Wimbish Medical Centre

Carver Barracks, Elder Street, Wimbish, Essex, CB10 2YA

Defence Medical Services inspection report

This report describes our judgement of the quality of care at Wimbish 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 remotely in line with COVID-19 restrictions and guidance and undertook a visit to the practice.

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

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

The key questions are rated as:

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

We carried out this announced comprehensive inspection on 25 and 27 January and 8 February 2022. The inspection was carried out remotely on 25 January and included a visit by a CQC inspector, the GP and practice manager specialist advisors on 27 January. The Primary Care Rehabilitation Facility (PCRF) was inspected remotely on 8 February. 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 leadership team had a clear understanding of key issues and had developed plans to resolve or mitigate identified risks. However, plans had not always been hastened and some actions were long overdue.
- An effective system was in place for managing significant events and staff knew how to report and record using this system. This was supported by an open door culture.
- Risks had been identified and recorded but there was a lack of evidence showing actions had been completed.

- Arrangements were in place for infection prevention and control. These included steps taken to minimise the risks associated with COVID-19. Standards including high-level and low-level cleaning could be improved.
- Arrangements were in place for managing medicines, including obtaining, prescribing, recording, handling and disposal in the practice. However, there was no formal process for monitoring patients on high risk medicines.
- Standard operating procedures (SOPs) had been developed to ensure that appropriate coding, outcomes and templates were consistently used by clinicians. However, there was no formal processes to ensure ongoing monitoring of clinical staff.
- Patient feedback about the service was positive. It showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.
- The practice had developed a quality improvement programme which was largely around monitoring administrative process. This could be improved to deliver the best possible outcome for patients.
- The practice had a system to ensure that staff completed the required mandated training and held the appropriate professional registrations. Following the inspection, this was extended to include Defence Primary Healthcare (DPHC) staff who worked in the practice to maintain their professional registration.
- Effective medical cover was in place to cover the times when the practice was closed. This was clearly communicated to patients.
- Staff understood the Mental Capacity Act (2005) and how it applied in the context of the service they provided.
- Staff and patients were able to give feedback (including anonymously) and the most recent survey showed a high level of patient satisfaction.
- Some information systems and processes were in place or being developed to deliver safe treatment and care including referral tracking. However, there was scope to improve the summarising of patient notes and ongoing audit of clinical record keeping.
- 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 building and equipment was sufficient to treat patients and meet their needs. The exception was the PCRF where temporary arrangements provided were not suitable and were not being utilised.
- Peer Review arrangements were informal and could be strengthened to include documented discussion.
- The practice made use of privacy screens and curtains but these did not extend to all rooms used for delivering treatment.
- Staff understood and adhered to the duty of candour principles.

The Chief Inspector recommends to the practice:

- Complete the administration around waste collection to provide full traceability.
- Ensure cleaning arrangements are sufficient for the needs of the building and equipment.
- Implement a formal system to manage patients on high risk medicines.
- Complete planned training for staff in how to identify and deal with medical emergencies.
- Ensure that the Primary Care Rehabilitation Facility (PCRF) facilities are safe and suitable to deliver the appropriate treatment.
- Provide formal peer review for all clinical staff to include effective auditing of notes.
- Review the audit programme to provide more focus on driving improvement in clinical outcomes.
- Implement an effective process for proactive health promotion. This is to include recall for all long-term conditions and recommended procedures.
- Improve arrangements to ensure patients have privacy when receiving treatment.
- Improve the information and signposting for patients with caring responsibilities and cared for patients.
- Strengthen governance improvements to include:
    - Recruitment checks are carried out on all staff;
    - patient notes summarising is competed in line with DPHC policy;
    - the risk register is complete and regularly reviewed to include following up outstanding actions;
    - alerts are managed on an ongoing basis; and
    - all complaints are recorded.

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, nurse, physiotherapist, practice manager and a pharmacist.

Background to Wimbish Medical Centre

Wimbish Medical Centre provides a routine primary care service to a patient population of approximately 900 service personnel. The practice also provides occupational health to service personnel only. Dependant families are signposted to register at one of the local

GP practices. The barracks is the home to three regiments, the 33 Engineer Explosive Ordnance Disposal (EOD) and Search Regiment, 35 EOD and Search Regiment and 29 EOD Search and Rescue Group. In addition, occupational health is provided to a squadron of 254 Medical Regiment (a reserve unit based in Cambridge) and the practice is a site for Cambridge University Officers Training.

The medical centre is not a dispensing practice. This service is outsourced to a nearby community pharmacy. The medical centre is located in an old repurposed building with additional portacabins and the reception area is shared with the dental centre.
A Primary Care Rehabilitation Facility (PCRF) is located in the gym and portacabin close to the medical centre and provides a physiotherapy and rehabilitation service for service personnel only.

Opening hours are from 08:00 to 16:30 hours Monday, Tuesday and Thursday and from 08:00 to 12:30 hours on a Wednesday and from 08:00 to 14:00 hours on a Friday. A duty doctor is on call until 18:30 hours on weekdays and can be contacted by a mobile phone. Outside of these hours including weekends and public holidays, cover is provided by NHS 111.

The staff team at the time of the inspection

Position	**Numbers**
Medical team	Civilian Senior Medical Officer (CSMO)
Nursing team	Civilian practice nurse Band 6 Civilian practice nurse Band 5
Practice management	Military practice manager
Administration team	Two (one E2 and one E1)
PCRF team	Physiotherapist Band 6 - gapped Exercise Rehabilitation Instructor (ERI) Band 5
Medical Assistant (medics) team	Regimental Medical Officer (RMO) General Duties Medical Officer (GDMO) (assigned to Wimbish from 3 Regiment) Five Combat Medical Technicians (CMTs)

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

Are services safe?

