for short term absences. Locum cover was requested for longer term absences, such as planned leave. The risks associated with just one doctor (and the only prescriber for the practice) were recognised and had been added to the practice's issues register. It was also addressed in the business continuity plan (BCP). In addition, the SMO advised us they were well supported by an experienced sub regional SMO.

To ensure locum staff were suitable for the role, relevant documentation was checked before they started working at the practice, including their DBS check and training. Locum staff completed both a Defence Primary Healthcare (DPHC) and local induction.

The emergency trolley was located in one of the clinical rooms and was easily accessible in the event of an emergency. Records showed the duty medic checked the equipment on the trolley each day and also fridge and ambient temperatures. The nurse carried out a full check of the contents of the trolley each month, including medicines for medical emergencies as gas cylinders. There was a contents list of items held on the trolley. We were not provided with evidence of risk assessments for contents not kept on the trolley as the senior nurse who managed the trolley was not available on the day of the pharmacy inspection. After the inspection, the senior nurse confirmed the risk assessment from the

DPHC SOP, Emergency Kit Drugs for Common Medical Emergencies in Primary Healthcare, was used and a paper copy of the risk assessment added to the emergency trolley. Glucometer testing strips were held on the trolley. However, there was no control solution to calibrate the meter. No evidence was available to confirm the glucometer machine was being calibrated and that checks were being completed. The automated external defibrillator (AED) pads were not held with the AED and staff were unaware where they were. This was rectified as staff located the pads and placed them with the AED.

All staff were up-to-date for training in basic life support, anaphylaxis and the use of the AED. Sepsis training was provided for the team in March 2022. The administrator completed sepsis training during inspection. Heat stroke training was last conducted in June 2021 and thermal injury training was scheduled to take place in May 2022. Sepsis red flag posters were visible throughout the practice. The clinical room where the emergency trolley was located had a display with MEWS score (early warning check for clinical deterioration) and emergency processes. The public health notice board provided information on thermal injuries.

Patients could be observed at all times as there was CCTV in both waiting rooms which streamed to the reception.

Information to deliver safe care and treatment

We were advised that DMICP was slow and frequently crashed. In the event of no DMICP access, the practice provided emergency appointments only and staff used paper copy forms, a stock of which were held in all clinical rooms. York Medical Centre had access to the practice's DMICP so could provide staff with the clinic lists. DMICP access was captured in the BCP.

There was some confusion at the practice between records summarisation and new patient registration checks. Although not always necessary, all new patient records (mainly students) were summarised when they registered at the practice. A regular search was not undertaken to identify patients (permanent staff) whose records required summarisation every three years in accordance with DPHC Guidance Note 02. We found the records were being summarised every three years due to turn around of service personnel posted. A recent audit undertaken by the nursing team showed 99% of patient records had been summarised.

The nurses, including the locum nurse, formally audited each other's clinical records which involved a random selection of five DMICP records. The last audit was completed in January 2022 and indicated a 93% compliance score. The audit was due to be repeated in three months. It was unclear if the outcome of the audit was shared with the wider team to support learning. A process to audit the SMO's consultations was not in place. We were advised that the SMO met with the medics after the emergency clinic (referred to as sick parade) for discussion and reflection about the management of patients. The medics said the SMO checked their consultation records and provided feedback. It was not clear if this way of monitoring medics' records was formally recorded. The Band 7 physiotherapist sub regional lead previously undertook an audit of both the physiotherapists record keeping. It was over a year since the last audit. The ERI's record keeping was audited by their line manager at York PCRF.

The administrator managed external referrals and had in place an effective start to completion process to monitor the progress of referrals, including urgent two-week-wait referrals. Internal referrals such as those to the Department of Community Mental Health, Regional Rehabilitation Unit and occupational health were monitored by the referring clinician. This had been raised as a potential risk recently by region so the practice was in the process of introducing the management of internals in the same way as external referrals. There was no evidence that internal referrals had been missed or lost in the system in the way they had been managed.

