Wyton Medical Centre

RAF Wyton, Huntingdon, Cambridgeshire, PE28 2EA

Defence Medical Services inspection report

This report describes our judgement of the quality of care at Wyton Medical Centre. It is based on a combination of what we found from information provided about the service, patient feedback and 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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Summary

About this inspection

We carried out an announced comprehensive inspection of Wyton Medical Centre on 17 December 2019. The practice received an inadequate rating overall, with a rating of inadequate for the safe, effective and well-led key questions. The responsive key question was rated as requires improvement with a rating of good for the caring.

A copy of the previous inspection reports can be found at:

https://www.cqc.org.uk/what-we-do/services-we-regulate/defence-medical-services#medical

We carried out this announced follow up comprehensive inspection on 22 and 24 June 2021. The first day we gathered our evidence remotely and the lead inspector visited the service on the second day. The report covers our findings in relation to the recommendations made and any additional improvements made since our last inspection.

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

The key questions are rated as:

Are services safe? – good

Are services effective? – good

Are services caring? – good

Are services responsive? – good

Are services well-led? - good

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

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

At this inspection we found:

- The practice was well-led and the leadership team demonstrated they had the vision, capability and commitment to provide a patient-focused service and consistently sought ways to develop and improve.

- The leadership team had a clear understanding of the issues and challenges the service was vulnerable to and had strategies to mitigate these.
- An inclusive whole-team approach was supported by all staff who worked collaboratively to provide a consistent and sustainable patient-centred service.
- There was an open and transparent approach to safety. An effective system was in place for managing significant events and staff knew how to report and record using this system.
- The arrangements for managing medicines, including obtaining, prescribing, recording, handling, storing, security and disposal minimised risks to patient safety. There was an effective and holistic approach to the monitoring of patients on high risk medicines.
- The practice worked collaboratively with internal and external stakeholders, and shared best practice to promote better health outcomes for patients.
- The healthcare governance workbook was well-developed and captured a wide-range of information to illustrate how the practice was performing.
- Quality improvement activity was embedded in practice, including various approaches to monitor outputs and outcomes used to drive improvements in patient care.
- The practice pro-actively sought feedback from patients which it acted on. Feedback showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.

We identified the following notable practice, which had a positive impact on patient experience:

- A pro-active approach was taken to manage prolonged staff absence, including gaps in key roles. For example, the revised role of the Medical Sergeant had maximised leadership resilience. The introduction of the Friday 'team huddle' supported with advance workload planning in line with staff availability. Alongside this, the 'active task list' with cross-cover for specific lead roles, meant key tasks were not overlooked during expected or unexpected staff absence. The inclusive approach to locum staff had influenced locums volunteering to undertake audits to support quality improvement activity within the practice.
- To manage staffing gaps in the primary care rehabilitation facility (PCRF), the practice developed an interim referral pathway that enabled locally triaged access to exercise rehabilitation instructor (ERI) services to avoid unnecessary delays for patients. To ensure patient safety within this bespoke triage arrangement, patients requiring a diagnosis, manual therapy or traditional physiotherapy input were referred to another PCRF. The regional team were actively involved, including a twice weekly telephone triaging from a regional Band 7 physiotherapist as well as face-to-face support from another local unit. The Regional Rehabilitation Unit lowered its threshold to accept patients from the PCRF to facilitate timely and effective pathway management. Patients were not disadvantaged during this challenging period despite significant staffing uncertainty.
- Through the COVID-19 pandemic the practice developed effective and sustainable working relationships with the local Primary Care Network (PCN). The SMO and practice nurse volunteered at the PCN-led vaccination centre. This engagement led to improved outcomes for patients in terms of accessing vaccinations outside of the programme criteria. The practice had used this new collaboration to develop a pre-

emptive palliative care policy and improved access to information for patients referred on the two-week wait system.

- The PCRF was pro-actively involved with re-starting course therapy for army personnel. The ERI had engaged with army unit physical training instructors (PTI) and attended their three weekly physical training sessions to deliver individual programme reviews and exercise progression to patients. This led to an increase in PTI exposure to guided rehabilitation delivery and progression of care. The ERI had also coached and mentored the PTIs in relation to each patient's capability. This initiative had been well received and supported by the Chain of Command.

The Chief Inspector recommends:

The service should ensure that waiting patients can be observed by staff.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

The inspection team was led by a CQC inspector and comprised specialist advisors including a primary care doctor, practice manager, physiotherapist and another CQC inspector.

Background to Wyton Medical Centre

Located in RAF Wyton Station, the medical centre provides a primary healthcare, occupational health and force protection service to a tri-service patient population of 880. Patients include those from station-based units and three satellite units. The practice also provides an occupational health service for three reserve units.

A PCRF located in a separate building across from the medical centre provides a physiotherapy and rehabilitation service. As there is no dispensary at the practice, medicines are dispensed from a local pharmacy.

The medical centre is open from 08:00 to 12:00 and 13:00 to 16:30 Monday to Thursday and until 16:00 hours on a Friday. Medical cover until 18:30 each weekday is provided through a duty doctor, accessed by contacting the guard room. Outside of these hours, including weekends and bank holidays, cover is provided by NHS 111.

The staff team at the time of the inspection

Staffing	Numbers
Doctors	Civilian Senior Medical Officer (SMO) Locum Civilian Medical Practitioner (CMP) Recruitment is in progress for permanent CMP
Practice Manager	One (civilian)
Nurses	Senior practice nurse - Band 6 (civilian) Recruitment is in progress for a Band 5 nurse
PCRF	Locum physiotherapist ERI
Administrators	One E2 One E1 Recruitment is in progress for an additional E1
Medical Sergeant*	One (42 Regiment)

*In the army, a Medical Sergeant 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 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:

- infection prevention and control (IPC);
- safeguarding:
- emergency equipment;
- specimen management;
- health and safety;
- emergency alarm system;
- significant events; and
- medicine and safety alerts.