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

We have rated the practice as requires improvement for providing safe services. We identified areas that needed strengthening including information required to provide treatment, gaps in health and safety arrangements and management of safety alerts.

Safety systems and processes

The practice had safety policies including adult and child safeguarding policies. Policies accessible electronically to all staff (including locums) outlined clearly who to go to for further guidance including the contact details for the Essex safeguarding team. The safeguarding policies were reviewed annually, the most recent completed in December 2021. Staff received safeguarding information as part of their induction and refresher training.

There was an appointed lead and deputy for safeguarding, both had completed level 3 safeguarding training. All staff had completed safeguarding and safety training appropriate to their role and knew how to identify and report concerns.

Regular communication took place with the local NHS GP surgery where most of the families of service personnel were registered. The CSMO sat on the local safeguarding board for Essex.

Vulnerable patients were identified during consultations, through the new patient registration process or on referral from another department such as the welfare team. There was a risk register of vulnerable patients and a system to highlight them on the electronic patient record system (referred to as DMICP). The register was reviewed during meetings with the Unit Health Committees (UHC) for all three regiments. These took place monthly and were attended by the Chain of Command (there was no Welfare Officers in post at the time of inspection), Regimental Medical Officer (RMO) and physiotherapist (when the post is not gapped). A note of any discussion was added to the patient record. There was also a vulnerable register meeting (VRM) meeting held between the RMO and Unit when needed.

Staff who acted as chaperones were trained for the role and 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. Clinical staff were used to chaperone and there was a policy that included any patient under 18 to be offered a chaperone. Posters advising patients about requesting a chaperone were clearly displayed in clinical rooms. We suggested the addition of a list of trained chaperones to help visiting clinicians.

The full range of recruitment records for permanent staff was held centrally. However, the practice could demonstrate that relevant safety checks had taken place at the point of recruitment, including a DBS check to ensure staff, including locum staff, were suitable to

work with vulnerable adults and young people. DBS checks were renewed every three years for civilian staff and every five years for military staff.

Arrangements were in place to monitor the registration status of clinical staff with their regulatory body. All staff had professional indemnity cover. New staff were required to complete the Defence Primary Healthcare (DPHC) mandated induction which included specific elements for the different roles. There was an induction checklist which recorded progress and completion of induction. All new staff had commenced their induction and all permanent staff had completed an induction. A member of staff who had recently joined spoke positively of the induction and support provided. The practice manager was using this induction to review the process and make any improvements

Professional registrations were checked monthly and recorded on the staff database. This was recorded on the personnel spreadsheet held in a limited area on SharePoint. Information was in place to confirm staff had received all the relevant vaccinations required for their role at the practice. SharePoint is a document management and storage system that allows information to be shared electronically.

The practice manager confirmed that there had been no locum staff since in post but was aware that all recruitment checks would be undertaken by the approved agency used by DPHC. Locum staff would be asked to complete a specific induction pack which had more recruitment checks than permanent staff.

The lead nurse had the lead infection prevention and control (IPC) role and had completed role-specific training. The staff team was up-to-date with IPC training. An internal IPC audit had been undertaken in January 2022 and found the practice to be 91% compliant. Concerns had been identified with flooring in the reception area; minor issues identified were mainly due to the cleaning standards.

Environmental cleaning was provided by an external contractor. Dedicated cleaners attended the practice twice daily. Staff told us that a deep clean of the premises took place annually during the Christmas closure. Although we found no significant concerns with the cleanliness of the premises, there was scope to make improvements. There was evidence of dust that showed both high- and low-level cleaning were not routinely done. Staff told us that they had identified this, reported it to the contractor and were in discussion about the standard of cleanliness. Staff felt that the amount of time allocated to cleaning the facility was not adequate.

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. Clinical waste was logged, stored and collected by an external contractor. External storage was in a lockable waste skip, not held in a secure area, but secured to a wooden post with metal chains. Consignment notes went to the contract’s manager, but the nurse obtained copies to check against stock of waste. We noted that the waste was being collected by the contractor without being signed off by a staff member. The check and signature of a staff member is necessary to confirm all waste is collected and incinerated.

The practice had recently taken steps to ensure that facilities and equipment were safe and that equipment was maintained according to manufacturers’ instructions. The servicing of the gymnasium equipment was managed by the physical training instructors (PTIs). There was a documented check of PCRF equipment but it was not evident if checks were being completed as per DPHC policy. Requests for improvement work had

been submitted to the contractor for maintenance and the IPC lead had categorized urgent requests to make them a high priority.

Risks to patients

Although there were gaps in the established staff structure at the time of the inspection, the practice had implemented workarounds and the leadership team felt that staffing levels and skill mix were adequate for the practice. Systems to assess, monitor and manage risks to patient safety were established but we identified areas which could be tightened to minimise any risk to patients.

The physiotherapist had left in December 2021. Support was being provided by Regional Rehabilitation Unit (RRU) staff at Colchester and patients could travel there to be seen or have a telephone consultation. We saw that the case load of patients had been reviewed and assigned to ensure treatment and care continued while a new physiotherapist was recruited.

Clinical staff from within Defence Primary Healthcare (DPHC) worked at the practice to maintain their professional registration were not on the staff database that ensured all recruitment checks and mandatory training were completed. The practice confirmed that they had been added the week after the inspection and recruitment checks had been completed.

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. Emergency kit, including a defibrillator, oxygen with masks and emergency medicines were accessible to staff in a secure area of the practice; all staff knew of its location. Equipment was checked daily and the crash trolley checked monthly.

Staff had completed basic life support training and had been trained in how to use the automated external defibrillator. Formal training for emergency response had not been delivered but staff told us that there were plans to deliver this in 2022. Future plans included additional training such as emergency call handling and simulation of potential scenarios.