The senior nurse was the lead for the management of specimens and followed the local SOP. We found specimens were well managed, including action taken if results were not received in a timely way. The SMO reviewed Path Links daily. Although no longer required, the practice continued to undertake a results management audit.

Safe and appropriate use of medicines

The SMO was the lead for medicines management. The pharmacy technician (PT) oversaw the operational management of medicines. Both their terms of reference reflected this arrangement. The practice worked to DPHC medicine management SOPs.

Patient Group Directions (PGD) were used to allow nurses to administer medicines in line with legislation. PGDs were in date, authorised by the SMO and signed by the nurses. The nurses used a rolling three month check to ascertain what PGDs were likely to expire to ensure they were only utilising the most up-to-date ones. A PGD audit was completed by the SMO in March 2022. The nurses completed immunisation training in July 2020. Evidence was seen that medics had been signed off in January 2022 by the SMO as competent to utilise Medics Issuing Protocols (MIP) specified for medic use.

The PT ordered vaccines and was responsible for ordering, receipting, time expiry and care of vaccines including the fridge in the nurses department. All vaccines were stored in pharmaceutical fridges and stock management was recorded and logged on DMICP. Monthly time expiry reports were conducted to identify stock that may be due to expire. A log was in place for daily fridge temperatures monitoring; minimum, maximum and current temperatures were in range and checked twice daily. Appropriate arrangements were in place to monitor cold chain medicines if transfer to another location was required or in the event of a power failure. Measures were in place to minimise the fridges being switched off accidentally.

Although an SOP was not in place, there was a consistent approach for the management of information about changes to a patient's medicines received from other services. The administrative team tasked the SMO to action changes required. Any paperwork related to these changes was then scanned onto the patient's clinical record and a consultation added by SMO. The patient's record was then adjusted to reflect the changes.

The storage, receipt and issue of blank prescriptions was in accordance with the DPHC guidance. The practice manager carried out regular stock checks of the prescriptions held. Repeat prescriptions were received by eConsult, email or by the patient completing the repeat prescription request form. The PT only dispensed prescriptions if they had been signed by the doctor. The PT issued repeat medication only if the patients medication review was in date. If a patient's medical condition had deteriorated, they failed to attend a

for a review or were not compliant with their medication then the PT raised the issue with the SMO or nurses. Our review of patients' records showed that medicines were appropriately prescribed, including the issuing of repeat prescriptions.

The PT reminded patients that they had medication to collect and if there are any concerns, such as uncollected antidepressants or antibiotics, the SMO was informed. Uncollected medication was recorded via the pharmacy intervention template on DMICP and returned to stock after eight weeks.

The SMO was responsible for the management of high risk medicines (HRM) and for updating the high risk medicine register. The register identified just one patient. A record entry confirmed the SMO had requested the shared care agreement from secondary care. The patient's record had an HRM alert and noted all relevant requirements for blood monitoring. Regular searches were undertaken for HRMs and the SMO and PT met twice a week to discuss the register and any actions required. The SMO advised us that they regularly checked national guidance in relation to DMARDs used to treat inflammatory conditions.

Medicines with a potential for misuse, referred to as controlled drugs (CD), were managed in accordance with the CD regulations and DPHC policy including secure storage, monthly and quarterly checks and safe destruction. The last CD audit was completed in 2020 and we highlighted that CD audits should be conducted on an annual basis to check compliance of prescribing.

The SMO completed an antibiotic audit in July 2020. The PT carried out a cold chain management audit in February 2022. The PT confirmed audits were discussed at clinical meetings.

Track record on safety

There were a wide range of risk assessments in place for both clinical and non-clinical risks. These included management of sharps, slips, trips and falls, pregnancy and lifting/handling. All risk assessments, including COSHH (Control of Substances Hazardous to Health), were reviewed in February 2021. A current and retired risk register and a current and retired issues log were in place. The risk register was in line with DPHC guidance and applied the 'four T's' (transfer, tolerate, treat, terminate). However, the practice had not formally transferred the risks it could not tolerate using the candidate risk form within the DPHC Guidance Note. Our review of minutes confirmed risk was a standing agenda at the monthly healthcare governance meetings.

