Lyneham Medical Centre

Calne Rd, Lyneham, Chippenham SN15 4XX

Defence Medical Services inspection report

This report describes our judgement of the quality of care at Lyneham 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?	**Requires improvement**	
Are services effective	**Good**	
Are service caring?	**Good**	
Are services responsive to people's needs?	**Outstanding**	
Are services well-led?	**Good**	

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Summary

About this inspection

We carried out this announced comprehensive inspection on 30 November 2021.

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

Are services safe? – requires improvement

Are services effective? – good

Are services caring? – good

Are services responsive to people's needs? – outstanding

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:

- Patient feedback about the service was positive. It showed patients were treated with compassion, dignity and respect and were involved decisions about their care and treatment. Information about services and how to complain was available to patients.
- Most patients found it easy to make an appointment and urgent appointments were available the same day. Some patients suggested that getting through by telephone had been difficult in previous months but had recently improved.
- A programme of quality improvement activity (QIA) was in place and this was driving improvement in services for patients.
- Additional work was needed to ensure that referrals and repeat prescriptions were managed in a failsafe way.
- There was a backlog in summarisation of new patient notes, although mitigation was in place to identify and prioritise those patients with long-term conditions.

- Leadership capacity was stretched given key staffing gaps in administration and nursing. Staff were undertaking tasks outside their key roles to mitigate for staffing gaps.
- The practice had particularly positive lines of communication with the units they supported, welfare team and co-located Department of Community Mental Health (DCMH) to ensure the wellbeing of service personnel.
- Arrangements were in place for managing medicines including high risk medicines, but there was scope to improve monitoring for quetiapine.
- Staff were clear that Lyneham Medical Centre was a positive workplace and they appreciated the open culture and supportive leadership style.

The Chief Inspector recommends to Lyneham Medical Centre:

- Repeat and acute prescriptions must be signed as authorised by a qualified doctor before medicines are dispensed.
- Progress actions from the infection prevention and control audit and incorporate deep cleaning within the cleaning contract.
- Address the summarisation backlog.
- Ensure that referrals are managed effectively and safely.
- The PCRF should consider the benefits of instigating a system of peer review / watched assessments with feedback.
- Introduce a tracking mechanism to ensure that MIAC (PCRF external referrals) are not lost within the system.

The Chief Inspector recommends to DPHC:

- The regional team keeps staffing levels under review to ensure there is clinical and administrative resilience in the system. Recruitment to vacant posts should be progressed in a timely way and outcomes communicated to the medical centre.
- Ensure that back-up power is available for medicine and vaccine fridges in case of electricity outage.
- Ensure that DCMH services and medical centres can access an agreed list of drugs used to support mental health where monitoring and shared care agreements require consideration.

We found the following areas of notable practice:

- Areas for improvement identified by the Physiotherapy lead following a notes audit one year ago resulted in additional measures and support for staff. This included a new administrative standard operating procedure (SOP) and synonym for both new and follow-up patients. A repeat audit showed significant improvement.

- During 2020 and 2021 Lyneham Medical Centre staff went the extra mile to ensure that patients who tested positive for coronavirus were treated compassionately, with dignity and in the place of their choice. Staff worked to establish a safe area within the practice where patients could come for treatment and advice and medical centre staff also visited and cared for significant numbers of patients who were living in isolation on the base. Staff told us how important it had been to ensure that isolating units could access compassionate care during what were sometimes enduring periods of segregation. The medical staff had provided a vaccination service to ensure easy access for its military patients.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

The inspection team was led by a CQC inspector and comprised specialist advisors including a primary care doctor, nurse, physiotherapist, pharmacist and practice manager. The inspector and the specialist advisors were all on site on 30 November. However, it was necessary to conduct some interviews virtually after the inspection as some staff were not available on the day of the on-site inspection.

Background to Lyneham Medical Centre

Located in Chippenham, the medical centre provides a primary care, occupational health and rehabilitation service to military electrical and mechanical engineers. In 2020 and 2021 the patient population increased by 1,700 to include patients from Colerne, Hullavington and South Cerney. At the time of the inspection there were 3,600 registered patients. In addition, occupational health services are provided for reservists. Families and dependents of military personnel are not registered at the practice so are signposted to local NHS practices. The medical centre team provide their service to people representing 31 different nationalities from all continents.

Facilities within the building include a dispensary and a Primary Care Rehabilitation Facility (PCRF).

The staff team

Medical team	One Senior Medical Officer (SMO) Three Civilian Medical Practitioners (CMPs) (one post currently vacant and two covered by locums)
Nursing team	One Band 7 Advanced Nurse Practitioner (vacant) One Military Sergeant Primary Healthcare Nurse Two Band 6 nurses (one vacant) Two Band 5 nurses (vacant) One Healthcare Assistant (vacant and covered by a locum)
Practice management	One Military practice manager (PM)
PCRF	One Band 7 physiotherapist Four Band 6 physiotherapists (two vacant) Two Exercise rehabilitation instructors (ERI)
Dispensary	Pharmacy technician
Administrators	Six (four posts vacant)
Military medic team* (Three currently deployed)	One Regimental Medical Officer (currently covered by locum) Two Medical Sergeants (currently one is deployed) Six Medics (currently five are deployed)

* In the army, a Medical Sergeant and Medics are soldiers who have received specialist training in field medicine. It is a unique role in the forces and their role is similar to that of a health care assistant in NHS GP practices but with a broader scope of practice.

