Woodbridge Medical Centre

Rock Barracks, Woodbridge, Suffolk, IP12 3TW

Defence Medical Services inspection report

This report describes our judgement of the quality of care at Woodbridge 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 short visit to the practice.

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

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

The key questions are rated as:

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

We carried out an announced comprehensive inspection of Woodbridge Medical Centre on 15 January 2020. The practice was rated as inadequate overall, with a rating of inadequate for the safe and well-led key questions, requires improvement for the effective and responsive key questions and good for the caring key question. A copy of the report from the previous inspection can be found at:

https://www.cqc.org.uk/sites/default/files/Woodbridge_Medical_Centre_9_March_2020.pdf

We carried out this announced follow up inspection on 29 and 30 June 2021. The inspection was carried out digitally on 29 June followed by a visit by the inspector on 30 June. 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 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:

- Increases in staffing levels throughout the practice provided resilience and the capability to deliver safe and effective care.
- The arrangements for recruitment had been strengthened to ensure all staff have the appropriate checks carried out.

- Improvements made in the assessment and management of risk included staffing levels, training and shared learning from significant events. There was opportunity to further strengthen processes.
- Effective arrangements were in place for infection prevention and control. These included steps taken to minimise the risks associated with Covid-19.
- The acquisition of additional hardware provided an effective workaround for timely access to patient records during outage periods in the electronic patient record system (DMICP).
- 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 good lines of communication with the units and welfare team to ensure the wellbeing of recruits.
- The practice had implemented a system to ensure that staff complete the required mandated training. A named lead created a training programme developed to ensure all staff have the correct skills and knowledge for their roles. Of note, the training completion rates were the highest in the region.
- Effective medical cover was in place to cover the times when the practice was closed.
- Staff understood the Mental Capacity Act (2005) and how it applied in the context of the service they provided.
- Safe and effective processes were in place for the management of significant events and patient complaints. However, records of actions and outcomes from significant events lacked detail.
- The outcome of clinical audit was used to improve patient outcomes. The practice had developed an integrated audit programme, designed so all staff groups participated in service improvement activity.
- Standard operating procedures had been developed to ensure appropriate coding, outcomes and templates are consistently used by clinicians. A programme of ongoing audit of clinical records had been established to ensure standards of record keeping are monitored.
- Governance systems, activities and working practices had been strengthened and better integrated. A list of lead roles for the practice was clearly displayed so staff are aware of the roles and responsibilities of colleagues.
- Information systems and processes to deliver safe treatment and care had been developed including referral tracking, notes summarising, audit of clinical record keeping and the management of referrals.
- The building and equipment were sufficient to treat patients and meet their needs.
- The privacy and dignity of patients was respected with clinicians using privacy screens, curtains and in use signs when treating patients.
- The arrangements for managing medicines, including obtaining, prescribing, recording, handling and disposal in the practice minimised risks to patient safety.

- Staff understood and adhered to the duty of candour principles.

The Chief Inspector recommends:

- Strengthen the arrangements for waste management to minimise risks associated with clinical waste.
- Further strengthen the medicines management procedures to include controlled access and accurate records of stock items.
- Follow-up and ensure patients had received their result following cervical screening.
- Improve the documentation of clinical review meetings and significant events reviews to provide an accurate record of discussions held.
- Continue to explore ways to ensure that all patients are supported to identify risks that might lead them to develop poor long-term health.
- Evaluate the potential need for a hearing loop to support patients with a hearing impairment.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

This inspection was undertaken by a CQC inspector and the inspection team comprised specialist advisors including a primary care doctor, a practice nurse, a practice manager, a physiotherapist and a pharmacist.

Background to Woodbridge Medical Centre

Woodbridge Medical Centre provides a routine primary care service to a patient population of approximately 617 service personnel. Families and dependants are signposted to nearby NHS services. At the time of the inspection there were no registered patients under the age of 18 and 70 patients over the age of 40. The practice also provides occupational health to service personnel only.

The medical centre is not a dispensing practice and this service is outsourced to a community pharmacy in Ipswich. A Primary Care Rehabilitation Facility (PCRF) is co-located with the medical centre and provides a physiotherapy and rehabilitation service for service personnel only.

Opening hours are from 08:30 to 12:30 and 13:30 to 16:30 hours Monday to Thursday and until 12:30 on a Friday. Patients are able to attend Colchester Medical Centre up until

18:00 each weekday. 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
Regimental Medical Officer (RMO)	one
Civilian medical practitioners (CMP)	one full-time position (cover provided by locum at time of inspection)
Civilian practice nurse	one
Civilian practice manager	one
Physiotherapist	one
Exercise Rehabilitation Instructor (ERI)	one
Administrative staff	one
Combat medical technicians (medics)	three

Are services safe?

We rated the practice as good for providing safe services.

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

- assessment and management of risks;
- safeguarding training:
- waste management;
- routine summarisation of patient notes;
- referral tracking (internal); and
- significant events.

