# Wattisham Medical Centre

Wattisham Station, Ipswich, Suffolk IP7 7RA

**Defence Medical Services inspection**

This report describes our judgement of the quality of care at Wattisham 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.

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

# Contents

# Summary

## About this inspection

We carried out this announced inspection across two dates: the medical centre was inspected on the 1 March 2022 and the Primary Care Rehabilitation Centre (PCRF) on 14 March 2022.

**As a result of this inspection the practice is rated as good overall in accordance with CQC's inspection framework.**
The key questions are rated as:

Are services safe? – good

Are services effective? – good

Are services caring? – good

Are services responsive? – good

Are services well-led? – good

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

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

**At this inspection we found:**

- The practice had effective leadership although this was hindered by staff shortages. Staff worked well as a team and said they were well supported and included in discussions about the development of the service.
- Despite the staffing challenges patient feedback indicated staff responded promptly to ensure they received timely and effective care. 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.
- Patients found it easy to make an appointment and urgent appointments were available the same day.
- Mandated training for staff was up-to-date with the exception of thermal injuries training.

- The practice had good lines of communication with the unit, the Primary Care Rehabilitation Facility (PCRF), the welfare team, the Padre and the Department of Community Mental Health to ensure the wellbeing of service personnel.
- An inclusive whole-team approach was supported by all staff who worked collaboratively to provide a consistent and sustainable patient-centred service.
- The arrangements for managing medicines was good. However, the management of prescriptions needed slight improvement in accordance with Defence Primary Healthcare policy.
- Quality improvement activity was evident but required recording to enable better reflection moving forward.
- The practice 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.

**The Chief Inspector recommends that the medical centre:**

- Review the approach to risk management and ensure all risk assessments required are in place.
- Ensure all staff are engaged with the peer review process.
- Formally record quality assurance processes.
- Ensure staff are fully aware of their responsibilities as per their terms of reference.
- Ensure all nurses have a role specific induction.
- Ensure safety systems are in place including an effective alarm system and a process to monitor national and local safety alerts.
- Ensures all staff complete thermal injuries training.
- Uses Read coding effectively and consistently.
- Ensure the PCRF uses the correct process, via the clinical system to manage referrals.

**The Chief Inspector recommends to DPHC:**

- The regional team keeps staffing levels and additional staff roles under review to ensure there is clinical resilience in the system.

**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. The team comprised specialist advisors including a primary care doctor, a practice manager, a physiotherapist, a pharmacist and a nurse.

## Background to Wattisham Medical Centre

Located near Ipswich, Wattisham Medical Centre delivers a primary healthcare, occupational health and force protection service to a patient population of 1,475 regular service personnel. This can increase to approximately 1,550 due to the reservists from local areas and regular assignments for service personnel into Wattisham Station.

Families and dependants are signposted to nearby NHS services. There were no registered patients under the age of 18 at the time of the inspection.

A Primary Care Rehabilitation Facility (PCRF) is located in the station gymnasium and provides regular service personnel with a physiotherapy and rehabilitation service.

The practice is open from 08:00 to 16:30 hours Monday, Tuesday, Wednesday and Friday and 08:00 to 12:30 hours on a Thursday. Emergencies can be accommodated in the afternoons when it is closed. From 16:30 hours until 18:30 hours access to emergency medical cover (referred to as shoulder cover) is provided by a duty doctor. Outside of these hours, including weekends and bank holidays, cover is provided by NHS 111.

### The staff team

| | |
|---|---|
| Civilian Senior Medical officer (SMO) | Gapped |
| Regimental Medical Officer (RMO) | One |
| Civilian medical practitioner (CMP) | One (locum) |
| Practice manager | One |
| Nurses (civilian) | Two |
| Pharmacy technician | One |
| Exercise rehabilitation instructors (ERI) | One |
| Physiotherapists | Two |
| Administrators | Three (one is a locum) |
| Combat medical technicians* (CMTs)<br>(referred to as medics throughout this report) | 11 |

*In the army, a medical sergeant and CMT is a soldier who has received specialist training in field medicine. It is a unique role in the forces and their role is similar to that of a health care assistant in NHS GP medical centres but with a broader scope of medical centre.

# Are services safe?

**We rated the practice as good for providing safe services.**

## Safety systems and processes

The Regimental Medical Officer (RMO) was the lead for safeguarding. All staff had received up-to-date safeguarding training at a level appropriate to their role.

There was a risk register of vulnerable patients and a system to highlight them on DMICP (electronic patient record system). Regular searches were undertaken to inform the register of vulnerable patients. he doctors had strong links with unit welfare teams and commander's monthly health review (previously referred to as the unit health committee meeting).