Are services safe?

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

Safety systems and processes

- The Senior Medical Officer (SMO) was the lead for safeguarding and a civilian GP was the deputy lead. Both had completed level 3 safeguarding. Not all staff we spoke with were aware who the deputy safeguarding lead was. All GPs and the Band 6 nurse had completed level 3 adult and child safeguarding training, all other clinical staff are trained to level 2 and the administrative staff have completed level 1.
- The practice 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 different practices.
- Monthly searches were undertaken to identify under 18s in the patient population. At the date of our inspection, Lyneham Medical Centre was providing care for 167 minors under the age of 18. Our review of DMICP (electronic patient records) demonstrated that alerts were applied to patients under 18 and those with additional vulnerabilities. The practice had effective links with Welfare services. Clinicians held virtual clinics every morning to discuss any safeguarding concerns and/or patients with complex needs. In addition, vulnerable patients were discussed at monthly Phase 2 training mental health meetings, at the weekly mental health forum and at quarterly garrison health and wellbeing meetings. A close working relationship has been developed with the local NHS practice and safeguarding training and awareness sessions had been jointly delivered. The SMO attends the Local Health Partnership Safeguarding Board.
- Clinical staff had received chaperone training. 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.
- The Band 6 nurse was the lead for infection prevention and control (IPC) but had not yet completed link practitioner training. According to the database, eight staff members were out of date for IPC training. The last IPC audit was undertaken in November 2021 and the practice achieved a compliance score of 72%; which sits below the 85% target set by Defence Primary Healthcare (DPHC). The action plan did not contain dates for completion of work or dates for progress to be reviewed. Deep cleaning had not been included within the cleaning contract and this issue had been recorded on the risk

register. However, two cleaning staff worked in the centre regularly and the Practice Manager maintained oversight of standards and the contract. The medical centre was visibly clean, spacious and free from clutter.

- The Healthcare Assistant (HCA) empties the clinical waste weekly or as required. The waste bags are annotated with the practice code and recorded in the waste log. However, the bags are tied but not secured with a zip tie as this has not been included in the clinical waste contract. This issue has been included in the practice issues log and we were told that a business case was due to be submitted for contract amendment to include zip ties. A log of consignment notes was maintained by the practice. The last annual waste audit was conducted in August 2021. Lockable skips are secured in a locked compound adjacent to the Medical Centre.
- Arrangements to ensure safety of facilities and equipment were in place. A fire risk assessment was undertaken in March 2021, water safety, legionella, gas and electricity checks were provided by Station contract staff.
- A number of Clinicians within the PCRF were qualified in and practiced acupuncture. The DPHC SOP was being followed in addition to the latest national guidance with regard to informed consent recording for acupuncture. An acupuncture related ASER (significant event) has been raised in the last year, due to an acupuncture needle being found on the floor by a cleaner. As a result of the ASER, a new synonym was introduced for when acupuncture is being performed, which included a count in and out of acupuncture needles.
- The PCRF had two groups of equipment : Physical Training Equipment (PTE) and PCRF Equipment. PCRF equipment was managed as part of the wider medical centre equipment spreadsheet, while PTE was managed by the Military ERI. Management of the PTE was tracked by an equipment spreadsheet. The yearly servicing was funded by a business case submission from the military ERI. All equipment had been serviced appropriately.

Risks to patients

- From a patient perspective, clinical staffing levels were sufficient as patients interviewed told us they had prompt access to a clinician (although they did state that their phone calls to the medical centre sometimes went unanswered). Waiting times for an appointment with a clinician confirmed this. However, there were potential risks with the capacity and consistency of clinical staffing levels. Four of the nursing posts were vacant at the time of our inspection and staff told us that it had proved difficult to secure locums. To mitigate, medical officers were seeing patients with minor illness and injury. Shrivenham and Tidworth Medical Centres were providing vaccines and Force Health Protection services to Lyneham’s patients. Administrative staffing gaps posed an issue and meant that the SMO was at times manning the front desk and answering calls. We were told that vacancies were not currently being actively recruited to. Staff were covering numerous tasks outside of their primary role and daily re-prioritisation of tasks to minimise backlogs was essential. We spoke with the regional team who indicated that recruitment efforts for administrative and nursing staff had been unsuccessful.