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

Safety systems and processes

- A child and adult safeguarding policy was in place for the practice and was available to the staff team on the Wyton File Hub. Staff interviewed during the inspection were fully aware of the policy, including how to report a safeguarding concern. Safeguarding was included in the induction for new staff.
- The SMO was the safeguarding lead for the practice with the CMP post identified as the deputy safeguarding lead. The practice was in the process of recruiting a CMP at the time of the inspection. All staff had completed safeguarding training at a level appropriate to their role. Clinicians were due to participate in a regional safeguarding level 3 refresher webinar training arranged to take place on 28 June 2021.
- We were advised that alerts were applied to clinical records to identify patients considered vulnerable. A monthly search of DMICP (electronic patient record system) was undertaken to ensure the register of vulnerable patients was current. Although the practice had no young people registered at the time of the inspection, a DMICP search was conducted each month to identify any patients under the age of 18.
- Measures were in place to ensure vulnerable patients were identified and supported, including through collaboration with the welfare teams and units. Vulnerable patients and safeguarding concerns were discussed at the regular welfare meetings and Unit Health Committee (UHC) meetings established for the various units across the station. These meetings also supported with identifying vulnerable service personnel who may not have been in contact with the medical centre. Case conferences were held as needed and included all necessary stakeholders. The practice provided an example of a case conference requested by the Chain of Command to agree the support for a vulnerable patient. Consent was routinely requested from patients to discuss any confidential information with coding added to the clinical record to confirm consent was agreed.

- All staff were trained chaperones. Information about the chaperoning service was displayed throughout the practice.
- 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 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 five years. The practice manager carried out monthly checks of professional registration. The vaccination status of staff was captured by the nursing team. Detailed checks of all locums were conducted when they started.
- The IPC lead for the practice had undertaken the required training for the role. An IPC audit for the medical centre and PCRF was completed in February 2021 and the practice achieved a compliance score of 88.3%. The actions identified had been addressed. The staff team was up-to-date with IPC training.
- In accordance with the cleaning contract, a cleaning schedule was in place. A cleaning team was established and were included in the practice team. There was regular communication between the cleaning manager, practice manager and IPC lead. The cleaning manager participated in the monthly check of the environment. Any practice requests for deep cleaning due to COVID-19 were directed to the cleaning manager who responded promptly.
- Risk assessments and guidance had been developed in response to COVID-19. To minimise the risk of the virus spreading, the practice had split into two teams and identified a one way flow of patients. This had since been relaxed in line with national changes to the COVID-19 response.
- Arrangements were in place for the management of clinical waste including a waste log and consignment notes. Clinical waste was stored in a secure area outside of the building. The PCRF was in a building across from the medical centre and PCRF staff carried the clinical waste bags, containing used personal protective equipment (PPE), across to medical centre's clinical waste bin. There was a risk a bag could break so the practice manager confirmed after the inspection that a suitable container for transporting this waste had been sourced. A waste audit was undertaken in February 2021 and indicated a 90.3% compliance.

Risks to patients

- Since the last inspection there had been a significant change in the staff team with almost half the team new to the practice, including five staff taking up post since February 2021. We were advised that the turnover of staff had not impacted provision of clinical care as a locum CMP had been secured and nursing support provided by Chicksands Medical Centre. A locum physiotherapist had started a week before the inspection. Recruitment was in progress for a practice nurse (Band 5), CMP and medical administrator.
- To maximise skills and leadership resilience, the role and responsibilities of the Medical Sergeant for 42 Regiment had been revised in consultation with the Chain of Command. The Medical Sergeant was appointed as an assistant practice manager and was undertaking training and being supported into this role.
- Locum staff we spoke with said they were well prepared before they started seeing patients and received an induction specific to their role; for doctors this included

interviews and presentations to ensure they were well prepared to safely see patients. Locum staff were involved in professional development activities such as peer review which meant they felt part of the team and were better able to ensure and contribute to safe patient care.

- The full staff team was suitably trained in emergency procedures, including basic life support (BLS). In-service training to recognise the deteriorating patient (sepsis) had been provided and staff we spoke with were aware of the signs and symptoms of sepsis. Clinical staff had recently engaged with local supervision whereby thermal injuries and the approach to managing these were discussed. In addition, the SMO had circulated a heat illness information leaflet to station stakeholders on heat exhaustion.
- Not all areas of the waiting areas could be observed. We were advised a SON (statement of need) requesting CCTV had been submitted to the station in November 2019 and again in September 2020 but had not been actioned. The practice manager submitted another SON in June 2020 but this time to the DPHC. Whilst awaiting an outcome on the SON, and as an interim measure, a transverse mirror was being sourced. Reception staff carried out regular checks of the patient waiting area. The practice nurse observed patients post-vaccine while they were in the clinical room, which was in accordance with Public Health England guidance (The Green Book) on immunisation procedures.
- The practice was equipped to deal with medical emergencies. Emergency medicines and equipment were checked regularly, and records maintained. An automated external defibrillator (AED) was available in both the medical centre and PCRF. Staff provided examples of when they had taken appropriate and timely action in response to a medical emergency.