The physiotherapist and exercise rehabilitation instructor (ERI) were both responsible for risk associated with the PCRF. Risks were recorded on one form which did not allow for easy reference or safe grading. Known risks associated with use of the unit gym facilities were not identified, such as non-compliance with IPC standards. In addition, PCRF and unit gym risks had not been included on the practice risk register.

Although evidence of health and safety checks was not routinely shared by the contractor with the practice, the practice manager confirmed fire, gas and electrical checks were up-to-date. Portable appliance testing was carried out in February 2022. The legionella risk assessment was in date and taps were run monthly to maximise water safety. The practice manager carried out monthly health and safety checks. The equipment audit (referred to

as LEA) was undertaken in November 2021. The duty medic carried out daily checks of frequently used clinical equipment and weekly checks of infrequently used equipment. The ERI oversaw the management of rehabilitation equipment which was in date for servicing.

The three yearly fire risk assessment was carried out in July 2020 and the fire alarm tested weekly. A fire safety plan for evacuation of the building was displayed. The annual evacuation practice took place in February 2022 in conjunction with staff from the co-located dental centre. Staff were up-to-date with fire safety training undertaken as part of the DPHC mandated training policy.

The practice was working to a local COVID-19 risk assessment updated in October 2021. The number of people accessing the building had been reduced, visitors to the building were checked for symptoms at reception, social distancing measures were in place, face coverings were mandated and the number of chairs in the waiting room had been reduced. COVID-19 information was displayed and a protective screen was in place at reception. Hand sanitiser and sufficient supplies of personal protective equipment were available. An eConsult system had been introduced for permanent staff.

The practice did not have an integrated alarm system in place. Instead portable alarms were located in each room. During the inspection, the alarms could not be located by staff in a timely way in three clinical areas. There was evidence in place to show that the alarms were checked in March 2022 but not in the rooms we checked as they were in use at the time of the check. Not all staff were aware of how to use the alarm. Training in the use of the alarms had recently been provided but not all of the staff team had been available to attend.

Lessons learned and improvements made

Significant events and incidents were reported through the electronic organisational-wide system (referred to as ASER). A lead and deputy were identified for ASER and staff followed the DPHC guidance when managing significant events. All staff had an ASER login and had received training in using the system.

Part 2A ASER access was held by the SMO, practice manager and senior nurse. A log was maintained of significant events and minutes showed they were a standing agenda item for discussion at practice meetings. A significant event analysis was undertaken for 2021/22 and included a summary of the event, action taken, date discussed with the team and lessons learned. Staff provided examples of significant events, including improvements made as a result of the outcome of investigations. Some staff expressed that they would benefit from more detailed discussions at practice meetings so there was the opportunity to learn from significant events rather than just being given the outcome.

The pharmacy technician was responsible for managing patient safety alerts with the practice manager and senior nurse covering in their absence. Alerts were a standing agenda item at the practice meeting. A register of alerts was in place that included a link to the alert and outlined the action taken. Staff also were informed of alerts through the DPHC newsletter.

Are services effective?

We rated the practice as good for providing effective services.

Effective needs assessment, care and treatment

Processes were in place to support staff to keep up-to-date with clinical developments including National Institute for Health and Care Excellence (NICE) guidance, the Scottish Intercollegiate Guidelines Network (SIGN), clinical pathways, current legislation, standards and other practice guidance. Staff were kept informed of clinical and medicines updates at the monthly healthcare governance meetings. We were advised that the NICE draft guidance regarding a new injection for obesity had recently been discussed. Staff also received updates through the Defence Primary Healthcare (DPHC) newsletter circulated each month.