- The PCRF was currently managing two B6 Physiotherapist gaps, and despite efforts to recruit, it is likely that these gaps will continue into 2022. Currently, the PCRF is managing well despite these gaps. However, if future increases in patient population occur, then the impact of these gaps, if they endure, may become much more significant.
- The PCRF has also been impacted by the lack of administrative support. The PCRF currently needs to allocate 1.5 hours a day for one clinical staff member to triage and book appointments. Although the triaging (approx. 30-mins of time) would always need to be done by a PCRF clinician, the booking of appts (60-mins of time) is currently being done by a clinician. With full staffing, this would normally be completed by an administrative officer.
- All staff, including locums, complete the DPHC mandated induction which included locum and cadre specific elements. The Practice retained copies of competed induction packs.
- The emergency trolley was accessible and secure and regular checks were undertaken. We reviewed the drugs on the trolley and found them to be appropriate and in date. Defibrillators were located in the medical centre and also in the gym for the ERI to access. Oxygen was held and was accessible and appropriate signage was in place.
- All staff completed sepsis training in August 2021. Recently a patient with symptoms of sepsis was treated promptly at the practice. The patient was managed at the practice for a longer period of time due to delays with the ambulance service to transfer the patient to secondary care. Information about sepsis was displayed in various areas of the practice. The administrative team had access to a fact sheet about recognising the sick and deteriorating patient. Clinical staff had recently received training in climatic injury/illness.
- Waiting patients could be observed at all times by staff working on the front desk. This included patients who have received vaccinations.
- Staff had received training in basic life support, anaphylaxis and automated external defibrillator use, although the training for four staff members had recently expired.

Information to deliver safe care and treatment

- Clinical records were routinely printed for planned outages or during periods of known IT fragility so the practice are aware of the patients they are expecting on the day. Clinical activity was reduced during an outage to emergency consultations only and these were recorded on hard copy forms which were then scanned onto DMICP. The Business Continuity Plan (BCP) included IT losses.
- The Practice were not currently able to conduct routine three yearly note summaries due to reduced staffing levels. Higher risk patients such as Phase 2 trainees were reviewed. The lack of note summaries had been articulated on the Practice issue log and there was a plan for GPs to conduct some note summaries to reduce the backlog. As at 1 November 2021 there were 1085 patients whose electronic notes had not been

summarised. The Practice has an SOP which was last reviewed on 1 September 2021.

- Clinical notes audits were conducted regularly (five cycles). The last audit was conducted on June 20 and noted recommendations for improvement included clearer safety netting documentation and use of the sepsis template. The Healthcare Governance Workbook documented that action points and audit results were shared. There was scope to ensure that the SMO's clinical notes were also audited.
- Within the PCRF, time is allocated for a monthly peer case review, in which clinicians discuss complex cases with another clinician within the PCRF team. There was currently no process for peer review / watched assessments, in which clinicians watch and provide feedback to each other on clinical assessments / follow-ups. A notes audit was completed in the PCRF 12 months ago and identified a number of areas for improvement. As a result, a number of improvements, including an admin SOP and synonym for new patients and follow-ups were implemented. The notes audit was repeated recently and showed significant improvement.
- The system to manage specimens was failsafe and consistently followed. An SOP was in place for the management of specimens and had been updated in September 2021. Specimens sent to the laboratory were Read coded and the HCA maintained a register.
- Referrals were routinely sent to a separate mailbox on DMICP for action. However, only the Practice Manager had access to this mailbox meaning there was insufficient resilience in the process when the Practice Manager was absent. The Practice Manager advised there is sometimes a backlog of routine referrals awaiting action but they are managed in date order. This is articulated on the issues log in relation to administrative staff shortages. The referrals register was held on SharePoint in a protected folder and it included referrals to DCMH. Although all referrals appear to have been added to the register, only a handful of entries had been updated with appointment details. We noted numerous two week wait and urgent referrals dating back more than six months that did not have an appointment date annotated. We discussed this with the SMO and requested that they review all of these referrals immediately. We note that there was some mitigation in that the eRS (electronic referral system) notified the practice if a patient failed to book an appointment and these referrals were always followed up.
- There is currently no tracking mechanism to ensure that MIAC (PCRF external referrals) are not lost within the system. There was scope to implement this in order to provide an extra safety net to prevent any referrals getting missed / lost in the system.

Safe and appropriate use of medicines

- The SMO was the lead for medicines management at the practice and was also responsible for the dispensary. 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.
- 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 two nurses had been authorised by the SMO 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. We noted that some nicotine patches were out of date.

- The Pharmacy Technician carried out a PGD audit annually with the latest undertaken in September 2021. The aim of the audit was to ensure that each PGD had been correctly authorised by the SMO, was within date and signed by the authorised nurses to use. Overall compliance was satisfactory and we noted that recording of allergies had been improved.
- 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, signature of a prescriber was evident and staff competency was up-to-date. A PSD audit was undertaken in September 2021 and overall compliance was satisfactory.
- 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 in the dispensary in a locked cupboard. There was a logbook for receiving new blank prescriptions. When doctors took blank prescriptions from the dispensary they recorded the serial numbers. The remaining prescriptions stayed in the printers over night as the doors to the consultation rooms were locked.
- Due to some clinicians working remotely (and in the absence of electronic prescribing), not all repeat prescriptions had been authorised by doctors. We saw a prescription being dispensed on the day of our inspection which had not been signed by a doctor. There was an SOP in place to state that it was the responsibility of the duty doctor to authorise all repeat and acute prescriptions generated by remote doctors : however this had not always been followed.
- Uncollected prescriptions were checked monthly by the Pharmacy Technician (PT). 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 (CD). 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 PT. Each quarter an external stock check was undertaken by an officer from the unit. We carried out a check of a CD and it matched the last stock check carried out.
- Destruction of CDs was completed in accordance with the local SOP and records maintained. 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. However, we noted that the fridge had lost power due to electricity outage and that there was no backup power for medicine fridges with the risk of loss of stock. An ASER had been submitted with the aim of preventing future risk of stock loss.

