Care Quality Commission

Bassingbourn Medical Centre

Bassingbourn Barracks, Royston, SG8 5LX

Defence Medical Services inspection

This report describes our judgement of the quality of care at Bassingbourn Medical Centre. It is based on a combination of what we found through information provided about the service, patient feedback and through interviews with staff and others connected with the service.

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 follow up inspection

We carried out an announced comprehensive inspection at Bassingbourn Medical Centre on 7 March 2023. Bassingbourn Medical Centre had recently taken on staff and patients from Wimbish Medical Centre which had been temporarily closed. Although a decision on the future of Wimbish was pending, the facilities were closed so this inspection report and ratings only refers to Bassingbourn. 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:

- A person centred culture was embedded to ensure patients received quality and compassionate care to meet their individual needs.
- Patients received effective care reflected in the timeliness of access to appointments, reviews and screening/vaccination data. The travel time for patients based at Wimbish had increased but they were granted protected time to attend appointments and transport was provided.
- The medical centre worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs.
- Multidisciplinary team meetings were held in the medical centre on a monthly basis, and care plans for complex patients drawn up jointly with other professionals to ensure the best care was provided.
- Processes were in place to identify patients who were considered vulnerable and coding was applied on the patient record. Staff had completed safeguarding training appropriate to their role.
- There was a safe system for the management of specimens and referrals. The process could be strengthened to improve clinical oversight.
- Effective medicines management processes were in place but there was scope to improve storage arrangements.
- The medical centre had suitable health and safety arrangements in place to ensure a safe service could be delivered.

- Risks to the service were recognised by the leadership team. The main risks resultant from a lack of connectivity to the NHS spine had been escalated and workarounds implemented. A range of risk assessments were in place for the medical centre.
- Facilities and equipment at the medical centre were sufficient to treat patients and meet their needs. Facilities at Wimbish had temporarily been closed and all services were being provided at Bassingbourn.
- Staff were aware of the requirements of the duty of candour and monitored compliance. Examples we reviewed showed the practice complied with these requirements.
- The practice had effective leadership although this was due to be reviewed once the future of Wimbish practice has been confirmed.
- Staff worked well as a team and said they were well supported and included in discussions about the development of the service.

The Chief Inspector recommends to Defence Primary Healthcare:

- The regional team confirm future plans for Wimbish Medical Centre to allow firm plans to be implemented.

The Chief Inspector recommends to the practice:

- Review the access to emergency equipment and medicines for clinicians working on the first floor.
- Strengthen the storage arrangements for medicines and medical gas.
- Review the recall process for patients requiring vaccinations to ensure all those eligible are captured.
- Further develop clinical audit to drive improvement. This should include peer review within the nursing team.
- Ensure that continuity and incident plans for the station provide clear instructions on the role of the medical centre and its staff.
- Ensure all job descriptions and terms of reference are signed.
- Conduct a review of the units ‘Communicable Disease Outbreak Management Plan’ to ascertain what actions lie with the practice.

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Chief Inspector of Hospitals and Interim Chief Inspector of Primary Medical Services

Our inspection team

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

a physiotherapist. Two specialist advisors new to the CQC were also in attendance as observers.

Background to Bassingbourn Medical Centre

Located in Bassingbourn Barracks, Bassingbourn Medical Centre provides routine primary care and occupational health care service to a patient population of 1,150 military personnel. The population can increase by approximately 2,000 with transitory patients. These patients who are temporarily staying at Bassingbourn include those in training, those due to deploy and those returning from deployment. The medical centre was opened in July 2022, although was delayed from being operational until October 2022. Bassingbourn Medical Centre had recently taken on all staff and patients from Wimbish Medical Centre due to the emergency closure of their facilities for 6 months (this arrangement had not been formalised and future plans for both medical centres were due to be announced soon after we inspected). The patient lists had been merged on 1 November 2022. A Primary Care Rehabilitation Facility (PCRF) is in the medical centre and provides personnel with a physiotherapy and rehabilitation service. The medical centre is open from 08:00 to 16:30 hours on a Monday, Tuesday and Thursday, and from 08:00 to 12:30 on a Wednesday and Friday. A duty rota covered the week day hours up until 18:30. On weekdays from 18:30, at weekends and on public holidays, patients can access emergency care through NHS 111.

The staff team

Doctors	One Senior Medical Officer (SMO) One civilian Senior Medical Officer (CSMO) One civilian medical practitioner (CMP) Two locum general practitioners
Regimental Medical Officer (RMO)	One (unit asset non DPHC)
Practice manager	One (Bassingbourn) One (Wimbish)
Nurses	One senior nurse (post vacant, recruitment underway) One nurse (Band 6) One locum nurse (Band 5)
PCRF	Two physiotherapists (one permanent, one locum)

	One exercise rehabilitation instructor (ERI)
Administrators	Three (one post vacant)
Pharmacy technicians	One
Combat Medical Technicians* (CMTs)	Two (DPHC assets, not unit)

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

Are services safe?

We rated the medical centre as good for providing safe services.