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

Safety systems and processes

Systems to keep patients safe and safeguarded from abuse had been strengthened.

- Measures were established to protect patients from abuse and neglect, including adult and child safeguarding policies. One of the doctors was the safeguarding lead and maintained a vulnerable patient register for the practice. Reviewed in January 2021, the safeguarding policy included contact details for the local safeguarding team; it was displayed in the waiting room and all clinical areas. The policy differentiated between vulnerable adults, children and young people and was supported by a safeguarding standard operating procedure (SoP). The safeguarding lead linked in with the Suffolk GP Federation facilitating links to outside agencies. The policy included the phone number for 'Customer first' which is the local Safeguarding team within Suffolk Social Care services.
- Staff received safeguarding training and update training at a level appropriate to their role. Coding and alerts were used to highlight vulnerable patients on the electronic patient record system (referred to as DMICP). At the previous inspection, Regimental Aid Post (RAP) staff working at the practice, had not received safeguarding training and update training at a level appropriate to their role. RAP staff are clinicians who are attached to units rather than employed to work directly at the medical centre. At this inspection, we saw that they had been trained to level two in safeguarding.
- A vulnerable patients register was held on the electronic patient record system. Coding and alerts were used to highlight vulnerable patients. Previously, there was no formal process to review the register. A new process had been implemented, supported by a SoP and included in the induction brief. The Regimental Medical Officer (RMO) reviewed the register monthly and discussions together with actions were recorded.

- Chaperones were always clinical staff and a list of trained chaperones was available. Chaperone posters were clearly displayed in clinical rooms and information was provided in the patient leaflet.
- The full range of recruitment records for permanent staff was held centrally. The practice could demonstrate that relevant safety checks had taken place at the point of recruitment, including a Disclosure and Barring Service (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. Previously there were gaps found with no checks completed for a combat medical technician (CMT). All checks, including CMTs, were now recorded on a staff database and an audit in May 2021 showed 100% compliance.
- Arrangements were in place to monitor the registration status of clinical staff with their regulatory body. Professional registrations were all in date and staff had professional indemnity cover and had received the appropriate vaccinations for their role (all vaccinations were given as part of the onboarding process for doctors and nurses). The locum induction included a check of vaccinations.
- There was an effective process to manage infection prevention and control (IPC), including a lead who had completed role specific training. The staff team were up to date with IPC training. An IPC audit was undertaken each year. At the most recent in February 2021 the practice achieved a score of 94% compliance. An action plan detailed areas of non-compliance together with actions to be taken and a target completion date. Three of the actions remained outstanding from the previous (December 2019) audit. The practice told us that funding had been approved for the sinks and taps to be replaced and they awaited works approval. New notice boards had been ordered for the primary care rehabilitation facility (PCRF) and quotations had been requested for new flooring. Soap dispensers were not attached to the walls in the areas required.
- For PCRF clinicians practising acupuncture, arrangements were in place for the safe provision of this treatment, including a SoP that referenced national guidance and a consent form signed prior to any treatment.
- Environmental cleaning was provided by an external contractor. Cleaning schedules and monitoring arrangements were established, including cleaning before the practice opened and at lunchtime. A deep clean of the premises took place on a rolling programme that extended to all rooms. We identified no concerns with the cleanliness of the premises. As part of the Covid-19 response, cleaning of clinical rooms took place in between each patient.
- A new contract for clinical waste was in place with an approved contractor. The clinical waste contractors held the consignment notes although the practice could obtain copies on request. A waste management audit was last carried out in May 2021. However, there was missing information from the audit; no waste classification (EWC) codes, no battery box despite the need for this as some of the kit and equipment used required batteries. The audit stated incorrectly that there was no cytotoxic bins nor drug waste bins. On the day we visited, the practice had amended the audit to include the missing information.

Risks to patients

Systems to assess, monitor and manage risks to patient safety had been strengthened following the previous inspection. However, we found some areas that could be further strengthened to minimise risk to patients.