- 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 was undertaken in November 2021. We reviewed a sample of patients prescribed an HRM and found that national guidance had been followed in most instances. We noted patients who had been prescribed Quetiapine by DCMH (Department of Community Mental Health) staff : there was scope to ensure that these patients were being appropriately monitored. Clinicians at the Medical Centre confirmed shortly after this inspection that they had Read coded patients in receipt of this medicine so that monthly clinical searches captured them. Conversations with DCMH staff around shared care arrangements had also taken place.
- An antibiotic prescribing audit was last undertaken in June 2021 and showed 100% compliance. The audit acknowledged that guidance on prescribing for pyelonephritis had been updated.

Track record on safety

- There was a current and retired risk register on the healthcare governance workbook along with current and retired issues. The registers appeared to articulate the main risks identified by the practice team including staff shortages and process delays. The registers were last reviewed on 23 November 2021. There were a range of risk assessments in place including both clinical and non-clinical risks. The assessments included lone working, sharps and health and safety. There were also five Control of Substances hazardous to Health (COSHH) risk assessments dated September 2021 and both practice level and individual staff Covid-19 risk assessments. The PCRF held specific risk assessments for exercise, acupuncture, heat packs, ultrasound and Theraband.
- The practice was working to a COVID-19 risk assessment undertaken. 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 fixed alarm system in place which was tested weekly. Hard copy forms of alarm checks are held by the Practice.

Lessons learned and improvements made

- Significant events and incidents were reported through the electronic organisational-wide system (referred to as ASER) but worked to the DPHC ASER policy. A local ASER SOP was in place. All staff had an ASER login and this was discussed and confirmed in practice meeting minutes. The second stage was overseen by the SMO, Lead Nurse and Practice Manager; the SMO conducted the root cause analysis.

- ASERs were discussed at the Practice meetings and identified in the minutes by ASER number although little detail was recorded in the meeting minutes and lessons learned not clearly identified. We were advised that lessons learned were discussed at the meeting and the detail would be recorded on the ASER log on the Healthcare Governance (HG) workbook but this had not been updated since June 2021 due to staff shortages. At the practice meeting of 2 November 2021, four ASERs were discussed. Although details on the log and in the minutes were brief, it was clear from our discussions with staff that lessons learned were shared with the team.
- The Practice Manager had registered the practice's group mailbox with the Medicines and Healthcare products Regulatory Agency (MHRA). Alerts were received into the Group mailbox and distributed to relevant staff; drug alerts to the Pharmacy Technician, clinical alerts to GPs and Nurses. The Central Alerting System (CAS) patient safety alert log was held on HG workbook including detail of action taken. The last entry on the register was 30 November 21. Alerts were also discussed at the practice meeting as a standing agenda item.

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 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 clinical meetings.
- 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.
- The PCRF had a treatment room and gym. The space and equipment available was sufficient to meet patients' needs.

Monitoring care and treatment

- The lead role for long-term conditions management (LTC) was shared between a civilian GP and a Band 6 nurse. 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 38 patients recorded as having high blood pressure. 32 patients had a record for their blood pressure taken in the past nine months. 32 patients had a blood pressure reading of 150/90 or less. Six patients were due a review and staff confirmed that they were being contacted.
- There were 11 patients on the diabetic register and eight had a last measured total cholesterol of 5mmol/l or less which is an indicator of positive cholesterol control. For 11 patients, the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.
- A process was in place to identify and monitor patients at risk of developing diabetes. A QRISK 3 (calculation the determine risk of developing a heart attack or stroke) search was undertaken each month which identified patients over 40 who required screening and who were not captured through LTC monitoring. As part of the QRISK 3 assessment, HbA1C (blood glucose levels) were tested every three years for patients over 40 and annually for those with an existing LTC. Urine was also checked for glucose when patients attended the practice for a medical. Annual glucose and HbA1C testing was carried out for patients identified as having pre-diabetes.