Safety systems and processes

- The practice worked to the Defence Primary Care Healthcare (DPHC) Tri-Service safeguarding policies. A local safeguarding policy was in place and it included references to adults and children. The policy included contact addresses and telephone numbers for the local safeguarding teams, and these were displayed throughout the practice in the waiting areas and clinical rooms. Any changes to policy were emailed to all staff members which enabled them to identify who they would contact if they had a safeguarding concern. Staff interviewed during the inspection were fully aware of the policy, including how to report a safeguarding concern. An electronic library had been set up so all staff had access to essential information including internal and external safeguarding contact details. Families and dependants were signposted to register at the local Ashwell & Bassingbourn Practice. Close links had been established with the Ashwell & Bassingbourn Practice and staff were able to liaise directly if any safeguarding concerns needed to be raised.
- The status of safeguarding and vulnerable patients was discussed regularly with the welfare team. In addition, the needs of vulnerable patients were discussed at the monthly 'Mission Ready Training Centre Unit Health Committee' (UHC) meetings. We contacted the Welfare Officer for the camp who told us they provided a welfare service to military personnel and dependents for matters such as home sickness, domestic abuse, sexual assault, self-harm, mental health, housing issues etc. They confirmed they had a good relationship with the medical centre and communication between the two was good.
- The Senior Medical Officer (SMO) was the safeguarding lead with the civilian Senior Medical Officer (cSMO) acting as his deputy. Both were trained to safeguarding adults and children level 3. All other staff had completed safeguarding training appropriate for their role. The exception was the practice manager who was yet to completed safeguarding adults level 2 training. However, we could see that this training was planned and had only not been completed due to issues accessing the online training platform.
- The team made regular contact with all military personnel considered vulnerable. The team had a network of contacts with internal and local services such as the Multi-agency Safeguarding Hub team. The medical centre worked closely with Department of Community Mental Health (DCMH) and the army and unit welfare services.
- Vulnerable patients were identified during consultation, DMICP (electronic patient record system) searches and on referral from another department such as the welfare team. Coding was applied to clinical records to identify patients considered vulnerable and urgent appointments were offered. A monthly search of DMICP was undertaken to ensure the register of vulnerable patients and patients under the age of 18 was current. The search results acted as the vulnerable patient register and was discussed monthly during the clinical meeting attended by all clinical staff. Patients were identified by their

DMICP number during the meetings and their DMICP record was updated accordingly following each review. Due to the delays with low risk patients obtaining initial DCMH appointments, the practice had implemented a system whereby the SMO or CSMO reviewed each patient on a 4-6 week basis until treatment commenced with the DCMH.

- The practice captured chaperone training on induction and the training lead monitored the staff database on a monthly basis and informed personnel if their training was due to expire or had expired. Chaperone training consisted of a staff member watching the chaperone training presentation and on completion, being assessed by a clinician. There were 7 staff members deemed competent to fulfil the role of a chaperone and all these individuals were in-date with their Disclosure and Barring Service (DBS) certificates. Lists of trained chaperones were displayed throughout the practice at reception and in each clinical room. A copy of all trained chaperones was also held within the Healthcare Governance Workbook (HcG Wb, a system that brings together a comprehensive range of governance activities).
- The full range of recruitment records for permanent staff was held centrally. However, the practice could demonstrate that relevant safety checks had taken place for the majority of staff, at the point of recruitment, including a DBS check to ensure staff were suitable to work with vulnerable adults and young people. The practice maintained a spreadsheet that identified when each member of staff was required to renew their registration and this included a link to a screenshot of their current registration status.
- Staff were up to date with their Hepatitis B vaccination and there was a Hepatitis B register available to view.
- A process was in place to manage infection prevention and control (IPC). The current IPC lead was the practice nurse who had completed specific training for the role. Once recruited, the Band 6 nurse was scheduled to become the designated IPC lead for the practice and as part of their induction, will be required to complete the IPC links course.
- Regular IPC audits were carried out, stored on the regional SharePoint page and linked on the HcG Wb. Both Bassingbourn and Wimbish buildings had been audited within the last 6 months but there were some minor items that were outstanding from the action plan. Spill kits were not identified in time to allow for prompt ordering which had led to them going out-of-date and a toilet was awaiting a planned repair.
- Environmental cleaning was provided by an external contractor. The practice manager conducted a series of checks weekly which were documented in the HcG Wb. Any issues identified were recorded on a ‘cleaning issues’ spreadsheet. The cleaning manager also conducted monthly audits/inspections on the premises including ad hoc snap inspections throughout the year. At the time of inspection, the medical centre appeared to be clean and no issues had been identified in the 9 months since the practice had opened. A deep clean had not been carried out since the practice opened but had been scheduled in for July 2023.
- Healthcare waste was appropriately managed and disposed of. A practice nurse was the named person responsible for the management of healthcare clinical waste. Clinical waste was monitored daily and when required, yellow bags containing waste were secured, labelled and locked in containers awaiting collection. Clinical waste was collected weekly. Consignment notes were retained at the medical centre and an annual waste audit was carried out in September 2022 which recorded no observations that required action.

- The practice informed us that one staff member was currently providing acupuncture to patients. There was an in-date acupuncture standard operating procedure and risk assessment which all staff were aware of. Written consent was gained and scanned onto DMICP.
- Gym equipment in the Primary Care Rehabilitation Facility (PCRF) treatment area was maintained and monitored. Servicing on the equipment was in-date and checks were completed daily. One piece of equipment (watt bike) was marked as unserviceable and remedial action from the supplier had been requested. Equipment in the Bassingbourn and Wimbish gyms was managed by the unit's physical training instructors (PTIs). The equipment was not seen but reported appropriate for their needs and in good order. All items were checked before and after use by a patient receiving treated by the PCRF team. We looked at the cleaning schedule for the PCRF and highlighted that the equipment used should be cleaned between patients.