Clinicians knew how to identify and manage patients with severe infections including sepsis. Sepsis training had been delivered to the practice team on the day before we inspected. A support aid was displayed in clinical rooms that guided staff in recognising the signs of sepsis and prompts were built into templates on DMICP. No formal training had been carried out in thermal injuries. The practice planned to introduce this and told us that informal training had taken place using scenarios.

When there were changes to services or staffing, the practice covered any gaps on the rota with regional staff. Clinical staff not affiliated to the practice (hosted by the practice to maintain their professional registration) provided medical cover to support the doctors.

The medical centre did not have an air conditioning system although air conditioning was available in the treatment room and a doctor’s room. The exercise rehabilitation instructor (ERI) had not completed training on heat injury and heat illness prevention. Gymnasium

staff monitored heat stress using wet-bulb globe temperature daily readings. Results were posted outside the gymnasium and checked by the ERI before starting any rehabilitation.

The PCRF completed their own risk assessments and had an alarm in the clinical rooms to summon attention in the event of an emergency. The servicing of gymnasium equipment was completed by the unit's physical training instructors who in turn provided a copy to the physiotherapist (or ERI in the absence of a physiotherapist). There was no alarm system in the gymnasium but an audible warning would alert one of the physical training instructors (PTIs) (at least one was present in the gymnasium at all times).

A COVID-19 risk assessment had been completed. Measures introduced to minimise the risk of spreading infection during the COVID-19 pandemic included:

- The majority of appointments were done via telephone with face-to-face appointments offered only when required;
- a one-way system was implemented into the building;
- signs placed throughout on walls and floors to encourage social distancing;
- hand sanitiser dispensers placed at the main entrance and exit;
- a 'red room' was used for patients presenting with COVID-19 symptoms. This room was close to the exit so could be accessed without having to walk through the main part of the building; and
- personal protective equipment (PPE) was provided to staff. This included face masks that protect staff from airborne infection (known as FRSM masks) when seeing patients.

Information to deliver safe care and treatment

Management information work had been carried out to review the long-term condition registers and update the population eligible for health screening. However, we found examples of where the registers did not marry with the clinical operating system, referred to as DMICP resulting in potential risk when recalling patients.

Practice nurses completed the summarising of patient notes supported by the practice manager who ran regular searches on DMICP. Initial summarising was up-to-date with six sets of recently received notes that required summarising. However, the searches only captured those records that required initial summarising, not those patients whose notes had not been reviewed in the last three years in accordance with DPHC policy. The search criteria was amended on the day and the result showed 560 patient notes had not been summarised in the last three years.

Staff described regular loss of connectivity with DMICP, meaning clinics could be delayed. If this happened, the business resilience plan was followed, and only urgent patients were seen. Consultation notes were recorded on to paper copies and scanned onto DMICP at a later date. The practice was waiting for Wi-Fi and new laptops with updated software that would allow remote working and a contingency for times of power outage. These had been recommended following the last Healthcare Governance Assurance Visit (HGAV) in

March/April 2021. Requests had been made to region, although we noted this had not been entered on the risk register.

The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. Referrals to other departments and external health care services, including urgent referrals, were managed by the doctors who entered each referral onto a tracker which was then monitored by a receptionist (the responsibility was about to transfer to a new member of the administration team). Patient appointments were booked through the NHS e-Referral service (e-RS).

Referrals made from the PCRF were managed by the medical officers in the absence of a physiotherapist and were integrated with the wider referral tracking system for the practice. The system included internal referrals; for example, referrals made to the Regional Rehabilitation Unit (RRU).

There was an effective system in place to ensure specimen samples were taken safely, appropriately recorded on DMICP and results reviewed and actioned by a clinician within seven days. This was supported by a standard operating procedure (SOP). The practice had identified an issue with samples going missing once they had left the building. A piece of quality improvement work (QIP) had been completed and audits since showed 100% compliance.

Safe and appropriate use of medicines

A lead and deputy were identified as the subject matter experts for medicines management with the day-to-day management of medicines scheduled to be delegated to the practice nurse. Safe procedures were in place for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment. We found all items were within date and appropriately stored.

Dispensing was outsourced to a local community pharmacy. The only stock held was dispensed items awaiting collection, vaccines and medicines to be used in an emergency. Medication requiring refrigeration was monitored daily to ensure it was stored within the correct temperature range. The vaccine fridge had no back up power supply but there a contingency in the event of a loss of power (the vaccines would be moved to a different medical centre and transportation vessels were kept at temperature in readiness). The practice had used a data logger to record minimum and maximum temperatures. However, this had failed calibration and a replacement was on order.

Appropriate arrangements were established for the safety of accountable drugs (ADs), including destruction of unused ADs. Monitoring and storage arrangements were in accordance with guidelines and policy. Discussion around CDs took place in doctor's meeting and audits were carried out by the lead nurse. No controlled drugs (CDs) were held in stock.

There was no formal process for the management of and monitoring of patients prescribed high risk medicines (HRMs). Monitoring was done on an ad hoc basis when the patient submitted a repeat prescription request. The patient records we checked showed that monitoring was completed within recommended timescales but the approach was not proactive and relied on patient engagement.

We reviewed the clinical records of four patients prescribed an HRM. We noted that alerts were in place and monitoring was carried out in accordance with the recommended frequency. Shared care agreements (SCA) were in place for the patients that required them. SCAs are important to provide clear responsibilities between clinicians involved in the patient's care.

Written procedures (SOPs) were in place to support safe dispensing practice. Staff who were prescribers had signed the SOPs applicable to them. However, the fax machine used for faxing prescriptions to the local pharmacy had been broken for approximately one year. A workaround was in place for prescriptions to be scanned and emailed to the pharmacy. The SOP had not been updated and the workaround created more margin for error.

