Tidworth Medical Centre

Queen Elizabeth Memorial Health Centre, St Michaels Avenue, Tidworth, Wiltshire SP9 7EA

Defence Medical Services inspection report

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

Overall rating for this service	**Good**	
Are services safe?	**Good**	
Are services effective	**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 Tidworth Medical Centre on 22 March 2018. The practice received a rating of requires improvement overall, with a rating of inadequate for the safe key question. The effective and well-led key questions were rated as requires improvement. The caring and responsive key questions were rated as good.

A copy of the previous inspection report 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 14,15 and 27 September 2021. The first two days we gathered our evidence remotely and the lead inspector visited the service on the 27 September 2021. 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

Are services safe? – good

Are services effective? – good

Are services caring – good

Are services responsive to people's needs? – 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, the military healthcare regulator, the Defence Medical Services Regulator (DMSR) has regulatory and enforcement powers over the DMS. The DMSR is committed to improving patient and staff safety and will ensure implementation of the CQC's observations and recommendations.

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

At this inspection we found:

- The practice 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. Some minor improvements were required in relation to shared care agreements.
- 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 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:

- Clinicians piloted HARK, a validated screening tool for domestic violence and abuse (DVA). The HARK was completed with 257 patients at the practice's sexual and reproductive health clinics. It led to disclosures of active DVA and patients were referred to appropriate organisations. The practice received positive feedback from patients about being provided with the opportunity to disclose DVA. This work was identified as a quality improvement project, presented at the quality forum and published in August 2021 in the BMJ - Military Health. More pilots were planned across Defence Primary Health Care with a view to wider use.
- The practice was committing to providing a wide range of sexual and reproductive health services and had developed effective and sustainable working relationships with Salisbury Sexual Service. This collaboration and pooling of resources had led to joint sexual health clinics which both military and NHS patients could access. Other practices could refer patients for procedures such as long acting reversible contraceptives (LARCs) and the removal of intra-uterine devices (IUD). A training need had been identified across the region resulting in funding being granted for the practice to deliver accredited training to nurses in conjunction with the Faculty of Sexual and

Reproductive Health. In addition, a menopause conference for clinicians from other practices and external clinicians was scheduled to be facilitated by clinicians.

The Chief Inspector recommends:

- The infection prevention and control (IPC) audit for the primary care rehabilitation facility (PCRF) is undertaken as part of the wider IPC audit for the practice.
- Adequate administration support should be provided for the PCRF.
- A plan is developed to address the three yearly summarising of clinical records for military patients.
- The personal emergency alarms held by PCRF staff should be regularly checked as part of the checks for the wider practice.
- Ensure that shared care agreements are correctly recorded on the alert. The alert should refer to the shared care agreement from the secondary health care provider and not to the Defence Medical Service's form that is used as acceptance of shared care.
- Ensure the review templates for patients with a long term condition are consistently used.
- Access to the practice by telephone should be kept under review to ensure improvements are made.
- Review the process for tracking internal referrals to ensure it is failsafe.
- Review the system to identify and refer patients for national screening programmes to ensure all patients are captured.

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, physiotherapist, practice manager and pharmacist. A dedicated member of the team interviewed patients as part of the inspection.

Background to Tidworth Medical Centre

Tidworth Medical Centre, also known as Queen Elizabeth Memorial Health Centre, is one of the largest medical centres within Defence Primary Healthcare (DPHC). Located in Wiltshire, the medical centre includes provides a primary care service to approximately 7,866 military personnel and approximately 2,272 families of military personnel, including 1,383 under the age of 18. The list size increased significantly in 2019 following the

relocation of units to Tidworth and the closure of an NHS GP practice in the village where families of military personnel were registered.

The practice provides medical support to 16 main units with various roles including infantry units, armoured regiments, engineers, medical regiments. It also provides a service to a range of minor units and support units, including the army headquarters in Andover. The practice also provides medical support to the Tidworth Personnel Recovery Unit (PRU) where the most complex medical patients are managed from across the South West Region.

Occupational health is based in Bulford but travel health, physiotherapy and rehabilitation services are provided at the practice. Family planning advice is available with referral onwards to NHS community services. Maternity and midwifery services are hosted at the practice and provided by NHS practices and community teams.

The practice is open:

Monday 08:00 -12:30 and 13:30 -16:30.

Tuesday 08:00 -12:30 (closed in the afternoon except for urgent patients)

Wednesday 08:00 -12:30 and 13:30 -16:30

Thursday 08:00 -12:30 and 13:30 -16:30

Friday 08:00 -12:30 and 13:30-16:00

Outside of these hours, patients can contact the duty doctor and duty nurse at Tidworth Medical Centre for emergency cover up to 18:30. From 18:30 on weekdays, weekends and public holidays patients can access emergency care through NHS 111.

The staff team at the time of the inspection

Staffing	**Numbers (total 143)**
Medical team	Senior Medical Officer (SMO) Deputy Senior Medical Officer (DSMO) Regimental Medical Officer (RMO) x 7 General Duties Medical Officer (GDMO)[1] x 5 Civilian Medical Practitioner (CMP) x 7 Locums GPs x 2 GP trainee
Practice management team	Practice manager Deputy practice manager
Nursing team	Senior Nursing Officer (SNO) Deputy Senior Nursing Officer (DSNO) Advanced nurse practitioner (ANP)

	Nurses x 8 Regimental aid post (RAP) nurse x 3 Health care assistant (HCA) x 2 Locums nurses x 3
Primary Care Rehabilitation Facility (PCRF) team	OC PCRF 2IC PCRF Physiotherapists x 10 Exercise rehabilitation instructor (ERI) x 6 Locums x 4 (3 physiotherapists and 1 ERI)
Combat medical technician (CMT) team	CMT[2] x 63
Pharmacy team	Pharmacy technicians x 2 Locum pharmacy technicians x 1
Administration team	Administrators x 9 Storeman x 1

[1] A GDMO is a junior army doctor attached to a field unit before commencing higher specialist training.

[2] In the army, a CMT is a soldier who has received specialist training in field medicine. It is a unique role in the forces and their role is similar to that of a health care assistant in NHS GP 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);
- medicines management, including high risk medicines (HRM);
- the management of referrals;
- the identification of vulnerable patients; and
- the management of patient safety alerts.

We found the recommendations we made at the last inspection had been actioned.

Safety systems and processes

- The deputy Senior Medical officer (DSMO) and the advanced nurse practitioner (ANP) were the safeguarding leads for the practice. With the exception of staff deployed or on extended sick leave, all staff were up-to-date with safeguarding training at a level appropriate to their role. Staff we interviewed were aware of the child and adult safeguarding policy and gave examples of safeguarding concerns raised by the practice. Safeguarding reporting arrangements were displayed in clinical areas and included the contact details for local safeguarding agencies.
- Monthly searches were undertaken for patients considered vulnerable, including military patients under 18, children and adults. Registers were maintained for patients with a severe mental illness and children adult safeguarding, Alerts were applied to clinical records to identify patients identified as vulnerable. The Senior Medical Officer (SMO) conducted a search for vulnerable patients each month in line with the practice's vulnerable person's protocol. Clinical workstations had been provided with guidance for coding patients as vulnerable to prompt correct data input thus ensuring the accuracy of searches. Safeguarding concerns were discussed at healthcare governance (HCG) meetings and/or practice meetings.
- Vulnerable military patients were reviewed at the Unit Health Committee (UHC) meetings. A monthly Multi-agency Safeguarding Hub (MASH) meeting was held which involved the community midwife and health visitor. At the meeting the risk register for children and families was reviewed.
- Communication and support networks were in place to ensure vulnerable patients were effectively supported. The unit Welfare Officers held monthly meetings with practice department leads, the military chaplain and unit Commanding Officers. Case conferences were scheduled if there was a concern that a patient may be at risk or if an urgent care assessment plan was required.
- Military patients who had been in care (up to age of 25) were coded as vulnerable in line with the new DPHC policy and added to the care leavers register. They were

identified at registration, coded appropriately and offered a same day appointment when they contacted the practice.