Information to deliver safe care and treatment

- The SMO reported that DMICP access could be problematic but it had been more stable recently. In the event of an IT outage impacting DMICP access, staff referred to the business resilience plan (BCP). The SMO, practice manager, practice nurse and Medical Sergeant had Windows 10 laptops which provided remote access to DMICP.
- A process was established to ensure summarisation of patients' records was undertaken in a safe and timely way by the nursing team. The administration team carried out regular searches to identify any patients who were due a three yearly review/summarisation. At the time of the inspection three sets of clinical notes were outstanding and in the process of being reviewed.
- Clinical staff participated in group peer review each month. Using a comprehensive recording proforma, patient records were reviewed as a group and a log of the clinical notes reviewed was maintained. Records for all staff were reviewed in turn including nursing, locum staff and the SMO's records. This approach to peer review was used to support the practice nurse who recently undertook the non-medical prescribing (NMP) course.
- An annual clinical records audit was undertaken for PCRF staff with the most recent in May 2021. It showed the standard was generally high with many sections achieving 100% compliance. A few areas for improvement included the recording of outcome measures and patient goals; consistent with the findings across Defence Rehabilitation. We reviewed a selection of PCRF records as part of the inspection. The ERI's records were of a high standard. The SMO confirmed that supporting the new locum

physiotherapist with record keeping would be included in their induction. We were advised that joint ERI and physiotherapist peer review would re-start when the locum physiotherapist had settled into the role.

- The NHS e-Referral service (e-RS) was checked weekly to monitor the status of referrals. If a patient had not received their referral letter then the practice followed this up. In addition, a military referrals register had also been also implemented so military referrals could be tracked to ensure patients had received appointments. Two-week-wait (2WW) appointments were checked to ensure the patient received a referral letter promptly. A 2WW information leaflet was given to patients to explain the process. Referrals that had been rejected or delayed because of COVID-19 were tracked in order to ensure they were actioned once services were operational.
- The SMO advised us that communication between the practice and secondary care services was effective, including with the Regional Rehabilitation Unit (RRU) and Department of Community Mental Health (DCMH). The administrative lists for the Joint Medical Employment Standard (JMES) was monitored by RAF Wittering on behalf of Wyton due to lack of medical administration staff at the practice.
- A process was in place for the management of specimens. A clinical test request was produced and printed by the doctor and passed to the nursing team. A bound book was used to log each specimen, including the dates when the specimen was taken, sent to the lab and when the results were received. Checks of the system were undertaken daily by a doctor. Patients were informed of the result whether it was normal or not. A register was maintained of imaging requests by the administration team who staff monitored results had been received and are actioned by the doctor. The practice nurse carried out a weekly review of all specimens and the DPHC mandated specimen audit each month.

Safe and appropriate use of medicines

- The SMO and the practice nurse were the leads for medicines management. In the absence of a practice dispensary, all medicines were stored in a temperature controlled locked medical store. Prescribed medicines dispensed by the local pharmacy were delivered to the practice in a sealed bag, arranged by issue date and alphabetic order ready for collection by patients. If not collected after four weeks, the practice nurse carried out a review and either disposed of the medication or notified the prescribing doctor.
- Patient Group Directions (PGD) had been developed to allow the practice nurse to administer medicines in line with legislation. These were up-to-date and signed by the SMO. A PGD audit was completed in Sept 2020.
- A register was maintained to track accountable and controlled medicines (medicines with a potential for misuse). If these medicines were not collected on a same day, they were stored in the controlled drugs cabinet. Extra supplies of emergency accountable and controlled medicines for the medical centre and also the co-located dental centre was stored in the controlled drugs cabinet.
- Our review of clinical records for patients prescribed high risk medicines (HRM) demonstrated safe clinical care. There were no patients requiring a shared care agreement with secondary care. Medicines prescribed by secondary care were recorded on DMICP to ensure risks, such as interactions, were captured. Regular reviews were undertaken utilising the HRM drug searches to ensure all patients were

included for discussion at the clinical meetings. Each patient was reviewed individually and the review took account of, not just HRM monitoring, but holistic clinical care in terms of vaccination for flu, COVID-19 and chronic conditions.

- The doctors followed local guidance on antibiotic prescribing which was available to all prescribing staff. Although an audit had not been undertaken in the last 18 months due to other pressures associated with the COVID-19 pandemic, antibiotic prescribing was monitored. The SMO described good relationships with the laboratory staff highlighting a recent discussion about a patient with multi-drug resistant infection. Peer review of consultations through the clinical meetings also covered appropriate prescribing which included local guidance on antibiotic prescribing.
- An epilepsy audit was undertaken in September 2020. A monthly search was also undertaken to identify female patients prescribed valproate, including women of childbearing age.

Track record on safety

- The practice manager was the lead for health and safety. Policies and risk assessments pertinent to the practice were in place, including lone working and risk assessments for products hazardous to health.
- COVID-19 risk assessments had been completed to reflect changes in working practices. A comprehensive BCP was in place. It was actioned during the COVID-19 pandemic and proved to be effective. The changes made included the one way flow through the building and alternative arrangements for patients to collect their medication. Risk assessments and checks were undertaken for patients entering the building. In addition, the practice procured mobile hand washing facilities in the event hot water supplies were disrupted.
- Systems were in place and up-to-date for the checking of electric, equipment and water safety at both the medical centre and PCRF. The medical centre had recently been subject to an annual fire inspection. The practice manager and fire safety lead carried out regular health, safety and fire inspections of the building. The practice lead for fire safety carried out a range of weekly and/or monthly checks, including checks of fire doors and the fire alarm system. Staff were up-to-date with fire safety training undertaken as part of the DPHC mandated training policy.
- Planning was in progress to upgrade the emergency integrated alarm system at the medical centre. The system covered clinical areas but not the whole of the building so staff used personal alarms in addition. These were tested on a regular basis. There was no integrated alarm system at the PCRF and this area was to be included in the upgrade planning. PCRF staff carried a mobile phone to summon assistance in the event of an emergency.

