Odiham Medical Centre

Hook, Hampshire, RG29 1QT

Defence Medical Services inspection report

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

Overall rating for this service	**Good**	
Are services safe?	**Good**	
Are services effective	**Outstanding**	
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

As a result of this inspection the practice is rated as good overall

The key questions are rated as:

Are services safe? – good
Are services effective? – outstanding
Are services caring? – good
Are services responsive? – good
Are services well-led? - good

We carried out an announced comprehensive inspection of Odiham Medical Centre on 4 December 2018. The practice was rated as requires improvement overall, with a rating of requires improvement for the safe and well led key questions. The practice was rated as good for the effective, caring and responsive key questions. A copy of the report from the previous inspection can be found at:

https://www.cqc.org.uk/sites/default/files/20190129_odiham_medical_centre%20Final.pdf

We carried out this announced follow up inspection on 7 and 8 September 2021. The inspection was carried out remotely on 7 September and included a short visit by a CQC inspector on 8 September. This report covers our findings in relation to the recommendations made and any additional findings made during the inspection.

The CQC does not have the same statutory powers with regard to improvement action for 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 Defence Medical Services.

At this inspection we found:

- The practice was well-led, and the leadership team demonstrated they had the vision, capability and commitment to provide a patient-focused service and consistently sought ways to develop and improve.
- The leadership team had a clear understanding of the issues and had developed plans to resolve or mitigate identified risks.

- 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 governance arrangements for infection prevention and control had been strengthened. Additionally, the practice had taken steps taken to minimise the risks associated with COVID-19.
- The arrangements for managing medicines, including obtaining, prescribing, recording, handling and disposal in the practice were now effective and minimised risks to patient safety.
- The practice had developed an audit programme to improve patient outcomes and the practice could demonstrate how quality improvement work was driving improvement.
- The practice had a system to ensure that staff completed the required mandated training.
- Effective medical cover was in place to cover the times when the practice was closed.
- Governance systems, activities and working practices had been strengthened. The healthcare governance workbook was well-developed and captured a wide range of information to illustrate how the practice was performing.
- Information systems and processes to deliver safe treatment and care were established and included referral tracking, audit of clinical record keeping and the management of referrals.
- The practice had good lines of communication with the units and welfare team to ensure the wellbeing of patients. Links had been developed both internally and externally to enhance the support provided to patients.
- The practice pro-actively sought feedback from patients which it acted on. Feedback showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.
- Staff understood and adhered to the duty of candour principles.
- An inclusive whole-team approach was supported by all staff who worked collaboratively to provide a consistent and sustainable patient-centred service.
- The medical centre demonstrated a thorough awareness of the needs of its patient population and had put measures in place to improve outcomes for patients identified as being at risk. This was particularly evident in the work undertaken around safeguarding and the management of long-term conditions. The practice closely monitored its quality improvement work to ensure a comprehensive understanding of the impact it had on patient outcomes.

Notable Practice

- The PCRF have a thorough understanding of the aircrew role at Odiham including the specific conditioning demands. The aircrew conditioning programme was developed primarily for fast jet pilots and was aimed at strengthening neck muscles and developing cardiovascular fitness in order to reduce injury and increase performance. The package was developed by the RAF Centre for aviation medicine. All aircrew were

mandated to complete Aircrew Conditioning Programme (ACP) training. However, the package was not viewed as suitable for rotary aircrew whose role is very different to a fast jet pilot. The Exercise Rehabilitation Instructor (ERI) at Odiham PCRF in an effort to drive improvement has joined the ACP working group which was aimed at developing and monitoring the ACP pathway. Odiham have taken the lead in developing a package of four training modules for rotary rear crew and a functional test to identify any potential vulnerability to injury. The programme is in the process of being approved and will ultimately help to ensure rotary aircrew are screened and have targeting injury prevention training to hopefully improve their fitness for role and reduce injury risk. It will have a wider reach to influence testing and injury prevention across the tri-service rotary environment.

- The medical centre staff were proactive in their approach to improvement. An example of this is when a recent police incident occurred on the base and safeguarding concerns were not escalated appropriately. As a result of this the medical centre initiated cross-station safeguarding training. The welfare team including the Soldiers, Sailors, Airmen and military Families Association (SSAFA) social workers, padres, personnel management services, and the police section were all invited. General safeguarding awareness training followed, including small group discussions of case scenarios that any of the disciplines may come across, these were then shared with the other groups. This increased collaborative working and good relationships across station, and it triggered the police section to explore arranging more formal safeguarding training for their personnel. They are now all at least Level 1 trained. This is going to be held six monthly to account for staff turnover. As well as the police now completing some more formal training the Community Development Officer following the training session has become a Military of Defence (MOD) Level 2 course instructor to enable more accessible and timely training to others who would benefit.
- Initiated by a member of the administrative staff the medical centre has initiated a self-help menopause group meeting every 1st Wednesday of the month at the Hive centre.
- The aim was to give those going through this stage of their life a safe place to discuss this topic with others in a similar situation. This was open to military, dependants and civilian women. The intention was that the doctor will become the expert menopause lead for continuity and advice. The group meet once a month and guest speakers are going to be invited.
- The Deputy Senior Medical Officer (DMSO) had devised an information document for patients who may need to access local mental health services. The document named ‘Mental Health Support for Patients’ described what actions to take if ‘Stretched’, ‘Stressed’ or ‘Unwell’. It contained advice and most importantly the contact details of all local organisations that could offer help, 24 hours a day.