- We reviewed a range of clinical records for both military and civilian patients assessed as vulnerable and noted that appropriate alerts, clinical coding and safeguarding measures were in place. There was evidence of appropriate engagement with MASH and regular discussion within the practice.
- The Welfare Officer advised us that there had been a notable increase in domestic abuse during COVID-19 and indicated that the impact of lockdowns had led to more people seeking help rather than managing the issue themselves. The Welfare Officer had been invited to attend a recently established domestic abuse forum in the local area.
- The DSMO and ANP developed a domestic violence and abuse (DVA) policy for the practice in August 2019 and provided training for staff. The ANP and one of the doctors led on a pilot using a validated screening tool for DVA (known as HARK) between December 2019 and May 2020. The HARK was completed with 257 patients at the practice's sexual and reproductive health clinics. DVA was identified in 8% of patients with 13 disclosures of active DVA made. All were referred to appropriate organisations, including Wiltshire police, the local DVA support group, local authority and local sexual assault service. The patients received a three month follow up at the practice. The practice received positive feedback from patients about the initiative and the opportunity to disclose. This work was identified as a quality improvement project (QIP), presented at the quality forum and published in August 2021 in the BMJ - Military Health. We were advised more pilots were planned across the DPHC with a view to a wider use of HARK.
- Only clinical staff were used as chaperones and they received chaperone training in June 2021. Staff unable to attend the training received a copy of the training presentation. Information advertising the availability of chaperones was displayed in all clinical rooms and included in the practice leaflet. The alerts on records for military patients under the age of 18 stated that a chaperone must be offered in line with best 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. All clinical staff currently working in the practice had an up to date DBS certificate or a risk assessment in place in accordance with DPHC policy. Equally, professional registration of clinical staff was monitored. Gaps in DBS and professional registration was largely for Regimental Medical Officers (RMO) and combat medical technicians (medics) who were deployed and other staff on extended sick leave. DBS checks were renewed every five years. The vaccination status was monitored and recorded on the staff database.
- A lead for IPC was identified and they were being mentored by another nurse whilst completing the link practitioner training. Staff were up-to-date with IPC training and links to IPC resources were held on Sharepoint, which all staff had access to. Within the region, all practices carried out the annual IPC audit within the same time frame based on the regional audit calendar so practices could identify themes and share

learning. The Primary Care Rehabilitation Facility (PCRF) undertook its own IPC audit. Because PCRF staff did not have the formal IPC link training, we discussed the PCRF handing this audit to the IPC lead for the practice.

- The practice participated in regular meetings with the DPHC IPC lead and regional nurse advisor. Regional IPC forums were held regularly and IPC updates were circulated to the practice via the regional IPC advisor.
- Additional IPC measures had been put in place in response to COVID-19. These included staff changing from outdoor clothes to clinical uniforms/scrubs and social distancing in waiting areas. COVID-19 risk assessments had been completed for all staff and were revised if the health or social needs of an individual member of staff changed. Patients potentially infected with COVID-19 accessed the premises via a separate entrance and were seen in a dedicated room. Staff wore personal protective equipment in line with DPHC guidance.
- The temporary accommodation the PCRF was using during the refurbishment did not meet IPC standards. For example, there were not enough hand washing sinks in treatment areas, taps were incorrect and clinic areas were carpeted. This had been added to the risk register. There were handwashing facilities available outside clinic rooms and these were easily accessible between patients. The PCRF was due to move to the refurbished premises next month and the facility was compliant with IPC standards.
- The physiotherapists provided acupuncture and a named physiotherapist was responsible for the local safety policy on acupuncture.
- A contract was in place for environmental cleaning. Cleaning staff worked to cleaning schedules with non-clinical areas cleaned throughout the day and clinical areas in the evening. Cleaning had intensified during COVID-19, to include more frequent cleaning of touch points and chairs in the waiting area. A card on each seat in the waiting area was turned over after use to alert the cleaning team that the chair needed cleaning. A deep clean had been undertaken as each phase of the refurbishment was completed. The contract manager carried out daily spot checks of the premises. Staff were responsible for cleaning equipment before and after use, such as computers, desks and the phone.
- With oversight from the practice manager, the storekeeper was responsible for the day-to-day management of clinical waste. A waste log was in place and consignment notes retained. A waste audit was completed in June 2021.Clinical waste was stored in a lockable waste bin in a secure cage outside the medical centre.

Risks to patients

- Although there were staff vacancies, the clinical staff we spoke with said there were sufficient numbers of staff and an appropriate skill mix to ensure safe patient care. An annual leave spreadsheet was maintained to identify and forward plan for times when there were low staff numbers. The administrative team was depleted due to sick leave and DPHC-wide delays in recruitment. The practice had funding for two health care assistants to support the administrative team and a suitable locum was due to commence employment shortly. In addition, medics were supporting the team by

answering calls at reception, using their duty mobile and the text message service for patients to access the emergency clinic (sick parade). The practice had implemented a nurse triage clinic to prevent delays with calls for patients requesting same day appointments.

- The administrative support of 0.9 WTE for the PCRF was inadequate for its size. The lead physiotherapist (OC PCRF) had undertaken a service evaluation since the rebasing programme which identified a substantial increase in referrals to the PCRF. Although the clinical staff numbers increased, no associated administrative support was provided. Patient feedback indicated it had been a challenge contacting the department by phone. The only mitigation available had been to use a clinical member of staff on reception which meant removing them fully from their clinical duties. It had also prevented development of service improvements to the department which would usually be led by the administration team, such as the text messaging service, patient data collection and direct access screening. This issue was identified on the risk register as a transferred risk. A business case had been submitted requesting additional administrative support.
- A duty doctor, duty support doctor, clinical supervisor and duty nurse were available each day to support the clinical team. The doctor with the clinical supervisory role and the duty nurse had no clinics each day but supervised medics facilitating the emergency clinic in the morning and provided advice. The clinical supervisor reviewed all patients seen by the medics to ensure safe and effective care. They were also available to support other trainees, respond to staff clinical queries, including providing a second opinion.
- There was no Military Aviation Medical Examiner (MAME) trained doctor at the practice (although a locum is MAME trained). Patients requiring a MAME doctor could be referred to Middle Wallop Medical Centre. The practice also had access to a MAME doctor and/or aviation advice at Bulford and Brize Norton medical centres. Parachute and diving medicals could be facilitated at the practice. Gliding medicals were referred to RAF Upavon. Due to COVID-19, non-essential medicals had temporarily ceased, including boxing and sports diving medicals.
- Locum staff checks were conducted on the online booking system and again when locums started working at the practice. Locums completed the same induction as permanent staff and were included on the staff database. Locum staff we spoke with described an excellent induction programme including, supernumerary time and shadowing other clinicians.
- The Senior nursing Officer (SNO) held a diploma in Immediate Medical Care and was trained in intermediate life support so was the resuscitation lead for practice. The SNO was responsible for reviewing guidance in response to updates from the Resuscitation Council UK. The practice was equipped to deal with medical emergencies. The deputy SNO (DSNO) carried out checks of the emergency trolley and the SNO undertook spot checks. The staff team was up-to-date with training in emergency procedures, including basic life support, anaphylaxis and the use of an automated external defibrillator.
- Scenario based training was held regularly, including thermal injuries in June 2021 and sepsis in August 2021. The triage nurse was co-located with reception each day so could provide advice to reception staff if a patient contacted the practice with potential symptoms of a deteriorating condition. Staff had received training in recognising the

sick child. Staff provided an example of an unwell child who presented at the practice and how they were managed until the ambulance arrived. The event was also discussed at the nurses' meeting to ensure all staff were aware.