Risks to patients

- The management team believed that the establishment of the practice was adequate for the patient list size. However, gaps in the established staffing levels remained a concern both in terms of resilience and workload. As the Wimbish practice had temporarily closed and the staff had relocated to the Bassingbourn practice in September 2022, staffing shortfalls within the practice such as the gapped Band 6 practice nurse posts had not yet impacted on practice outputs. However, a decision on the future of the Wimbush practice re-opening was due to take place on the 13 March 2023. Adequate availability of nursing staff could be impacted depending on the outcome of this meeting and the lengthy recruitment process for the Band 6 practice nurse. The practice manager was aware of this and had already liaised with regional headquarters (RHQ) regarding locum recruitment. Requests to the RHQ had been productive and regional staff supportive towards locum recruitment. The practice currently had 2 locum doctors and 1 locum nurse in post.
- We found that access to appointments was good and a system was in place which facilitated same day face to face appointments with a doctor when needed. However, the ability to deliver specialised occupational appointments, especially diving medicals was highlighted as a risk. Although supporting a unit with occupational divers the practice only had two suitably qualified occupational dive doctors and one spirometry trained nurse, these were both needed to compete a diving medical.
- One of the three established administrative staff posts was vacant at the time of the inspection. Staff highlighted that tasks had to be prioritised when one of the two administrators was absent. Although we found that administrative tasks were up-to-date, staff told us that tasks such as scanning and updating the referral tracker could be delayed temporarily when single-handed.
- Arrangements were in place to check and monitor the stock levels and expiry dates of emergency medicines. We saw evidence to show that an appropriately equipped medical emergency kit and trolley were in place and were regularly checked. Emergency training courses completed by staff online had been supplemented by face to face training delivered by the clinical team.

- The staff team was suitably trained in emergency procedures, including basic life support, sepsis and anaphylaxis. There had been emergency simulation training in the PCRF section of the building which was isolated from the main practice area. This led to the practice requesting an emergency pack and crib sheet being placed in the PCRF to support immediate medical management. We highlighted that this exercise should be repeated for clinical rooms situated on the first floor as equipment and medicines were kept on the ground floor. With there being no lift, this would delay the response time to a medical emergency.
- The nurses had conducted their hot/cold injury mandatory training online. A practical session was conducted at the end of 2022.
- A closed circuit television system (CCTV) in the waiting rooms allowed patients to be observed whilst waiting. The monitors covered all of the cameras situated in the key waiting areas such as the PCRF, clinical area, pharmacy, lobby and the upstairs and downstairs waiting areas. It was the responsibility of the designated receptionist to monitor the CCTV cameras.
- Wet Bulb Globe Temperature (WBGT), used to indicate the likelihood of heat stress, was carried out in the unit's gym, and was led by the PTIs. PCRF staff were aware of actions to take in accordance with WBGT monitoring The unit physical training instructors monitored and recorded temperature readings and the ERI had access to these as they used the same building. The gym was well ventilated and adequately heated.
- The ERI was the PCRF lead for risk assessments (RAs). PCRF staff were aware of the RAs and knew where to access them. The RAs we checked were in-date but not all were on the correct template.

Information to deliver safe care and treatment

- The practice followed the DPHC standard operating procedure (SOP) for the summarisation of patients' notes. The nursing team was allocated protected time to summarise notes. The process for scrutinising and summarising records of new patients to the practice and conducting the 3 yearly review was managed by the Wimbish practice manager. A monthly search was conducted and forwarded to the Band 6 nurse to review. The practice was 99% in-date with summarising of records (6 of 600 notes awaited summarising).
- A peer review programme of doctors' DMICP consultation records was in place. The only DPHC nurse in post had conducted their own prescribing audit to maintain competence to practice. Medics received support and training from the SMO, CSMO and practice manager (medics were not conducting face to face consultations but supporting the practice to ready patients for deployment).
- There was a peer review process in place for all PCRF staff whereby each clinician was formally reviewed by a peer at six month intervals (or sooner if required). Staff told us that they had aspirations of establishing a regional peer review programme with 3 other local PCRFs. There was also an informal peer mentorship programme between the 2 physiotherapists.

- Co-ordinated by the administration team, an effective system was in place for the management of both internal and external referrals. Each referral was added to a tracker and this was reviewed weekly. Urgent referrals were highlighted and prioritised. The administration team monitored the referral tracker daily but we highlighted that better oversight could be gained, for example, by making urgent referrals a standing agenda item at the monthly clinical meetings.
- A process was in place for the management of specimens but there was scope to make improvements. The practice had had to implement a workaround due to problems connecting Bassingbourn Practice with the NHS spine (the system that links up healthcare IT systems and allows information to be shared securely between services and providers). Results were printed, handed to a clinician for review and then signed. There was a log kept of samples on the restricted area of SharePoint. However, not all results were clearly coded and there appeared to be limited assurance in transcriptions which were manually entered and therefore more prone to error.
- The Business Resilience Plan (BRP) was last reviewed in April 2022 include an annex for actions to be carried out in the event of any DMICP outages and system freezes. The reception staff printed off the next day clinic lists each night in case of a potential outage and as per the BRP, hard copies of consultation paperwork were available for clinicians in the continuity pack-ups located in the library. In the event of an outage, the hard copies would be utilised and scanned onto DMICP once the system was serviceable. In the event of an outage, each clinic would be reviewed, and non-urgent appointments would be re-scheduled accordingly and only essential/urgent patients would be seen during this period. If DMICP was compromised for several days, patients and staff could be diverted to either Wyton Medical Centre or Chicksands Medical Centre to perform clinics, or the practice could provide a telephone consultation service working remotely.