The Chief Inspector recommends:

- Review the premises and facilities within the Primary Care Rehabilitation Facility (PCRF) to establish whether improvements can be made to provide an environment that minimises risks for the patients and staff.
- A review of systems including the management of healthcare waste and a review of the handwashing facilities within the PCRF.

- A review of Read coding to ensure consistency.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

This inspection was undertaken by a CQC inspector and the inspection team comprised specialist advisors including a primary care doctor, a practice nurse, a practice manager, physiotherapist and a pharmacist. Prior to the inspection the medical centre asked patients to give written feedback via feedback cards available in reception. We received 20 completed feedback cards all the feedback from patients was positive.

Background to Odiham Medical Centre

Odiham Medical Centre is a helicopter flying station. There are approximately 1,650 patients, all of which are military service personnel predominantly aged between 18 and 55. In addition to routine GP services, the practice provides a range of other services including, immunisations, minor operations, occupational health medicals, screening, smoking cessation, cervical cytology, ages 30 and 40 health screening and chronic disease management. The Primary Care Rehabilitation Facility (PCRF) is located nearby and the dispensary is located in the building. Maternity and health visitor services are provided by NHS practices and community teams.

The practice is open on Monday to Friday 08:00 to 17:00, and from 17:00 to 18:30 for urgent appointments and ad hoc requests only. On a Wednesday there is a reduced service in the afternoon to allow for maximum attendance at meetings and staff training, but access to a GP for urgent cases is still available. At weekends and on bank holidays, patients are diverted by a telephone message to NHS 111 services.

The staff team at the time of the inspection

Position	Numbers
Senior Medical Officer (SMO)	one
Deputy Senior Medical Officer (DSMO)	one
Civilian medical practitioners (CMP)	one
Medical Officers (MO)	two
General Duties Medical Officer (GDMO)	one

GP locum job share	two
Nurses	four (two military, two civilian)
Physiotherapists	three
Exercise Rehabilitation Officer (ERI)	one
Military practice manager	one
Administrative staff	one E1 three E2
Regimental clinical staff (medics)	14

Are services safe?

We rated the practice as good for providing safe services.

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

- Improving the environment to minimise risks for patients and staff
- assessing and monitoring risks including the management of infection control and some aspect of medicines management.

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

Safety systems and processes

At the previous inspection we found improvements were required to keep patients fully safe. At this inspection we found improvements had been made and systems were established to keep patients safe, including processes to safeguard patients from abuse.

- The practice had safety policies including adult and child safeguarding policies which were reviewed, displayed in clinical rooms and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. Policies were accessible to all staff and outlined clearly who to go to for further guidance. Safeguarding policies were reviewed annually. There was a patient focussed safeguarding notice board in the waiting room and a separate one for staff in the main administrative office. All clinical rooms had safeguarding referral process details and contact details displayed. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns.
- There was a risk register of vulnerable patients and a system to highlight them on the electronic patient record system (referred to as DMICP). Review meetings to discuss vulnerable patients were held every four weeks and additionally if required. All patients under the age of 18 had been added to the vulnerable register. At the time of the inspection there was only one patient under the age of 18. A monthly search of DMICP was undertaken to ensure the register of vulnerable patients was current. We reviewed clinical records for vulnerable patients and noted appropriate alerts and coding were used.
- Staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. The chaperone policy was available to patients in a dedicated leaflet. In addition, advice on chaperones was provided in the patient information leaflet. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.
- The practice carried out staff checks, including checks of professional registration.
- There was now an effective system to manage infection prevention and control (IPC). The practice IPC lead nurse had completed role specific training and was supported by

an IPC lead for the region. Audits were carried out monthly and we saw a log that showed actions highlighted had been completed.

- The PCRF had no hand washing facilities. The staff relied of the use of hand gel to keep their hands clean. A Statement of Need (SoN) had been submitted and approved and the work was not likely to be completed until 2022.
- The practice manager was the lead for cleaning and the contract was outsourced to an approved company. Systems in place included a process for reporting issues and monitoring the standard of cleaning. Annual deep cleaning took place and regular checks of compliance were made by the senior nurse to check on cleaning standards.
- There were systems for safely managing healthcare waste supported by a policy. Clinical waste and pre-acceptance audits were carried out annually, the most recent in March 2021. The external bins used to store waste for the medical centre while awaiting collection were secured and locked. However, arrangements for the management of waste from the PCRF required improvement. Staff transported clinical waste by car to the medical centre as the PCRF did not have their own dedicated waste bin.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. The safety certificates for water, gas, electric and legionella were held by the unit and copies were made available to the practice.
- The practice provided minor surgery and the related standard operating procedure (SoP) took account of IPC. For PCRF clinicians practising acupuncture, arrangements were in place for the safe provision of this treatment, including a SoP that referenced national guidance and a consent form signed prior to any treatment.