Lessons learned and improvements made

- All permanent staff had access to the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events and incidents. The practice manager confirmed they were looking into securing electronic access for the recently appointed locum physiotherapist.

- From interviews with staff and evidence provided, it was clear there was a culture of reporting incidents. Both clinical and non-clinical staff gave examples of incidents reported through the ASER system including improvements made as a result of the outcome of investigations. An ASER log was maintained on the health governance workbook (HGW) including any changes made. The HGW is the system used to bring together a range of governance activities, including the risk register, significant events tracker, lessons learnt log, training register, policies, meetings, quality improvement and audit. ASERs were discussed at healthcare governance (HCG) meetings.
- The practice manager received patient safety alerts to the group mailbox and circulated them to the staff team. They were logged by the practice nurse to ensure all had been actioned. Relevant alerts were discussed at the HCG meetings.

Are services effective?

We rated the practice as good for providing effective services.

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

- the management of chronic conditions;
- quality improvement activity (QIA)
- staff induction;
- peer review;
- health screening;
- vaccination data; and
- support for patients with a caring responsibility.

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

Effective needs assessment, care and treatment

- Processes were in place to support clinical staff to keep up-to-date with NICE (National Institute for Health and Care Excellence), the Scottish Intercollegiate Guidelines Network (SIGN), clinical pathways, current legislation, standards and other practice guidance. The main forums for this was through the clinical meetings and the HCG meetings. Updated guidance was also circulated via the monthly DPHC Newsletter.
- PCRF staff were aware of Department of Defence Rehab (DDR) guidance. Our review of records showed they routinely used Rehab Guru with exercise programmes recorded on DMICP for individual patients. This enhanced continuity of care across the department and for the RRU should involvement be needed.
- The PCRF was sufficient in size for the patient population. However, at the time of the inspection the main PCRF space was being used by the station to undertake COVID-19 testing.
- There was not sufficient equipment for a PCRF of its size. However, PCRF staff utilised the station gym equipment which was meeting the requirement of its patients.

Monitoring care and treatment

- Processes were in place to effectively manage and monitor patients diagnosed with a chronic disease. A chronic disease register was maintained and updated by the practice nurse. The practice provided us with the following data:
    - There were seven patients on the diabetic register. For five patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For six patients, the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.

    - Two patients with a gestational diabetes diagnosis were identified on the diabetic register and both had relevant testing (HbA1c) within the last year.
    - There were 18 patients recorded as having high blood pressure. Fifteen patients had a record for their blood pressure taken in the past nine months. Eleven patients had a blood pressure reading of 150/90 or less.
    - There were 17 patients with a diagnosis of asthma. Sixteen had an asthma review in the preceding 12 months using the DMICP asthma template. The one patient who had not had a review was diagnosed with atypical asthma by secondary care after substantial investigation and was yet to have their first annual review.
- Our review of the chronic disease management documentation and a sample of patient records showed the clinical management of chronic disease was good despite earlier audits in 2020 showing some areas needed improving. Patients were recalled for necessary chronic disease management issues, such as retinal screening for diabetes. A record was kept both in the patient's individual record and on a chronic disease management spreadsheet when recalls were due. The SMO provided a detailed overview of the management of individual patients with diabetes and hypertension, which was appropriate and patient-centred. The practice had identified through this work that blood pressure checks should be increased in frequency to nine months from one year and had taken steps to amend their recalls accordingly. We also discussed with the SMO the potential for optimisation in relation to chronic disease management.
- Physiotherapy and rehabilitation records showed patients received appropriate treatment and care in line with their clinical need.
- In line with the April 2020 DPHC directive, routine audiometry had ceased. Some overdue patients had their audiometry due dates extended in line with the guidance but this had only been done once. The practice was awaiting further guidance as to when routine audiometry could be resumed. Fifty two percent of patients' audiometric assessments were in date (within the last two years).
- In terms of mental health, the practice provided step 1 of the mental health pathway. Diagnosis was based on a combination of objective and subjective tests, including recognised self-administered tests for anxiety and depression, which patients could complete on e-consult. Standardised clinical codes were used with low mood the most commonly used (until a diagnosis confirmed) followed by depression and depression with anxiety. Step 1 was often delivered in conjunction with the Headspace and listening/counselling services provided by the station. We looked at a sample of records and determined that patients were effectively supported, safeguarded and referred to the DCMH as appropriate to their assessed risk. Wyton Station operated a mental health first aid process and the practice assisted with monitoring this to ensure the station did not exceed its remit.
- Occupational medicine activity for patients with mental health needs was carefully managed with oversight and input from the Regional Occupational Health Team (ROHT) as appropriate. There was a detailed process for managing personnel unfit to use live arms. A register was kept and notified, with patient consent, to the chief clerk and Armoury and Force Protection.
- The practice participated in quality improvement activity (QIA). A QIA planner was established for 2021 along with a log of quality improvement activity (QIA) from 2018 to 2020. Both were held on the HGW. QIA comprised both clinical and non-clinical audits, service evaluations, mandated audits and data searches. In addition, a record was

maintained of the peer review/case discussions that took place at the clinical meetings. The PCRF had undertaken a number of mandatory audits and some relevant clinical audits/service evaluations. For example, a service evaluation of the management of low back pain was measured against NICE Guidelines. From the 35 patients audited, 81% had recommendations met; the other 19% were partially-met.