Safe and appropriate use of medicines

The medical centre had systems in place for the safe handling of medicines. A number of minor issues were raised to make systems and processes fully effective.

- Arrangements were established for the safe management of controlled drugs (CD), including destruction of unused CDs. We saw that monthly and quarterly checks were completed. A CD was held in the accountable drugs book, this was swapped into the CD book after it had been highlighted.
- Emergency medicines were easily accessible to staff in a secure area of the medical centre and all staff knew of their location. The storage of oxygen and Entonox cylinders required improvement to minimise the risk of damage and conform to promote safety.
- Medication requiring refrigeration was monitored twice a day to ensure it was stored within the correct temperature range. The pharmacy fridge was used to hold a lot of stock for vaccinating reserves, the fridge was at capacity. A second large fridge was needed to accommodate the over flow.
- All staff who administered vaccines had received the immunisation training as well as the mandatory anaphylaxis training.

- Prescription pads were stored securely. There was a system to track their issue and usage so all prescription numbers could be traced to the prescriber.
- Patient Group Directions (PGDs) had been signed off to allow appropriately trained staff to administer medicines in line with legislation. The PGDs were current and signed off by the authoriser. Medicines that had been supplied or administered under PGDs were in-date. There was no PGD cupboard (to store PGD medication) at the time of inspection but plans were in place to source and install one.
- Requests for repeat prescriptions were managed in person or by e-Consult, in line with policy. A process was in place to update DMICP if changes to a patient's medication was made by secondary care or an out-of-hours service. The repeat prescription process was detailed in the practice leaflet but we suggested that a poster at the dispensary hatch would aid communication to patients.
- We saw evidence to show that patients' medicines were reviewed regularly and the doctor's notes in DMICP around medication changes were comprehensive.
- The practice had carried out a review of 19 patients prescribed with antibiotics in the previous six months. The audit results showed that prescribing had been appropriate with 2 exceptions. Findings had been discussed at the healthcare governance meeting but there was no evidence that the audit findings had been written up and used to give individual feedback.
- A process was established for the management of and monitoring of patients prescribed high risk medicines (HRM). The register of HRMs used at the medical centre was held on DMCIP and all doctors and relevant clinicians had access to this. We looked at a sample of patient records, we saw that all had been coded or had shared care agreements in place. The nurse monitored the chronic disease register and as a failsafe, one doctor monitored recalls for blood tests, and another doctor handled the recalls for long-term conditions. This made it safer as it was a cross-check to ensure patients were seen and treated in line with clinical guidelines. Of note, regular searches were carried out for medication that required a pregnancy prevention plan. An SOP was set up and searches regularly run to ensure any eligible patients were captured in a timely manner.

Track record on safety

- Measures to ensure the safety of facilities and equipment were in place. A 6 monthly workplace inspection was carried out with the most recent completed in December 2022. Electrical and gas safety checks were in-date. Water safety measures were regularly carried out with a legionella inspection undertaken in November 2022. A fire risk assessment of the building was undertaken annually. Firefighting equipment tests were current. Staff were up-to-date with fire safety training and were aware of the evacuation plan.
- A system for logging and monitoring the servicing of all clinical/non-clinical equipment was established, this included equipment in the PCRF.
- The practice had adopted the current risk template as per DPHC guideline. However, there were a number of minor improvements highlighted; for example, the template did

not contain columns for 4Ts (treat, tolerate, transfer or terminate) management nor whether the risk was clinical or non-clinical. In addition, two different risk assessment forms were being used, one army and one joint service. We recommended that this be standardised into the use of a single template. The practice manager and the deputy practice manager had completed the necessary courses to conduct risk assessments and all risk assessments were in-date at the time of the inspection.

- The HcG Wb contained active and retired risk registers. The active risk register was last reviewed on the 10 November 2022. Risk management was a standing agenda item at the monthly practice and healthcare governance meetings.
- Lone working after hours was included on the risk register and there was also a lone worker risk assessment dated 17 November 2022. However, the policy required updating to include all areas of PCRF activity.
- The station major incident plan, last updated in 2021, was held in the medical centre, and although comprehensive in covering the most likely causes of a major incident, there was no reference to the role of the medical centre within it. The practice confirmed that this was because other services would be used to deal with major incidents and they had no partin the response.
- The practice had a fixed alarm system that sounded at reception, this required the reception staff to react and notify others. The practice had mitigated this by bringing a different alarm system in from the Wimbish building. However, not all rooms had an alarm, and an isolated clinical room (treatment room 3) was not used as a clinical space as it did not have an effective method of calling for assistance in an emergency.
- Staff had the information they needed to deliver safe care and treatment to patients most of the time. If there was an unplanned DMICP outage, the medical centre would use laptops and Wi-Fi if it was a server issue. The BCP detailed workaround steps should problems with connectivity continue.

Lessons learned and improvements made

- All staff had access to the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events and incidents. The staff database showed that all staff had completed ASER training and discussion around learning took place at the monthly practice management and healthcare governance meeting. A record of ASERs was maintained by the practice manager and we saw they were completed in a timely manner and included a note of any lessons learnt.
- From interviews with staff and evidence provided, it was clear there was a culture of reporting incidents from those staff able to access the system. Both clinical and non-clinical staff gave examples of incidents reported through the ASER system including the improvements made as a result of the outcome of investigations. An ASER log was maintained on the HcG Wb including any changes made. We looked at minutes of PCRF meetings and we noted that they did not include ASER discussion as a standing agenda item. The addition of this would help increase awareness and promote a learning culture.