Risks to patients

There was an effective system to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. Each department had a rota which was managed by the departmental lead to ensure staffing levels were adequate. When a locum was required, the request was submitted to Regional Headquarters (RHQ) for approval. All departments had a mixture of military and civilian staff to ensure continuity. The practice managers ensured all out of area deployments were staggered so the practice management and airfield cover could be maintained.
- An induction system was in place for temporary staff and this had role specific elements. All staff had completed a workplace induction, and this has been recorded on the staff database.
- Clinicians adhered to military guidance around sickness periods for personnel. They communicated effectively with Chain of Command so that line managers knew which tasks personnel could safely undertake.
- The practice was equipped to deal with medical emergencies. The staff team was up to date in medical emergency procedures, including basic life support training, use of the

automated external defibrillator (AED) and anaphylaxis. Thermal injuries training was undertaken in July 2021and sepsis training in April 2021. Sepsis guidelines were displayed throughout the practice. Staff had received medical emergency training in the last 12 months which included dealing with chest pain and major sports injuries. There were weekly training simulating various types of emergency, for example airfield crashes and a patient collapse in the waiting room. All staff were involved in station wide emergency scenarios and training.

Information to deliver safe care and treatment

- The system to manage pathology results was effective. Several individuals had been trained to cover any period of absence. There were clear lines of responsibility and a tracker that was checked daily (the tracker was a list of all outstanding sample test requests). There was an electronic system that had a record of received test results awaiting review, this was checked daily.
- The practice had a process for the electronic summarising of patient notes in place. They had adapted the Defence Primary Healthcare (DPHC) new patient registration form and used a template that identified any chronic disease or outstanding health needs. Recently an error was identified with the practice DMICP search for summarising and, although all patients have had an initial summary of their notes, not all patients had the follow up three yearly note summaries completed. As a result, the medical centre had submitted a request for a locum nurse to clear the backlog, this has been approved.
- Our review of nursing and doctors' records indicated that they have been peer reviewed and identified no concerns with record keeping. An audit of the PCRF team's notes had been carried out in January 2021 and showed good compliance.
- Referrals and hospital appointments were managed by the administrative team and patients were well supported to obtain the timeliest access to secondary care. There was a dedicated administrator for managing referrals, but other administrative staff were also familiar with the system should they need to provide cover. The practice used the e-Referral System (e-RS) to manage referrals to the NHS, including the urgent two-week referrals. The administrator checked the status of the e-RS twice a day. The practice was informed by the hospital if patients failed to attend for their appointment. This was recorded in the patient's clinical record and a request made for the patient to make an appointment with their doctor. All referrals were also entered onto DMICP as a shortcut so that clinicians could see at a glance the status of the patient's referral.
- Staff told us that the medical centre was not adversely affected by DMICP outages other than planned outages. If there were an unplanned outage, the clinics were printed daily, and they would revert to emergency appointments only. Hard copy forms were held in preparation for upload to DMICP when the service resumes. Medication requests would be outsourced for the duration of the outage.

Safe and appropriate use of medicines

Systems for appropriate and safe handling of medicines had improved following the previous inspection:

- Regular checks were routinely carried out on medicines, including vaccines, and emergency medicines and equipment. We found all items were within date and appropriately stored.
- The practice's arrangements for the access, storage and monitoring of prescription stationary was good. Blank prescription pads and prescription paper were stored securely, and an effective tracking system was in place.
- Controlled drugs (CDs) were managed effectively.
- Staff had access to British National Formulary (BNF) and prescribing formulary. An antibiotic prescribing audit ensured that prescribing practice was in line with local guidelines.
- Prescriptions were signed before medicines were dispensed and handed out to patients.
- Patients taking high risk medicines (HRMs) were monitored within recommended timescales. We found an effective system was in place and patients on HRMs were well managed and the relevant monitoring checks were recorded as completed before a repeat prescription was issued. A doctor led on the monitoring of HRMs and completed monthly searches that included a cross check (searches were run by both Read code and the medicine list) and any new patients were referred to the prescriber if any concerns were found.
- PGDs (Patient Group Directions) were in use to allow non-prescribing staff to carry out vaccinations in a safe way. PGDs were appropriately managed, staff had received training and authorisation by the SMO had been recorded. The practice stated that PSDs (Patient Specific Directions) were not currently used. All patients requiring medication were referred to a prescriber. PGD audits were carried out annually by the doctors.

Track record on safety

- The practice manager was the lead for health and safety. A risk register, policies and risk assessments pertinent to the practice were in place, including lone working and risk assessments for products hazardous to health. A range of risk assessments specific to the PCRF were in place.
- A COVID-19 risk assessment had been completed to reflect changes in working practices. The changes made included chairs spaced out in the waiting area, signage indicating distancing and a dedicated area to see patients presenting with potential symptoms of the virus. Risk assessments and checks were undertaken for patients entering the building. A separate COVID-19 risk assessment was in place for PCRF gym.

- Systems were in place and up to date for the safe management of utilities, including electricity, equipment and gas. A legionella risk assessment was undertaken in February 2021. Records were maintained of the weekly flushing of water outlets. A fire risk assessment took place in June 2021. The practice manager checked the fire extinguishers each month. Staff were up to date with fire safety training undertaken as part of the DPHC mandated training policy.
- There was a partial integrated emergency alarm system in place, but it did not cover all areas of the medical centre, a full alarm system was due to be installed in 2022. All staff have been issued with a personal alarm as an interim measure. The alarms are tested weekly and recorded on the Healthcare Governance (HCG) workbook. The HCG workbook is the system used to bring together a range of governance activities, including the risk register, significant events tracker, lessons learnt log, training register, policies, meetings, quality improvement and audit.