- There were 38 patients with a diagnosis of asthma. A total of 29 patients had received an asthma review in the preceding 12 months. The other nine patients had been contacted and booked in for a review. The asthma DMICP template was used which included asthma control test results.
- 55% of patients' audiometric assessments were in date (within the last two years). Routine audio assessment was deferred for 12 months under DPHC HQ's Covid guidance. Only those who required recall based on clinical need or didn't have two audios such as trainees were recalled. Staff confirmed that there was a catch-up plan in place and that this included the delivery of increased audiometric tests monthly.
- Significant work had been undertaken around education and training with the units to address the relatively high numbers of people with mental health requirements (5% of patient population). GPs were providing step 1 management to patients in line with DPHC guidance. Monthly review meetings for all vulnerable patients took place and were recorded in DMICP. Individual case conferences were held with Unit staff for patients in crisis. We reviewed five patients who were receiving care for a mental health concern and saw that all were being actively managed. An audit of Read coding for mental health patients was undertaken in 2021 and highlighted that inconsistent Read coding was used. Work was done to address this, including the establishment of a Read code list. A repeat audit is due in order to close the cycle. The practice had also audited the referral tracking of internal DCMH referrals. This audit was conducted to monitor reviews of patients due to the issues/delays in appointments from DCMH.
- 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 MSKHQ (musculoskeletal health questionnaire). Electronic copies of other outcome measures were also available including KOOS (knee injury and osteoarthritis outcome score), Tampa scale of kinesiophobia (a 17 item scale developed to measure the fear of movement related to chronic lower back pain) and HAGOS (the Copenhagen Hip and Groin Outcome Score).
- A structured audit programme was in place and all audits mandated by DPHC had been completed. We saw evidence of regular clinical audit with learning and action points and noted that findings had been shared with the practice team. An example of practice improvement was seen in an audit of PSD's undertaken in February 2021 which found issues around Read coding and documentation by GPs. A 'pause' on immunisation under PSD was mandated whilst practice training was given. The audit was repeated in September 21 and results showed that 90% had been Read coded correctly, and 100% had been documented correctly.
- The PCRF completed an audit of appointment format (face to face / telephone / attend anywhere) during the first and second COVID lockdowns, along with reasons for the selected format. The audit demonstrated that during the second lockdown, more effective mitigations (better personal protective equipment supply / rota planning and social distancing) allowed for a greater proportion of face to face appointments to be offered where required.

Effective staffing

- All staff, including locums, completed the DPHC mandated induction which included locum and cadre specific elements. The Practice Manager retained copies of competed induction packs. The PCRF had a standardised induction process for all new staff, including a tick list of all essential activity and mandatory training. New PCRF staff were allocated a mentor to facilitate their integration into the PCRF.
- Performance appraisals were conducted by line managers for all staff and uploaded to HR (Human Resource) systems. All GPs were in date for their appraisal and all doctors and nurses had completed timely revalidation. Peer/notes review for PCRF staff was conducted in September 2021 and GPs in June 2021. The peer reviews had been uploaded to the audit calendar on the HG workbook.
- Mandatory training was monitored by the Practice Manager and recorded on the staff database. All staff had protected time for one afternoon per month for the completion of mandatory training and attendance at group training. Considering staffing gaps, compliance with mandatory training was satisfactory with clinical courses appropriately prioritised.
- All PCRF clinicians received regular appraisals (JPA for Military and HMRS for civilian staff). ERIs attended the monthly MDT meeting where input was reviewed by colleagues for selected patients. Physiotherapists completed peer review in which selected cases were reviewed with colleagues on a regular basis through review of DMICP notes. We noted that there was scope to regularly complete watched assessments with written feedback from peers.

Coordinating care and treatment

- There were seven Unit Health Committee meetings (UHC) per month (to discuss the health and care of vulnerable and downgraded patients) and they were attended by the SMO. PCRF staff attended as required and trends and injury prevention strategies were discussed. The Practice Manager prepared the required statistics for each UHC. The SMO and PM had forged excellent links with all Unit Chains of Command and Welfare staff and we were told that a mutually supportive communication stream was in place.
- 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.

Helping patients to live healthier lives

- The military nurse was the lead for health promotion and a calendar was in place which reflected current campaigns pertinent to the patient population. At the time of this inspection, smoking 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. Medical Centre staff attended Unit Health Fairs.
- The military nurse was the lead for sexual health and they had completed the required training (referred to as STIF). Patients could be referred to both internal and external specialist sexual health services. Free condoms and chlamydia kits were available at the practice. Information about sexual health, contraception and pregnancy was displayed in the patient waiting area.
- A health screening programme was in place and identified patients that could benefit from screening . Regular searches were undertaken for bowel (no patients identified), breast (three patients identified) and abdominal aortic aneurysm screening (no patients identified) in line with national programmes.
- The number of eligible women whose records confirmed a cervical smear had been performed in the last three - five years was 194 which represented an achievement of 89% which exceeded the NHS target of 80%. A monthly smear clinic was in place and patients were contacted monthly to arrange appointments.
- During COVID-19 routine vaccinations ceased in line the April 2020 DPHC directive. The practice had resumed the vaccination programme since as restrictions relaxed. The vaccination statistics were identified as follows:
    - 93% of patients were in-date for vaccination against diphtheria.
    - 93% of patients were in-date for vaccination against polio.
    - 86% of patients were in-date for vaccination against hepatitis B.
    - 94% of patients were in-date for vaccination against hepatitis A.
    - 93% of patients were in-date for vaccination against tetanus.
    - 99% of patients were in-date for vaccination against MMR.
    - 96% of patients were in-date for vaccination against meningitis.
- The medical centre had worked with the NHS Covid vaccine service to ensure that military patients could access their vaccine in the most convenient way and this involved offering a vaccination service on site. They identified that one Unit had a low uptake of the Covid vaccine and held a brief for that Unit and held dedicated vaccine clinics for them the following week which were then fully booked.