- A system was in place for managing patient safety alerts. All alerts were received into the ‘Group’ mailbox and forwarded to the pharmacy technician for action. There was a register on SharePoint which detailed the alert and the action taken by the medical centre in response; the register was up-to-date. Safety alerts were a standing item on the agenda at the medical centre meetings. The register included details of action taken by the practice in response to each alert. Alerts pertinent to the practice were distributed to all staff and discussed at the monthly practice meeting.

Are services effective?

We rated the medical centre as good for providing effective services.

Effective needs assessment, care and treatment

- Arrangements were in place to ensure staff had a forum to keep up-to-date with developments in clinical care and guidance. These included twice weekly informal ‘huddles’, monthly medical centre meetings and daily clinical discussions. The formal meetings included an agenda item to discuss national clinical guidance, including NICE (National Institute for Health and Care Excellence) and the Scottish Intercollegiate Guidelines Network (SIGN).
- Our review of clinical records demonstrated that clinicians carried out assessments and provided care and treatment in line with national standards and guidance, supported by clear clinical pathways and protocols.
- Staff were kept abreast of clinical and medicines updates through the Defence Primary Healthcare (DPHC) newsletter circulated to individual staff and to the medical centre each month. Participation with regional events and forums also provided an opportunity for clinicians to keep up-to-date.
- The Primary Care Rehabilitation Facility (PCRF) staff all used Rehab Guru (software for rehabilitation plans and outcomes) for exercise programmes for patients. A review of (PCRF) notes carried out as part of the inspection highlighted that best practice guidance was followed. However, there was scope to improve the re-recording of the musculoskeletal health questionnaire every 6 weeks or upon discharge.

Monitoring care and treatment

- Long-Term Conditions (LTCs) was managed by the Senior Medical Officer (SMO) with the nurse as deputy. DPHC standard operating procedures (SOPs) outlining the management and monitoring arrangements for LTCs required developing to reflect current management at practice level. We looked at a sample of patients’ notes, they were comprehensive and in good order. The medical centre provided us with the following data:
    - The small numbers of patients on both the hypertension and diabetic registers were regularly monitored in accordance with best medical practice guidance. Processes were in place to identify and monitor patients at risk of developing diabetes.
    - Patients with a diagnosis of asthma had received an asthma review in the preceding 12 months using the asthma review template.
    - Audiology statistics showed 83% of patients had received an audiometric assessment within the last two years.
- Through review of clinical records and discussions with the doctors, we were assured that the care of patients with a mental illness and/or depressive symptoms was being

effectively and safely managed, often in conjunction with the Department of Community Mental Health (DCMH). To maximise support for patients including timely access to support, the doctors had developed relationships with local mental health teams, including the crisis team. Self-help leaflets and subscriptions to the Headspace application (provides guided lessons on mindfulness and sleep) were available to patients.

- We looked at the clinical records of patients currently receiving support from the PCRF. We saw that it took a holistic view of patients, including mood, sleep and lifestyle. Patients could be signposted to different outside agencies for further support and advice.
- We saw that referrals to the Regional Rehabilitation Units and minor injury assessment clinics were made promptly with manageable wait times for the patients.
- An audit calendar was in place. However, there had been little clinical audit activity in the time since the medical centre opened. This extended to the PCRF where audits completed did not include clinical audits that measured outcomes from treatment provided and adherence to best practice guidelines.

Effective staffing

- The DPHC induction programme had been enhanced to include elements specific to Bassingbourn Medical Centre and included links to relevant documents for reference. All staff had completed the bespoke DPHC mandated induction programme which had been amended accordingly to include role specific elements and information relevant to the unit. On completion, the staff database was updated accordingly. This was further evidenced on review of their individual training folders.
- On arrival, all locum staff complete the DPHC mandated locum induction programme which has been amended accordingly to include cadres specific elements and information relevant to the unit. According to the staff database, all locums had completed their induction programme and evidence of this was shown at the time of the visit.
- The practice had a training calendar and there was a record of mandatory training, compliance was good across the team. The training lead monitored compliance, discussed required training activity in the practice meetings. Time was available to staff every Wednesday afternoon to complete training.
- Newly assigned staff were provided mentorship on arrival. All staff received mid-term and annual appraisals which provided guidance and assurance on how they are performing and available continued professional development opportunities. On review of the ‘staff appraisal’ spreadsheet in the Healthcare Governance Workbook (HcG WB), it was evident that this was still in progress as a majority of the columns were incomplete.
- Peer reviews had been undertaken recently by the doctors and PCRF. The nursing team had a programme of peer review that was being developed at the time of inspection. On completion, the audit schedule was amended and a review date was set.

- The practice could demonstrate how it ensured role-specific training and updating for relevant staff. For example, the practice manager and deputy practice manager had completed the necessary health and safety course that enabled them to undertake risk management and complete risk assessments. All staff had been made aware that they could apply for funding for external courses.
- The PCRF team delivered musculoskeletal training (included NICE and best practice guideline updates) during the medical centre's multidisciplinary (MDT) meetings.
- Staff administering vaccines had received specific training which included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to online resources and discussion at nurses' meetings.