- PCRF staff were facilitating rehabilitation in the garrison supergym. Wet Bulb Globe Temperature (WBGT), which was used to indicate the likelihood of heat stress, was monitored daily by the gym Physical Training Instructors. The refurbished PCRF facility had air conditioning in one of the rehabilitation areas but not both. Staff planned to risk assess this and whether the distance from the WBGT would suffice to cover the PCRF.
- CCTV was installed to ensure reception staff could observe patients in the waiting area.

Information to deliver safe care and treatment

- Staff advised us that unplanned IT outages were infrequent. They could be managed easily as all clinical staff had a laptop with WIFI access in the building. If there was a complete outage of DMICP, the practice reverted to emergency appointments only and the use of paper copy forms. Clinic lists were also printed daily in the event that DMICP could not be accessed.
- Secondary care referrals were sent to the referrals inbox on DMICP which four staff had access to. Referrals were actioned through the NHS e-Referral service and added to the referrals register held in a restricted area on Sharepoint. Separate worksheets were maintained to track two-week-wait (2WW) referrals, imaging, general secondary care and CAMHS (children and adolescent mental health services). There was a colour coding system in use for ease of review. We noted three 2WW referrals did not have an appointment date recorded but a review of DMICP provided assurance that the patients had been offered an appointment. A 2WW audit was undertaken in July 2021 which led to change including confirmation of the patient attending the appointment. Due to staff shortages within the administration team, not all referrals included closure details. We were assured that all had been actioned and monitored. Referrals to the Regional Rehabilitation Unit was tasked to the practice administrative team for entry onto central spreadsheet.
- Not all internal referrals, such as those to the Department of Community Mental Health (DCMH) and Regional Occupational Health Team (ROHT), were tracked in the same way as external referrals. They were completed electronically through DMICP by the referring clinician. An acknowledgement from the internal referrals receiver was received via DMICP tasking system. Referrals to the Department of Community Mental Health (DCMH) were checked monthly by SMO.
- A standard operating procedure (SOP) was in place for the summarisation of patient records. The administrative team logged new patients and then sent tasks to the nursing team, who had the lead with summarisation and had allocated time for the task. As of the 14 September 2021, there were a total of 121 dependent notes awaiting summarisation; 44 of which were patients under 18 with the longest having arrived on 6 August 2021. A schedule was in place for the nursing team to summarise these records; 15 sets of notes were due to be summarised on the afternoon of the

inspection. If a dependent patient needed to see a doctor prior to their notes being summarised, the doctor requested access to the paper notes.

- There was no process in place for summarising military notes every three years in accordance with DPHC policy. During the inspection a search was created and run which showed there was no significant backlog. However, the practice manager added it to the risk register until a process was put in place and the backlog addressed.
- A peer reviewed audit of clinician's record keeping was undertaken regularly. The SMO reviewed the quality of doctors' consultations. This was a structured audit cycle of two audits based on appropriate criteria and standards, which showed whether standards were met or exceeded. For nurses, records were audited every three months and undertaken by the SNO. The SMO peer reviewed the SNO's clinical records. The outcome of peer review audits were discussed with the individual clinician and actions agreed. Emerging themes were discussed at wider meetings. For PCRF staff, a comprehensive annual peer review of clinical records was undertaken and discussed with individual staff as part of their annual objective setting.
- A safe process was in place for the management of samples, a role assigned to the HCAs who were given dedicated time each week for this activity. Samples were logged in a book, including the patient's DMICP number and the name of the clinician who requested the sample. Samples were stored in a dedicated fridge until collected by the courier each day. Twice a week the HCAs reviewed the samples log and checked DMICP to see if results were back. Once results had been returned, the clinician was tasked to review them. A re-check was carried out to ensure the task had been completed. The laboratory was contacted if there was any delay with results. Nurses carried out the three monthly specimen management audit. The practice achieved 100% compliance for the June 2021 audit.

Safe and appropriate use of medicines

- The DSMO was the lead for medicines management and the pharmacy technician was responsible for the day-to-day operation of the dispensary. Safe procedures were in place for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment.
- Stock medicines were regularly checked. Medication requiring refrigeration was monitored twice a day to ensure it was stored within the correct temperature range. A process was in place to ensure the cold chain was maintained when medicines were transferred between medical centres.
- Controlled drugs (medicines with a potential for misuse) were stored securely, including the keys to access the controlled drugs (CD) cabinet. Registers were used to record the receipt and issue of CDs. Destruction of CDs was completed in accordance with policy and records maintained.
- Patient Group Directions (PGD) had been developed to permit nurses to administer medicines in line with legislation. We looked at a range of PGDs and all were current and signed. Nurses using PGDs had completed the required training which was signed off by either the SMO or DSMO. A PGD audit had been undertaken which showed good compliance. An action plan was developed where improvement was required.

- Supported by an SOP, a meticulous approach was taken with all aspects of the operation, record keeping and monitoring of Patient Specific Directions (PSD); used by Combat Medical Technicians (CMT) to provide vaccinations for military patients. There were clearly defined roles for individuals who were appropriately trained to conduct the relevant parts of the process for the PSD. Documentary evidence of the training received and appropriate authorisation to complete the PSD was in place. This was accurately reflected on the patient's clinical record as well as on the PSD. CMTs completed PSD training and were signed off as competent once they had been observed and completed their mandated training portfolio. This comprehensive approach meant we found no errors throughout the PSD process.
- The ANP maintained their competencies for non-medical prescribing through regular clinic sessions, clinical supervision and feedback from the SMO and duty clinical supervisor.
- Prescription forms were securely stored and their use monitored. Repeat prescriptions were safely managed with only written requests accepted. Repeat prescriptions were only issued following authorisation from the prescriber. Patients prescribed medicines for a chronic condition were reviewed every six months. Uncollected prescriptions for antibiotics, antidepressants and antipsychotics were brought to the attention of the prescribing clinician.
- A process was established for duty doctors to manage changes made to patient's medicines by other organisations, such as out-of-hours and secondary care services. Prescriptions and correspondence was scanned onto DMICP and assigned to either the referring clinician or the duty doctor for review, including the option to offer the patient an appointment. The process had not been documented and this was completed during the inspection.
- Searches for patients with a chronic disease and prescribed high risk medicines (HRM) were carried out each month and held on DMICP. We looked at the records for five patients prescribed an HRM. Most of the patients on shared care agreements (SCA) had their SCAs attached to their clinical record and the practice was undertaking the monitoring as outlined in the agreement. There were some patients where the SCA could not be located even though the alert on the patient record referred to a document in the records. When this was accessed it was not a SCA, rather a form signed by the doctor accepting the SCA. Patients from Defence Medical Rehabilitation Centre (Stanford Hall) did not have a SCA in their records. Despite this, we noted from our review of records that patients were monitored and managed well.
- The quality improvement activity register showed various medicine related audits. For example, a DMARD (medicines commonly used to treat rheumatoid arthritis) audit had been completed by the SMO on an annual basis. An annual antibiotic audit had been undertaken and was due to be repeated in October 2021. Regular searches (most recent in August 2021) were undertaken to check for female patients of childbearing age prescribed valproate (medicine often used to treat epilepsy). A pharmacy risk audit was undertaken by the regional pharmacist and an action plan developed if any improvements were needed.