Staff had access to British National Formulary (BNF) and prescribing formulary. We saw that the prescribers were working to both local and national guidelines for prescribing. A structured programme of audit, including an audit of antibiotic prescribing, had been implemented. A review of the antibiotic audit showed 100% compliance with local guidelines produced by the Clinical Commissioning Group (CCG).

Patient Group Directions (PGDs) had been developed to allow nurses to administer medicines in line with legislation. The PGDs were current and signed, evidenced in the results of an audit had been carried out in December 2021. Patient Specific Directions (PSDs) were not used and we found no instances where they would be required. PGDs are a written instruction allowing non-prescribing clinicians to administer certain medicines to a group of patients. PSDs are a written instruction that must be signed in advance of a medicine being administered to a named patient after the prescriber has assessed the patient on an individual basis.

The practice's arrangements for the access, storage and monitoring of prescription stationary were effective. Blank prescription pads and prescription paper were stored securely and an effective tracking system was followed.

Requests for repeat prescriptions were safely managed and no telephone requests were accepted. The process for repeat prescriptions was maintained and monitored by the CSMO. 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. Prescriptions were signed before medicines were dispensed and handed out to patients. A patient had recently complimented the practice on the speed of reply when requesting a repeat prescription over the Christmas period.

Track record on safety

Although the practice had a good safety record, gaps identified at the inspection presented potential risks to safety:

Measures to ensure the safety of facilities and equipment were in place but they had not been reviewed and updated in accordance with review dates. Risk assessments had not been updated since June 2019 despite the policy to review annually. It was noted that the practice did not use the DPHC East Region Headquarters risk register and staff were not aware of it. Risk assessments in place included both clinical and non-clinical risks. For example, needle stick injury, lifting and handling, legionella management, COSSH (control

of substances hazardous to health) and lone working (no staff were permitted in the building alone).

The practice manager was the lead for health and safety and was in the process of completing role-specific training. The safety certificates for water, gas, electric and legionella were held by the station safety team and copies were made available or had been requested by the practice. We viewed those for fire, gas, water and legionella on the inspection visit and found them to be in date. There was a programme to flush taps twice weekly in order to prevent the build-up of bacteria that can lead to legionella. There were active and retired risk registers but we found examples of risks that had not been recorded. For example, the fire risk assessment had an action relating to a door lock that required a specific lock and signage. There was no mention of this in the risk register and no evidence to say that the issue had been actioned.

Data sheets were held for hazardous substances. The station lead for health and safety carried out an annual assessment. Equipment checks, including the testing of portable electrical appliances were in-date.

There was a fixed alarm system in place which was checked on the day and staff responded promptly. There was no alarm system in the gym but there was always at least one PTI present at all times and the layout meant a call for assistance would be audible.

Staff working on reception had full view of the waiting room so patients could continue to be observed whilst waiting to be seen.

Lessons learned and improvements made

The practice shared learning and made improvements when things went wrong.

There was a system and policy for recording and acting on significant events (referred to as ASERs) and incidents. This was supported by an SOP and staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.

There was evidence that the practice learned and shared lessons and took action to improve safety in the practice. Staff we spoke with could recall the learning from a recent significant event when a medic had received a needlestick injury. A framework of meetings and minutes of meetings had been implemented. ASERs were a standing agenda item at the monthly practice meeting and weekly healthcare governance (HG) meeting. However, minutes of meetings lacked detail on the lessons learnt and action taken.

The practice manager was responsible for managing medicine and safety alerts. In their absence, the responsibility fell to the lead nurse. Alerts were sent from regional headquarters and the practice manager was also registered to receive alerts direct from the Medicines and Healthcare products Regulatory Agency (MHRA) website. We checked recent alerts and found they had been received. However, there was no evidence of searches being re-run to check for any patients that may now be at risk.

Are services effective?

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

We have rated the practice as requires improvement for providing effective services. We identified areas that needed strengthening including oversight of clinicians with formal documented reviews, proactive health promotion aimed at preventative intervention and clinical audit to drive improvement in patient outcomes.

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. We saw that meeting agendas did include clinical guidelines but the minutes from a sample of meetings held in November and December did not include any evidence of discussion.

Our review of patients' notes showed that NICE best practice guidelines were being followed.

Staff we spoke with could refer to and gave examples of updates they had acted on and clinical guidelines was a standard agenda item at healthcare governance (HG) and practice meetings.

The Defence Primary Healthcare (DPHC) team produced a newsletter that was circulated to clinicians providing further information and a summary of relevant safety updates.

The exercise rehabilitation instructor (ERI) reported ad hoc utilisation of patient outcome measures; for example, they utilised the musculoskeletal health questionnaire (MSK-HQ) on all new patients, a tool developed to allow patients to report their symptoms and outcomes from treatment in a standardised way. We looked at a sample of clinical records from the PCRF. There were some gaps; for example, the written consent form for acupuncture was not attached to two sets of notes, exercises given by the physiotherapist had not been specifically recorded and the musculoskeletal health questionnaire(MSKHQ) had not been used after the initial appointment.

There was not enough space or equipment in the unit gym for later stage rehabilitation or for anything that required more than basic rehabilitation equipment. A portacabin provided was not fit for purpose due to the floor and having only single door access. Equipment purchased for this room was now in storage.

Monitoring care and treatment

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 (LTCs) are often significantly lower at DPHC practices, we are not using NHS data as a comparator. The CSMO was the lead for the management

of patients with LTCs with the Band 5 nurse as deputy. The population manager facility (referred to as 'popman') was used to identify and monitor patients with an LTC.

A total of eight patients were recorded as having high blood pressure and all had a record of their blood pressure having been recorded in the last 12 months. A total of seven patients had a follow-up blood pressure reading of 150/90 or less (this is in an indicator for mild hypertension).

There were four patients on the diabetic register and all had a total cholesterol of 5mmol/or less, an indicator of positive cholesterol control. The practice planned to add a search for patients identified as at risk of diabetes so monitoring could be implemented.