Primary Care Rehabilitation Facility (PCRF) staff were familiar with Department of Defence Rehabilitation Guidance and provided examples of treatment provided based on evidence-based guidelines and care pathways. We noted from the records we looked at that Rehab Guru (software for rehabilitation exercise therapy) was used consistently and with continuity. The physiotherapist reported good use of remote video consultation by patients for clinical reviews.

The PCRF team had effective relationships with the unit physical training instructors (PTI) who were encouraged to maintain patients participation with unit physical therapy while undergoing rehabilitation. The PCRF had produced a comprehensive booklet for patients to keep a diary of rehabilitation which was used by PTIs to monitor activity.

The exercise rehabilitation instructor (ERI) worked mainly from the unit gym due to a lack of space in the PCRF. Although the gym was not compliant with infection prevention and control (IPC) standards and afforded little privacy during consultations, it had a good range of equipment. Discussions were taking place with the unit to utilise a separate room in the gym for rehabilitation. IPC and privacy arrangements would need to considered to take this option forward.

Monitoring care and treatment

The practice nurse was the lead for long term conditions (LTC). Patients with such a condition were identified through new patient checks, obesity checks and opportunistic screening. They were also identified through over 40 health checks, although these checks were not currently taking place due to COVID-19 restrictions but were due to be reinstated. The nurse ran DMICP searches to invite patients for reviews and also followed up on patients who had not responded and were overdue a review. The nurse worked directly from the searches rather than maintaining an LTC register. Submission of a prescription by a patient was also used to identify monitoring needs. Given the small numbers of patients with an LTC, this system was safe but would need to be reconsidered if the numbers of patients with an LTC increased.

Data submitted by practice in the lead into the inspection showed there were no patients with a diagnosis of diabetes. The small number of patients diagnosed with asthma all had an asthma review in the preceding 12 months. The 11 patients diagnosed with high blood pressure had a record for their blood pressure taken in the past 12 months and 10 had a blood pressure reading of 150/90 or less. From our review of clinical records, a small number of patients who had undergone routine screening had a borderline high blood pressure reading. While there were no significant safety concerns, we indicated a check of the rest of the patients would ensure that any required active management was not missed. In addition, the practice would benefit from developing a standard operating procedure to ensure that follow up is arranged for abnormal results. This could form the basis of a quality improvement project.

No patients were prescribed Valproate (medicine to treat epilepsy and bipolar disorder) registered at the practice. Valproate searches were managed by the pharmacy technician on the basis of prescriptions requested.

Forty four percent of patients were in date for audiometric assessments (within the last two years). This low figure resulted from restricted access during COVID-19 in line DPHC directive (April 2020). The practice had resumed audiometry as restrictions relaxed and were working to address the audiology backlog. Joint Medical Employment Standards (JMES) were managed in an appropriate and timely way.

Step 1 of the DPHC mental health pathway was delivered by the SMO. Patients who needed intervention beyond step 1 were referred to the Department of Community Mental Health (DCMH). The Senior Medical Officer (SMO) described an approachable and effective relationship with the DCMH team. It was clear from discussions with the SMO and welfare team that there was a responsive and supportive network in place to support people vulnerable due to their mental health.

We looked at a broad range of patient records on DMICP and they showed patients received timely and effective care. Although analysis of results was not evident, PCRF records demonstrated consistent use of the musculoskeletal Health Questionnaire (MSK-HQ) and other outcome measures.

The practice nurse was the lead for audit. A log of audit/quality improvement activity (QIA) was in place from February 2020. The QIA log predominantly comprised mandated audits and data searches. Although some clinical areas were monitored through searches, such as cytology, asthma and diabetes, audit in terms of measuring clinical outcomes against best practice guidance was underdeveloped. The log provided a link to the audits, outcome in terms of compliance, when the audit was next due and who undertook each audit. We were not provided with a QIA forward plan to confirm what QIA was planned.