Track record on safety

- Policies and risk assessments pertinent to the medical centre and PCRF were in place, including for clinical rooms, the building, substances hazardous to health and new and expectant mothers. A COVID-19 risk assessment to reflect changes in working practices was revised in June 2021. The senior exercise rehabilitation instructor (ERI) managed the risk assessments for the PCRF and the review of these risk assessments had increased with COVID-19 restrictions.
- A current and retired risk register and issue log was in place. Although departmental leads were asked to consider current and future risks at the practice meeting in August 2021, the risk register had not been updated. Resolved risks remained active and recent clinical risks were not included on the register. The risk register was reviewed during the inspection an updated to reflect the current position.
- Processes were in place and up-to-date for the checking of electrics, equipment and water safety. Portable electric appliances were checked in October 2020. The senior Exercise Rehabilitation Instructor (ERI) was responsible for PCRF equipment. The ERI maintained a detailed equipment management spreadsheet which was updated weekly including dates for equipment servicing.
- Health and safety monthly workplace inspections were undertaken with the most recent in September 2021. Fire safety checks were carried out 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. The fire risk assessment was due for review in February 2021 but had been deferred whilst the refurbishment was in progress subject to certain conditions which had been actioned by the practice team.
- There was a fixed emergency alarm system in place. We were advised checks of the system were undertaken to demonstrate functionality, audibility and responses but not documented. This was rectified during the inspection; a random test was conducted and a record for regular checks created including action required. Two further recent checks were also documented. Although there was no lone working in PCRF, staff carried personal alarms but there was no evidence to show these had been tested.

Lessons learned and improvements made

- All staff had access to the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events, incidents near misses and sentinel events. A sentinel event is a patient safety event that results in death, or significant harm. The SNO was the lead for managing ASERs and all staff had a log in to access the system. A register was maintained which tracked the progress of each ASER including whether a root cause analysis was undertaken and change implemented. Sentinel events were dealt with by the SMO and reported to the Regional Clinical Director.
- From interviews with staff it was clear there was a culture of reporting, investigating and learning from both clinical and non-clinical incidents. Staff provided examples of incidents reported through the ASER system, the action taken and improvements made as a result of the outcome of the incident being investigated. Staff advised us that

lessons learnt and resulting changes were discussed at HCG meetings and, if relevant, at departmental meetings. Minutes from the March and August 2021 HCG meetings confirmed this. Staff unable to attend the meetings received a copy of the minutes by email. It was evident from the detailed examples staff provided that the practice was keen to make improvements to maximise safe and effective care for patients.

- The pharmacy technicians received alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). They checked for stock held in response to an alert and emailed clinicians. Alerts were a standing agenda item at both the practice and HCG meetings and the minutes included links to the alert spreadsheet and relevant websites.

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 keep patients and staff safe including gaps in:

- The review of patients diagnosed with a long term condition;
- peer review of clinical notes for nursing staff;
- the uptake of health checks for patients aged 40 and over; and
- clinical oversight of Personnel Recovery Unit (PRU) patients.

We found the recommendations we made at the last inspection had been actioned.

Effective needs assessment, care and treatment

- Processes were in place to support clinical staff to keep up-to-date with developments in clinical care including NICE (National Institute for Health and Care Excellence) guidance, the Scottish Intercollegiate Guidelines Network (SIGN), clinical pathways, current legislation, standards and other practice guidance. Guidance was shared through the group mailbox, at practice meetings, HCG meetings and departmental meetings. For example, we were provided with evidence to show updated antibiotic guidance had been shared with the practice. Staff were also kept informed of clinical and medicines updates through the DPHC newsletter circulated to staff each month.
- It was clear that clinicians were responsive and supported each other to ensure effective patient treatment and care. The doctors held meetings twice a week; an informal meeting on a Tuesday to discuss complex patients and a formal minuted meeting on a Thursday to discuss patients and review relevant NICE guidelines. Physiotherapists had prompt access to the doctors and nurses directly or via the task system on DMICP. As an example, a doctor responded to an urgent query about a PCRF patient despite being in the middle of a clinic.
- To ensure effective needs assessment and care, the PCRF used the monthly patient reviews, clinical supervision, informal case discussions and in-service training case studies. All staff were assigned a dedicated clinical mentor on induction with whom they had scheduled time to discuss patient management.
- Clinicians participated in local area Practice Based Small Group Learning (PBSGL) sessions facilitated by one of the doctors at the practice. Based on the established PBSGL programme endorsed by NHS Education for Scotland, it involved virtual clinical case discussions with between five and 10 clinicians attending each monthly meeting.
- The PCRF routinely used Rehab Guru (software for rehabilitation exercise therapy) and exercise programmes were recorded on DMICP for individual patients.
- The PCRF was working from two temporary buildings while the refurbishment was taking place. Review of equipment was being undertaken by the senior military

Exercise Rehabilitation Instructor (ERI) prior to moving to the new location which will provide more space than the previous facility. Whilst the refurbished building will provide increased space, limitations were identified, such as ceiling height and space for equipment. The OC PCRF was confident the PCRF could work around these issues.

Monitoring care and treatment

- A doctor and a nurse were identified as the leads for a specific long term condition (LTC). Following the release of a new DPHC LTC management policy permitting the use of a locally produced and held LTC register, the practice had revised its LTC management SOP.
- The DSNO was leading on developing a system to track and manage patients with an LTC, which took account of the patient's needs from a holistic perspective. Although in the early stages of development, the system provided an overview of all patients on the one register and included HRMs and review requirements. The leads for each LTC also conducted searches using the population management process (referred to as POPMAN) to check the accuracy of the data. It was anticipated this new process would improve health outcomes by encouraging patients to engage with LTC reviews and make the process more efficient and accessible.
- We looked in detail at the diabetes register and it included review dates for: the Q-risk3 (to predict cardiovascular risk); eye screen; foot check; last annual review; months to next annual review; HbA1c target (blood glucose levels); blood pressure; cholesterol; It also took into account pre-diabetes and gestational diabetes. The lead nurse for diabetes sent a letter inviting the patient for a review and a further two letters if there was no response. If necessary they telephoned the patient. A standard template was used for reviews and a face-to-face consultation for tests. If the diabetes was not well controlled then the patient was invited for more frequent reviews. Patients at risk to diabetes were also identified at the over 40 health check through a HbA1c test.
- The practice provided us with the following chronic disease data:
    - There were 32 patients on the diabetic register. The last blood pressure reading for 90% of patients was less than150/90 which is an indicator of positive blood pressure control. The HbA1c for 64% was less than 59. A foot risk assessment had been carried out in the last 12 months for 71% of the patients.
    - There were 142 patients recorded as having high blood pressure taken in the past 12 months. The last blood pressure reading was less than 150/90 for 57% of patients.
    - There were 154 patients with a diagnosis of asthma. Seventy nine percent had an asthma review in the preceding 12 months. Fifty nine percent had undertaken a reversibility test (check to see if lung function improves with medication). Seventy five percent had a smoking history recorded.
- Patients referred to the Personal Recovery Unit (PRU) were regularly reviewed.