. The status of safeguarding and vulnerable patients was discussed at the twice monthly meetings with the Welfare Officer. In addition, the needs of vulnerable patients were discussed at monthly multi-disciplinary meetings. We spoke with the Welfare Officer for the camp who told us they provided a welfare service to military personnel. They confirmed they had a good relationship with the practice and praised the responsiveness of the doctors when urgent intervention was required.

Notices advising patients of the chaperone service were displayed. Staff had conducted online chaperone training in January. Information was included about chaperones in the practice leaflet. Staff who acted as chaperones had received a Disclosure and Barring Service (DBS) check. 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 where relevant, on recruitment and on an ongoing basis. All clinical staff currently working in the practice had an up-to-date DBS certificate or a risk assessment in place in accordance with Defence Primary Healthcare (DPHC) policy.

The Band 6 nurse was the lead for infection prevention and control (IPC) and had completed the link practitioner training. The last IPC audit was undertaken in December 2021 resulting in a compliance score of 80%. Areas noted for improvement were actioned.

A contract was in place for environmental cleaning. Cleaning staff worked to cleaning schedules with non-clinical areas cleaned throughout the day and clinical areas in the evening. The practice manager carried out regular checks of the premises with the nurse and reported any issues to the cleaning contractors.

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 October 2021.

The Primary Care Rehabilitation Facility (PCRF) was located in the main gymnasium and had an upstairs section of the building for rehabilitation. All equipment was maintained by the exercise rehabilitation instructor (ERI) under the Ministry of Defence service plan. Maintenance was carried out once a year as was in date. All gymnasium equipment was maintained by the unit physical training instructors (PTIs). There was a close working

relationship between the PTIs and PCRF. Any rehabilitation equipment that was broken was quarantined and reported in accordance with defence rehabilitation processes.

Both physiotherapists used acupuncture. An updated standard operating procedure (SOP) was in place to support this practice, patient consent was sought and recorded on DMICP. Sharps boxes in treatment room were in date and correctly stored.

## Risks to patients

From a patient perspective, clinical staffing levels were sufficient as patients interviewed told us they had prompt access to a clinician. Waiting times for an appointment with a clinician confirmed this. However, there were potential risks with the capacity and consistency of clinical staffing levels. Staff attached to units (Regimental Aid Post) staff were worked at high readiness to deploy.

An RMO led the practice. The Senior Medical Officer (SMO) post had been vacant since September 2021. A new SMO had been recruited and was due to start in March 2022. The locum civilian medical practitioner (CMP) was due to become a permanent member of staff within the next few weeks. A General Duties Medical Officer was due to be posted to the practice shortly, along with a second later in the year.

The practice was supposed to have four whole time equivalent doctors in post but only had two, with one being a locum. There had been occasions (in the past few weeks) when there were no doctors available. This was captured and managed within a SOP, including the use of other medical centres (Colchester and Honington medical centres).

The was currently sufficient staffing within the PCRF, however, there will be vacancies over the next few months with the current staff member being assigned elsewhere and the new incoming staff member still deployed. Gaps were managed through the temporary healthcare worker contract. Staff advised us it was difficult to secure staff due to the remote location of the unit.

There were appropriate risk assessments in place to ensure physical activity was conducted safely. The ERI did not conduct outdoor sessions therefore was not involved in measuring wet globe bulb test monitoring (used to indicate the likelihood of heat stress). There was temperature control within the building.

An automated external defibrillator (AED) was located in the main gym, all staff were clearly able to identify where it was located. No oxygen or other emergency drugs were stored on site, these were held in the practice. Staff advised that they follow the routine response process as well as placing a call to the practice to get support whilst waiting for an ambulance if required.

The arrangements in place to check and monitor the stock levels and expiry dates of emergency medicines were effective. The practice staff were fully trained in emergency procedures, including basic life support and the use of an AED, sepsis and anaphylaxis training. Staff had not yet received training in thermal injuries. We saw sepsis guidelines displayed throughout the practice.

A COVID-19 risk assessment had been completed; we saw measures in place that had been introduced to minimise the risk of spreading infection during the COVID-19 pandemic. These included

- signs placed throughout to encourage social distancing,
- hand gel was readily available
- personal protective equipment was provided to staff when required. This included face masks that protect staff from airborne infection (known as FP3 masks) when seeing patients.
- A one-way system

  Waiting patients could be not be observed at all times by staff working on the front desk. Funding for CCTV had been approved but this had yet to be installed.