- Staff we spoke with said staffing levels had improved since the previous inspection and were adequate to meet the needs of the patient population. We found there was a good clinical skill mix and the practice benefited from increased support from the unit medics. However, a number of positions were about to be vacated and not all had been covered, most notably the practice nurse.
- All staff including locums were required to complete an extensive induction programme which contained elements that were role specific. In addition, all permanent staff had a site induction recorded on the staff database. At the last inspection we noted induction records for locum staff had not always been fully completed and/or clearly recorded. At this inspection, we found records were complete. Staff spoke positively when asked about their induction.
- The practice was equipped to deal with medical emergencies and staff on the database were suitably trained in emergency procedures, including staff trained in life support. Staff were now in date for training. An 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. A first aid kit and accident book were available. Weekly and monthly checks were in place to ensure the required kit and medicines were available and in-date. The emergency trolley was stored behind a keypad coded door which was easily accessible to staff. The trolley was kept in an access controlled room but was not secured using a tag so there was no certainty of items having been removed. On the day we visited, the trolley had been relocated into the treatment room and was secured with a tag.
- Medics had access to anaphylaxis kits when vaccinating. The kits were single use but it was not clear who was managing the expiry dates. There was a doctor's bag and daily documented checks on medicines and equipment that it contained.
- We previously found that the staff database showed gaps in training for basic life support (BLS) and anaphylaxis training. The practice evidenced that all staff were now in date with BLS, automated external defibrillator (AED) and anaphylaxis training.
- Training sessions were held to make staff aware of how to identify patients with severe infections. Sepsis training was refreshed annually and had last been delivered in May 2021 and Covid-19 risk review and FRAGO (fragmentary order, issued to add or change a previously issued Operation Order) reviews were carried out during the weekly practice meeting.
- Adjustments in how services were delivered were made in response to the challenges faced due to Covid-19. Consultations had been made available through email and video link. Sick parade had been adjusted from face to face into a remote triage clinic where patients were triaged by a doctor and only asked to come in person if deemed essential. There was a foot operated hand sanitiser dispenser at the main entrance and hand sanitiser available throughout the building. Personal protective equipment (PPE) was available to staff and required to be worn by clinical staff and patients.

- All staff has received an individual COVID risk assessment to confirm whether they were at risk of COVID infection and that their working location had been adjusted accordingly. Any staff member needing to isolate had been supported.
- The indoor areas where personal training took place were monitored using a wet-bulb globe temperature test (WBGT-used to determine appropriate exposure levels to high temperatures). There was a heating system but no air conditioning. If too hot, windows were opened and staff told us no issues had been raised regarding the temperature.

Information to deliver safe care and treatment

Information systems to deliver safe care and treatment to patients had been strengthened.

- There was a consistent use of templates and an agreed list of codes that clinicians could refer to.
- Staff told us that monitoring or audit of clinical records was now consistently taking place for all clinician groups. The system included regular peer to peer review of the clinical notes made by the RMO.
- Scrutiny and summary of new patient records was considered a priority and a reliable process was in place. The practice nurse reported that 97% of notes were in date for note summarising with eight sets of notes waiting to be summarised.
- Staff described regular problems with loss of connectivity with DMICP, meaning clinics could be delayed. However, improvements had been made since the previous inspection with Modnet (the secure military network) 4G laptops provided to key personnel.
- Referrals and hospital appointments were managed by the administrative team and patients were well supported to obtain the timeliest access to secondary care. A standard referral template letter was in use by clinicians and auditing of referral letters showed they were being written in the most effective way. All referrals were discussed at multidisciplinary team meetings (MDT) and a SoP was being developed to support this process.
- Internal referrals, such as those to the Department of Community Mental Health (DCMH) and Regional Rehabilitation Unit (RRU) were now tracked, implemented following the previous inspection. PCRF referrals were monitored by the physiotherapist and exercise rehabilitation instructor (ERI). The PCRF had a tracking system that included all referrals and was accessible by all medical centre staff. This tracker included referrals made to the RRU and the Multidisciplinary Injury Assessment Clinic (MIAC).
- A record was kept for the two-week referrals. We noted referrals were well managed and checks of individual DMICP records confirmed patients had received their appointment.
- A sample review of clinical notes for PCRF staff showed that appropriate templates and Read codes were being used.
- We found specimens and results were effectively managed. A system was in place to ensure samples were taken safely, appropriately recorded on DMICP and results

reviewed and actioned in a timely way by the appropriate clinician. All specimen tests were recorded and checked weekly by the practice manager to ensure all samples had a result returned. Records were retained for one month or longer for any samples that required longer.

Safe and appropriate use of medicines

Processes for managing medicines were appropriate and safe. This included arrangements for managing, storing and disposal of medicines, including vaccines, medical gases, emergency medicines and equipment.

- The practice nurse was identified as the lead for medicines with the RMO as the deputy lead. This was reflected in the terms of reference.
- Safe procedures were in place for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment. All the medicines and equipment we checked were in date and fit for use. Medication requiring refrigeration was monitored twice a day to ensure it was stored within the correct temperature range.
- The dispensing was contracted to a community pharmacy in Ipswich. There was a secure storage room within the medical practice for medicines to be stored whilst awaiting collection. A list of those staff with authorised access was on the door but there was no access record to evidence who had been in.
- Prescription pads were stored and managed safely by the dispensary. DMICP records were used as a routine method to check medicine stocks, including vaccines. However, we found two items where the DMICP stock did not match the physical stock. The practice nurse found that a delivery had not been entered and that one item was in the dispensing queue (waiting to be allocated).
- Controlled drugs (medicines with a potential for misuse) and the keys to controlled drugs (CD) stocks were not routinely kept in the building but outsourced dispensed prescriptions could be held securely if awaiting collection.
- All staff who administered vaccines had received immunisation training as well as the mandatory anaphylaxis training.
- Green bins were used to dispose of medicines and these were regularly collected. The practice had a contract to secure purple-lid bins for cytotoxic waste, such as hormonal and immunosuppression medication.
- Requests for repeat prescriptions were safely managed and no telephone requests were accepted. Clear directions were available to patients about requesting repeat prescriptions. A process was in place to update patient's records if any changes were made by secondary or out-of-hours services. A DMICP code was used to identify uncollected prescriptions. If it was an antibiotic, then the prescriber was alerted.
- Defence Patient Group Directions (PGD) were not required as the nurse was an independent prescriber. There was now a formal process in place to maintain clinical oversight of the nurse's prescribing. Patient Specific Directions (PSD) were in place and signed by the prescriber to permit medics to vaccinate patients. An audit of PSDs was carried out six monthly with the last one completed in June 2021. The audit