- In line with DPHC directive, routine audiometry had decreased during COVID-19. The practice was awaiting further guidance as to when routine audiometry could be resumed. Sixty six per cent of patients' audiometric assessments were in date (within the last two years).
- The Welfare Officer advised us that there had been a notable increase in mental health issues during COVID-19 and said more people were seeking help rather than managing issues themselves. The Welfare Officer described effective communication and support with the practice with the management of people with mental health needs. The welfare team had access to six counselling sessions for patients.
- Where possible face-to-face consultations were offered to patients with a mental health need, which involved a risk assessment and agreeing a management plan with the patient. There were different pathways for referral on for military and civilian patients. Civilians were referred to local mental health services, including the NHS psychological therapies services (IAPT). Military patients could be referred to the Department of Community Mental Health (DCMH). Criteria for referral was based on individual need and clinician assessment. For example, conditions such as eating disorders were referred straight to specialist services. If the diagnosis was for anxiety/depression and assessed as low risk then Step 1 of the DPHC mental health pathway was provided at the practice. If the doctors had any concerns then the DCMH was contacted for advice.
- We observed a range of mental health information for patients at the practice, including a leaflet on maintaining mental health fitness which included apps and information about how to access other services, such as bereavement counselling and army welfare. A clinical coding list for mental health was available in each clinical room.
- We looked at a broad range of patient records on DMICP including the records for patients with asthma, diabetes, high blood pressure, with a mental health diagnosis and patients receiving care from the PCRF. They showed effective clinical management. However, we noted the use of templates for recording of chronic disease reviews was not consistent. Records indicated the Joint Medical Employment standard (JMES) was reviewed to reflect the patient's ability to deploy and remain employed in their normal duties.
- One of the doctors and the SNO were the leads for quality improvement activity (QIA). A QIA planner was established for 2021 along with a log of QIA from 2019 to 2021. QIA comprised both clinical and non-clinical audits, service evaluation, mandated audits and data searches. The outcome of QIA was communicated to all clinical staff through HCG meeting and at departmental meetings if relevant to clinical practice.
- It was evident that action was taken based on the outcome of QIA. Clinical audit was often triggered by change in NICE guidelines and took account of LTCs and other clinical conditions, such as the management of gout (form of arthritis) and opioids (medicine for pain) prescribing. There was evidence of repeat audits and changes made as a result. For example, an initial audit of short-acting beta-agonists (medicines used to treat asthma), identified potential over prescribing and issues with clinical coding. Changes were made and improvements were seen in coding and prescribing on the repeat audit.
- A clinical audit carried out in December 2020 using some of the targets for LTCs identified that clinical coding and review templates were not consistently used. As a result, one of the doctors developed guidance on diabetes including the benefits and

limitations of medication treatment options. It was discussed at the doctors' meeting. It was also determined that POPMAN was not a reliable tool for auditing and this was added to the risk register.

- The PCRF demonstrated substantial evidence of QIA. There was a clear culture of evidence-based learning and development throughout the PCRF team with opportunities taken to reflect and develop the service. For example, the musculoskeletal Health Questionnaire (MSK-HQ) was used for all patients. It was embedded as a link in the patient information leaflet, circulated through the text service and a QR code available in the department. The MSK-HQ was audited regularly as part of ongoing service evaluation. Other recent examples included a service evaluation of the administrative resource, evaluation of the tendinopathy class and the patient-reporting outcome measures (PROM) using the texting service.

Effective staffing

- An induction programme was in place for permanent staff. It took account of DPHC requirements, local expectations and the role of the staff member appointed. A lead was identified to monitor mandated training, managed through the staff database. A monthly compliance check for all training was undertaken and staff who were due to refresh training were contacted individually. Compliance with mandated training was good across the practice. Most gaps in training were due to deployments and extended sick leave. DMICP access was removed if key mandated training was not completed in a timely way.
- Staff with lead roles were provided with appropriate training. For example, the IPC lead and another military nurse had completed link practitioner training. The practice manager and deputy practice manager (DPM) had both completed the DPHC practice managers course. The DPM had completed risk assessor training and the practice manager had undertaken the DMICP administrators course. Chaperone, consent, mental capacity and Caldicott training was well attended in June 2021.
- Staff had dedicated time each month for continual professional development. Staff advised us that the leadership was supportive of courses they wished to attend. The Training Scrutiny Board considered requests for external training so long as mandated training had been completed.
- The practice accommodated a large number of clinical trainees, including GP registrars, General Duty Medical Officers (GDMO) and trainee medics on placement. Formal arrangements for supervision of trainees and staff on courses was in place and we noted these arrangements were discussed at the practice meeting in July 2021. Videos were made of consultations to support both trainers and learners. Consent was sought in accordance with the Royal College of GP standards. A duty clinical support doctor was allocated each day to support trainee clinical staff. One staff member of the PCRF team was responsible for managing physiotherapy student placements. A comprehensive student pack was provided pre-placement. Positive student feedback this year resulted in PCRF staff being nominated for an educator's award.
- Medics were required to produce evidence of competence on an annual basis. They spend time with the training lead as part of their induction and were required to

complete a portfolio which was signed off by a registered clinician. In addition, medics completed the Royal College of Nursing vaccination competency pack for non-registered staff. Internal clinical assurance was undertaken every six months. If not up-to-date, DMICP access was removed. Following a period of deployment, medics were required to undertake a mini induction to the practice, including shadowing other medics.

Coordinating care and treatment

- The practice was represented by a clinician at each of the Unit Health Committee meetings, at which the health and care of vulnerable and downgraded patients were reviewed. The practice had close links with local NHS services, social services and voluntary organisations. For example, NHS midwives carried out routine antenatal care at the practice and facilitated high risk antenatal care which a consultant obstetrician attended. The SMO was a member of the local council health and wellbeing committee which facilitated discussion and raised the profile of military health care. The leisure centre in Tidworth was funded by the military and available to the public. The PCRF provided aqua therapy sessions for military patients at the centre.
- For patients leaving the military, pre-release and final medicals were offered. For patients with complex needs, the clinician aimed to have a discussion with the NHS practice the patient was registering at. If there was an ongoing safeguarding issue then the practice liaised with social services and MASH. If the patient was leaving from the Personal Recovery Unit (PRU) then planning would involve the clinical coordinator and social worker at the PRU and NHS and social care services.
- During the pre-release phase the patient received an examination and a medication review. Patients were given a service leavers pack at their pre-release medical which included details for their new GP about coding them as a service veteran and signposting them to numerous agencies that support veterans.