The use of Direct Access Physiotherapy had been audited for the last three years and its use attributed to a reduced number of days for the patient on rehabilitation. In addition, class attendance had been audited annually for the last three years and consistently showed that attendance was poor with only approximately 50% of available classes attended. Actions such as changing class times and engaging with the unit had resulted in minimal change. However, a two cycle audit of the rehabilitation passport completed by patients and shown to the unit PTI demonstrated class attendance had improved. The PCRF had an audit plan for 2022 captured as a standard operating procedure with specific ERI and physiotherapist audits identified.

Effective staffing

The practice used the DPHC generic induction with local information added in which covered individual job roles. A specific PCRF induction was not in place and the physiotherapist had plans to develop one. Staff we spoke with described an effective induction that prepared them for their role.

The staff database captured mandated training for the team and it was monitored by the practice manager and discussed at the practice meetings. The staff team was up-to-date with training with the exception of one staff member out-of-date for infection prevention and control training. The senior nurse managed in-service training in key topics relevant to the practice. A log was maintained of the training provided and who attended. PCRF staff participated in regional in-service training with the Regional Rehabilitation Unit.

Role specific training was provided for staff with lead roles and those who were undertaking specialist practice. For example, the senior nurse had completed link practitioner training as IPC lead and the practice nurse recently requalified in cervical cytology. The practice manager had undertaken the relevant training for systems administrator lead but, due to COVID-19 and cancellation of the course, they had not completed the practice management training. The SMO had not completed specialist training, such as for aviation or diving medicals, as this was not a need for the patient population.

Various opportunities were in place to support staff with continual professional development (CPD) and revalidation, including dedicated time on Wednesday afternoon and Friday morning. The nursing team had a process in place for peer review, including the senior nurse receiving peer support from the sub regional nurse advisor. In addition the nurses engaged in informal supervision and the senior nurse was a member of the regional clinical supervision working group. The physiotherapist described good support both clinically and administratively through the region; particularly important given their lone working physiotherapy post. The SMO was keen to develop the skills of the medics and spent time with them each day using case discussion for reflection. The SMO attended regional CPD meetings hosted by the SMO at Catterick Medical Centre. Furthermore, the SMO was exploring options for peer support to minimise the risk of professional isolation given they were the only doctor working at the practice.

Coordinating care and treatment

Discussions with staff, supported by clinical records, confirmed the practice had a range of established links with internal teams and services. In particular, the practice worked closely with the welfare team and the DCMH. The practice, including the PCRF, was represented at the Commanders Monthly Heath Review meetings at which the care of vulnerable and downgraded patients was reviewed.

The practice had effective links for treatment pathways with local health services. For example, the SMO has secured access for patients with a local vasectomy service. Safeguarding links and social service links were in place. The practice had access to the local midwife service.

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 doctor. Patients with complex mental health needs were handed over to civilian services by the mental health team. 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 medics coordinated the health promotion programme with oversight from the senior nurse. A health promotion programme was in place that took account of the NHS health calendar and national public health initiatives. The medics participated in unit health fairs, although these had been postponed due to COVID-19. Information about mental health, sexual health, nutrition, tropical diseases and smoking cessation was displayed at the time of the inspection.

The physiotherapist had a special interest in nutrition and was completing an MSc dissertation using unit data. A large percentage of students were overweight and deconditioned so the focus of the PCRF was to encourage healthier lifestyle and increased activity. The physiotherapist had produced a range of patient information leaflets – back, neck, ankle, knee, shoulder, pain, which were sent to patients following triage of the referral.

Testing for sexually transmitted infections could be carried out at the practice or patients could be signposted to the local service. The sexual health nurse from the NHS (Conifer House) held a clinic at the practice each Monday. Uptake for this service had been slow. It had been advertised through standing orders troop commanders. It was also highlighted through patient enquiry or referral.

Monthly searches were undertaken and current data indicated that no registered patients were eligible for bowel, breast or abdominal aortic aneurysm screening in line with national programmes. The number of eligible women whose records showed that a cervical smear had been performed in the last 3-5 years was 32 which represented an achievement of 80%. The NHS target was 80%.