identified human error with a missing data entry but this had not resulted in any harm to the patient. Medics had completed vaccination training. A medic is trained to provide medical support on various operations and exercises. In a medical centre setting, their role is similar to that of a health care assistant in NHS GP practices but with a broader scope of practice.

- Patients prescribed high risk medicines (HRM) received in-depth medicine reviews. We looked at a range of patient's records and confirmed they were well managed with appropriate alerts used and regular monitoring took place in between medicine reviews. A register was maintained of the patients prescribed HRMs with a search repeated every two weeks. We looked at a range of historic patient's records and confirmed they were well managed with appropriate alerts used.

Track record on safety

Arrangements to ensure the safety of the premises and facilities had been strengthened.

- The practice manager was the lead for health and safety and had received training for the role. Arrangements were in place to check the safety of the water. A fire risk assessment of the building was undertaken every five years. The fire system was tested each week and the fire evacuation drill was last carried out in January 2021. Staff were up to date with fire safety training and were aware of the evacuation plan. Confirmation of electrical, legionella and gas safety testing were available on the day. This information was not available at the previous inspection.
- A member of staff was the lead for equipment held at the practice, equipment checks were up to date.
- Previously, there were numerous risk registers in place and it was not clear which was the latest risk register and which was the issues log. A risk register and issues log were now in place and these had recently been reviewed along with individual risk assessments. These assessments included review dates and a record of actions taken. The risk register included assessments for both clinical and non-clinal risks.
- Records showed that all staff were up to date with safety training, for example fire safety training.
- Products hazardous to health (referred to as COSHH) were used for cleaning. In accordance with COSHH regulations, data sheets, risk assessments and a log of COSHH products were stored securely in the treatment room.
- An alarm system was available in clinical areas to summon support in the event of an emergency. Testing of the alarm system took place weekly. A lone working policy was in place and it was reviewed in February 2021.
- The waiting room was directly in front of reception so could be easily monitored from the desk.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff used the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events, incidents and near misses. All staff had electronic access to the system, including locum staff. The system had now been extended to include input from and discussion with the full team (including locum staff) and actions taken were documented. This included causation analysis on all ASERs.
- Lessons learnt and improvements were made as a result of significant events. For example, an ASER was recorded after a prescription was delayed due a broken fax machine at the community pharmacy contracted to dispense for the practice. A new system was implemented for all prescriptions to be emailed by noon each day and any exceptional requests after noon to be taken direct or collected by the driver. However, the recording of ASERS lacked detail on actions and outcomes.
- The practice manager was responsible for managing medicine and safety alerts. Alerts were received into a group email box which was checked daily. Any alerts were placed into a folder, logged onto a register and reviewed with the practice nurse and marked as actioned once completed. We highlighted that the process could be strengthened with easier navigation on the SharePoint (shared electronic folder of information accessible by all staff), for example, links to relevant alerts on the front page.

Are services effective?

We rated the practice as good for providing effective services.

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

- quality improvement activity (QIA)
- formal supervision for clinical staff;
- training; and
- health screening;

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

Effective needs assessment, care and treatment

The practice had processes to keep clinicians up to date with current evidence-based practice.

- Processes were in place to support staff with keeping up-to-date with current legislation, research and guidance, including NICE (National Institute for Health and Care Excellence) and the Scottish Intercollegiate Guidelines Network (SIGN). These were discussed at the weekly practice meetings.
- Staff were also kept informed of clinical and medicines updates through the Defence Primary Healthcare (DPHC) newsletter circulated to staff each month.
- The PCRF team referred to the Defence Rehabilitation website for best practice guidance. We reviewed DMICP notes to find all had the musculoskeletal (MSK) outcome completed and the Read codes were correct.

Monitoring care and treatment

The practice undertook quality improvement work to review the effectiveness and appropriateness of the care provided.

- The DMS have a responsibility to deliver the same quality of care as patients expect in the NHS. Because the numbers of patients with long term conditions are often significantly lower at DPHC practices, we are not using NHS data as a comparator.
- The practice nurse was the lead for the management of patients with long term conditions (LTC). The population manager facility (referred to as ‘popman’) was used to identify and monitor patients with an LTC. All patients identified as having high blood pressure had their blood pressure recorded in the last nine months. There were no patients on the diabetic or asthma registers. Those patients categorised as at risk were reviewed monthly.