Lessons learned and improvements made

At the last inspection action was required to show learning and improvement was identified and shared following a serious incident. At this inspection we found processes had been improved.

- Both clinical and non-clinical staff gave examples of incidents reported through the ASER system including improvements made as a result of the outcome of investigations. An ASER log was maintained on the HCG workbook including any changes made. The practice manager was the lead for the management of medical and patient safety alerts. The medical centre had developed a new alert register on the direction of RHQ to capture relevant alerts only; this was included in the healthcare governance workbook which all staff could access. The new register clearly identified the action taken for each alert and included evidence in meeting minutes that alerts were discussed and documented.

Are services effective?

We rated the medical centre as outstanding for providing effective services.

Following our previous inspection, we rated the medical centre as requires improvement for providing effective services. We found inconsistencies in processes for providing effective services including gaps in:

- Effective recall of patients with long term conditions.
- Standardise use of Read coding to facilitate accurate clinical searches.

At this inspection we found the recommendations we made had been actioned and additional improvements had been embedded.

Effective needs assessment, care and treatment

- Clinicians were aware of relevant and current evidence-based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. Clinical meetings had been held and minutes contained a record of discussion of best practice guidance.
- Our review of patients' notes showed that NICE best practice guidelines were being followed. Staff we spoke with could refer to this and gave examples of updates they had acted on and discussed within the practice.
- The PCRF team referred to the Defence Rehabilitation website for best practice guidance. We reviewed DMICP notes to find all had the musculoskeletal (MSK) outcome completed and the Read codes were correct.
- The Defence Primary Health Care (DPHC) team produced a newsletter that was circulated to clinicians providing further information and a summary of relevant safety updates.
- Guidelines were communicated via the DPHC newsletter and discussed in healthcare governance meetings.

Monitoring care and treatment

The practice undertook quality improvement work to review the effectiveness and appropriateness of the care provided. The Defence Medical Services (DMS) have a responsibility to deliver the same quality of care as patients expect in the National Health Service (NHS). Because the numbers of patients with long term conditions are often significantly lower at Defence Primary Healthcare Services (DPHC) practices, we are not using NHS data as a comparator.

- We found that chronic conditions were managed well. The practice nurse and the DSMO shared the lead for management of patients with long-term conditions (LTC). The population manager facility (referred to as 'popman') was used to identify and

monitor patients with an LTCs. Monthly searches were run by the nursing team in conjunction with DSMO, patients were recalled twice by email followed by a letters and telephone call if needed. This initiative had improved statistics significantly, for example reviews of asthma had increased from 70% to 97%. The tracking log for LTC's was very clear and very comprehensive. Alongside this the DSMO had produced an SOP for managing chronic disease reviews to ensure consistency. A management plan template had also been developed for asthma patients. Once completed this was emailed to patients and recorded on DMICP.

- The medical centre provided step 1 of the mental health pathway. The Welfare Officer advised us that mental health issues, exacerbated by the isolation of the location, were the main reasons people sought support from the service. The Welfare Officer worked closely with the medical centre and provided recent examples of how they worked together to safely and effectively support individual patients. Our review of patient records showed patients were effectively supported, safeguarded and referred to the Department of Community Mental Health (DCMH) as appropriate to their assessed risk. Standardised clinical codes were not always applied. We saw low mood was the most commonly used code (until a diagnosis confirmed). The practice recognised that differing codes were used and, although clinicians were encouraged to be consistent with read codes, there was no definitive list for staff to follow. The medical centre recognised this and found it particularly difficult when DCMH were not always consistent with their coding. Patients with mental health needs were routinely coded as vulnerable.
- Information from the Force Protection Dashboard, which uses statistics and data collected from military primary health care facilities, was also used to gauge performance. Service personnel may encounter damaging noise sources throughout their career. It is therefore important that service personnel undertake an audiometric hearing assessment on a regular basis (every two years). Audiometric assessments were in date for 69% of patients. This was low as guidance had been issued from strategic command during the COVID-19 pandemic to reduce face-to-face appointments.
- The practice had implemented a structured programme of audits to monitor and systematically review clinical and non-clinical outcomes to ensure treatment and care was being provided in accordance national and local standards. A doctor led on clinical audit. Audits undertaken in 2020/21 included:
    - high risk medicines prescribing, including the prescribing of sodium valproate (used to treat epilepsy and bi-polar disorders) in females with childbearing potential;
    - controlled drugs prescribing;
    - minor surgery
    - hypertension
    - diabetes
    - depression
    - Direct Access (PCRF)
    - DoFit (PCRF) (an Army instigated initiative aimed at providing education and support for weight management).