Coordinating care and treatment

- The SMO, Band 6 nurse and physiotherapist attended the Unit Health Committee meetings at which the health and care of vulnerable and downgraded patients was reviewed. The civilian SMO had forged good safeguarding links with community teams.
- The PCRF communicated well with the medical centre both in person and electronically, they told us this worked well. The physiotherapist and ERI attended the weekly MDT meeting where patients could be discussed with the SMO and nurse. They also attended meetings with welfare and the regional rehabilitation unit (RRU) to provide input into named individuals the unit wished to discuss. As part of the referral's tracker, there was a log for recording referrals to the RRU and Multidisciplinary Injuries Assessment Clinic.
- 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. In addition to this, the reception staff provided a service leavers policy which included signposting to veterans' services both locally and nationally. We were provided with an example of where the medical officers had gone the extra mile to support a vulnerable patient who had been discharged from DCMH.
- Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred or after they were discharged from hospital. Information was shared between services and we saw that a full copy of findings from investigations and any further treatment requirements were sent to the medical centre to update the patient's records. The practice nurse maintained links with NHS consultants from Addenbrooke Hospital.

Helping patients to live healthier lives

- The medical centre had recently named a lead and deputy for health promotion. The nurses were aware of the location of key resources and the NHS health promotion calendar. Although the practice were yet to implement a structured programme of health promotion activity, we were told that promotions and board rotations happened throughout the year. The medical centre staff has been involved in supporting health fairs in Bassingbourn (November 2022) and Wimbish (January 2023), in which PCRF and nurses were involved.
- The CSMO took the lead on sexual health training. Deputised by the nurse who was STIF trained, they provided sexual health support and advise. Patients were signposted to local sexual health services for procedures not undertaken at the medical centre. Details of clinics were available in the building on a patient noticeboard.
- The PCRF staff participated in unit health fairs at both Bassingbourn and Wimbish. Staff told us that these opportunities were used to discuss injury recovery and prevention. On noticing a trend of Wimbish patients recently discharged from the PCRF returning after re-injury under PTI-led reconditioning, PCRF staff instigated a meeting with the PTIs to discussed current issues, delivered some training, and created new entry-criteria to ‘goalpost’ discharge from PCRF (4km tab with 20kg weight). Since the meeting and training, no patients had returned having failed reconditioning.
- The number of eligible women whose notes recorded that a cervical smear had been performed in the last 3-5 years was 35 which represented an achievement of 97%. The NHS target was 80%.
- Regular searches were undertaken to identify patients who required screening for bowel, breast and abdominal aortic aneurysm in line with national programmes. At the time of the inspection there were a small number of patients identified that met the criteria for screening. A recall system was in place that monitored uptake and those eligible were in-date for screening.
- Patients due a vaccination were identified when summarising patient notes. The units were responsible for ensuring their individuals booked in for their own vaccines. However, the system used did not show non-required vaccine such as Men ACWY and typhoid which are not routinely given unless for specific reasons. In spite of this, force protection performance was high with vaccination statistics identified as follows:

- 91% of patients were in-date for vaccination against polio.
- 98% of patients were in-date for vaccination against hepatitis B.
- 95% of patients were in-date for vaccination against hepatitis A.
- 91% of patients were in-date for vaccination against tetanus.
- 99% of patients were in-date for vaccination against MMR.
- 98% of patients were in-date for vaccination against meningitis.
- 91% of patients were in-date with vaccination against diphtheria.

Consent to care and treatment

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw evidence that showed consent for minor surgical procedures was obtained and coded appropriately on DMICP. We discussed the need to ensure consent was recorded for patients discussed at unit health committee meetings. A review of consent had been carried out by way of audit.
- Clinicians had a good understanding of the Mental Capacity Act (2005) and how it would apply to the population group. All staff received training as part of their mandatory programme.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- In advance of the inspection, a patient feedback questionnaire was sent out to patients. A total of 2 patients responded and feedback was positive. We also observed staff being courteous and respectful to patients in person and on the telephone.
- We contacted six patients as part the inspection. The patients praised the service provide but those travelling from Wimbish highlighted concerns with travel times that they commented on as a reason at times for colleagues deciding not to seek out treatment.
- The Mission Ready Training Centre (MRTC) welfare centre on camp provided a range of information to patients who had relocated to the base and surrounding area. MRTC welfare provided information about facilities available on the station and locally including civilian healthcare facilities.

Involvement in decisions about care and treatment

- Patients identified with a caring responsibility were captured on a DMICP register. Information to support carers was available in the patient waiting area. Patients with caring responsibilities and cared for patients were identified through the new patient registration form and at new patient medicals. There was a carer’s poster situated in the waiting area which informed what additional services the practice offered. These included new patient checks, annual flu jabs and annual carer health checks. Details were also documented in the practice leaflet.
- The carer’s lead for the practice was the Senior Medical Officer and the Band 6 nurse was the designated deputy. A search was conducted each month and the caseload was discussed during the clinical meeting. At the inspection, it was noted that the DMICP search highlighted that only one of the carer’s Read codes was being searched for. The additional Read codes for ‘Has a Carer’ and ‘Is a Young Carer’ were added at the time of visit to ensure all carers were captured.
- We were advised patients usually identified themselves as a carer through the new patient registration form or when the Unit Welfare Officer shared this information with the medical centre. Alerts were added to all registered carers and they were offered flexibility with appointments.
- Staff could access ‘The Big Word’ translation service if they needed it. There was a sign to inform patients of the translation service. Staff told us of a recent occasion when the service was used to translate written documents and they were aware of the process for accessing translators by telephone.