## Information to deliver safe care and treatment

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

Peer review of doctors DMICP consultation records was frequent and regular. We saw it had recently been undertaken with the RMO undertaking a peer review of all clinical cases seen by himself and his colleague in October 2021. This amounted to over 100 patients. They used a standardised proforma, then fed back the observations to their colleague and invited them to also undertake peer review for objectivity. This has been planned. This activity was written up as an audit. There was a plan to undertake the activity periodically throughout the year. Similar activity was undertaken by the Medical Sergeant who reviewed the medics' clinics. This was written up as an audit. The RMO checked medics notes on an ad-hoc basis. The nurses were planning to undertake this activity in the future. The PCRF undertook a clinical notes review every six months and the findings were discussed with staff. Recent notes audits highlighted issues with completion of Patient Reported Outcome Measures (PROMs) and the recording of patient expectations and Specific, Measurable, Achievable, Realistic and Time Based (SMART) goals This has been discussed by the team with the intention to review it at the next notes audit.

There was evidence of effective patient handovers between clinicians. There was regular communication between clinical staff to ensure clinical problems were highlighted and handed-over when required.

Staff reported that the IT network connection was slow. We also observed this. Laptops were used as a backup. If these failed, then the business continuity plan was actioned; appointments for the following day were routinely printed, patients were phoned to rearrange their appointments, local/neighbouring practices were used and only emergency patients were seen.

There was a failsafe system in place to manage referrals. The majority of external referrals were made via the NHS electronic referral system (eRS) which was managed by one member of the administration team, with cover in place in the event of absence. A referrals

tracker with limited access was maintained and included external and internal referrals, including radiology. Internal referrals to the Regional Rehabilitation Unit, occupational health team and Department of Community Mental Health were also tracked to ensure that appointments were both secured and attended.

A failsafe process was in place for the management of specimens. A record was maintained of all samples sent so when results were returned they could be tracked and any missing results identified. We noted the specimens' management SOP required updating to include who managed this process if the nurse was absent.

PCRF staff were not following routine DMICP processes specifically the use of the administration list which was used to track referrals and discharges to the department. This presented a risk that patients may get lost in the system if referred from other units. Furthermore, patients were verbally referred to the ERI and not through the proper processes, potentially this could cause patients to slip through the net.

## Safe and appropriate use of medicines

The RMO was the lead for medicines management at the practice and was also responsible for the dispensary. The RMO was unaware of this, we were unable to see the Terms of Reference to confirm. The pharmacy technician was responsible for the day-to-day operation of the dispensary. Safe procedures were in place for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment.

Arrangements were established for the safe management of controlled drugs (CD), medicines with a potential for misuse, including destruction of unused CDs. We saw that monthly and quarterly checks were completed.

Medication requiring refrigeration was monitored twice a day to ensure it was stored within the correct temperature range.

All prescription pads were stored securely. However, the management of prescriptions needed minor improvement to ensure compliance with DPHC policy.

Patient Group Directions (PGD) had been signed off to allow appropriately trained staff to administer medicines in line with legislation. The PGDs were current and signed off correctly. Medicines that had been supplied or administered under PGDs were indate. We noted that the PGD audit had been undertaken by the pharmacy technician; PGD audits must be undertaken by a nurse or doctor only. This was noted by the practice and agreed for the next audit cycle.

Requests for repeat prescriptions were managed in person or by email in line with policy. A process was in place to update DMICP if changes to a patient's medication was made by secondary care or an out-of-hours service.

We saw evidence to show that patients medicines were reviewed regularly. The doctor's notes in DMICP were comprehensive. The pharmacy technician demonstrated good awareness of the requirements for monitoring and was clearly familiar with the patients on the register. They regularly checked when patients needed a review and arranged for these to be done before repeat medications were issued.

The practice followed DPHC protocol and local SOP for high risk medicines (HRM). The RMO carried out regular searches to identify patients on HRMs. We reviewed three sets of patients records who were prescribed HRMs and they were subject to a shared care agreement with secondary care, where necessary. The register of HRMs used at the practice was held on DMCIP and all doctors and relevant clinicians had access to this. The pharmacy technician demonstrated good awareness of the requirements for monitoring and was clearly familiar with the patients on the register. They regularly checked when patients needed a review and arranged for these to be done before repeat medications were issued.

## Track record on safety

The practice manager was the designated health and safety lead and a board was displayed near the reception and was regularly externally audited. Measures to ensure the safety of facilities and equipment were in place. Electrical and gas safety checks were up to date. Water safety measures were regularly carried out with a legionella inspection undertaken in February 2021. A fire risk assessment of the building was undertaken annually. Firefighting equipment tests were current. Staff were up-to-date with fire safety training and were aware of the evacuation plan.