- The PCRF had a very good understanding of the aircrew role at Odiham including the specific conditioning demands. The aircrew conditioning programme was developed primarily for fast jet pilots and was aimed at strengthening neck muscles and developing cardiovascular fitness in order to reduce injury and increase performance. The package was developed by the RAF Centre for aviation medicine. All aircrew were mandated to complete ACP training. However, the package was not viewed as suitable for rotary aircrew whose role was very different to a fast jet pilot. The ERI at Odiham in an effort to drive improvement had joined the ACP working group which is aimed at developing and monitoring the ACP pathway. Odiham had taken the lead in developing a package of four training modules for rotary rear crew and a functional test to identify any potential vulnerability to injury. The programme was in the process of being approved and will ultimately help to ensure rotary aircrew are screened and have targeting injury prevention training with the aim to improve their fitness for their role and reduce injury risk. There is a potential for it to have a wider reach to influence testing and injury prevention across the tri-service rotary environment.
- An internal quality assurance tool, the Defence Medical Services (DMS) Common Assurance Framework (CAF) was used to monitor safety and performance. The DMS CAF was formally introduced in September 2009 and since that time has been the standard healthcare governance assurance tool utilised by DMS practices to assure the standards of health care delivery within DMS.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and chronic disease management.

- An induction programme was in place for permanent staff. It took account of DPHC requirements, local expectations and the role of the staff member appointed. Mandated training was monitored by the practice manager who confirmed training was up to date for all staff.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating doctors and nurses.
- All staff were all encouraged to gain more experience and skills. Internal and external training sessions were available to staff. For example, two nurses had received extra funding and completed spirometry training.
- Aircrew could see a physiotherapist by direct access. We noted that at times patients were seen by one of the physiotherapists that was not Military Aviation Medicine Examiner (MAME) trained. This had been entered onto the risk register with mitigations that the patient must have a doctor consultation immediately. This posed a risk if at any time a doctor was unavailable.
- The medics had SOPs and terms of reference (TOR) to set out their duties. They completed mandatory training and competency checks as part of their induction refreshed annually thereafter.

Coordinating care and treatment

Staff worked together and with other care professionals to deliver effective care and treatment. The practice met with welfare teams and line managers to discuss vulnerable patients who were both trainees and permanent staff.

- The medical centre had established links with local NHS services, these included connections with the local minor injuries unit and the local clinical commissioning group.
- The medical centre staff were proactive in their approach to improvement. An example of this was when a recent police incident occurred on the base and safeguarding concerns were not escalated appropriately by a member of the military police.. As a result of this, the medical centre initiated cross-station safeguarding training. The welfare team including SSAFA social workers, padres, personnel management services and the police section were all invited. General safeguarding awareness training followed, including small group discussions of case scenarios that any of the disciplines may come across, these were then shared with the other groups. This increased collaborative working and good relationships across station, and it triggered the police section to explore arranging more formal safeguarding training for their personnel. They are now all at least Level 1 trained. This training is going to be held six monthly to account for staff turnover. As well as the police now completing some more formal training, the Community Development Officer following the training session has become a MOD Level 2 course instructor to enable more accessible and timely training to others who would benefit.
- PCRF staff reported good access and an effective service from the Regional Rehabilitation Unit (RRU) at Aldershot, including timely access to the multi-disciplinary injury assessment clinic (MIAC), podiatry and rehabilitation courses.
- For patients leaving the military, pre-release and final medicals were facilitated. During the pre-release phase the patient received an examination and a medication review. A summary print-out was provided for the patient to give to the receiving doctor.

Helping patients to live healthier lives

The practice identified patients who may need extra support and signposted them to relevant services. For example:

- Patients at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.
- Initiated by a member of the administrative staff, the medical centre had set up a self-help menopause group meeting every 1st Wednesday of the month at the Hive centre. (The HIVE is an information network available to all members of the service community). The aim was to give those going through this stage of their life a safe place to discuss this topic with others in a similar situation. This was open to military, dependants and civilian women. The intention was that the doctor will become the expert menopause lead for continuity and advice. The group meet once a month and guest speakers are going to be invited.

- The practice nurse had the lead for health promotion. The health promotion strategy was underpinned by national priorities and initiatives to improve the population's health including, stop smoking campaigns, women's health and tackling obesity. It also took account of the patient population need and seasonal variation impacting health.
- Two nurses had the appropriate sexual health training and provided sexual health promotion. Patients were signposted to local sexual health services for procedures not undertaken at the practice.
- RAF Odiham were the first RAF station to run DoFIT course (this is an Army instigated initiative aimed at providing education and support for weight management). They have run three DoFIT courses with another planned for October. The audit results of last three courses found overall positive impact on weight loss following attendance at a DoFIT course. The PCRF have been running this for all station personnel not just rehab patients with the aim of improving health and wellbeing of station personnel and reducing risk factors for injury.
- Notice boards were used in the waiting area for health promotion campaigns. These were dated and refreshed in line with the strategy. There was a monthly programme whereby promotions were refreshed in line with seasonal and/or topical demand. There had not been a health fair since the previous inspection due to COVID-19 but these would re-start if risks could be mitigated.
- A mental health information display was available for patients that considered wellbeing and mindfulness. It provided details about websites patients could access for further information. The DMSO had devised an information document for patients who may need to access local mental health services. The document named 'Mental Health Support for Patients' described what actions to take if 'Stretched', 'Stressed' or 'Unwell'. It contained advice and most importantly the contact details of all local organisations that could offer help, 24 hours a day.
- The practice recalled patients for preventative health checks. Health checks can help to identify any conditions that patients may be at-risk of and could be avoided by preventative treatment and lifestyle choices.
- A quarterly search was undertaken for all patients aged 50 to 64 years who were entitled to breast screening. The practice also engaged with all national screening programmes and had a mechanism to ensure that eligible patients were referred into the bowel cancer or abdominal aortic aneurysm (AAA) screening programs.
- The number of women aged 25 to 49 (there were no women patients aged 50 to 64) whose notes recorded that a cervical smear had been performed in the last three to five years represented an achievement of 96%. The NHS target was 80%. Invite letters were sent out and followed up if not responded to.
- It is important that military personnel have sufficient immunity against the risk of contracting certain diseases. The World Health Organisation sets a target of 95% for vaccination against diphtheria, tetanus, pertussis and polio and measles, mumps and rubella. The data below from August 2021 provides vaccination data for patients using this practice (regional and national comparisons were not available):
    - 96% of patients were recorded as being up to date with vaccination against diphtheria.