- The sample of clinical audits we looked at followed a recognised structure to guide with audit planning (such as that identified by the Royal College of General Practitioners). However, re-audit was limited. We highlighted that repeating these audits would formally demonstrate the improvements the practice had achieved, particularly in relation to chronic disease. The SMO advised that work in this area was anticipated once the COVID-19 workload/activity settles and there is a full complement of clinical staff.
- The practice utilised internal and regional resources and networks to support shared learning and clinical development of the practice. For example, monthly multi-disciplinary team meetings were held between the PCRF and the SMO. In addition, the SMO participated in the regional SMO meeting at which best practice was shared. The SMO had engaged with the ROHTs to improve the standard and accuracy of occupational medicine assessments. This had supported the SMO with the appraisal and peer review of the work of clinical staff at the practice.
- Furthermore, the practice nurse had worked collaboratively with the practice nurses at Wimbish Medical Centre to develop a protocol for over-40 health screening/assessment leading to the introduction of health promotion guidance for patients within this age group. This work had paused due to COVID-19 with the intention to re-instate it once the new practice nurse takes up post.
- Through the COVID-19 pandemic the practice developed good and sustainable working relationships with the local PCN; a group of four local NHS GP practices running a COVID-19 vaccination service. Both the SMO and practice nurse volunteered time to support the vaccination centre, including at weekends. This engagement had facilitated the development of wider links such as with the prescribing network and key individuals. It had provided improved outcomes for patients in terms of accessing vaccinations outside of the programme criteria. The practice had used this new collaboration to develop a pre-emptive palliative care policy and process. In addition, the practice identified that 2WW patients should be provided with a patient information leaflet explaining the 2WW process. Having identified this, the practice sourced a leaflet, which is now given to each patient referred as a 2WW.

Effective staffing

- Staff had received an appropriate induction. In addition to the generic induction, the practice manager had developed role-specific induction packages for new staff and sought feedback on these to support continuous improvement. A new member of staff to the PCRF spoke highly of the induction process, which has included the RRU offering bespoke training from an experienced physiotherapist to enhance the induction process. Staff appraisals were up-to-date.
- Their mandated training was monitored by the practice manager who confirmed training was up-to-date for all staff. In-service staff training was also scheduled for key topics relevant to the practice.

- Role specific training was provided for staff with lead roles and those who were undertaking specialist practice. Although there was no active flying from Wyton Station and a paucity in aviation medicine, the SMO's Military Aviation Medical Examiner (MAME) training was current which supported with the provision of any flying medicals in the event they may be required for those in non-flying roles. In addition, the SMO had undertaken self-directed learning in army occupational medicine and had undertaken training in Royal Air Force (RAF) and Royal Navy (RN) occupational medicine. The practice manager, who was new to post, had applied for a bespoke practice manager course. The practice nurse was scheduled to undertake BLS instructor training following the recent departure of the previous BLS instructor. The ERI was due to start a placement at the RRU to progress with their Post Graduate Mentorship Programme.
- Various opportunities were in place to support staff with continual professional development (CPD) and revalidation, including peer review and joint work with other practices in the region.

Coordinating care and treatment

- The SMO attended the UHC meetings for each unit at which the health and care of vulnerable and downgraded patients was reviewed. In the absence of regular physiotherapist, the ERI provided data, analysis and input for these meetings.
- Most referrals from the PCRF were to the RRU at RAF Honington. Referrals could be made to other PCRFs if a patient was posted whilst under treatment. Staff reported good access and an effective service from the RRU, including access to the multi-disciplinary injury assessment clinic (MIAC), podiatry and rehabilitation courses.
- For patients leaving the military, pre-release and final medicals were offered. During the pre-release phase the patient received an examination and a medication review. A summary print-out was provided for the patient to give to the receiving doctor, and a letter if the patient was mid-way through an episode of care. Patients were also made aware of the Veterans Health Service and, if appropriate, the Veterans Mental Health Transition, Intervention and Liaison Service (TILS).

Helping patients to live healthier lives

- Prior to the COVID-19 pandemic a health and wellbeing committee was established for the station which the practice was linked with. The committee has since focused on managing the COVID-19 and minimising outbreaks. The SMO was actively engaged with this work and attended the meetings.
- Plans were underway to make the station smoke-free from December 2021. The practice manager was actively involved in support of this initiative and had engaged local pharmacy services to promote the campaign. Station-wide smoking cessation events were planned.
- Health promotion boards were displayed throughout the premises including information about over-40 health checks, sepsis, use of antibiotics and smoking cessation.
- The practice nurse was the lead for women's/sexual health and undertaken appropriate skills for the role including training in cytology, contraception and sexually transmitted

infections. Patients were signposted to local sexual health services for services not undertaken at the practice. Local services were utilised appropriately. The practice nurse provided an example of recent liaison with the local sexual health clinic regarding the management of a patient. Patients could also be referred to the military sexual health consultant in Birmingham.

- Monthly searches were undertaken to identify patients who required screening for bowel, breast of abdominal aortic aneurysm in line with national programmes. At the time of the inspection five patients were identified that met the criteria for breast screening. Data at the time of this audit showed the practice had an uptake of 90.4%. for cervical cytology screening. The NHS target is 80%.
- As a result of the COVID-19 pandemic and in accordance with DPHC directive, routine immunisations were ceased and remained so at the time of the inspection. Only operationally essential vaccinations were administered. The vaccination statistics were identified as follows:
    - 98.1% of patients were in-date for vaccination against diphtheria.
    - 98.1% of patients were in-date for vaccination against polio.
    - 92.6% of patients were in-date for vaccination against hepatitis B.
    - 94 % of patients were in-date for vaccination against hepatitis A.
    - 98.1% of patients were in-date for vaccination against tetanus.
    - 100% of patients under 25 were in-date for vaccination against MMR.
    - 100% of patients under 25 were in-date for vaccination against meningitis.