Medics were responsible for the recall of patients for their vaccinations. Vaccination statistics were identified as follows:

- 82% of patients were in-date for vaccination against diphtheria.
- 82% of patients were in-date for vaccination against polio.
- 62% of patients were in-date for vaccination against hepatitis B.
- 42% of patients were in-date for vaccination against hepatitis A.
- 82% of patients were in-date for vaccination against tetanus.
- 88% of patients were in-date for vaccination against MMR.

- 86% of patients were in-date for vaccination against meningitis.

The data included the student population who had not been receiving entry vaccinations in phase 1 training due to the COVID-19 restrictions. We were advised that the practice was awaiting direction regarding the resumption of services.

Consent to care and treatment

Clinical staff understood the requirements of legislation and guidance when considering consent and decision making, including the physiotherapist who took written consent for acupuncture. Although monitoring of consent was not formally undertaken, the records we reviewed showed that consent was taken.

Information about the Mental Capacity Act (2005) was displayed in the practice and staff we spoke with had a good understanding of how it would apply to the patient population group. Training in mental capacity was scheduled June 2022.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

A recent patient feedback survey carried out by the practice (11 respondents) indicated staff treated patients with kindness, respect and compassion. The patients we spoke with as part of the inspection shared this view as did the patients who responded to the Defence Medical Services Regulator's patient satisfaction survey which complemented this inspection.

Based at the barracks, an information network (known as HIVE) was available to members of the service community and provided a range of information to service personnel and their families who had relocated to the area. We were advised that the unit organised social events and activities regularly for the students.

The clinicians and welfare team provided a range of examples of how they had worked together to provide compassionate, supportive and patient-centred care to individuals.

Involvement in decisions about care and treatment

Respondents to the patient feedback survey and the patients we spoke with said they were involved with decision making and planning their care. Our review of patient records confirmed this.

The practice nurse was the carers lead. Carers notices were displayed in the waiting room and patients with a caring responsibility were identified through the patient registration process, summarisation and patient health checks. An alert and clinical code were added to the patient's record which meant new carers were captured in subsequent DMICP searches. A small number of carers were identified and all had been offered the flu vaccine. The last search was run in March 2022. Carers were discussed at the vulnerable patients meeting.

The Primary Care Rehabilitation Facility (PCRF) appropriately used light duties and physical therapy prescriptions. In addition, the PCRF produced a comprehensive booklet for each patient detailing their rehabilitation plan and pain scores, which was used to inform physical training instructors and to encourage attendance. Use of these booklets had made a positive impact on attendance at Level 1 physical training.

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

Privacy and dignity

All sources of patient feedback confirmed that the privacy and dignity of patients was respected. Consultations took place in clinic rooms with the door closed. Headphone sets were used for telephone consultations. There were privacy curtains in all clinical rooms. Information was available advising patients they could speak with a member of staff in private if required. Staff had completed the Defence Information Management Passport training which incorporated the Caldicott principles. The practice could accommodate patients if they wished to see a clinician of a specific gender by signposting them to an alternative practice or PCRF, usually York Medical Centre.

Are services responsive to people's needs?

We rated the practice as good for providing caring services.

Responding to and meeting people's needs

Staff provided several examples of how the practice responded to meet patient need. For example, the Senior Medical Officer (SMO) and nurses were actively involved with the unit to ensure appropriate access for the patient population. Clinics were often scheduled for specific requirements that needed a timely response, such as deployment vaccinations, audiology assessment and boxing medicals.

In addition, a patient focus group in November 2021 (70 patients participated) addressed patient concerns about eConsult access during Covid-19. A face-to-face emergency clinic was re-introduced for students to improve access as eConsult was proving difficult with their inflexible training programme. This also resulted in a reduction with non-attendance. A further outcome of the focus group was to restart the sexual health clinic and the first clinic was held at the practice in January 2022. In addition, the practice arranged for the COVID-19 bus to come to the barracks, which made it easier for patients to access vaccinations within their training programme.