We looked at the practice's arrangements for the provision of a safe service. A risk register was maintained that took account of the 'four T's' (transfer, tolerate, treat, terminate) to indicate where and how risks were being managed. Risk was discussed as part of the practice governance meeting which was held twice monthly. Insufficient staffing was the main risk and this was clearly articulated on the register. Other risks had been identified and included on the register. There were some risk assessments in place, but not all. For example, there were no assessments for clinical waste, medical gas, moving patients and medical samples. The practice did not have sight of the Control of Substances Hazardous to Health (COSHH) assessments as these were held by the cleaning contractors. The practice manager confirmed they would secure these following the inspection.

The practice is an older building and had no integrated alarm system. Two of the clinical rooms had portable alarms but these could not easily be heard throughout the building. This was identified on the risk register and the practice were actively trying to find a resolution.

## Lessons learned and improvements made

All staff had access to the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events and incidents. The staff training database showed that all staff had received up to date training.

Both clinical and non-clinical staff gave examples of incidents reported through the ASER system including the improvements made as a result of the outcome of investigations. All ASERs were raised and discussed at the practice meeting. The learning points and actions for improvement were discussed and agreed. A recent example involved poor initial management of an acute injury. Findings of the ASER recognised that subsequent

training was required to improve initial management and the appropriate referral of acute injuries.

One member of staff was nominated the junior ranks ASER Lead. This was implemented to support the junior staff in raising ASERs.

An ASER log was maintained on the healthcare governance workbook, a system that brings together a comprehensive range of governance activities including any changes made.

The pharmacy technician was responsible for managing safety alerts, these were sent to the nurse and the medical sergeant but not the doctors. There was no evidence to show these were discussed in practice meetings or governance meetings. The practice manager was already aware that improvement was needed, and this had been discussed at a recent practice meeting.

# 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 National Institute for Health and Care Excellence (NICE) guidance, clinical pathways, current legislation, standards and other practice guidance. Staff were kept informed of clinical and medicines updates through the Defence Primary Healthcare (DPHC) newsletter circulated to staff each month. Updates were also discussed at multi-disciplinary clinical governance meetings. Clinicians also took turns to summarise the latest guidelines and present them at the monthly practice meetings.

## Monitoring care and treatment

We found that chronic conditions were managed well. A standard operating procedure (SOP) outlining the management and monitoring arrangements for chronic conditions was in place. Monthly searches were run by the nurse and the pharmacy technician independently of each other to ensure no recalls were missed. Patients were recalled by letter or email and followed up by a telephone call if needed.

All patients over the age of 40 were invited to a full health check including bloods and identifying risk factors. Lifestyle and health advice was provided as appropriate both verbally and written. This check was repeated every three to five years unless identified as a risk when patients were recalled annually for blood testing. All patients with a chronic disease had an annual screening including blood tests or more frequently if required.

There were very low numbers of patients on the diabetic register and their care indicated positive control of both cholesterol control and blood pressure. Patients at risk of developing diabetes were identified through the over 40’s screening, which included relevant testing, such as HbA1c (blood glucose levels). There were low numbers of patients recorded as having high blood pressure. All were recorded as having a blood pressure check in the past nine months. There were low numbers of patients with a diagnosis of asthma and all had an asthma review in the preceding 12 months.

Audiology statistics showed 58% of patients had received an audiometric assessment within the last two years. During COVID-19 routine audiometry had ceased in line the April 2020 DPHC directive. The practice had resumed audiometry as restrictions relaxed. We were advised the unit managed audiology recalls and prioritised those with a high readiness for deployment and those most at risk.

Through review of clinical records and discussions with the doctors, we were assured that the care of patients with a mental illness and/or depressive symptoms was being effectively and safely managed, often in conjunction with the Department of Community Mental Health The Regimental Medical Officer (RMO) offered an enhanced service of hypnotherapy for low level anxiety conditions. We noted in our review of patients records that inconsistent Read codes (the standard clinical terminology system used in NHS

medical practices in the UK. They provide a standard vocabulary for clinicians to record patient diagnoses, treatment and procedures) were used depending on the presenting symptom or diagnosis meaning information used to monitor performance and the delivery of quality care was not always accurate. Staff told us that they were aware of inconsistent use of Read codes and they understood how this could lead to inconsistent delivery of care for patients. They assured us this would be addressed as a team.

The Primary Care Rehabilitation Facility (PCRF) measured performance based on patient outcomes. The use of Patient Reported Outcome Measures (PROMs) including the Muscular Skeletal Healthcare Questionnaire (MSK-HQ) had been recognised as areas for improvement. There was no administrative support in the PCRF so the handing out of PROMs was reliant on the clinicians. The team had identified this as an area for development following a notes audit.

The exercise rehabilitation instructor (ERI) made effective use of objective outcome measures when planning and progressing patient care. This was measured at the start of treatment, reviewed every four to six weeks and measured again on completion of rehabilitation. There was clear evidence of using objective markers from best ractice guidelines.