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 in the safeguarding training.

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

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

- We interviewed four patients as part of the inspection and feedback indicated staff treated patients with kindness, respect and compassion at all times. Two patients explained how medical staff centre routinely went the extra mile to ensure that the mental health needs of patients were met in a timely, respectful and compassionate way. This included home visits, out-of-hours support and consistent telephone support from the doctors. One patient told us that the consistent, compassionate and skilled support they had received from one of the GPs had been instrumental in their 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 GP workload. It was clear that doctors were responding to patients with kindness and compassion, ensuring that patients had the space and time to talk when they needed to. We also discussed patients who were receiving palliative care from the doctors and we noted that patients were benefiting from a particularly caring approach which allowed them to receive care in the place they preferred.
- An information network (known as HIVE) was available to members of the service community and provided a range of information to patients who had relocated to the base and surrounding area. Each unit had their own welfare staff and there were other communal support services for the training unit which all service personnel can access.
- We interviewed almost all staff working in the medical centre at the time of the inspection. All staff told us that Lyneham 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.
- During 2020 and 2021 Lyneham Medical Centre staff went the extra mile to ensure that patients who tested positive for coronavirus were treated compassionately, with dignity and in the place of their choice. Staff worked to establish a safe area within the practice where patients could come for treatment and advice and medical centre staff also visited and cared for significant numbers of patients who were living in isolation on the base. Staff told us how important it had been to ensure that isolating units could access compassionate care during what were sometimes enduring periods of segregation.
- Nineteen 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 overwhelmingly about the kind and compassionate support for patients with welfare needs. Respondents described a medical centre staff team that proactively listened to what matters to patients and who went the extra mile to ensure that patients felt valued.

Involvement in decisions about care and treatment

- All four patients we spoke with said they were involved with decision making and planning their care. Two patients said that the healthy lifestyle information on offer was appropriate and targeted to the patient population.
- Nineteen registered patients responded to the DMSR patient satisfaction survey which complemented this inspection. All patients who responded to the patient survey, stated that there were given full information about any drugs or medicines that were prescribed to them, including their side effects when issued via the dispensary staff. 95% of survey respondents said that they knew how to obtain results from their test or investigation. 95% of respondents also said that knew how to obtain advice about their general health and lifestyle if required.
- 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. A carers lead had been appointed and had joined the Wiltshire Carers accreditation programme: ‘Courage to care’. They were working towards gaining silver accreditation for their support to carers.
- Medical centre staff provided care to patients from 31 different cultures covering all continents. An interpretation service was available for patients who did not have English as a first language.

Privacy and dignity

- Nineteen registered patients responded to the DMSR patient satisfaction survey which complemented this inspection. All patients who responded to the patient survey stated that they were confident that the facility would keep information about them confidential. All respondents stated that they felt that their dignity and privacy were upheld by medical centre staff.
- All patients we spoke with said their privacy and dignity was respected. Consultations took place in clinic rooms with the door closed. 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 PCRF clinic area was composed primarily of curtained clinics, which presented some confidentiality issues. The following mitigations were in place: A private side room was available and utilised if greater levels of privacy were needed. A radio was present and was on during clinic time in order to reduce noise transmission between curtained clinics.

- Patients were able to see clinicians of either gender according to their preference. If patients wished to see a physiotherapist of a different gender, they could be referred to Tidworth. 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 Lyneham Medical Centre building was new and custom built as a medical facility. 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.
- The practice was responsive 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.
- Medical centre staff had received training to support the appropriate and effective care of people who were transitioning gender. We spoke with clinical staff about individuals who had decided to transition. They described an open and positive environment where Chain of Command and medical centre staff were able to support people in their journeys, ensuring that they had access to therapy as required and that medicine requirements were supported and monitored to ensure safe treatment.
- Lyneham Medical Centre is currently supporting 167 trainees who are aged under 18. Staff were aware of the needs of this patient group and worked with Chain of Command and welfare teams to support a culture in which young people could speak up if they were struggling in anyway. We saw evidence that a number of young people had received wrap around care to support their mental health needs during the COVID lockdown period. During this period, it had been necessary for large numbers of personnel to isolate.
- During the past 18 months, a significant number of personnel on the base tested positive for Covid-19 and the medical centre was heavily involved in responding to the needs of the units; supporting Phase 2 training to continue whilst managing the risks associated with the virus. Medical centre staff assisted the Units with force health protection planning, implementation of household bubbles and isolation planning. At one point 750 military personnel were living in isolation on camp, and there were also significant outbreaks in two other units off site. Medical centre staff were involved daily in planning and update meetings looking at issues such as catering, cleaning regimes and how to monitor effectively and safely those personnel who were isolating. The Medical Centre set up and ran a virtual Covid ward for isolating personnel. This included supporting unit staff to monitor and check on isolating patients through set questions three times daily and also medical centre staff providing remote monitoring of observations and twice daily calls. This service was provided out of hours and through weekends to ease the pressure on the NHS. This in turn ensured timely release from isolation for all personnel affected. All medical staff completed the learning course on Covid-19 and in turn ran training for unit staff around medical emergencies (in particular Covid-19 related) and how to recognises sepsis and 'the sick patient'.