An Equality Access Audit for the premises was completed in January 2022. The building was accessible for people with mobility needs including an accessible toilet. A hearing loop was not required based on the current needs of people who used or accessed the building. It was unclear if the unit gym used regularly for rehabilitation had been assessed for access.

The SMO provided examples of patients seen for gender dysphoria and advised that there were lengthy waiting times for support following. These patients were supported as needed clinically by the practice.

Timely access to care and treatment

Patients had the option of using eConsult with the exception of those under the age of 18. Face-to-face appointments were available as COVID-19 restrictions had relaxed.

The medics coordinated the emergency clinic each morning and also had appointments available during the day. Urgent appointments with the SMO could be facilitated on the day and, for routine appointments, the wait was two weeks. Nurses could accommodate patients within two days but usually they had availability on the same day a patient requested an appointment. Patient feedback, including the patients we spoke with, confirmed they received an appointment promptly and at their preferred time.

For access to the Primary Care Rehabilitation (PCRF), patients were triaged by the nurse on arrival to determine if they needed to see a doctor first. They were advised to self-refer if they met specific criteria. This approach was not fully in line with organisational guidance on Direct Access Physiotherapy (DAP). The PCRF also received referrals from the SMO.

The physiotherapist advised that the flow of referrals was manageable but fluctuated according to population changes.

An urgent physiotherapy appointment was available within one day and a routine appointment within five days. All appointments with the exercise rehabilitation instructor (ERI), including access to a rehabilitation class, could be accommodated within 14 days. The PCRF was meeting key performance indicators. We were advised that as the referral rate increases, the main impact will be for the ERI as they worked part time at the practice and part time at York Medical Centre.

There was a wait of 28 days for access to occupational health. The SMO highlighted that there were significant delays with accessing secondary care, particularly for neurology and ear, nose and throat services.

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

Listening and learning from concerns and complaints

The practice manager was the lead for patient complaints, which were managed in accordance with the organisational complaints policy (JSP 950). A complaints log was maintained and included verbal and written complaints. Through discussing examples, it was clear complaints were effectively managed, discussed at the practice meetings (if appropriate) and lessons learnt shared.

Patients were made aware of the complaints process through the practice information leaflet and information displayed in the waiting room. Patients we spoke with 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 good for providing caring services.

Leadership, capacity and capability

Staff we spoke with described a service that was well-led and said structure and consistency had improved since the Senior Medical Officer (SMO) and practice manager took up post within the last two years. Staff told us the SMO recognised strengths in the team and promoted an open forum approach to encourage ideas and input from the whole team. The SMO said they were well supported by a more senior SMO in the sub region and also described good input from the regional team. Equally, the senior nurse said they were effectively supported by the regional nurse advisor.

In terms of leadership capacity, resilience was a challenge with just one doctor working at the practice. We identified that the SMO was 'spread quite thinly' with current ways of working. We discussed with the SMO the benefits of a patient access analysis so the practice could identify average clinical requirements for each department. This would support improved time management for dedicated administration and time to focus on the leadership.

Vision and strategy

The practice worked to the DPHC mission statement, identified as:

> "DPHC will deliver a unified, safe, efficient and accountable primary healthcare and dental care services for entitled personnel to maximise their health and to deliver personnel medically fit for operations"

Even though the leadership team was focussed on embedding governance structures, it was evident they considered the needs of the patient population when developing the service. For example, the introduction of a sexual health clinic and access to the COVID-19 vaccination bus was based on direct patient feedback.

Culture

It was clear from patient feedback, interviews with staff and the welfare team there was a patient-centred culture at the practice. This was evident in the practice's response and compassion for vulnerable patients and pro-active approach to developing the service based on the views of patients.