  - 96% of patients were recorded as being up to date with vaccination against polio.
  - 99% of patients were recorded as being up to date with vaccination against Hepatitis B.
  - 99% of patients were recorded as being up to date with vaccination against Hepatitis A.
  - 96% of patients were recorded as being up to date with vaccination against Tetanus
  - 99% of patients were recorded as in date for vaccination against MMR (50% of patients were recorded as in date for vaccination against meningitis although only patients under the age of 25 or those held at high readiness or deploying to a high-risk location require this vaccine. 93% of under 25-year olds were in date for this vaccine.

- Units were responsible for ensuring their personnel kept up to date with vaccinations. The practice worked collaboratively with Chain of Command to ensure all personnel requiring additional immunisations in line with operational requirements were identified and vaccinated within an appropriate timeframe. Monthly searches were undertaken to recall patients for vaccinations.
- On leaving the Armed Forces, personnel underwent a release medical with the approach tailored to individual patient's needs. The welfare team were engaged throughout the process to ensure all issues were adequately addressed. Transition to NHS services was managed to ensure continuity of care.

Consent to care and treatment

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making. They had received in-service training and had a good understanding of the Mental Capacity Act (2005) and how it would apply to the patient population.
- Doctors records showed that consent was appropriately taken and recorded. The physiotherapists recorded consent to share information with the Chain of Command. Our review of nursing records showed consent was routinely documented.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

- Staff and patients provided us with numerous examples of when the practice had gone the extra mile to ensure patients received individualised and compassionate care. For example, the nurse developed a tracking spreadsheet for clinically vulnerable patients and those shielding during the COVID-19 pandemic. From the outset patients were contacted by telephone to offer support and guidance. Home visits were undertaken when required for these patients including for routine blood tests. We received patient feedback that described this service as ‘brilliant’. One of the nurses telephoned all patients in these groups each month to check on welfare if they hadn’t been seen otherwise. When prescriptions were required home delivery was arranged with help from the police department
- On return to work all patients had bespoke risk assessments arranged with the Environmental Health Technician. Feedback from patients was that was very reassuring.
- For vaccinations the nurse divided the tracker spreadsheet into cohorts according to need and worked with the regional nurse advisor to facilitate vaccines soonest considering the higher priority groups who were not automatically recognised by the NHS booking system.
- The practice had an information network available to all members of the service community, known as HIVE. This provided a range of information to patients who had relocated to the base and surrounding area. Information included what was available from the local unit and from civilian facilities, including healthcare facilities.
- The station welfare team staff kept a register of patients who were also carers and provided extra support as required. There was a note for carers in the practice leaflet and posters in reception. The practice had a guidance note for staff on how to support carers. Carers were identified during the new patient registration process and coded accordingly. Patients with a caring responsibility were encouraged to book a double appointment to discuss any support they may require. Carers were reviewed monthly by the carers lead (doctor) who also ran the monthly DMICP search to identify the carers in the patient population. The medical centre also has a carers SOP which included the support offered to carers and this was reviewed in November 2020.

Involvement in decisions about care and treatment

- Patient feedback suggested the health care needs of patients were effectively addressed and they received appropriate information to make decisions about care and treatment.

- Our review of patient records showed that the PCRF team appropriately used physical training recovery, maintenance and light duties prescriptions to guide patient's return to fitness.
- The Patient Experience Survey showed 97% of patients said they were listened to.
- An interpretation service was available for patients who did not have English as a first language. We were advised it had not needed to be used.
- The practice acted in a compassionate way toward any patient that had to be discharged on health grounds. We saw that the practice reassured these patients and signposted to personnel within the military who could guide them through the exit process and transition to NHS care and other support functions.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Privacy screening was provided in doctors', nurses' and medics' consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. Clinic room doors were closed during consultations.
- There was no cubicle within the PCRF gym to provide confidential treatment meaning privacy was compromised, portable screens and a radio were used to best mitigate this. We saw this was identified on the risk register and a statement of need had been submitted and approved but improvements were not likely to be completed until 2022.
- There was a clearly marked box to ensure patients are required to stand back at reception until called forward. The medical centre had rooms available for patients who wished to discuss a matter in private, this was advertised in the waiting area.
- The practice could facilitate patients who wished to see a clinician of a specific gender.