Helping patients to live healthier lives

- One of the HCAs had the lead for health promotion. A health promotion calendar was in place based on the Public Health England health promotion programme, patient population need and seasonal influences. Various health promotion information was displayed in patient areas including the management of ticks (common to the area), management of colds and flu, COVID-19, mental health awareness, heat injury awareness and sepsis. Unit health fairs ceased during COVID-19. Instead the nursing team made videos on smoking, healthy eating and sexual health which were shown in the canteen on the garrison. Unit health fairs resumed last month.
- Health promotion advice was given during individual patient consultations, particularly during over-40 screening. The last smoking cessation audit showed a large proportion of staff offered smoking cessation to patients who were smokers. PCRF staff described how lifestyle questions were included in the assessment. ERIs used the Anti-Gravity Treadmill to simulate a reduction in weight of patients who were obese so they could experience how it would feel if they lost the extra weight.

- The ANP was the lead for sexual health and had appropriate experience and training for the role. Two years ago, Salisbury sexual health service reached out to the practice because it was receiving a lot of referrals for military patients. Now the practice runs joint sexual health clinics with Salisbury sexual health service, which includes a team of two health advisors and two consultants. Approximately 40 patients are seen per session and includes a mix of NHS and practice patients. The Ministry of Defence approved 'Gov.UK Notify' text messaging service was used to provide results to patients This was supported by an SOP.
- The ANP was involved in setting up PReP (pre-exposure prophylaxis for HIV prevention) aimed at men. Initial counselling was provided at the practice and medication prescribed from Salisbury sexual health service. Patients were monitored every three months.
- A long-acting reversible contraceptives (LARCs) service was provided at the practice by one of the doctors and the ANP. The patient was provided with counselling prior to the procedure. Other practices could refer patients for this procedure. An audit of LARCs had been undertaken.
- Because of referrals from other practices for intra-uterine device (IUD) removal, the ANP surveyed other practices and identified a learning need for this procedure. In conjunction with the Faculty of Sexual and Reproductive Health (FSRH), the ANP and a faculty trained consultant had a date scheduled to deliver accredited training to 25 nurses across the region.
- The ANP had completed the menopause British Society special skills training and since January 2021 had been developing a menopause clinic with a menopause clinic held each week. At the first appointment patients were encouraged to use the Balance app to track symptoms. Three months later the patient was seen and the data reviewed. A regional survey identified a learning need for clinicians about the menopause. Facilitated by one of the doctors, a menopause conference for clinicians was scheduled to take place at the end of September. To be held at the practice, invitations to the conference included clinicians from other practices and from external services.
- The ANP was a member of the Defence Menopause Working Group and had produced a poster specifically targeting workplace adjustments for women experiencing menopause symptoms.
- Regular POPMAN/DMICP searches were undertaken to identify patients who required screening in line with national programmes. A dedicated nurse was responsible for monitoring screening and a tab for screening was held on the LTCs register. We carried out a search and identified 31 patients that met the criteria for breast screening. We looked at the records for six patients and 50% had had a mammogram. The other three were aged 51-53 so may not yet have had a mammogram but there was no evidence of referral for screening found in coding of the notes. Two of these were civilian patients. The lead for mammography confirmed that all the patients on the recall list were in-date for review and this was documented in their clinical records. A search was run monthly and the lead said they would re-run the search to see if any new patients had been identified since the previous search. The practice queried whether there may be an issue with which search was run during the inspection and whether it corresponding to the one used locally.

- Six patients met the criteria for bowel screening and five had been screened. No patients met the criteria for AAA screening. Data at the time of this audit showed the practice had an uptake of 89% for cervical cytology screening. The NHS target is 80%. Evidence was seen in all the clinical records reviewed that patients who were not in date were being recalled appropriately.
- One of the doctors had the lead for over-40 screening. The process to identify eligible patients has been revised, including an SOP and searches by age group in five year blocks. Patients were offered two appointments; the first face-to-face and the second virtual. An audit had been undertaken which identified an increase in the number of patients invited for a check. Information about over-40 screening was displayed in a patient area of the practice.
- 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:
    - 87% of patients were in-date for vaccination against diphtheria.
    - 87% of patients were in-date for vaccination against polio.
    - 84% of patients were in-date for vaccination against hepatitis B.
    - 73% of patients were in-date for vaccination against hepatitis A.
    - 87% of patients were in-date for vaccination against tetanus.
    - 93% of patients were in-date for vaccination against MMR.
    - 85% of patients were in-date for vaccination against meningitis.
- Children's immunisations were managed by the local NHS health visiting team who held clinics at the practice. For the two eligible children under the age of 12 months, 50% had received their first primary vaccinations. For the three eligible children, 67% had received their second primary vaccinations and 92% (55 children) had received the third primary vaccinations. Records showed 92.5% of children had received their one year vaccination and 71.4% had received the pre-school vaccination. Records showed the practice followed up on children who did not attend for their appointment. Mitigating circumstances for vaccinations not given were recorded in the patient's records.
- A process was in place to identify patients due a vaccination. For service personnel, recall was through the individual units. The Chain of Command scrutinised the vaccination statistics and liaised with the unit RMO or Medical Sergeant. For children, immunisations were monitored by an independent health provider. The practice received a list of children who were due a vaccination. If a child failed to attend for their vaccination then a phone call would be made to the parent/guardian. Two baby clinics were held each week at the practice.

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. The SMO had recently

provided consent training for the staff team. The presentation was emailed to staff who were unable to attend.

- Clinicians advised us that implied consent was accepted for basic procedures such as the taking of blood pressure. Verbal consent was taken for more intimate examinations. Written consent was taken for minor operations (not being carried out at present due to COVID-19), acupuncture and for sharing occupational health information with the Chain of Command.
- Staff understood the competency test for young people under the age of 16 (referred to as the Gillick competence test). Nurses said they would refer to a doctor if they were concerned about the competency of a young person. A record was made in DMICP when a parent consented for their child.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

- We took into account a variety of methods to determine patients' views of the service provided at the practice. These included direct interviews with patients, the 2020 PCRF patient satisfaction survey, the eConsult token survey, the 2020 patient experience audit, the regional-wide patient survey (referred to as GPAQ) and the DMSR patient satisfaction survey circulated ahead of this inspection. Responses indicated staff treated patients with kindness, respect and compassion.
- The practice information leaflet included contact details for army welfare services. There was also a HIVE (a network providing a range of information to service personnel who had relocated to the camp and surrounding area) in the garrison.
- Staff and patients provided us with various examples of when the practice had gone the extra mile to ensure patients received individualised and compassionate care. For example, a patient with post-traumatic stress disorder which was triggered by being in military facilities was given video and telephone consultations for their rehabilitation until they were confident enough to access the facilities. We also heard about an occasion when a doctor called to a patient's home when they were concerned about the lack of contact with the practice and no response to phone calls.