There was a graded programme of rehabilitation delivery, with exercise sheets for patients to work with. Rehab Guru (a comprehensive exercise programme) was being used for consistency and continuity.

An audit log was in place. The audit lead was the physiotherapist. An audit register was held and maintained by the practice manager. The register demonstrated ongoing audit activity. The practice was pro-active in involving more junior members of the team to become involved in audit activity, with appropriate supervision. Examples of two cycle audits are;

- The RMO was keen to improve the system for identifying vulnerable patients. A two-cycle audit was undertaken which demonstrated an improvement in alerts being active on the notes of vulnerable patients; from 75% cycle one to 98% cycle two.

- The practice wanted to ensure that those patients prescribed medicines for insomnia had received documented sleep hygiene advice. The second cycle demonstrated an improved outcome following the audit intervention.

- Routine audits were completed by the PCRF including infection prevention and control (IPC), and a notes audit. Further audits had been carried including a direct access review.

## Effective staffing

We looked at the induction process for new and existing staff. There was a role specific induction in place for permanent staff with the exception for one for nurses. Mandated training was monitored by the practice manager and was recorded on the staff database. All staff had protected time for the completion of mandatory training and attendance at group training. All staff were encouraged to maximise use of the external training DPHC)

funds). The graduate ERI in the PCRF had been supported to complete the Post Mentorship Programme.

Clinicians had the appropriate skills for their role and were working within their scope of practice. Opportunities were in place to support clinical staff with continual professional development and revalidation. Peer review for nurses was not currently being undertaken and needed formalising., We noted there was no formal, recorded clinical supervision for the nursing staff, instead they met at multi-disciplinary meetings where they had clinical discussions. They also met amongst themselves frequently to discuss any issues. Medics received clinical supervision from the nurses and doctors. A process of peer review for the doctor and physiotherapist was established. All PCRF staff received regular appraisals, attended regular multi-disciplinary team meetings and discussed clinical cases.

The skill mix of staff was good with a wide range of experience. The presence of an Aviation Medicine Consultant was an asset to the practice and we were told this was is a great support to the practice especially in light of the challenging staffing levels. As an active flying station, the doctors needed to be Military Aviation Medical Examiner (MAME) trained. The two doctors had completed this training. Incoming staff would complete the MAME course as part of their induction. All doctors were aware of the need to remain up to date with their MAME continual professional development.

The RMO was an advanced life support instructor and ensured he provided training at least twice a year. The RMO also held a postgraduate diploma in hypnotherapy and provided this as an optional service to patients. They kept updated with the National Council for Hypnotherapy.

Staff administering vaccines had received specific training which included an assessment of competence. Staff who administered vaccines could demonstrate how they were up-to-date with changes to the immunisation programmes, for example, by access to online resources and discussion at nurses' meetings.

## Coordinating care and treatment

The practice met with welfare teams and line managers to discuss vulnerable patients. Staff told us that they had forged some good links with other stakeholders, including the local NHS, social services and voluntary organisations. There were a number of local services which supported the station e.g. Alcoholics Anonymous and an optician who offered discounts. There were excellent contacts with the local welfare team and Padre.

The local sexual health service had moved to a postal system for sending our self-testing kits. Many patients found this a barrier to accessing tests due to the way parcels and letters were delivered to those living in the accommodation blocks on site. The practice had overcome this by offering to undertake the investigations for the patients instead.

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 was provided for the patient to give to the receiving doctor and a letter if the patient was mid-way through an episode of care. A structured mental health questionnaire was also completed.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred or after they were discharged from hospital. Information was shared between services and we saw that a full copy of findings from investigations and any further treatment requirements were sent to the practice to update the patient's records.

Referrals from the PCRF were sent to Regional Rehabilitation Unit (RRU) or local NHS as required. Waiting times for the RRU were within the key performance indicators (KPIs). Podiatry referrals were seen on average within six weeks. Currently there was only one day per week of face-to-face multi-disciplinary Injury Assessment (MIAC) clinics available which could limit access if patients were not available on that day. This was highlighted as a potential concern with the return to normal military activity following Covid-19. The remainder of MIAC appointments were conducted virtually.

## Helping patients to live healthier lives

The nurses shared the lead for health promotion and had had the appropriate experience for the role. We saw information leaflets were available in the treatment rooms.

There were notice boards located in various places around the practice, some example topics covered included, sepsis, smoking and alcohol.

The nurse had the appropriate sexual health training and provided sexual health support and advice. Patients were signposted to local sexual health services for procedures not undertaken at the practice.

All eligible female patients were on the national cervical screening database and were recalled by the nurse. The latest data confirmed a 100% uptake. Regular searches were undertaken to identify patients who required screening for bowel, breast and abdominal aortic aneurysm in line with national programmes. Alerts were added to their DMICP record which allowed for opportunistic discussion with a health professional. DMICP searches had been created for all national screening.