Consent to care and treatment

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making. They had a good understanding of the Mental Capacity Act (2005) and how it would apply to the population group.
- Consent was checked as part of the peer review of clinical records.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

- A regional-wide patient survey (referred to as GPAQ) was conducted between February and April 2021. There were 44 respondents for Wyton Medical Centre. Ninety-eight per cent said they were satisfied with their care and would recommend the practice to family and friends. Patients we interviewed expressed a similar view.

Involvement in decisions about care and treatment

- All patients who responded to the GPAQ patient survey rated the practice as either excellent or good for providing information and effectively addressing their healthcare needs. Patients we interviewed expressed a similar view.
- The ERI used both the Rehab Guru for individual programme prescriptions and physical training prescriptions to guide patient's return to fitness towards the end of recovery. The use of the physical training chits with army personnel was facilitated in close communication with the PTIs which supported increased staff awareness and patient safety.
- We were advised patients usually identified themselves as having a caring responsibility, often through the new patient registration form or when the welfare team shared this information with the practice. Alerts were added to clinical records to identify carers so they could be offered flexibility with appointments. A carers register was maintained and reviewed monthly to ensure carers were offered the COVID-19 and flu vaccines.
- An interpretation service was available for patients who did not have English as a first language. We were advised it had not needed to be used.

Privacy and dignity

- All patients who responded to the GPAQ patient survey rated the practice as either excellent or good for ensuring privacy and dignity.
- In the medical centre patient consultations were conducted in clinic rooms with the door closed. Headphone sets were used for telephone consultations. All clinical rooms had a separate screened area for intimate examinations. If a patient presenting at reception was distressed or wished to discuss a sensitive issue, they had the option to talk with a member of staff in a private area.
- There was a risk of confidentiality being compromised when rehabilitation classes were taking place in the main gym also being used by station personnel. Staff reported that patients were informed of the risks before and could join a class if consent was gained. This was particularly pertinent during the army rehabilitation classes that occurred during unit physical training times where both patients and non-patients could be co-

located within the gym. We discussed the importance of consent being documented in the patient's notes; especially for sessions in communal space.

- A radio was located in the waiting area to minimise conversations being overhead in a nearby clinical room.
- The SMO was the Caldicott lead. The practice manager conducted monthly DMICP Caldicott checks. All staff had received training in information governance.
- In the event that a clinician of a preferred gender was not available then patients could be referred to an alternative local service.

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 compliance with the Equality Act 2010 and access to physiotherapy services.

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

Responding to and meeting people's needs

- The practice took account of the Equality Act 2010 in responding to the needs of individual patients. For example, transgender patients were provided with information and encouraged to access clinical services appropriate to their clinical needs, such as screening.
- The practice manager and building custodian had completed an equality access audit for the medical centre and PCRF. A SON was submitted to improve the visibility of the paintwork indicating the accessible parking bays. In the interim, signage had been put in place to highlight the parking bays. The station had agreed to fund automatic doors for entrance into the medical Centre. There was an accessible toilet in the medical centre. There was no hearing loop at the medical centre and the practice nurse confirmed that none of the registered patients used a hearing aid. The equality access audit was due to be repeated annually or more frequently if there was a change in the patient population.
- In response to restrictions associated with COVID-19, a remote triage model including, the use of eConsult, was implemented by the practice. The main focus had been telephone consultations with face-to-face assessment if clinically required.
- Urgent appointments were available daily with a doctor or nurse with routine appointments available within 48 hours. Access for vulnerable patients was prioritised, including collection of medicines outside of working hours. A routine physiotherapy appointment was available within seven working days, a follow-up appointment within two days and an urgent appointment facilitated within one day. The ERI could accommodate a routine or follow-up appointment within three days.
- Routine immunisation clinics had ceased in accordance with DPHC guidance. Doctors prioritised occupational health medicals with operational and recreational medicals deferred. As restrictions relaxed patients could now request face-to-face appointments.
- The PCRF was pro-actively involved with re-starting course therapy for army personnel. The ERI had engaged with army unit PTIs and attended their three weekly physical training sessions to deliver individual programme reviews and exercise progression to patients within this cohort. This greatly increased the PTI's exposure to guided rehabilitation delivery and progression of care. The ERI had also formulated regular reviews with the PTIs to coach and mentor them in relation to each patient's capability and provided advice about progression towards full fitness. This initiative had been well received and supported by the Chain of Command.
- Over the last 12 months the PCRF has had several unexpected and often long-term staffing gaps. Some periods were covered by a locum physiotherapist. However, there

had been occasions when locum cover had not been available. During these times, the cover was appropriately sustained by intuitive and effective models. The SMO and ERI agreed interim referral pathways that enabled direct patient access to locally triaged ERI to avoid unnecessary delay. To ensure safety of patients within this bespoke triage arrangement, patients requiring a diagnosis, manual therapy or traditional physiotherapy input were referred to another PCRF. The regional team were actively involved, including a twice weekly telephone triaging from a regional Band 7 physiotherapist as well as face-to-face support from another local unit. The RRU also lowered their threshold to accept patients from Wyton PCRF to facilitate timely and effective pathway management. The team, including the SMO, said patients were not disadvantaged during this challenging period despite the significant staffing uncertainty.