- The practice had low numbers of patients with an LTC so the nurse provided us with an overview of the current status for each patient, including the action taken if patients failed to respond to recall letters.
- 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 DCMH if their clinical need was assessed as greater than what step 1 could provide.
- The PCRF used the musculoskeletal health questionnaire (MSK-HQ) for initial patient assessments with patients issued appropriate measures based on their injury. A review of patient notes highlighted good record keeping. Discharge measures were captured and Read coding was consistent and accurate. Patients records showed Rehab Guru (software used for rehabilitation plans and outcomes) was routinely used to provide exercise rehabilitation programmes for patients.
- 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 72% of patients. This was low as guidance had been issued from strategic command during the COVID pandemic to reduce face-to-face appointments.
- The practice had implemented a structured programme of audits to monitor and systematically review clinical and non-clinical outcomes to ensure treatment and care was being provided in accordance with national and local standards. The clinical lead led on clinical audit; this was included in the TORs. We noted the audit programme was recently implemented, therefore many of the audits were first cycle. However, second cycles had been completed in some and evidenced that they were driving improvement. For example, the campaign to immunise at risk patients against flu had been enhanced to include a phone call to each patient. The audit programme was focussed on the needs of the patient population, took account of national guidance, action to be taken and identified a timeframe for a repeat cycle. There had not been a non-medical prescribing audit within the last year although we were told the RMO carried out regular, informal reviews of the nurse's clinical notes. Audits undertaken in 2020/21 included:
    - antibiotic prescribing;
    - flu (to monitor the uptake within the eligible population);
    - handwashing;
    - asthma care;
    - Thyroxine use;
    - hypertension management;
    - leg press use for the return to running programme;
    - stress fractures; and

  - vaccination coding.

- The PCRF had their own audit plan integrated into the audit schedule. The PCRF had started looking at audits on the length of time of referrals to Regional Rehabilitation Unit (RRU) and completion of the initial injury template. Minutes of meetings demonstrated that the outcome of audits were discussed at clinical, practice and governance meetings.

Effective staffing

Continuous learning and development opportunities were promoted for staff. Progress had been made following the last inspection. However, there was scope to make further improvement.

- A generic and role-specific induction was in place for new staff to the practice. All staff had completed the programme.
- Mandated training was monitored by the practice manager. Staff were sent an email each month reminding them of training they needed to complete and a link to the training. Compliance in mandatory training was the highest in the region with a compliance rate of 100%.
- The nurse attended quarterly meetings in Colchester Medical Centre for support with revalidation. However, this was not documented. Formal supervision was now in place to maintain oversight of their work (including prescribing). We were told that the RMO met with the practice nurse monthly but the discussions were not documented.
- Internal and external training sessions were available to staff. For example, the civilian practice manager had completed the DPHC practice manager's course and a course in health and safety (IOSH). The practice nurse had completed 'IPC Link' training since the previous inspection.
- The practice had implemented a formal peer review process for the ERIs and physiotherapists. Regional meetings and forums were established for staff to link with professional colleagues in order to share idea and good practice.
- The duty medics role had a SoP and terms of reference (TOR). These had recently been introduced and were still in the process of being implemented. The Regional Medical Officer (RMO) signed off competency to use protocols for the medics. Records of this were maintained by the RMO.

Coordinating care and treatment

At the previous inspection, there was no evidence of engagement with external health and social care organisations. Staff had now established some links with external health and social care professionals.

- The clinical records we reviewed showed appropriate staff, including those in different teams, services and organisations were involved in assessing, planning and delivering care and treatment.

- The practice had developed links with external health and social care organisations. For example, the RMO was a member of the Suffolk GP federation and safeguarding training had been combined with local social services.
- The RMO attended monthly Unit Health Committee (UHC) and welfare meetings to discuss the occupational health needs of the units, the needs of patients who were medically downgraded and those who were vulnerable.
- The practice worked closely with the welfare team to support service personnel who had opted to leave the army. A process was in place for leavers classed as vulnerable.

Helping patients to live healthier lives

Staff supported patients to live healthier lives. At the last inspection we highlighted that there was scope to adopt a more proactive approach. Opportunities to improve had been discussed but had not been implemented. This was in part due to the Covid-19 pandemic but we were also told that it was due to the constraints of time with priority given to other areas.