An effective process was in place to recall patients for their vaccinations. Vaccination statistics were identified as follows:

- 88% of patients were in-date for vaccination against polio.
- 99% of patients were in-date for vaccination against hepatitis B.
- 99% of patients were in-date for vaccination against hepatitis A.
- 99% of patients were in-date for vaccination against tetanus.
- 98% of patients were in-date for vaccination against MMR
- 98% of patients were recorded as being up to date with vaccination against typhoid.
- 98% of patients were recorded as being up to date with vaccination against diphtheria.

## Consent to care and treatment

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. They understood the Mental Capacity Act (2005) and how it would apply to the population group. All staff had been training appropriately.

Clinicians advised us that implied consent was accepted for basic procedures such as the taking of blood pressure. Written consent was taken for more intimate examinations. We noted there appeared to be a lack of documented evidence of a chaperone being offered/declined and a lack of Read code use.

# Are services caring?

**We rated the practice as good providing caring services.**

## Kindness, respect and compassion

An information network known as HIVE was available to patients on the camp. This provided a range of information to patients who had relocated to the base and surrounding area. HIVE provided information about facilities available on the station and locally including civilian healthcare facilities.

We spoke with seven patients as part of the inspection and feedback indicated staff treated patients with kindness, respect and compassion at all times. This included extended appointments, and wellbeing support. We also spoke with the Padre and the Welfare Officer who described the care and compassion given to patients by practice staff as exemplary.

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

Thirty-seven registered patients responded to the Defence Medical Sevice Regulator (DMSR) patient satisfaction survey which complemented this inspection. All patients who responded to the question about how well clinicians listened to them, said that their experience was very good or good.

## Involvement in decisions about care and treatment

The clinicians and staff at the practice recognised that the personnel they provided care and treatment for could be making decisions about treatment that could have a major impact on their military career. Staff demonstrated how they gauged the level of understanding of patients, gave clear explanations of diagnoses and treatment, and encouraged and empowered patients to make decisions based on sound guidance and clinical facts.

The e-referral service had been implemented and was used to support patient choice as appropriate. E-referral is a national electronic referral service which gives patients the choice of date and time for their first outpatient appointment in a hospital).

Patients identified with a caring responsibility were captured on a DMICP register. It included what had been discussed at the monthly practice/clinical meeting and any actions identified. The practice leaflet included information for carers.

Staff explained that they occasionally saw patients who spoke English as a second language. They could access a translation service if they needed it. Staff told us about a recent instance where ‘The Big Word’ was used to provide a translation service during consultation.

## Privacy and dignity

Patients who provided feedback about the service said their privacy and dignity was met at the practice.

All consultations were conducted in clinic rooms with the door closed. All clinical rooms had a separate screened area for intimate examinations.

The waiting room was away from the reception so conversations from reception could not be overheard.

The practice had doctors of both genders so patients could choose if they wanted to see a specific doctor. patients were offered a chaperone routinely.

# 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 patient population and tailored services in response to those needs. Appointments slots were organised to meet the needs of specific population groups. For example, the practice saw patients with any urgent needs each morning. Telephone consultations and eConsult appointments were alternative options for patients who required an appointment.

The practice was ready at all times to respond at very short notice to the occupational needs of patients who needed to deploy. Additional clinics were arranged at short notice in order to ensure that personnel could deploy at short notice. Patients and unit staff we spoke with confirmed how valuable this response was to support operational capability.

A policy was in place to guide staff in exploring the care pathway for patients transitioning gender. Medical centre staff had received training to support the appropriate and effective care of people who were transitioning gender.

The medical staff team were aware of the need to quickly identify and treat patients with mental health needs in order to ensure the best possible outcome. Access to mental health support was swift with trained staff members available to offer face-to-face care. Hypnotherapy could be offered within one week This enabled patients who remained operational to receive ongoing care and support.

An Equality Access Audit as defined in the Equality Act 2010 was completed for the premises in January 2021 and no significant concerns were identified, although it had not fully been completed. The practice manger was aware of this and completed it following the inspection. There was no hearing loop but the practice stated that they had no patients, staff or people who used the building with Who used a hearing aid.

Each week the practice reserved three appointments for reservists. When a reservist requested an appointment, they were first advised to obtain a brief summary of their medical record from their NHS doctor so that the clinicians had some insight into their health records.

The lead for diversity and inclusion was a member of the unit staff and the practice had good links with them for advice when needed. There was an information board in the practice providing information for staff and patients.

## Timely access to care and treatment

Details of how patients could access the doctor when the medical centre was closed were available through the base helpline. Details of the NHS 111 out of hours service was in the medical centre leaflet.