Involvement in decisions about care and treatment

- Patients we interviewed told us they were involved in planning their care and received information from the clinician that was easy to understand. All PCRF staff used the reconditioning chit to liaise with unit physical training instructors.
- The practice was part of a carer's initiative pilot project led by Wiltshire Council, which was being rolled out to DPHC practices, NHS services and other services within the council area. A carers lead was identified for the practice. The practice carers guide provided a definition of a carer, a carers registration form and contact details for Wiltshire Carers Support. A carers notice board in the patient waiting area.
- The practice regularly carried out searches for carers using a specific clinical code. Each carer had a named clinician, were offered a same day double appointment. In addition, they were screened for anxiety/depression, offered a health check and the flu vaccination.
- Before COVID-19, the carer's lead engaged with events (Carers Café) held by a local support group, 'Courage to Care', to offer and promote routine checks for carers. The lead was exploring the option for the practice to participate in a recognised accreditation scheme for carers.
- 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

- Patients who provided feedback about the service said their privacy and dignity was met at the practice. Breast feeding locations were identified for patients who preferred privacy.
- In the medical centre, patient consultations were conducted in clinic rooms with the door closed. All clinicians had headsets so patient responses were not audible to anyone other than the clinician in the consultation. All clinical rooms had a separate screened area for intimate examinations. There were privacy slips available which patients could use at reception to notify staff if they wished to discuss an issue in private. There were physical barriers and floor distance stickers to advise patients to keep their distance. The throughput of patients had significantly reduced due to COVID-19.
- Confidentiality was a concern in the temporary PRCF due to curtained cubicles. The staff used a radio to minimise conversations being overheard. Although curtained cubicles would still be in use, the refurbished facility for the PCRF will include an increased number of private clinical rooms.
- The SMO was the Caldicott lead. Staff had received training in DIMP (Defence Information Management Passport) and training in the Caldicott principles.
- 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 caring services.

Responding to and meeting people's needs

- The practice was committed to meeting the principles of the Equality Act 2010, including safeguarding people with protected characteristics. For example, a transgender healthcare had been developed for the practice. Transgender patients were provided with information and encouraged to access clinical services appropriate to their clinical needs, such as screening. The practice information leaflet had been translated for the Nepali population.
- An equality access audit had been reviewed in August 2021. The front doors were automatic, there was lift and an accessible toilet. A hearing loop was due to be installed as part of the refurbishment. The temporary accommodation for the PCRF did not support patients with a disability. This was added to the risk register and will be resolved when the PCRF moves to the refurbished premises next month.
- Difficulty accessing the practice by telephone was identified as a concern for patients at the last inspection. Feedback from patients indicated that this remained the case as there was only one telephone into the service. Twenty nine responses (out of 37) to the DMSR patient satisfaction survey said it was not easy to get through to the practice by telephone. We were advised that telephone access had been taken into account in the refurbishment and would improve on completion of phase 2 of the refurbishment.
- EConsult had had been introduced during COVID-19 and had provided patients with an alternative option for contacting the service. A patient leaflet was available explaining the eConsult process. Patients we spoke with expressed mixed views about the eConsult approach. Some patients liked it while others found it to be a protracted process or experienced connectivity issues. A patient feedback system using counters asked the views of eConsult over a period of a month. Of the 416 responses, 65% of patients were satisfied with the system but 17% were not. The practice manager acknowledged that the counter system did not provide the clarity required to make improvements and planned to better utilise the GPAQ process; the system implemented by DPHC for patient feedback.
- The practice responded to feedback from patients. For example, in response to requests for additional Warrior (yoga) classes as they booked up quickly, an extra class was added. In response to limited administration time, clinical staff were permanently staffing the reception so the incoming calls were answered in a timely way.

Timely access to care and treatment

- Urgent appointments were available daily with a doctor or nurse and routine appointments available within two days. Both urgent and routine appointments were available with a CMT each day. Access for vulnerable patients was prioritised.

- The PCRF had the highest referral rate of all PCRFs in any region. Statistics from January to March 2021 showed 88% of patients were seen for a routine appointment within 10 working days and 38% of patients with an urgent need within one day. Direct access to physiotherapy (DAP) was used by approximately 40% of patients. All staff undertook first line practitioner training online prior to using DAP. At the time of the inspection a routine physiotherapy appointment was available within 14 working days, a follow-up appointment within 14 days and an urgent appointment facilitated within one day. A routine ERI appointment was accommodated within 17 working days and a follow up appointment with a month. Rehabilitation classes were available the following week. There were no significant waiting times for access the RRU.
- Out of hours access to medical care was outlined on the patient information leaflet. A duty doctor and nurse were available for emergency cover up to 18:30. From 18:30 on weekdays, weekends and public holidays patients had access emergency care through NHS 111.

Listening and learning from concerns and complaints

- How to make a complaint was outlined in in the patient information leaflet. In addition, a complaints leaflet and display was in the patient waiting area.
- The DSMO and business manager were the leads for complaints, which were managed in accordance with the DPHC complaints policy and procedure. A local process for managing written and verbal complaints was in place. The OC PCRF managed complaints for the PCRF which were then linked into the medical centre's system in accordance with local protocol.
- The practice meeting minutes from July 2021 showed that an overview, outcome and improvements made from recent complaints was discussed with the team. For example, a complaint about accessing the practice by telephone highlighted that the patient was unclear about using the eConsult process. As a result, the practice advertised the eConsult system which resulted in an increased uptake of the service and further reduced the pressure on the single reception phone number. Patient feedback for the PCRF indicated that patients were not fully aware of how to make a complaint so the PCRF plans to add more posters to patient areas in the refurbished premises.
- A complaints audit was undertaken between August 2020 and Aug 20211. A trend relating to access via telephone was identified. The practice has mitigated this as much as possible. It was identified on the risk register as a transferred risk.

Are services well-led?

We rated the practice as good for providing caring services.

Following our previous inspection, we rated the practice as requires improvement for providing well-led services. This was due to shortfalls in governance arrangements.

We found the recommendations we made at the last inspection had been actioned.

Leadership, capacity and capability

- Some changes had been made to the leadership team since the last inspection. There had been a change of SNO and the practice manager and DPM had taken up post shortly before this inspection. The leadership team worked well together, including the OC PCRF, and leaders demonstrated high levels of experience, capability and resourcefulness to deliver responsive and sustainable care to the patient population.
- A leadership meeting was held each Monday and all departments were represented including the PCRF. The aim of the meeting was to ensure effective communication. The meeting minutes from August 2021 showed that locum and recruitment updates were standing agenda items along with room allocations, appointments, staff rota, regional updates, the refurbishment and staff training.
- Although key leadership roles were military, all departments had civilian staff to provide continuity and sustainability. The practice manager and DPM were both in non-deployable roles. There was a clear structure of accountability and responsibility for the service.
- The collaborative approach between the leaders meant the smooth running of the practice was not dependent on any one individual. All the staff we spoke with were pleased with the leadership of the practice. In particular, an RMO highlighted that the practice was not disadvantaged by the throughput of military medical staff due to effective and inclusive leadership.
- The Regional Headquarters (RHQ) was based in the garrison. Monthly SMO meetings were held by Skype to discuss common issues and any problems. The SMO had provided support when the Regional Clinical Director's post was vacant for a short period. The leadership team described close liaison with region with regular communication from the area manager, regional healthcare governance (HCG) team and regional pharmacist. Communication had increased in relation to the refurbishment, particularly regarding logistics and obtaining IT and equipment. Regional HCG virtual meetings had increased to biweekly during COVID-19. They had now returned to monthly meetings with the next meeting planned as a face-to-face meeting.

Vision and strategy

- The expansion of the premises and refurbishment was key to the vision and strategy for the service. It was considered from several perspectives including the size, needs of the patient population, resources, the units supported and the needs of organisation. The strategy took into account the potential for the population to increase. In particular, the PCRF needed to expand as it also provided a service to Bulford Garrison.
- Throughout the inspection it was clear staff were committed to providing and continually developing a service that embraced the vision and values of the service. The practice worked to the following DPHC mission statement:

  "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."