Are services responsive to people's needs?

We rated the practice as good for providing responsive services.

Responding to and meeting people's needs

The practice understood the needs of its population and organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

The practice provided rapid access for aircrew and staff were trained to provide specialist support.

- Patients were able to have 15minute appointments with a doctor and nurse.
- Same day appointments were available for those patients with medical problems that required it. Later appointments were made available if a patient required it after hours on a bespoke basis.
- In response to restrictions associated with COVID-19, a remote triage model including, the use of eConsult and telephone consultation was implemented by the practice. Face-to-face consultations were facilitated if clinically required.
- Patients were able to receive travel vaccines when required. The practice was a yellow fever centre.
- A text service was in operation as an appointment reminder.
- All clinicians worked together to make sure clinics ran smoothly and to time and would often help out others. This allowed clinicians to know they could spend more time with those patients should they need it.
- The practice trained staff in equality and diversity and there was a 'diversity and inclusion' lead within the medical centre.

Timely access to care and treatment

Patients' needs were met in a timely way.

- The practice accommodated patients with an emergency need on the day they presented at the practice. Routine appointments with a doctor could be facilitated within two days and gradings were available within five working days. Nurses had capacity to see a patient within one working day, but medics could provide earlier appointments to do blood tests. The patient questionnaire provided positive feedback on access to appointments.
- Outside of routine clinic hours after 18:30 hours patients were diverted to the NHS 111 service and/or e-consult (a message could be left for the practice to follow up on the following working day if not urgent). If the practice closed on an afternoon for training purposes, patients could still access a doctor in an emergency. In this way, the practice ensured that patients could directly access a doctor between the hours of 08:00 and

18:30, in line with DPHC's arrangement with NHS England. There were appointments made available to shift workers who could not attend during routine hours.

- There was a duty medic within the practice for out of hours airfield cover only. There was also an aviation medical doctor on call whose response time for phone calls was10 minutes, and in person within two hours. Over weekends, the aviation medicine cover was shared between Military Aviation Medical Examiner (MAME) trained doctors at two other stations under a memorandum of understanding between the Station Commanders of each station.
- Results from the practice's patient experience survey in August 2021 (61 responses were received) showed that patient satisfaction levels with access to routine care and treatment were high;
    - 99% of patients felt satisfied with the time of their appointment.
- The practice information leaflet included details about how to use the eConsult system to book an appointment with a doctor. The practice leaflet confirmed home visits were available and provided details for out of hours services.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- DPHC had an established policy and the practice adhered to this. The practice manager was the designated responsible person who handled all complaints in the practice. Following a review of complaints in 2020, it was clear that verbal complaints were not being documented or addressed. The practice management team reviewed the complaints process and as a result conducted local training. There were six complaints recorded in 2021, three verbal and three written which had been documented on the complaints log in the healthcare governance workbook and actioned. A further review of 2021 complaints were scheduled for the end of the year. Information was available to help patients understand the complaints system.

Are services well-led?

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

At our previous inspection, we rated the practice as requires improvement for providing well-led services. We identified shortfalls in governance arrangements around medicines management and infection prevention and control (IPC).

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

Leadership, capacity and capability

The leaders at the medical centre had been working hard to address areas they had identified as requiring improvement. Significant work had been undertaken and it was evident that a cohesive and comprehensive plan had been implemented by the practice management team. The impact of COVID-19 was had been well managed.

The senior staff in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. The SMO was visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff.

- Staff told us the practice held regular team meetings. We saw evidence of minutes and agendas for these, which included clinical meetings, half day training meetings, monthly carers' meetings with other health professionals and all staff meetings. Staff meetings were held monthly, and every member of staff was invited. Staff could add items to the agenda prior to the meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident in doing so and felt supported if they did.
- Staff said they felt respected, valued and supported by the more senior staff in the practice. All staff were involved in discussions about how to run and develop the practice, the more senior staff encouraged all members of staff to identify opportunities to improve the service delivered by the practice.
- The staff team was a very cohesive group who enjoyed their work at the medical centre. They held social events which they told us most staff went to and everyone enjoyed. Most recently the staff team undertook a 100-mile bike ride to celebrate the 100-year anniversary of the Chinook helicopter, all monies raised went to a cancer charity.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- The practice had a clear vision to deliver high quality care and promote good outcomes for patients. RAF Odiham's medical centres' mission was to 'facilitate operational readiness through collaborative and effective patient-centred care'. This was done by delivering consistent, safe and effective care, which was clearly at the forefront of the SMO's strategy and vision for the practice. This was adopted by all members of staff. All staff we spoke with were very content with their working environment. Staff also acknowledged that their opinions, observations and views were valued.
- Communication and information sharing structures were in place including a schedule of regular practice, governance, clinical and training meetings. The SMO attended the local clinical commissioning groups (CCG) with respect to the vulnerable patients identified at RAF Odiham. The SMO had worked hard to increase the profile of the medical centre and had forged good links to aid communication, and work together to improve patient care where possible.
- Feedback from staff, patients and the meeting minutes we reviewed showed regular engagement took place to ensure all parties knew and understood the vision and values.
- The practice was is a GP training practice having been reaccredited for three years. As the medical centre do not see families the GP trainees split their time between RAF Odiham Medical Centre and one of the local NHS practices forging good links and lines of communication aiming to provide consistent and safe care.