There were six patients on the asthma register and five patients had been reviewed in the last 12 months. One patient was scheduled having returned from Christmas leave. A consistent template had been implemented and included the appropriate Read codes to be used.

However, there was no formalised process in place for recall of other long-term conditions or for future recommended procedures. For example, post gestational diabetes and repeated colonoscopy. The recall of these procedures is important when the population is transient.

We looked at a range of patient records and were assured that the care of patients with a mental illness and/or depressive symptoms was being effectively and safely managed. Patients presenting with a mild to moderate anxiety or low mood were assessed in accordance with the pathway and treated initially at the practice (step 1) or referred to the Department of Community Mental Health (DCMH) team if their clinical need was assessed as greater than what step 1 could provide.

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 41% of patients. During COVID-19 routine audiometry had ceased in line the April 2020 DPHC directive. However, the practice had not recommended or planned any catch up programme as restrictions relaxed.

The Civilian Senior Medical Officer (CSMO) was the overall audit lead and the practice had implemented a calendar that included mandatory Defence Primary Healthcare (DPHC) audits. A named lead was allocated to each audit. Antibiotic prescribing audits had been repeated and showed an improvement in adherence to local area formulary guidance However, at the time of the inspection it was too early to see evidence that audit work resulted in quality improvement and the majority of audits on the calendar were around process rather than patient outcomes. The programme had recently been implemented (in January 2022). First cycle audits completed included:

- controlled drugs;
- treatment for depression;
- treatment for asthma
- IPC and handwashing;
- COVID-19 patient recall for at risk groups;

- specimen handling;
- pre-acceptance healthcare waste.

Minimal clinical audit was being done in the PCRF with only one audit that looked into compliance with best practice guidelines for treating anterior cruciate ligament injuries. Some audit of process was carried out; for example, records of patients who did not attend and monitoring the use of first contact templates. These had only been completed once so did not provide any evidence of improvement. The ERI had started to capture data to monitor attendance rates in the gym but no analysis had been carried out.

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. The practice manager was able to describe how the CAF was to be developed, for example, to make reviews a constant cycle not a quarterly activity.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date. There were some gaps in formal medical emergency and thermal injury training.

The practice understood the learning needs of staff and provided protected time and training to meet them. Up-to-date records of skills, qualifications and training were maintained. The practice was developing processes to provide staff with ongoing support. These included one-to-one meetings, appraisals, mentoring, clinical supervision and support for revalidation. The nursing team felt supported with both training and continued professional development (CPD). There was no formal peer review in place for the nurses or for rehabilitation staff. We were told that supervision was completed by the nurses quarterly but this had not been recorded. In the PCRF, notes audits had been completed but infrequently and not to a set time interval.

Protected time was allocated to training each week on a Wednesday afternoon.

The nurse prescriber had developed links with the local NHS GP practice and had planned to shadow staff to gain experience and confidence in prescribing. However, there was no evidence of internal support for the nurse prescriber.

The practice manager monitored mandatory training using the staff database and sent an email to staff when training courses were due to be renewed. All staff had protected time to complete mandatory training or take part in scheduled group training. The practice database showed 98% compliance for staff having completed mandatory training. The practice manager confirmed that visiting clinicians had been added to the database after their omission had been highlighted during the inspection.

Combat medical technicians (CMTs) maintained their own portfolios and the practice manager carried out a sample review of their consultations. However, this was not documented or annotated onto DMICP in the consultation note.

The nursing team linked in with peers through the Regional Nurse Forum, links with outside agencies and NHS nursing staff. In addition, support was available from nursing staff at other military medical centres.

Internal and external training sessions were available to staff. For example, the practice manager had completed the DPHC training programme and was in the process of completing the IOSH (managing health and safety) training course.

There was a formal review process in place for the ERI who had annual appraisals and was about to set objectives set for the following 12 months.

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.

The practice had established links with local NHS services. These included connecting with the MASH (multi-agency safeguarding hub) and local safeguarding teams.

The nurses had connected with the local sexual health clinic and promoted their services within the practice as well as signposting patients to the internet for online support.

On leaving the military patients underwent a release medical and summary of their clinical notes. Signposting and information on civilian life was delivered by the unit.

There was good communication between the ERI and physical training instructors (PTIs) and comprehensive programmes to follow for injury recovery and maintenance.

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. Annual blood tests were to be introduced to check for gestational diabetes (currently referred to maternity services) and it was planned to set up a search for pre-diabetes (patients at risk of developing diabetes where intervention could result in prevention).

One of the nurse team had the lead for health promotion and was supported by one of the administration team as a deputy. The health promotion strategy had been formulated into a calendar for the next 12 months and was underpinned by national priorities and initiatives to improve the population’s health. At the time of the inspection there were displays about cold injuries, sexual health and alcohol awareness (in line with ‘dry January’). Promotions were refreshed in line with seasonal and/or topical demand.

Information leaflets and booklets were normally on display but had been removed due to COVID-19. However, the television in the waiting room was being used to support health promotion initiatives and cards were available from reception and clinic rooms signposting patients to Essex Sexual Health Service.

The nurses had enrolled for STIF level one training before advising on sexual health. In the meantime, patients could be referred to local sexual health clinics. Contact information was detailed on posters in clinical rooms and a permanent sexual health notice board was sited in the patient waiting area. Patients were referred to a local clinic for family planning. Condoms were given out on request but there were no chlamydia testing kits available to patients.

Medical centre staff attended unit open days and staffed stalls to provide health promotion information to personnel. The most recent fair was held in December 2021 with 'stop smoking' as the main focus. PCRF staff had presented at Unit health fairs on injury prevention /reduction and laws of training.