Staff described how the leadership team promoted an inclusive and open-door culture with everyone having an equal voice, regardless of rank or grade. Through interviews with staff, we identified there had been a period of disharmony and tensions within the team. While the immediate issues had been addressed by the SMO, there was the potential for a

reoccurrence. Through discussion with the SMO, they agreed to explore team building options as a means to addressing any underlying concerns with the aim to build sustainable team cohesion.

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

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

Governance arrangements

The practice had spent the last two years developing governance structures following three years of fragmented leadership. The benefits of this were beginning to show and the practice demonstrated it now had a solid foundation to build on. There was a staffing structure in place and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. A review of lead roles could support with equal distribution of workload, including the allocation of lead roles to the Primary Care Rehabilitation Facility (PCRF) team.

The healthcare governance (HCG) workbook was the overarching system used to bring together a range of governance activities, including the risk register, training register, policies, quality improvement activity (QIA) and complaints. A monthly HCG meeting was held. We queried whether the level of integration between the medical centre and PCRF was sufficient as the PCRF team was only invited to participate in completion of the eCAF (internal quality assurance governance assurance tool to monitor performance) if relevant to their area of service delivery. In addition, the QIA log we received prior to the inspection did not include PCRF-led QIA.

The provision of care was monitored through an ongoing programme of QIA. While mandated audits had been completed, clinical audit in terms of measuring clinical outcomes against best practice guidance was underdeveloped. The SMO recognised there was scope to develop this area once the governance structure was embedded.

A range of meetings were held to ensure a communication flow within the team. These included daily ‘huddle’ meetings, weekly medicines management meetings, a monthly HCG meeting, head of department and risk management meetings.

The regional team undertook a governance review of the service in January 2022. The practice was working through a management action plan been developed following the review.

Managing risks, issues and performance

Processes to identify and manage risk were in place. Although the 'four T's' (transfer, tolerate, treat, terminate) DPHC Guidance Note on managing risk was referenced, risks were not always formally transferred if they could not be addressed at practice level. The way in which risk for the PCRF was identified and managed would benefit from a review to ensure all risks were effectively assessed and were captured on the practice-wide risk register.

The exercise rehabilitation instructor (ERI) worked part-time between the practice and York Medical Centre where their line manager was based. This arrangement would benefit from a review as we were advised public holidays and mandatory training time was taken from their hours at Leconfield rather than York which reduced their availability for service delivery time at Leconfield PCRF.

The business continuity plan was reviewed in October 2021 and took account of the usual and expected risks such as a fire, flood and loss of power.

Systems were in place to monitor national and local safety alerts, incidents, and complaints.

Appraisal was in date for all staff. Staff performance was dealt with by individual line managers. Any concerns with performance was discussed with the staff member, reasons explored and support offered before any formal action.

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 population of eCaf had been paused in anticipation of the replacement eHaf.

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.

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. A suggestion box was available in the waiting room for patient comments and a patient feedback form was available. A recent paper based survey generate 11 responses. A QR code for the patient survey was displayed throughout the practice. There had been little uptake so the practice manager was exploring options to increase patient feedback by this method. Because of limited feedback, a patient focus group was held in November 2021 with 70 participants. Another

was planned in the early half of 2022. It was clear the practice aimed to develop the service based on patient feedback.

A staff survey had not taken place. The practice would benefit from undertaking such a survey particularly to inform the development of a team building programme.

The practice had developed effective relationships with the unit, welfare team and local healthcare services.

Continuous improvement and innovation

The leadership team had identified deficits in governance when they took up post so the focus for the last two years was to develop a sustainable governance framework. It was clear from our findings that a lot of work had gone into this activity. Alongside this work, there was evidence to show the practice had made improvements to meet the needs of the patient population. The quality improvement register commenced in November 2021 and had 13 entries some of which included:

- Securing access to a local vasectomy service,
- Prescription security,
- Improving patient feedback,
- Initial trade training trainees (ITTT) class attendance and class time delays,
- ERI peer review development,
- ITTT discharge planning for improved outcomes.