- At local level, the mission statement was outlined as:

  "Our practice is committed to providing a high quality, comprehensive, cost effective and continuing service to patients, including the use of effective and economic prescribing methods, diagnostic tests and referrals to secondary care"

  "To achieve this aim we must undertake self-assessments that encourage the whole primary care team to reflect on performance and encourage a positive learning culture within the practice."

Culture

- A responsive and patient-centred focus was clearly evident with this ethos embedded in practice. Staff continually looked at ways to improve the service for patients.
- Both civilian and military staff described an approachable and supportive leadership team that was committed to ensuring cohesion, equality and inclusion. It was clear from discussions with staff that their contributions to the development of the service were valued. All staff attended the practice meetings where they could put forward suggestions or raise concerns. Locum staff were included in practice activity including HCG and practice meetings. This inclusive approach had been well received and locums had volunteered to undertake secondary duties despite not being contractually required to do so.
- All staff we spoke with described effective communication across all departments. There was a practice WhatsApp group for staff to engage with each other and a monthly 'tea & toast' session was held for staff to get together.
- 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 SOP and had access to the Freedom to Speak Up champions within the region.
- Processes were established to ensure compliance with the requirements of the duty of candour (DoC), 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.

- Although staff articulated a number of occasions when DoC had been applied, the DoC only had one entry dated April 2021. Leaders explained that DoC is observed for all incidents where a patient may have received less than the expected standard of care. This was often in the form of a verbal acknowledgement of the incident/event and an apology by the clinician/staff member to the patient. In these circumstances it would be recorded as an action within the ASER system and noted on the ASER tracker. Should an incident require more formal DoC action, this had taken the form of a letter and/or formal meeting with the patient to fully investigate the incident and inform the patient of the outcome. In this instance DoC would be recorded in the log. In line with legislation, DoC was carried out and formally recorded for incidents where significant harm had come to a patient or an incident effected multiple patients.

Governance arrangements

- The practice had a well-developed health governance workbook which covered all the key areas of governance and the staff team had access the it. The workbook is the system used in DPHC services 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. Governance was integrated between the medical centre and PCRF.
- The last RRU advisory visit took place in July 2018. The PCRF had addressed all the actions identified in the report.
- 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. Terms of reference were in place to support job roles, including lead roles for specific areas.
- A schedule of regular practice, HCG and departmental meetings were in place. Minutes showed the meetings were well represented by the appropriate departments.
- A programme of quality improvement activity (QIA) was established to monitor the outcomes and outputs of clinical and administrative practice. The leadership team supported staff to put forward ideas and engage with QIA.

Managing risks, issues and performance

- The risk register was integrated for both the medical centre and PCRF. There was an active and retired risk register, and a current and retired issue log. Although departmental leads were asked to consider current and future risks at the practice meeting in August 2021, the risk register was not up-to-date. Resolved risks remain active and other clinical risks were not on the risk register. The risk register was reviewed during the inspection. Resolved risks were moved to the retired risk register and other new risks such as a backlog in note summaries had been added.
- There were a range of risk assessments in place including clinical and non-clinical risks and lone working.

- The business continuity plan was reviewed in August 2021 resulting a tabletop exercise for staff of the fire evacuation plan. A major incident plan was in place for Tidworth Garrison.
- Staff were up-to-date with their appraisals. A structure was in place to manage under performance of individual staff. The first action was to talk to the individual to ascertain if there are any underlying health or welfare issues that may have caused a decline in performance. The next action was to conduct a training needs analysis to identify any required training. A review of workload was undertaken to ensure it was not excessive. If supportive measures were not effective, then more formal restoring efficiency or disciplinary action would be taken depending on the nature of the performance issues.
- Processes were in place to monitor national and local safety alerts, incidents, and complaints.
- Caldicott reports were reviewed weekly to ensure there were no confidentiality breaches and recorded in practice documents on DMICP.

Appropriate and accurate information

- The eCAF (Common Assurance Framework), an internal DPHC quality assurance tool, was used to monitor the service performance. It was integrated between the medical centre and PCRF. Each member of staff, including locum staff, was responsible for certain domains and inputted directly onto eCAF.
- 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. There was evidence in place to show that the SMO had effectively dealt with breaches of data security standards.

Engagement with patients, the public, staff and external partners

- The practice actively engaged with patients to identify areas for improvement including a patient participation group (PPG), a suggestion box and a token system for feedback. being held remotely during Covid. The last PPG was held in July 2021 and next was scheduled for September 2021. The token system used to seek the views on various topics was limited as patients did not always use the associated ‘how did we do?’ form to provide a rationale for their response. The DPHC GPAQ feedback survey had received 16 responses in 18 months, which was low considering the size of the patient population. Although the QR code and web link for the GPAQ was displayed in the patient, the practice manager said they would consider alternative ways to promote the survey. At the time of the inspection the GPQA survey was being run for patients to comment on their recent consultation and prescription.

- The PCRF send an online patient information leaflet to patients with a link to the patient satisfaction survey. Clinicians prompted patients to complete it after their consultation. Results were analysed monthly, six monthly and annually and staff informed at the PCRF meetings. Results of the survey were also discussed at the wider practice meetings and we noted this happened at the July 2021 practice meeting.
- The practice had listened to their patients with regard to phone access issues and had introduced measures to reduce the problem as much as possible until additional phone lines could be installed as part of phase 2 of the refurbishment. This included a daily nurse triage clinic and the emergency clinic (sick parade) accessed via text message to the duty mobile.
- Good and effective links were established with internal and external organisations including the welfare services, mental health services, voluntary services and local NHS providers.
- An anonymous staff survey was conducted in July 2021. The management team identified areas for improvement and have committed to addressing them, and plan to re-run the survey next year.

Continuous improvement and innovation

The staff team was committed to making improvements and took all opportunities to continually enhance the service for patients. Improvements were implemented based on patient population need, feedback about the service, complaints, the outcome of audits and significant events. A log of quality improvement projects was maintained. The following are some of the service improvements we identified during the course of the inspection:

- In response to COVID-19, the PCRF videoed patient information. This was now an e-resource based on the health literacy level of soldiers (average reading age 11 years old) and evidence based.
- Comprehensive e-resource provided for PCRF patients during COVID-19 restrictions was now integrated into practice.
- The PCRF had embedded the MSK-HQ measure within patient information to ensure better compliance.
- The MSc dissertation completed by one of the physiotherapists evaluating the clinical acceptability of the digitised STarT MSK tool had been positively biased towards developing current practice within the PCRF. It is anticipated this will have a positive effect on patient care.
- The availability of a clinical supervisor every day (and kept free of routine clinics) to provide oversight and support to medics, clinicians in training and to clinicians who may require a second opinion.
- The development of a comprehensive PSD SOP had provided a failsafe process to ensure patients were assessed correctly for their vaccination requirement and this was double checked by a suitable independent prescriber.

- The lead for carers was exploring the option for the practice to participate in a recognised accreditation scheme for carers.
- The piloting and introduction of HARK, a validated screening tool for domestic violence and abuse.
- The development of a sexual and reproductive health service for women and men in collaboration with local sexual health services.