On the day of inspection, the Regimental Medical Officer (RMO) was meeting with patients who were concerned about the Covid vaccination in order to provide further information and reassurance. We were told that this had been done on a number of occasions and had resulted in an increase in the uptake of the Covid vaccine.

A mental health information display was available for patients that took into account wellbeing and mindfulness. It provided details about websites patients could access for further information.

The practice offered preventative health checks to identify any conditions that patients may be at-risk of and could be avoided by treatment and lifestyle choices. However, there was no structured approach to patient recall and no recent checks had been carried out. A total of 125 patients were eligible for the over 40s health check. None of these patients had been invited for a health check.

A monthly 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. At the time of the inspection there were no eligible patients for screening.

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 was 28 out of 35 eligible women. This represented an achievement of 84%. The NHS target was 80%. Invite letters were sent out and followed up if not responded to, the nurses contacted patients by telephone.

We saw that the ERI included questions about lifestyle as part of their assessment and used wellness measures on Rehab Guru to monitor lifestyle and wellness activity. Rehab Guru is an app used to support patients with rehabilitation.

It is important that 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 January 2022 provides vaccination data for patients using this practice (regional and national comparisons were not available): military personnel have sufficient immunity against the risk of contracting certain.

- 93% of patients were recorded as being up to date with vaccination against diphtheria.
- 93% of patients were recorded as being up to date with vaccination against polio.
- 77% of patients were recorded as being up to date with vaccination against Hepatitis B.
- 98% of patients were recorded as being up to date with vaccination against Hepatitis A.
- 93% of patients were recorded as being up to date with vaccination against Tetanus.
- 99% of patients were recorded as in date for vaccination against MMR
- 97% of patients were recorded as in date for vaccination against meningitis.

The low figure for Hepatitis B was because the immunisation was not being given to patients who were temporarily on the base while in training. A catch up programme was planned once trainees had been posted to the barracks.

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.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance. For example, verbal consent was recorded in DMICP. Acupuncture had been administered by the previous physiotherapist. There was an SOP which included a written consent form.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (MCA) 2005. Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

When providing care and treatment for young patients aged between 16 and 18 years, staff carried out assessments of capacity to consent in line with relevant guidance. There were very few patients under 18 but clinical staff were aware of the protocols and were supported and were supported by DMICP templates.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

The medical centre had taken account of patients' personal, cultural, social and religious needs; for example, the Regimental Medical Officer (RMO) had learnt to speak Nepalese.

The practice gave patients timely support and information. A translation service was available and promoted in each clinical area, at reception and in the patient waiting area. Staff told us that there had been no lead due to languages spoken by the Civilian Senior Medical Officer (CSMO) and RMO.

The practice had an information network available to all members of the service provided through the Army Welfare Service. 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 contact details for the welfare team were included in the patient information leaflet and there was a poster at reception.

We spoke with a number of patients who had experienced personal problems and had approached the medical centre for help. Patients told us how the practice provided support above and beyond their duties to both themself and colleagues. This included meeting patients outside of the building to promote confidentiality and provide support.

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).

Results from the practice's Patient Experience Survey conducted by DMSR in the weeks before this inspection (44 responses were collated);

- 91% said they felt they had been given clear information regarding their treatment and care (9% did not respond or responded with not applicable).

- 82% of patients who responded said that they were treated with kindness and compassion (18% of patients gave no response).

The data presented by the practice was not benchmarked against regional and national averages for DMS, or against the previous year's performance.

Patient notices were displayed in the patient waiting area which told patients how to access a number of organisations. We saw information that was age appropriate and relevant to the patient demographic which was prominently displayed and accessible. For example, we saw dedicated notice boards to promote sexual health and condoms were available at the main entrance to the building. Mental health support services were promoted and campaigns were run during the year to give greater emphasis. Patient information leaflets were available but had been temporarily removed from the waiting area to reduce the risk of spreading Covid.

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.

The practice maintained a register of patients who were also carers and provided extra support as required. Carers were identified as part of the new patient registration process. The register included 11 carers and cared for patients would be on the vulnerable patients register. Carers and cared for patients were Read coded and recalled for annual flu immunisations and had been prioritised for COVID-19 vaccinations. There was an open-door policy for support to be provided and staff knew of services that carers could be signposted to. The nurse had helped vaccination centres in the community and used the opportunity to fast track vulnerable patients for immunisation

Information for carers was handed out by clinicians during consultations. However, there was no signposting for carers in the practice leaflet nor posters displayed in the waiting room.

Privacy and dignity

The practice respected patients' privacy and dignity.

Privacy screening was provided in some consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. A statement of need had been submitted to have curtain rails fitted in the nurse treatment room and in the RMO's surgery. This was raised in May 2021 but had not been completed.Clinic room doors were closed during consultations.

Although a separate room was used for rehabilitation in the Unit gymnasium, there was no curtain or doors to provide privacy. However, the gymnasium was only used when the patient reached a later stage of rehabilitation and the patient was asked to consent to receive treatment in a less private setting.

Privacy for patients when speaking with receptionists was supported by the layout with the waiting area set away from the desk. Signage asked patients to stand back while waiting to be seen and background noise (television) had been introduced to assist with privacy. A notice at the reception desk advised patients that a private room would be offered should

they wish to discuss sensitive issues. This had been temporarily removed during Covid and was replaced following the inspection.

The practice could facilitate patients who wished to see a clinician of a specific gender. Both doctors at the practice were male and both nurses female. Patients would be signposted to another military medical centre if wanting to see a clinician of the same gender (a standing agreement was in place with Colchester Medical Centre). Male patients for sexual health screening could be signposted to the local sexual health clinic to be seen by a male clinician.

Patients we spoke with told us that they felt their privacy and dignity was always respected.

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 organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

The practice understood the needs of its 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 had a walk in service (referred to as sick parade) available each morning. Telephone consultations and eConsult appointments were alternative options for patients who required an appointment. The eConsult appointments provided faster triage for clinical care for those patients who would have previously presented on sick parade.