- The practice responded to feedback from patients. For example, the patient feedback survey identified appointments were running late impacting on patients' time. In response, patients were notified if delays were predicted. The practice manager and receptionist monitored telephone appointments to ensure time targets were being met particularly for patients working in secure buildings who needed to leave the building in order to use their mobile phone. In addition, patients identified lengthy wait times for physiotherapy sessions, particularly during COVID-19. In response, further clinical space was opened up, wait time reduced and improved feedback was reported.
- Changes to working practices due to COVID-19 were advertised through a variety of means including Station Executives, posters in the guardroom, posters and Station Teams. The practice manager advised that the practice information leaflet would be updated now as COVID -19 restrictions are lifted and new colleagues join the team.
- A direct access physiotherapy (DAP) service was not available due to the impact of COVID-19 and absence of a physiotherapist.

Listening and learning from concerns and complaints

- The practice manager had the lead for complaints which were managed in accordance with the DPHC complaints policy and procedure. Written and verbal complaints were recorded on the complaints register and discussed at the practice meetings. The complaints register showed just one open complaint. Twenty six compliments had been submitted in the last 12 months.
- In response to complaints about delays with NHS appointments due during the pandemic, the practice manager reviewed the referral tracker to ensure all were in the system. The patient population were informed that delays with secondary care due to COVID-19.
- The practice gave an example of how it went over and above with what was required to support a patient with a clinical complaint despite the complaint not relating to care provided at the practice. The matter was discussed at a clinical meeting to ensure that lessons identified had been shared, in particular the risks and limitations with telephone consulting.

- Patients were made aware of the complaints process through the practice information leaflet, posters in waiting room, patient questionnaire link and through station communication channels. All patients who responded to the GPAQ patient survey said their comments and complaints about the service were listened to.

Are services well-led?

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

Following our previous inspection, we rated the practice as inadequate for providing well-led services. We identified shortfalls in governance arrangements and overall leadership of the service.

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

Vision and strategy

- In 2021 the staff team collectively developed the following vision for the practice:

> "For all staff to feel supported in order to deliver high quality, occupationally-focused primary healthcare to our eligible population, and to support the chain of command with relevant medical advice to allow delivery of Defence Intelligence and other Defence outputs."

- Alongside the vision, a strategy was developed covering four key areas; governance, service development, communication and people.
- In developing the vision and strategy, the practice considered the needs of a changing patient population. For example, due to a recent and ongoing increase in the RN population, the SMO had liaised with the RN ROHT to ensure the practice's processes were compliant with meeting the needs of this population group. In addition, the practice had reviewed its approach to delivering care for a unit with variable shift patterns to support their operational role. The leadership team sought advice from the units to better understand working practices with the aim to develop skillsets and empower practice staff to achieve and maintain the best quality care for patients.
- To promote a culture of partnership working within the practice, regular team building events had been held. As an example, a 'CQC engagement afternoon' facilitated an inclusive environment for all staff to be open and honest using the 'Stop, Start, Continue, Feedback' model. In addition, the practice manager worked with individual staff to ensure they were engaged with the planned changes.
- To ensure the work and dedication of staff was acknowledged, reward incentives were introduced including the civil servant rewards scheme and a thank you scheme. The 'Wyton Cup' was introduced and presented at the monthly practice meeting to the member of staff who had been nominated. In addition, one of the staff had been nominated by the practice and was successful in achieving a Commander DPHC's commendation.
- Both the SMO and PCRF staff shared with us ideas and plans to enhance staff development and opportunities now that more stability had been established. These included developing a peer review programme; both internally and across the region.

Leadership, capacity and capability

- Prior to the practice manager starting in February 2021, the post had been vacant for almost a year. The SMO and practice nurse had absorbed the practice management duties despite depleted numbers in the clinical team and responding to changes as a result of the impact of COVID-19. With a practice manager in post, the SMO and practice nurse had been able to shift their focus back to clinical leadership and outcomes for improving care for patients. Both the SMO and practice nurse volunteered time each week and at weekends to support the local NHS vaccination.
- The practice was engaged with the region and was represented at a range of regional events including the regional managers, IPC, HCG, nursing, RRU and Medical Officer meetings. The regional team had been supportive of the practice, particularly during the extended period the practice experienced depleted staffing levels. Effective communication, guidance and advice from the RRU supported the PCRF with ongoing operational management.
- The practice had been supported by staff from other regional units, including practice nurse support up to three days a week from Chicksands Medical Centre. This support meant the practice nurse could focus on governance, chronic disease management and other management roles. Local arrangements had also been made with a Chicksands Medical Centre to facilitate leave cover for the SMO in the absence of a second doctor.

Culture

- Staff clearly demonstrated a patient-centred focus and said this ethos was promoted by the leadership team and embedded in practice. This mindset was reflected in the vision developed for the practice.
- The leadership team demonstrated a commitment to ensuring equality and inclusion across the workforce. It was clear staff and their contributions were valued. The staff we spoke with were positive about how the practice was led and welcomed the changes, including the revised vision and strategy. Locum staff were included in practice activity including HCG and practice meeting. This inclusive approach had been well received and locums had volunteered to undertake QIA work to support the practice.
- Staff said there was an open-door policy with everyone having an equal voice, regardless of rank or grade. All were familiar with the whistleblowing policy and said they were comfortable raising any concerns. We were provided with examples of when staff had used the whistleblowing policy.
- Processes were established to ensure compliance with the requirements of the duty of candour, including giving those affected reasonable support, information and a verbal and written apology. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. It had been raised in HCG meetings to ensure all staff are aware of the duty. For example, the duty was applied was in relation to a significant event raised for an out-of-date medicine given by a temporary member of staff. Although unharmed, the patient was fully informed of the situation, risks and consequences. This was discussed with the team at an HCG meeting with lessons identified in terms of the event and also reinforcing the principles of the duty of candour.