Urgent doctor and nurse appointments were available on the day. Routine doctor appointments were available within three working days. Routine appointments to see a nurse were available within a few days.

The Primary Care Rehabilitation Facility (PCRF) offered direct access to appointments. A new patient or routine physiotherapy appointment was available within two days. There was capacity to see patients urgently on the same day if required. Appointments to see the exercise rehabilitation instructor (ERI) or a new or routine appointment were available within two to three days. There was no waiting list for rehabilitation classes.

Patients requiring an aviation medical could access one within three days. If there was an urgent need for a quicker medical turnaround, these could be turned around on the same day.

Outside of routine clinic hours, cover was provided by the doctors up until 18:30 hours (patients could contact the doctor on a mobile telephone number). From 18:30 hours, patients were diverted to the NHS 111 service and/or eConsult (a message could be left for the practice to follow up on the following working day if not urgent). If the practice closed in the 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 Defence Primary Healthcare's (DPHC) arrangement with NHS England.

We spoke with seven patients who had recently received care from the staff at the practice. They all told us that they could secure appointments when they needed them and were confident that they would be seen quickly if they had an urgent concern.

Feedback for the PCRF was gathered through the use of a QR code which was collated centrally by DPHC and the communicated to all PCRFs. A summary of findings was presented in the waiting area for all patients to read. All the feedback from the central questionnaire was positive with no change to practice required. The PCRF has recognised that the central patient experience questionnaire (PEQ) did not necessarily answer all the questions that they would like to ask, and feedback could be delayed. To resolve this issue, they have developed their own one-page questionnaire for patients. This has only recently been introduced therefore there was insufficient data at present to analyse trends.

## Listening and learning from concerns and complaints

The practice manager was the designated responsible person who handled all complaints in the practice. The practice had implemented a process to manage complaints in accordance with DPHC's complaints policy and procedure. The process included the recording of both written and verbal complaints.

There had been no complaints received within the past 12 months. Information was available to help patients understand the complaints system, including in the patient information leaflet and in the waiting room.

# Are services well-led?

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

## Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care. Their mission statement was:

> "To provide a well-led, safe, high-quality and patient-centred approach to healthcare; underpinned through a collective system of governance that deliver personnel whom remain medically fit for operations."

Staff were aware of and understood the vision, values and strategy and their role in in achieving them.

From our review of clinical care, including access to patient records and interviews with both patients and staff, we found practice staff were committed to delivering effective patient care. This focus showed patients were at the centre of practice delivery.

## Leadership, capacity and capability

The Regimental Medical officer (RMO) and the practice manager were the leaders for the practice and provided consistent leadership. They clearly understood the practice priorities and demonstrated they had capability to drive service change for the benefit of patients.

The staff team at the practice worked hard to deliver the best possible care to patients. All staff we spoke with described a committed and able leadership team. Staff had terms of reference for their main role and separate terms of reference for any key lead roles that they undertook. This required some improvement to ensure staff knew of their extended roles (medicines management).

A junior ranks forum has been established with the Medical Sargent chairing to empower the junior members of the team to voice concerns they may feel uncomfortable voicing to senior officers. There was a good breadth of experience and rank in the practice.

The support from the regional team was described as good. The practice were linked into the regional meetings and engaged about matters related to the practice e.g. staffing and recruiting.

Despite being in separate locations there was clearly a good working practice between the Primary Care Rehabilitation Facility (PCRF) and practice. This was established when talking with all the PCRF staff and the practice manager. There were frequent meetings to support close working.

## Culture

A responsive and patient-centred focus was clearly evident with this ethos embedded in practice. Staff continually looked at ways to improve the service for patients. There was evidence of a strategic approach by the practice to support the needs of the patient population. An example included the practice receiving prior notification of a change in policy which would have affected the employment of many army personnel. Due to the nature of the niche roles at Wattisham, many army personnel working there were medically non-deployable (MND). The new policy would have them discharged after 12 months. The practice pro-actively identified this issue and engaged the Chain of Command to start preparing patient's expectations and the required applications to try and retain personnel.

There was a practice focus on the 7% female population. A review of records was undertaken to determine if the female patients had a higher incidence of mental health issues due to being in the minority. The results were reassuring.

All staff described an approachable and supportive leadership team that was committed to ensuring cohesion, equality and inclusion. It was clear from discussions with staff that their contributions to the development of the service were valued. All staff attended the practice meetings where they could put forward suggestions or raise concerns.

We heard from staff that the culture was inclusive with an open-door policy and everyone having an equal voice, regardless of rank or grade. All were familiar with the whistleblowing policy and said they would feel 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. We were provided with examples of when duty of candour had been applied.