- Primary Care Rehabilitation Facility (PCRF) staff used ‘physical training chits’ (used to lighten the workload to aid rehabilitation) to guide the patients’ rehabilitation transition phase to physical training instructor led fitness sessions.

Privacy and dignity

- Screening was provided in consulting rooms to maintain patients’ privacy and dignity during examinations, investigations and treatments. Clinic room doors were closed during consultations.
- The PCRF had a separate area in the medical centre building with curtained cubicles and access to a clinical room that provided privacy for patients. Patients were informed about confidentiality issues in the gym and rehabilitation classes and given an option to request privacy.
- The layout of the reception area and waiting area meant that conversations between patients and reception would unlikely be overheard. If patients wished to discuss sensitive issues or appeared distressed at reception, they were offered a private room to discuss their needs. A sign at the reception hatch and a demarcation line on the floor promoted confidentiality.
- The mix of male and female staff allowed the medical centre to facilitate patients who wished to see a clinician of a specific gender. This included patients booking into the PCRF.

Are services responsive to people’s needs?

We rated the practice as good for providing responsive services.

Responding to and meeting people’s needs

- The medical centre used an appointment system where patients could be seen in person or remotely by phone or using video conferencing facilities. However, the temporary closure of Wimbish Medical Centre meant patients based at Carver Barracks, Wimbish had a round trip of approximately 2 hours. Military transport was provided but patients told us that this could further increase the amount of time they needed to be away for a face to face appointment.
- An access audit as defined in the Equality Act 2010 had been completed for the premises in July 2022. One issue was raised regarding staff training which had since been completed. The building was not purpose-built but had been adapted for ease of access. For example, vehicles could be parked close to the main entrance and as the front doors were not automatic, a bell allowed patients to call for assistance.
- No hearing induction loop was in available on the premises. The practice had carried out a formal review to confirm there was no requirement. A wheelchair was stored by the front entrance for any patient that may need support due to limited mobility.
- Dependant on the patient’s clinical need, the option of a telephone or face-to-face appointment or e-mail reply could be offered. The practice found this system to be highly effective for patients to gain access to appointments so had continued once COVID-19 restrictions relaxed.
- Telephone requests were added to a doctor’s routine clinic as appropriate.
- Home visits were not routinely carried but the Senior Medical Officer told us would be provided in exceptional circumstances when appropriate.
- The Wimbish practice manager was the designated diversity and inclusion (D&I) lead for the practice. The D&I board was situated in the staff room and could easily be accessed by all members of staff. There were also D&I posters displayed throughout the reception and the waiting areas. There was a designated D&I representative for the unit situated in the Mission Ready Training Centre. All staff had completed the mandated D&I course (except for one staff member who had it scheduled).
- A direct access physiotherapy (DAP) service (through self-referral) had yet to be implemented due to the rapid access rates and recent amalgamation between Bassingbourn and Wimbish. However, there was a plan to implement the DAP service in order to provide patients the choice of direct referral. Rehabilitation classes were being offered to patients at the time of inspection.

Timely access to care and treatment

- The medical centre and dispensary were open Monday, Tuesday and Thursday 08:00-16:30 hours and on a Wednesday and Friday 08:00-12:00. Outside of these hours, medical cover was provided on a weekly rotation with RAF Wyton up until 18:30 after which, patients were signposted to the NHS111 service or 999 service.
- Details of how patients could access the doctor when the medical centre was closed were available through the patient information leaflet, on the main entrance to the building and on the recorded message relayed when the practice was closed. Details of the NHS 111 out-of-hours service was in the medical centre leaflet and instructions were displayed at the main entrance so could be seen when the practice was closed.
- There was good availability of appointments for all clinicians. For example, urgent slots with a doctor were available on the day and routine appointments the following day. An appointment with the nurse could be secured within 2 days. Routine and follow up physiotherapy appointments were available within two days and an urgent appointment was available the next day. New patient and follow up appointments were available the next day to see an Exercise Rehabilitation Instructor.

Listening and learning from concerns and complaints

- The practice manager was the lead for complaints which were managed in accordance with the Defence Primary Healthcare (DPHC) complaints policy and procedure. Written and verbal complaints were recorded and discussed at the medical centre meetings. A complaints' audit had not been undertaken as there had been one complaint recorded since the practice opened in July 2022. However, we highlighted that the complaints data template on the DPHC Healthcare Governance website had several columns that were incomplete..
- We reviewed the one complaint received by the practice. It was handled appropriately and in a timely manner.
- The PCRF had not received any complaints since the practice had opened.

Are services well-led?

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

Vision and strategy

- The medical centre worked to the Defence Primary Healthcare (DPHC) vision of: 'Safe medical centre – by design'. They had also developed their own mission statement which was to: ''To deliver high-quality, safe, and effective healthcare which will meet the needs of the patient and the Chain of Command by maximising the skills of our workforce and improving access to Primary Health Care Services, resulting in medically fit and mobilised personnel thus greater deployability and employability across defence.' This was displayed throughout the practice.
- The management team had produced a 6 point vision statement that supplemented the mission statement. This included maximising the skills of the workforce, improving access to primary healthcare services and maximising the successful mobilisation of personnel.
- A practice development plan was held but was still work in progress and in the development stage. The future plans for Wimbish Medical Centre were imperative to finalising strategy as arrangements at the time of inspection were temporary.