Culture

- Staff demonstrated a patient-centred focus. Despite the challenges associated with staffing levels, it was clear staff made every effort to respond to the needs of patients in a safe, effective and timely way.
- The PCRF described their team as inclusive with an excellent team dynamic. They described a no blame culture throughout with their focus being to improve care for patients.
- Equality and inclusion of all staff was evident, staff told us their contributions to the service were listened to and that they felt valued. Team building meetings were held regularly.
- Staff said there was an open-door policy with everyone having an equal voice, regardless of rank or grade. All were familiar with the whistleblowing policy and said they were comfortable raising any concerns.
- Processes were established to ensure compliance with the requirements of the duty of candour, including giving those affected reasonable support, information and a verbal and written apology. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. There was a duty of candour register within the healthcare governance workbook but no explanation as to why an entry had been made. Staff had received training in the subject.

Governance arrangements

There were consolidated and clarified responsibilities and systems of accountability to support good governance and management. Since the last inspection, improvements had been made in the governance framework around medicines management and infection prevention and control.

- The leadership team had revised and/or developed systems and processes in accordance with DPHC expectations and the needs of the patient population. In particular, the practice manager had developed a comprehensive healthcare governance workbook which provided a detailed overview of how the service was being monitored. The practice effectively used the healthcare governance workbook to capture and monitor governance activity. All staff had access to the workbook which provided links to meeting minutes, policies and other information.
- Joint working with the welfare team, pastoral support and Chain of Command was in place with a view to safeguarding vulnerable personnel and ensuring co-ordinated person-centred care for these individuals.
- Shared care protocols were in place for patients taking high risk drugs and an effective system implemented for the controlled storage and tracking of prescription stationary.
- Practice leaders had established a number of policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. The practice had revised procedures and implemented an overarching SOP for mental health and long-term conditions. Clinical waste procedures had been strengthened after gaps had been highlighted at the last inspection, but some improvement was needed to ensure the PCRF were fully compliant.
- There was a programme of regular meetings that extended to include all staff. These included a heads of department and multidisciplinary team meeting (held weekly), practice governance and practice team meetings (held monthly). Minutes of meetings were recorded and made available to those unable to attend.

Managing risks, issues and performance

There were some clear and effective processes for managing risks, issues and performance.

- There was an established a governance structure that provided oversight of risk and the quality of service. The medical centre maintained a risk register and a record of short-term issues, and had plans in place for major incidents. We saw that these were reviewed regularly, acted on and staff had been trained. A record of retired risks was also held for reference. The business resilience plan had four elements, these were business continuity, mass casualty, pandemic outbreak and communicable disease. This was regularly reviewed, and staff had cue cards for actions to take in the case of emergency such as loss of power. The medical centre had a role in the unit major incident plan, and this was exercised regularly with both tabletop exercises and practical tests.

- Regularly reviews, risk assessments and audit was having a positive impact on safety. These covered a number of areas including COSHH (substances hazardous to heath), lone working, slips trips and falls and the management of sharps.
- The practice manager was able to describe processes that could be used to manage poor performance. These included welfare support, re-training, appraisal or, if required, disciplinary processes.
- All staff were in date for 'defence information passport' and 'data security awareness' training.

Appropriate and accurate information

- An understanding of the performance of the practice was maintained. The practice manager used the Common Assessment Framework (CAF) as an effective governance tool. A number of different meetings were held regularly and extended to the whole team. Cross-practice meetings had been established and provided a forum for effective discussion and shared learning. Minutes from meetings we reviewed demonstrated that key agenda items had been discussed including safeguarding, NICE guidance and patient safety alerts.
- There were robust arrangements at the medical centre in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, staff and external partners to support high-quality sustainable services.

- There were various options in place to encourage patients to provide feedback on the service and contribute to the development of the service. Patient feedback was requested monthly, and a patient experience survey was undertaken throughout the year. Patients were approached on an ad hoc basis in the waiting room and asked for feedback. There was a suggestion box in waiting room and feedback was requested via the medical centre social media page. All the feedback we saw was overwhelmingly positive about the care and support patients received.
- There was evidence that the practice acted on feedback from patients, these included offering later appointments for shift workers and changing the chairs in the waiting room.
- Each flying squadron had a dedicated doctor and physiotherapist to ensure continuity of support and advice. The PCRF was integral to the medical centre and staff attended all the medical centre meetings.
- DCMH Aldershot provided outreach clinics prior to the pandemic and provided appropriate support remotely.

- The SMO sits on the Station Executive committee weekly to ensure prompt and effective communication. Good and effective links with internal and external organisations were established, including with the welfare team, RRU and DCMH.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation. The practice maintained a quality improvement log on the health governance workbook. The practice had completed a number of quality improvement projects (QIPs) which were detailed on the quality improvement log. QIPs were also communicated to DPHC Regional Headquarters. There were good examples of quality improvement that included:

- Safeguarding training for the police on camp following a safeguarding incident.
- The ERI was seen to be going above and beyond leading with quality initiative projects and leading all classes and exercise delivery.
- The initiation of SOPs to ensure consistency and reduce risk.
- The introduction of a menopause group.