- Clinical records showed that staff encouraged and supported patients to be involved in monitoring and managing their health. Staff also discussed changes to care or treatment with patients as necessary.
- One of the medics had the lead for health promotion. The health promotion strategy was underpinned by national priorities and initiatives to improve the population's health including, stop smoking campaigns and tackling obesity. It also took account of the patient population need and seasonal variation impacting health.
- 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.
- Health promotion displays were available in patient areas. These were dated and refreshed in line with the strategy. At the time of the inspection there were displays about clean air and healthy lungs. There was a monthly programme whereby promotions were refreshed in line with seasonal and/or topical demand.
- The practice had a stand at the annual health and wellbeing fairs held on the base. However, there had not been a health fair since the previous inspection due to Covid-19. One of the medics had been seconded to support NHS secondary care during COVID-19.
- Although there was no appointed lead for sexual health, this did not impact the service provided. Information was available for patients requiring sexual health advice, including signposting to other services. Where appropriate patients were referred to local genitourinary clinic for screening. In the foyer, information about local sexual health pathways was displayed for patients. We were told that condoms and chlamydia testing kits were available at the practice on request. Leaflets were available on request but had been removed from the waiting room due to Covid-19.
- The practice had 12 patients who met the criteria for cervical cytology, 11 had notes recording they were up to date with screening. In line with DMS policy, all eligible

patients were sent three invite letters and a disclaimer if they did not respond. The practice nurse conducted monthly searches and sent letters accordingly. Cervical screening was not performed at the practice as the nurse was not trained. Instead eligible patients were asked to attend an NHS practice or Wattisham military medical centre (approximately 20 miles away). We highlighted that the administration of screening could be improved with the addition of a check to ensure the patient had received a result.

- The practice had no patients eligible for bowel cancel, breast cancer and abdominal aortic aneurysm screening.
- As we found at the last inspection, the practice had not recalled patients for preventative health checks. Health checks can help to identify any conditions that patients may be at-risk of and could be avoided by preventative treatment and lifestyle choices. Records showed this had been discussed at practice meetings and a recall system had been set up on DMICP. However, no checks had been completed due to a lack of medics, and more recently, Covid-19.
- It is important that military personnel have sufficient immunity against the risk of contracting certain diseases. The World Health Organisation sets a target of 95% for vaccination against diphtheria, tetanus, pertussis and polio and measles, mumps and rubella. Unit commanders were responsible for ensuring their personnel kept up to date with vaccinations. Based on clinical records, the following illustrates the current vaccination data for military patients:
    - 91% of patients were recorded as in date for vaccination against diphtheria.
    - 91% of patients were recorded as in date for vaccination against polio.
    - 91% of patients were recorded as in date for vaccination against tetanus.
    - 95% of patients were recorded as in date for vaccination against hepatitis B.
    - 95% of patients were recorded as in date for vaccination against hepatitis A.
    - 96% of patients were recorded as in date for vaccination against MMR
    - 97% of patients were recorded as in date for vaccination against meningitis.

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

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making. For example, consent was recorded when vaccinations are given via the protocol on DMICP.
- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. Staff we spoke with were aware of the Mental Capacity Act (2005) and how it could apply to their practice. The RMO provided an annual refresher training session, and in June 2021, this had been delivered remotely.
- Audits of clinical notes included monitoring the process for seeking consent. The practice did not perform minor surgery and templates for vaccination and cytology included a record of consent.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

Staff supported patients in a kind and respectful way.

- Results from the December 2020 Patient Experience Survey (40 respondents) showed 100% of patients would recommend the medical centre to their friends and family. The PCRF carried out a patient survey in December 2020/January2021. A total of 29 patients responded and all were satisfied with how staff treated them.
- An information network known as HIVE was available to all patients. This provided a range of information to patients who had relocated to the base and surrounding area.
- A practice information leaflet was available to ensure patients were clear about the facilities available including key members of the practice team, contact numbers, opening times and clinics provided.

Involvement in decisions about care and treatment

Staff supported patients to be involved in decisions about their care.

- Interpretation services were available for patients who did not have English as a first language.
- The Patient Experience Survey showed 87% of patients felt involved in decisions about their care.
- PCRF staff utilised the ‘light duties chit’ to support patients who were not fully fit to carry out their normal duties.
- A carers register was in place. Patients with a caring role were identified through the summarisation process and through the UHC meetings. Carers were highlighted on the clinical system and staff were aware of the need to be flexible with appointments for carers. All patients with caring responsibilities were offered the annual flu vaccine. Support services were advised through engagements with the unit healthcare meetings and welfare. Information for carers was detailed in a dedicated patient information leaflet.

Privacy and dignity

The practice respected the privacy and dignity of patients.

- Privacy screening was provided in doctors’, nurses’ and medics’ consulting rooms to maintain patients’ privacy and dignity during examinations, investigations and treatments. Clinic room doors were closed during consultations and there was an ‘in use’ sign used on the outside.

- The layout of the reception area and waiting area meant that conversations between patients and reception would unlikely be overheard. If patients wished to discuss sensitive issues or appeared distressed at reception, they were offered a private room to discuss their needs.
- The practice could facilitate patients who wished to see a clinician of a specific gender. The PCRF staff were all female but male patients were offered appointments at Colchester Medical Centre (approximately 30 miles distance away) if wishing to see a same gender clinician.
- The Patient Experience Survey showed 100% of patients 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.