## 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, standards operating procedures (SOPs), and Quality improvement activity (QIA) and complaints. The practice manager had identified improvements were needed with the flow of information and governance structures. These issues were being addressed as a priority. Work had started on the HGW to ensure it was developed and structured in line with Defence Primary Healthcare (DPHC) expectations.

The doctor ratio was at 50% of the established numbers. This has had an evident impact on the workload and morale of the practice staff. There had been times when there were no doctors in the practice meaning patients had to attend another practice 30 miles away. This will be rectified with the incoming Senior Medical Officer, General Duties Medical Officer and another RMO later this year.

The key roles in the practice had been reviewed and shared amongst those present; a thorough approach was adopted to ensure all personnel were happy with their assigned

roles. A proactive approach has been taken to identifying deputies for key roles and to writing SOPs to support those taking on new roles. The medics had been assigned some deputy roles to help in their development.

There was an audit programme in place led by the physiotherapist. Audits had designated names assigned to them on the audit planner/register. The medics had been engaged to be involved in audit activity, with supervision, to aid their development. There was an absence of quality improvement (QIP) on the register and the practice manager was aware that improvement was needed in documenting QIP activity. They recognised that they were undertaking a lot of QIP work but not recording it.

There was an assurance visit by the region last year. A number of areas were highlighted for improvement within the PCRF. Findings were used to develop a management action plan which was being actively managed and addressed with the majority of actions completed. There was a clear culture of learning and improvement as the whole department had actively worked to resolve issues raised from assurance visit.

A schedule of regular practice meetings was in place, within this meeting some governance issues were discussed. All staff attended the meetings and minutes were maintained.

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.

## Managing risks, issues and performance

The leadership team was mindful of risks to the service. The main risks identified were staffing levels and recruitment. During the inspection the RMO referred frequently to a lack of resilience in the service given the size of the service including the number of units and the requirement for them to rapidly deploy.

A system was in place to monitor performance target indicators. The system took account of medicals, vaccinations, cytology, summarising and non-attendance. Risk to the service were recognised and logged on the risk register. The PCRF recorded all risks on the practice HGW. There were no open risks and one retired risk from the last two years.

Processes were in place to monitor national and local safety alerts and incidents, but these were underdeveloped and needed further work to ensure patient safety.

Processes were in place for managing staff under-performance including external support for clinicians.

There were a range of risk assessments in place for the practice, but some were missing. There was evidence that the practice had reviewed the risk register to include all identified risks.

All staff were in date for the ‘Defence Information Management Passport’ and ‘data security awareness’ training. When a member of staff left the service smart cards were returned to the guard room and they were removed from having access.

There was a business resilience plan and a major incident plan that were reviewed regularly and tested through simulation. All staff were informed of updates to the business continuity plan.

Processes were in place for managing staff under-performance including external support for clinicians.

## 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 practice manager referred to the eCAF to monitor the practice.

National quality and operational information were used to ensure and improve performance. Quality and operational information was used to ensure and improve performance.

There were arrangements at the practice 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

There were systems in place to encourage patients to provide feedback on the service and contribute to the development of the service. There were various options in place to encourage patients to provide feedback on the service and contribute to the development of the service. These included a patient experience survey and a suggestions box was available in the waiting room.

The practice team stated that they felt well supported and had good communication streams with all units they supported. Welfare staff told us that their relationship with the practice team was positive. Communication channels with local NHS services, including NHS GP practices, local sexual health services and secondary care providers had been established and meant that patients could access the care that they needed locally.

All feedback to the PCRF has been positive therefore no change as a consequence to patient feedback. The PCRF have recently run two initiatives to improve the patient experience including an established area where patients can access the cryotherapy machine (a machine that's uses extreme cold to aid recovery) and use as required for the management acute injuries. The team were also in the process of establishing a gait analysis service with the use of a Ministry of Defence iPad to record gait and positioning of mirrors for visual feedback to patients. This was work in progress

## Continuous improvement and innovation

We identified that the practice had worked hard to continue to provide a good service over the last year despite many challenges, with staff clearly motivated to develop the service.

Some examples included the development of roles for more junior staff and several initiatives within the PCRF.

Within the PCRF there were no examples of completed QIPs however they had recently developed a patient tracking spreadsheet which had the potential to provide excellent information on injury trends, patient pathways and overall outcomes. All new patients were uploaded to the tracker (excel spreadsheet) and information about the location and cause of injury was entered. The spreadsheet was used to track patients and information would be entered regarding onward referrals, waiting times and overall time under physiotherapy. The tracker would also be used going forward to identify all injuries to support audits against best practice guidelines. The only identifiable information was a service number. The spreadsheet had only been in use since September 2021 therefore no reports or audits have been conducted to view injury trends and overall patient pathways.