Specific clinics were in place including vaccination and chronic disease.

An access audit as defined in the Equality Act 2010 was completed for the premises in June 2021 and no significant concerns were identified. However, a number of actions had been identified; for example, a recommendation of the audit was to have a drop kerb for any patient who required the use of a wheelchair. We were told that the request for a drop kerb had not been approved, although there was no evidence for the request and there was no entry on the risk register.

There was no hearing loop but the practice stated that they had no patients on their register with visual or hearing impairment.

The practice had a policy available to staff or patients that stated home visits would not be provided. We discussed the rationale for this and it had been decided that any patient unable to attend in person would be in need of more urgent treatment from the emergency services.

Patients could refer themselves directly by using the Direct Access to Physio (DAP) service.

The Equality and Inclusion Lead was the practice manager with the CSMO as deputy, all staff had completed training as part of their mandatory requirements.

Timely access to care and treatment

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 one day and gradings were proactively managed and all had appointments booked. Nurses had capacity to see a patient within two days. Wait times for physiotherapy were not clear as they were referred to the Regional Rehabilitation Unit whilst the physiotherapist post was

gapped. Appointments for new patients with the ERI were available within two working days and follow up appointments within five working days.

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 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 hours and 18.30 hours, in line with DPHC's arrangement with NHS England.

The nearest accident and emergency department was located at the Addenbrooke's Hospital in Cambridge (approximately 20 miles away) and minor injuries could be treated at the Herts and Essex Hospital in Bishop's Stortford (approximately 15 miles away, detailed in the practice leaflet). An airfield on the base was used for training and the Air Ambulance Service were aware and designated to provide any emergency medical support. An ambulance was positioned within 15 minutes travel time away.

Results from the practice's patient experience survey (44 responses were received) showed that patient satisfaction levels with access to routine care and treatment were high;

- 95% of patients said they were able to access healthcare easily.
- 90% of patients felt satisfied with the method of their appointment (in person, by telephone or by E-consult).

Electronic consultations with a clinician could be organised and details on how to arrange were outlined in the practice information leaflet.

The practice leaflet provided comprehensive 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.

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 the DPHC complaints policy and procedure.

There had been no recent complaints. However, there was evidence of discussion around two issues raised by patients in recent months. These had not been added to the complaints register as one had been communicated on social media and the other was not raised as a formal complaint.

Information was available to help patients understand the complaints system, including in the patient information leaflet. The complaints process was displayed as a flow chart in the waiting room. Forms were also available for patients.

Are services well-led?

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

It was evident the staff had worked hard to make significant improvements in the time since the last HGAV. We have rated the practice as requires improvement for providing well-led services. This is because we identified a number of gaps in the governance structure and in particular the lack a structured patient recall system to foster a proactive approach to patient care.

Leadership, capacity and capability

The leaders at the medical centre had been working hard to address areas they had identified as requiring improvement as well as building resilience and continuity within the team. Significant work had been undertaken and it was evident that a plan had been implemented by the leadership team following the last HGAV visit. The practice manager informed us that a total of 150 action points had been raised and this was now reduced to six.

Resilience was being developed through appointing deputies to support leads and provide cover in their absence.

Staff felt that they could raise concerns if they had them. A practice-wide meeting had been established where all staff could get together to share and learn from key messages. Staff spoke highly of internal communication.

The practice felt that support from the regional management team was provided but throughout the inspection it was highlighted that further operational support would support the practice with DPHC wide initiatives; for example, the use of the GPAQ (patient questionnaire) to capture patient feedback. This was fed back to the Regional Clinical Director after the inspection.

Leaders were knowledgeable about issues and priorities relating to the quality of services. As a result, key risks were being addressed. However, there were areas of Defence Primary Healthcare (DPHC) wide policy and protocol that the practice were not aware of and had not adopted.

Leadership roles had been established for key responsibilities.

The exercise rehabilitation instructor (ERI) had support from both the doctors and staff at Colchester Regional Rehabilitation Unit (RRU) in the absence of a physiotherapist. Recruitment for the vacant post was underway.

Terms of reference (TORs) were in place and reflected the key responsibilities given to individuals.

Vision and strategy

The practice had been through significant management of change to make improvements since the last HGAV inspection in 2021. This had been driven by a cohesive plan and credible strategies on implementation.

The practice followed the DPHC vision to ‘provide and commission safe and effective healthcare which meets the needs of the patient and the Chain of Command in order to contribute to fighting power’.

Staff were aware of and felt fully engaged in the vision, values and strategy and their role in achieving them. Key responsibilities had been and continued to be assigned throughout the team and all staff spoke positively about the improvements being made.

The leadership team were working on a shared set of folders held electronically to support good governance in the practice.

The medical centre planned its services to meet the needs of the practice population and liaised with unit personnel to promote their vision and values. Specialist diving medicals were provided to Wimbish patients, and occupational diving medicals to patients from five medical centres within the region.

Culture

Through discussion with practice staff, it was clear that the practice had fostered a ‘no blame’ culture. Key systems had been reviewed to make them more effective and staff we spoke with were aware of the whistle-blowing policy and freedom to speak up champion:

Staff stated they felt respected, supported and valued, and spoke positively about the leadership team.

Discussion with staff members indicated that morale was high and in particular staff were complimentary about the leadership in the practice.

The practice focused on the needs of patients. However, we highlighted that a more proactive approach could now be adopted following the relaxation of Covid restrictions. For example, health checks and audiometry assessments could now be carried out but had not been formally planned.

Leaders and managers had taken action to address gaps in the performance of the practice, specifically in response to those issues highlighted at the last HGAV (March/April 2021). The leadership team presented to us not only the work completed but also the future plans to continue and build on the work already done.

Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. There was information displayed to advise staff on the freedom to speak up process and this included signposting to ‘Speak Out’ a confidential helpline to support those who felt bullied , harassed or discriminated against. The management team had an open door policy and the meeting structure was inclusive in providing all staff the opportunity to offer their opinion.

Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They spoke of how the culture was one where both suggestions and concerns would be both listened to and acted on.

Processes were being implemented to provide staff with professional development. This included appraisal and peer review. All staff were scheduled to receive annual appraisals and were supported to meet the requirements of professional revalidation where necessary. Staff were encouraged to complete courses aimed at their professional development. For example, the practice nurses were being supported to complete training in sexual health.

Staff had completed equality and diversity training.

Governance arrangements

The leadership team had worked to consolidate and clarify responsibilities, roles and systems of accountability to support good governance and management. The practice had built in more resilience with leads, deputies and cross centre working, in particular utilising colleagues from nearby medical centres to provide both resilience and continuity for the PCRF. A different filing system to the rest of Defence Primary Healthcare (DPHC) was used and the practice manager was not aware of the healthcare governance (HG) workbook commonly used by military medical centres to support the governance. This decision was deliberate and justifiable. However, we found that the approach was not always joined up and there were instances when asking for evidence, the location of documents was not known.

The practice had a system to monitor all patients on high risk medicines (HRMs). Shared care protocols were in place for patients taking high risk drugs. Regular clinical searches were carried out to monitor patients on HRMs.

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. Through engagement, the practice had developed strong links with external safeguarding teams.

Practice leaders had reviewed, introduced and implemented a suite of policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. There were links to DPHC polices and some had been adapted to local policies.

An audit programme had recently been implemented. It was too soon to see positive outcomes but repeat cycles planned would provide visibility on quality improvement. The programme was focussed on monitoring processes and could be enhanced by more work around patient outcomes.

A meeting schedule was established and this included weekly healthcare governance meetings and monthly full practice meetings. Discussion at each meeting was recorded and made available to those unable to attend.

Gaps in the governance structure prevented some processes from being fully effective. These included:

- Recruitment checks were not being carried out on DPHC staff who were supporting the doctors and maintaining their professional registration.

- Patient notes were not being summarised in line with DPHC policy. DPHC policy requires notes to be summarised every three years.
- The risk register did not include all identified risks and for completeness a record of any hastening or action completed should be added.
- Some alerts required ongoing monitoring to ensure any new and existing patients have not become eligible and require intervention.
- Although the complaints process was effective, we found examples of verbal and indirect feedback that could have been recorded to promote learning and improvement.

Managing risks, issues and performance

There were some clear and effective processes for managing risks, issues and performance but a strengthening of arrangements would better promote safety and minimise risk.

Practice leaders had established a governance structure that provided oversight of risk and the quality of service.

The practice maintained a risk register a record of short-term issues. We saw that these were reviewed regularly and acted on. However, we found identified risks that were not on the register and issued that were historic but had no record of action or closure. For example, a faulty data logger was raised in June 2020 and there was still an issue with the piece of equipment. Where risks had been transferred to region or headquarters, there was no evidence of acceptance.

Although there had been no performance issues with staff, leaders were aware of policies to be followed and where to access support if advice was needed.

All staff were in date for ‘defence information passport’ and ‘data security awareness’ training.

There was a business continuity plan which had last been reviewed in November 2021 and included the pandemic outbreak. The plan also included directions to follow in the event of loss of DMICP access, vaccination fridge failure and loss of access to the community pharmacy contracted to provide dispensing services. All staff are recorded as having read the policy and any updates were emailed out to all staff.

Appropriate and accurate information

A number of different meetings were held regularly and extended to the whole team. A practice wide meeting was held monthly 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 CAS alerts. Meetings were used to keep staff updated on and included in the implementation of ongoing improvements. There was scope to add further detail, for example, around complaints and feedback.

The leadership team was aware of the Common Assessment Framework (CAF), an effective governance tool used in military practices to monitor performance. However, we highlighted that the information could be exported for review and management which would support evidence around actions that had been removed. There was an action plan formulated after the last HGAV but it was unclear on dates and actions being managed or reviewed.

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. A patient experience survey was undertaken throughout the year. The practice was unaware of the Governance, Performance, Assurance and Quality (GPAQ) Live, an established survey used to capture patient feedback on an ongoing basis. Additionally, issues raised were not formulated into an action plan; for example, there had not been a statement of need raised for privacy curtains in the Unit gymnasium.

Patients could leave feedback anonymously via a suggestion box and could record feedback in a complaints and compliments book. A notice board in the waiting area provided a summary of the complaint process and duty of candour principles. The suggestions box had temporarily been removed as part of the Covid measures.

The PCRF conducted their own patient survey and received positive comments when last carried out in December 2021.

Good and effective links with internal and external organisations were established, including with the welfare team, Quartermaster's department, Regional Rehabilitation Unit (RRU) and with the local safeguarding team.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation. The practice developed a plan of improvement following the last HGAV inspection (carried out in March/April 2021) and had addressed the majority of gaps found. The practice had completed a number of quality improvement projects (QIPs) although not all were detailed in the quality improvement folder. Good examples of quality improvement included:

The development and trial of new methodology to conduct patient questionnaires.

A new SOP for chronic disease management targeted at improving the outcome measures.

Use of QR (Quick Review) codes in the gymnasium to encourage compliance with the rehabilitation programme. This had been utilised well during Covid when patients were not able to be seen face to face.

Documentation of objective measures for lower limb testing on late stage patients. Pre-set formulas when making an assessment to reduce administration time and to provide a visual representation of improvement to inform the patient.

A QIP had been conducted involving the Unit and practice staff to drive improvement in timescales of return to fitness post injury. Several measures had been implemented which resulted in improved outcomes.