Following our previous inspection, we rated the practice as requires improvement for providing responsive services. Responsive processes were in place but needed to be strengthened including access to physiotherapy services and engagement with patient feedback.

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

Responding to and meeting people's needs

Services were organised and reviewed to meet patient needs and preferences where possible.

- Staff understood the needs of its population and tailored services in response to those needs. Appointments and clinics were organised to meet the needs of specific population groups. For example, specific emergency clinics (referred to as sick parade) were arranged around unit timings to not disrupt their training. Occupational medical appointments were arranged for the afternoon as physical activity and activities normally took place in the mornings; therefore, patients were more likely to have time in the afternoon.
- An access audit as defined in the Equality Act 2010 was completed for the premises in September 2020. No issues were identified from the audit. All rooms were on ground level and there were no steps into the building. The front doors opened automatically into the reception area.
- Although it had been discussed with the senior regional nurse, there was no hearing loop at the reception desk as the practice was considered too small.
- The practice lead for diversity and inclusion had attended additional training for this role. They also attended diversity and inclusion meetings at unit and national level. A diversity board was available in reception and it was up-to-dated with any new information.

Timely access to care and treatment

Patients' needs were met in a timely way.

- The practice accommodated patients with an emergency need on the day they presented at the practice. Routine appointments with a doctor could be facilitated the same day and gradings were available within two working days. Nurses had capacity to see a patient within one day. A routine physiotherapy new patient appointment was available within one day, a follow up physiotherapy appointment within two days and we were told urgent appointments would be accommodated on the same day. There was a longer wait of 10 days for exercise rehabilitation instructor (ERI) new patient

appointments and rehabilitation classes. This was due to annual leave being taken at the time of inspection.

- Outlined in the practice information leaflet, telephone consultations with a doctor could be organised. The practice leaflet confirmed home visits were not available. The RMO and duty medics would attend but this was a unit arrangement. Civilian clinicians did not have the indemnity to provide home visits. Although there was no medical centre specific SoP to support this, the practice manager referred to the generic DPHC SOP.
- The RMO provided medical cover when the practice closed at 16:30 and could triage patients to Colchester Medical Centre. From 18:30 during the week, weekends and public holidays patients were signposted to NHS 111.
- A direct access physiotherapy (DAP) service was in place for patients to self-refer to the PCRF. Patients using DAP were seen the next day in most instances.

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.

- Information was displayed in the waiting area, outlined in the practice leaflet to help patients understand the complaints process. There was a compliments box on the wall in the patient waiting area. There had been six compliments recorded in the last 12 months with a theme being good clinical care.
- The practice manager (lead) and practice nurse (deputy) were the designated responsible persons for the management of complaints. The practice managed complaints in accordance with DMS policy. Both written and verbal complaints were recorded and linked to the health governance workbook. There was only one complaint recorded in the last 12 months. We noted it was effectively managed and well documented.

Are services well-led?

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

At our previous inspection, we rated the practice as inadequate for providing well-led services. We identified shortfalls in leadership capacity, governance arrangements and managing risks.

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

Leadership, capacity and capability

The practice had historically experienced a lack of continuity with leadership. At the previous inspection we identified that the practice team's workload was beyond their capacity and that there was a lack of consistent clinical leadership. At this inspection we found that the situation had improved significantly and had benefited from stability in the clinical leadership.

- The RMO had been in post for 12 months and there was continuity in the clinical team which included a long-term locum doctor and a full complement of medics including a Medical Sergeant who coordinated the medics.
- There was now improved resilience with named leads and deputies responsible for both key duties and day to day responsibilities. Job roles and TORs had been updated to reflect the changes. Additionally, TORs had been agreed with the unit so support the medical centre so that all CMTs did not deploy at the same time.
- The regional management team worked closely with the staff team and staff spoke of being well supported.
- Arrangements with Colchester Medical Centre were introduced to provide oversight and support to the practice. The practice nurse could contact other practice nurses within the region for support if required.
- Within the near future there was going to be a large turnover of staff, not all positions had been filled at the time of inspection.

Vision and strategy

The practice worked to the recently revised DPHC mission statement of:

> "Provide and commission safe and effective healthcare which meets the needs of the patient and chain of command in order to contribute to fighting power."

Following the previous inspection, the practice had developed and followed a plan to develop processes and procedures. The regional operations manager had previously provided a detailed account of the vision and plans for the future which had been delivered on. Central to this was to increase the number of permanent staff to create stability and resilience. In addition:

- There were plans, subject to funding approval, for a third clinical room to enable medics to undertake concurrent sick and vaccination parades.
- The practice was about to undergo significant change in key personnel including the RMO and practice nurse. Not all duties had been reallocated as not all positions had been filled, in particular, the practice nurse.

Culture

The culture at the practice was inclusive and all staff were treated equally.