- Requests for Military Aid to the Civil Authorities (MACA) from the NHS in England were made during the pandemic and resulted in military personnel being deployed to support NHS activity. The medical centre facilitated short notice clinics to ensure that personnel were fit to deploy and to ensure that people were asked only to undertake tasks that took into account their personal health needs.
- An amended version of direct access to PCRF care was on offer: patients were briefly assessed via eConsult and then passed straight to the PCRF. This version maintained the requirement for Phase 2 students to be seen by an MO first, whilst ensuring rapid access by utilising eConsult.
- Medical centre staff worked closely with welfare to ensure that personnel who were leaving service under a medical discharge had as much information as possible. Patients who were leaving service due to their contract ending would receive a final medical assessment and information on how to register with an NHS GP. An information pack was available and contained the Met4Vet information (a trial for mental health support for males leaving the army via a telephone application for up to two years); information about charities than can provide mental health support, housing and family support/ financial advice. Signposting for ' veteran care services' was given. Consent was sought to discuss individual's health or safeguarding support needs with their new GP and a letter and summary was shared. The medical centre supported patients with Personal Independence Payments and other such claims, as well as any medical aspects of visa applications. Leaving medicals usually spanned three appointments to ensure everything was as in place as it could be. Where there have been policy changes about employability, staff have supported appeals and advocated for patients, and some have been extended in roles.

Timely access to care and treatment

- In response to restrictions associated with COVID-19, a remote triage model including, the use of eConsult and telephone consultation had been implemented by the practice. Face-to-face appointments were also frequently needed as the patient population required pre-deployment checks and vaccinations.
- The Medical Centre recognised that early uptake of Covid-10 vaccine was key to maintaining operational capability and so offered education about the vaccine for permanent unit staff and trainees through a series of remote question and answer sessions. With regional support, medical centre staff set up a vaccine centre in the gym and vaccinated 881 personnel including a second dose. Booster doses have since been offered. Clinicians spoke to anyone who was vaccine hesitant. Staff also provided a private vaccination environment for those who required it.
- Urgent and routine appointments with a doctor could be accommodated within one day, including virtual and face-to-face appointments. The nurses provided patients who had an urgent need with a same day appointment and a routine appointment could be accommodated within three days. The patients we spoke with during the inspection confirmed they received an appointment promptly and at their preferred time. Two patients told us that it had sometimes been difficult to get through to the centre on the telephone, but that this had improved more recently. One patient stated that they had

noted there was a lack of administrative support in the medical centre and that this put the other staff under some pressure.

- Patients were able to directly refer themselves to the PCRF. In line with DPHC policy, trainees could first engage via eConsult with a Medical Officer who would then refer them directly and swiftly to the PCRF as required. A routine physiotherapy appointment was available within one week, a follow-up appointment within one week and an urgent appointment facilitated on the same day. For the ERI, a new patient appointment was available within a few days and follow up appointments could be accommodated within a week. Patient access to a rehabilitation class was currently on hold due to COVID-19.

- Patients were currently being seen within the key performance indictors (within one day for acute referrals and within 10 days for routine referrals). Where patients did not attend an appointment, this was managed in accordance with the SOP.

Listening and learning from concerns and complaints

- The Practice Manager was the lead for complaints and the SMO the deputy lead. Although all the complaints on the practice log were written complaints, we were told that verbal complaints would also be recorded. Due to reduced footfall currently, complaints were more often submitted via email. A complaints log was maintained and there were eight complaints recorded in the past 12 months. A complaints audit had been scheduled for December 2021. We noted obvious trends that related to poor staffing levels, including gaps in referral management. Staff indicated that action had been taken to mitigate the risks indicated in the complaints log. We noted concerns around an incomplete consultation with a patient due to a failure in paper communications. The practice had introduced a specific task box on DMICP which multiple staff could access to ensure tasks were actioned and monitored to completion.
- 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 good 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 within the current staffing constraints. Staff we spoke with described a committed and able leadership team with an SMO at the helm who demonstrated strong and proactive leadership and employed impactful interpersonal skills. All staff owned terms of reference for their main role and separate terms of reference for any key lead roles that they undertook.
- Nevertheless, we identified risks in terms of nursing and practice management capacity. Insufficient capacity within both the nursing and administration teams was impacting on the larger staff team and their ability to carry out their own roles, in particular the Practice Manager and lead nurse. We also noted that the SMO was at times manning the front desk and answering phone calls. Staff told us that the four gapped administrative posts were not being actively recruited to and that there were no plans to cover the imminent six month leave for the practice manager role. The medical centre was aware that they may be asked in 2022 to register an additional patient cohort of up to 3,500 but planning to deliver this was not yet active.
- The regional team had offered support. The Regional Healthcare Governance Lead had been supportive in preparation for this CQC inspection. The Regional Nurse supported with clinics including cervical cytology. The regional team had supported the delivery of Covid vaccination clinics. In spite of this support, capacity remained insufficient to allow the practice to maintain key outputs such as referral monitoring and note summaries.
- We spoke with members of the Regional Headquarters (RHQ) team as part of this inspection and they acknowledged some key gaps in administrative and nursing roles. Efforts to recruit to gapped roles had been unsuccessful. Access to locum staffing had also proven unviable.