Governance arrangements

- Although DPHC direction advised reduced governance work during Covid-19, the practice continued with some governance work given that improvements needed to be made following the previous CQC inspection.
- There was an effective overarching governance framework in place which supported the delivery of good quality care. The practice effectively used the HGW to capture and monitor governance activity. All staff had access to the workbook which provided links to meeting minutes, policies and other information.
- There was a clear staffing structure in place and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. All roles had cross cover to take account of absence management. An active task list was maintained to ensure tasks did not get missed in the event of either expected or unexpected staff absence. This has effectively supported the practice with workload management and planning during significant periods of understaffing. This task list referenced which post lead roles aligned with so, as staff were appointed, the roles could be re-allocated. Terms of reference were in place to support job roles, including lead roles for specific areas.
- Communication channels had been strengthened and/or revised in line with the practice strategy. For example, the practice manager introduced an administrative 'team huddle' each Friday to plan for the next week. Staff valued this meeting and said it provided structure and an opportunity to advance plan workload in line with staff availability. A schedule of regular clinical, practice, rehabilitation and HCG meetings was well established. All staff were invited to the practice and HCG meetings. Minutes showed the meetings were well attended.
- A QIA programme was established to monitor the outcomes and outputs of clinical and administrative practice. Undertaking repeat population-based clinical audits had stalled due to depleted clinical staffing levels and the impact of COVID-19. However, our review of individual patients' records showed care was safe, effective and timely.
- The practice introduced a process to manage hour long appointments, such as those for a medical or occupational health. Patients were contacted the day prior to confirm attendance. Taking this approach had reduced the number of patients who failed to attend appointments so ensured the appointment system was fully utilised.

Managing risks, issues and performance

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety. Risks to the service were well recognised, logged on the risk register and kept under scrutiny through review at the HCG meetings. Centrally held, the risk register was also reviewed by Regional Headquarters (RHQ). This interactive approach meant risks were addressed in a timely way. For example, the practice manager recently added a staffing deficit risk due to the lengthy process for recruitment of an administrator. RHQ responded by providing additional administrative support.
- A lone working risk assessment and policy was in place and was discussed at the May 2021 HCG meeting. The practice manager carried out checks of lone working arrangements to ensure staff were working in accordance with the policy.

- Processes were in place to monitor national and local safety alerts, incidents, and complaints.
- The SMO was familiar with applying policy and processes for managing under-performance and ensured staff were supported in an inclusive and sensitive way taking account of their wellbeing. The priority has been to maintain patient safety whilst supporting individual members of staff with improving their performance.

Appropriate and accurate information

- The practice used the eCAF (Common Assurance Framework) to monitor performance. The eCAF is an internal quality assurance governance assurance tool utilised by DMS practices to assure standards of health care delivery within defence healthcare. It was clear the practice team had been diligent in addressing the deficits identified from the initial CQC inspection. In the absence of a regular physiotherapist, the PCRF had not been inputting the eCAF.
- The RRU undertook advisory visits with the most recent in November 2020 (virtual). A number of recommendations were made, many of which had been completed. Those which had not, related to reduced capacity across the PCRF, including CPD, peer review processes and audits.
- National quality and operational information were used to ensure and improve performance.
- Systems were in place that took account of data security standards to ensure the integrity and confidentiality of patient identifiable data, records and data management. In the absence of regular physiotherapy, the ERI had been granted physiotherapist rights to access DMICP to increase awareness and reduce patient risk.

Engagement with patients, the public, staff and external partners

- There were various options in place to encourage patients to provide feedback on the service and contribute to the development of the service. All patients who had an appointment were sent an email with a link to the feedback survey; this may have contributed to the practice having the second highest regional responses to the survey. Due to COVID-19, options for patients to provide feedback while visiting the practice were limited. A separate patient survey was carried out for doctors' appraisal. The outcome of patient feedback was displayed, including how the practice had responded.
- Good and effective links were established with internal and external organisations including the welfare services, (RRU), DCMH and local NHS PCN.

Continuous improvement and innovation

Underpinned by a refreshed vision and strategy, significant improvements had been made to the service since the last inspection with the staff collectively motivated to develop the service. We identified initiatives some of which merited recognition as a notable practice ASER and/or QIP. However, the practice had not had the capacity to report these activities

as improvements. It is noteworthy that the following summary of improvements and initiatives we identified were made in the context of depleted staffing levels and organisational changes as a result of the impact of COVID-19:

- The leadership team took a pro-active approach to the management of sustained staff absence and gaps/risks in key roles.
- Implementation of a variety of staff reward schemes to ensure the value of the work and dedication of staff was acknowledged.
- The participation of the SMO and practice nurse with the local PCN-led vaccination led to improved outcomes for patients and facilitated the development of sustainable engagement with local health care networks.
- A pro-active approach was taken to prompt patients to respond to the questionnaire, which likely contributed to the practice having the second highest regional response to the patient survey.
- The holistic and team approach to the review of individual patients prescribed an HRM meant wider clinical and social issues were considered, such as uptake of the flu vaccination, risks associated with COVID-19 and chronic condition management.
- The development of interim referral pathways to mitigate staff absence meant patient access to physiotherapy and ERI services avoided unnecessary access delays.
- The practice went over and above of what was required to support a patient with a clinical complaint despite the complaint not relating to care provided at the practice and ensured the team learnt lessons from the complaint.
- The ERI pro-actively engaged with unit PTIs to support with re-starting course therapy for army personnel when COVID-19 restrictions relaxed.
- The use of the physical training prescription forms with army personnel was facilitated in close communication with PTIs, which supported increased staff awareness and patient safety.