- All staff we spoke with were positive about the improvements made. The management took an interest in them so they felt included and valued regardless of rank or grade. This inclusion was promoted through informal discussions, the introduction of more structured meetings and clear areas of responsibility.
- Staff understood the specific needs population and tailored the service to meet those needs. In particular, the medical centre prioritised force protection which aligned with units that constantly had troops on high readiness to deploy at short notice.
- Openness, honesty and transparency were demonstrated when things went wrong. A no-blame culture was evident; complaints and incidents were seen as opportunities to improve the service.
- The practice had systems to ensure compliance with the requirements of the duty of candour, including giving those affected reasonable support, information and a verbal and written apology. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.

Governance arrangements

The responsibilities, roles and systems of accountability to support good governance and management had been strengthened. Since the assignment of the new RMO, leadership was noted to have improved. Lead roles had deputies assigned and responsibilities were mostly supported by role specific training. Staff we questioned believed that the staffing levels and structure were adequate to meet the needs of the patients.

- The practice worked to the health governance workbook, a system designed to bring together a comprehensive range of governance activities, including the risk register, significant events tracker, lessons learnt log, training register, policies, meetings, quality improvement and audit. The workbook planned had been developed to include the wider staff team and to become an effective working document.
- Lead roles for staff were identified and had been extended to capture all day-to-day tasks and activities. Staff we spoke with were clear on their own roles and the responsibilities of colleagues.
- A full range of practice SoPs covering all key areas of practice activity was now in place.

- There was an established set of meetings both formal and informal that supported communication and engagement processes. For example, clinical meetings took place and full practice meetings took place every week. Staff we spoke with said the practice meeting was valuable for sharing information relevant to their role. A healthcare governance meeting was held monthly for all staff and once a quarter with regional staff.
- The practice manager and contractor manager carried out monthly spot visits/inspections to each department.

Managing risks, issues and performance

Processes for managing risks, issues and performance had been strengthened.

- The practice had reviewed and updated its risks in line with the latest DPHC guidance. There was a practice-wide risk register and issues log in place. Risk assessments for the practice were linked to the risk register and were now clearly separated from issues.
- A reliable process was now established to monitor the performance of all clinical staff.
- The leadership team had oversight of national and local safety alerts, incidents, and complaints.
- Audit was a routine method used to measure the effectiveness and success of clinical and administrative practice. An audit programme was established following the previous inspection. There was evidence that clinical audits undertaken had led to positive change.
- A business continuity plan was in place for the practice and could be accessed electronically should access to the building be restricted. Included was a major outbreak plan that included Covid-19 policies and local control measures.
- Procedures were in place for managing poor performance. Civilian staff who were not performing would be managed in accordance with Ministry of Defence (MOD) policy, rules and guidance or through the appraisal process. All other staff concerns would be raised to their line manager or to regional headquarters staff to address.
- There was a planned programme to carry out health checks for patients aged 40 and over. However, patient recall had not commenced at the time of inspection.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- An internal quality assurance tool, the DMS Common Assurance Framework (CAF) was used to monitor safety and performance for the practice and included the PCRF. 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 had been hampered by frequent DMICP outages and poor connection. The problem had been largely mitigated with the purchase of laptops that did not rely on broadband connection and facilitated remote working.

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. In addition, patients could leave feedback via through the suggestion box. There was evidence that the practice acted on feedback from patients. For example, in response to the January 2021 patient survey, a report was produced and discussed with the practice team. Areas of improvement identified included better involvement in decisions about patient care by referral options to be routinely discussed with the patient, and, reception staff to always ask the patient if the appointment time offered was convenient for them.
- Implemented in response to their own patient survey, PCRF staff now provided a 'goal setting' objectives information pack to their patients.
- Good and effective links with internal and external organisations were established, including with the welfare team, RRU and the DCMH.
- The RMO had established links with the Suffolk GP federation. Staff told us that these links had been used to strengthen engagement with local NHS and civilian agencies. For example, staff spoke of links with the local safeguarding team.

Continuous improvement and innovation

The practice maintained a quality improvement log on the health governance workbook. This had been developed since the last inspection with improved records around areas of good practice entered onto a quality improvement log. The quality improvement log mainly consisted of audits and there was scope to introduce further quality initiatives.

One major piece of quality improvement work was the improved communication when outsourcing prescriptions. The practice had initiated this in response to an ASER and had managed to secure the funds to replace the old system of prescriptions being faxed by a new system in which all prescriptions could be processed electronically. This initiative had been adopted and rolled out across the region.

The practice had completed a number of quality improvement projects (QIPs) which were detailed on the quality improvement log. QIPs were also communicated to DPHC Regional Headquarters. There was a good examples of quality improvement that included:

- Occupational health check appointments was streamlined by asking units to carry out a Harvard step test in advance. The Harvard step test is a cardiac stress test for detecting and diagnosing cardiovascular disease.
- The PCRF reviewed and adapted their practice during Covid-19, moving to telephone and email to maintain regular communication with patients and using 'attend anywhere' to provide virtual clinics and manage access to rehabilitation support.