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"

  The practice also worked to the RAMC (Royal Airforce Medical Centre) mission statement, 'Faithful in adversity'.
- The PCRF had adopted the same vision, values and mission statement as the wider Medical Centre. However, there was no PCRF specific Practice Development Plan.

- 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 surge 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 staff supported each other to mitigate the shortfall in staffing. The team often covered tasks outside their primary role to ensure key tasks were completed. For example, the physiotherapy team assisted with administrative tasks. The medical centre team felt valued and appreciated by the Chain of Command in the Units they supported.
- The practice team operated an open and honest meeting culture where all staff were encouraged to attend and offer suggestions or raise concerns. This was supplemented by an open door management approach by the SMO and Practice Manager. Staff were aware of the process if they wanted to raise a concern.
- 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 several 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. Some elements of the HG workbook were not up to date due to staff shortages.
- Although the staffing establishment for the practice was appropriate, there were a significant number of gapped posts which meant a small number of staff covering the majority of the lead roles which is not sustainable in the longer term. The Practice was heavily reliant of a small number of key staff to carry out lead roles; the SMO, the lead nurse and the practice manager. This should ease once recruitment action is complete.

  Communication across the practice was good and an appropriate meeting structure and healthcare governance approach was in place for the practice. This included: monthly clinical, practice, healthcare governance and unit healthcare committee meetings; fortnightly chronic disease, safeguarding, cancer and PCRF meetings; weekly clinical departmental meetings and heads of department meetings.
- A meaningful and intelligence led quality improvement programme was in place. A sentinel event had driven an extensive review into mental health provision and had resulted in the implementation of a mental health referral tracker. The Practice were also working with the REME (Royal Electrical and Mechanical Engineers) charity on an

initiative called 'Lifting the decks' (a programme aimed at maintaining good mental health for both regular and reserve personnel). The charity has plans to fund six sessions of mental health support for eligible personnel whilst they wait to access DCMH services. The Practice are developing an SOP for approval by Regional Head Quarters.

- The PCRF contributed to the medical centre's eCAF (Common Assurance Framework) document which was reviewed with the PCRF on a monthly basis. The PCRF were involved in all key relevant meetings.

  The PCRF also attended the RRU regional in service training sessions and the lead physiotherapist attended the regional rehabilitation meetings.

Managing risks, issues and performance

- There was a current and retired risk register on the HG workbook along with current and retired issues. The registers articulated the main risks identified by the practice team including staff shortages and process delays. The registers were last reviewed on 23 November 2021. 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 also five COSHH risk assessments dated September 2021 and both practice and individual staff Covid risk assessments. Processes were in place to monitor national and local safety alerts, incidents, and complaints.
- The Business Continuity Plan (BCP) was last reviewed on 21 September 2021 and was last exercised on 14 July 2020. The BCP covered all the main risks to the service. The Practice had a Major Incident Plan which supported all Units and was also updated 21 September 2021.
- 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 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 has not received an HGAV since the new facility opened five years ago. However, the RRU had reviewed the PCRF.
- 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 rolling patient experience survey (a Lime Survey on My Healthcare Hub) and a suggestions box was available in the waiting room. There were plans to form a patient participation group in 2022 and advertising stationery had already been prepared.
- The practice had an open and honest meeting culture where all staff were encouraged to attend and offer suggestions or raise concerns. This was supplemented by an open door management approach by the SMO and Practice Manager. The staff were also aware of both the Whistleblowing policy and the Freedom to Speak Up process of they wanted to raise a concern.
- The practice team stated that they felt well supported and had excellent communication streams with all Units they supported. The Units understood the limitations placed upon the practice by reduced staffing levels. Unit support was seen as one of the main reasons the medical centre was able to function as well as it did. The Unit staff assisted with updating health promotion boards in the medical centre. Another unit loaned their biomedical scientists to the medical centre to provide administrative support and conduct audits of the specimens register.

Continuous improvement and innovation

- The Practice used incidents as a learning opportunity and had conducted audit work to identify improvements and measure its success. Examples included the mental health audit following a sentinel event and the implementation of the administrative task mailbox on DMICP following a patient complaint regarding a delayed referral.