Leadership, capacity and capability

The practice had temporarily taken over Wimbish Medical Practice at Bassingbourn so there was sufficient capacity, skills and experience in the staff establishment. If the decision was made to re-open Wimbish, it was felt that the establishment was still correct. However, two nursing posts were still gapped and therefore likely to impact the continuation of providing a timely service. The doctors were adequately staffed with the addition of 2 part-time locums in post and the combat medical technicians were also staffed accordingly. However, due to the Mission Ready Training Centre unable to fill their gapped posts, the practice was often called upon to provide a medic to assist with the mobilisation/demobilisation medicals for the reservists.

- Leaders within the medical centre provided direction, decision making and structure. Practice and huddle meetings took place regularly and minutes were provided to team members who were unable to attend.
- The staff spoke of a good working relationship with the regional team, of note when providing support through the approval of locum staff to cover some of the gapped posts. Decisions on the future of the Wimbish arrangement were imminent.
- The Senior Medical Officer (SMO) and the civilian SMO covered each other as the clinical leads during periods of leave, deployments, and other absences. The practice manager and deputy deconflicted their leave to ensure there was always a constant managerial presence within the practice.

- Medical centre staff had taken advantage of the opportunity that presented itself due to the delayed opening of the practice. The time had been used to develop a comprehensive induction pack which included a welcome booklet which helped new staff with essential information and processes. The internal governance systems for the practice had been developed to be comprehensive, inclusive and utilised the software platforms available.
- Job descriptions and terms of reference were in place for all members of staff. However, on review of the hard copies it was noted that not all had been signed by the incumbent or their line manager.

Culture

- Staff were consistent in their view that the medical centre was patient-centred in its focus.
- We heard from staff that the culture was inclusive with an open-door policy and everyone having an equal voice, regardless of rank or grade. All were familiar with the whistleblowing policy and said they would feel comfortable raising any concerns.
- The monthly meetings were inclusive with all staff encouraged to attend. Staff were encouraged to be involved and raise any concerns or issues within their department. ‘Thank you’ and in year bonuses were available for all civilian staff. On the 4th Wednesday of each month, the practice had a whitespace event for all staff to be involved. There was recently a quiz and games afternoon scheduled for all staff and at the end of the month.
- Processes were established to ensure compliance with the requirements of the duty of candour, including giving those affected reasonable support, information and a verbal and written apology. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. We were provided with examples of when duty of candour had been applied.

Governance arrangements

- A comprehensive understanding of the performance of the medical centre was maintained. The system took account of medicals, vaccinations, cytology, summarising and non-attendance.
- 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. Terms of reference (ToR) were in place to support job roles, including staff who had lead roles for specific areas.
- There was a detailed lead/deputy roles and responsibilities list displayed throughout the practice and on SharePoint. A number of staff took on multiple associated duties due to their particular expertise and skill sets.
- The practice had a well-developed healthcare governance workbook (HcG Wb); the overarching system used to bring together a range of governance activities, including the risk register, training register, policies, quality improvement activity (QIA) and

complaints. The provision of care was monitored through an ongoing programme of QIA.

- All staff had access to the HcG Wb which included various registers and links such as the risk register, ASER tracker, duty of candour log, IT faults and cleaning issues log. A range of information was accessible though quick links from the HcG Wb. These included risk assessments, TORs, and the standard operating procedure index. The workbook was continually being developed and was managed by the practice manager and deputy practice manager.
- On review of the electronic Healthcare Assurance Framework (eHAF) it was noted that each of the domains had been appropriately graded however, there was a significant amount of work that needed to be done to complete all of the 162 Key Lines of Enquiry (KLOEs). Several KLOEs that had previously been updated required review / updating as they were no longer applicable or key members of staff had moved on. The practice manager was aware of the need to complete the eHAF and was preparing to commence an eHAF meeting involving the various Head of Department to discuss a way forward.
- An audit programme had been agreed but it was too soon to see the positive impact of this on clinical outcomes. The programme of audit for the Primary Care Rehabilitation facility (PCRF) was not integrated.
- A range of meetings with defined topics for discussion were held to ensure a communication flow within the team. The practice had a designated meeting matrix in place which included the following clinics:
    - Practice and huddle meetings on a Monday and Friday morning.
    - Clinical meetings held weekly.
    - PCRF sub-regional meetings held monthly.
    - Full practice meetings held monthly.
    - In-house training held monthly.

Managing risks, issues and performance

- Effective processes were in place to monitor national and local safety alerts and incidents.
- An effective process to identify, understand, monitor and address current and future risks including risks to patient safety was in place. Risks to the service were well recognised, logged on the risk register and kept under scrutiny through review at the practice meetings.
- The main risk identified was around connectivity to the NHS spine (impacted the flow of information between service providers so impacted laboratory links, electronic referral system and cytology links). Workarounds implemented to mitigate risks left systems more prone to human error. An ASER has been raised to highlight this issue and investigations remained ongoing to resolve this issue.
- Appraisal was in-date for all staff. Although there had not been a need to use, the leadership team was familiar with the policy and processes for managing under-performance and ensured staff were supported in an inclusive and sensitive way taking account of their wellbeing.
- A business continuity plan was in place and had last been reviewed in April 2022. The major incident plan held by the unit did not involve any further engagement from the

practice to what is provided on a day-to-day basis. The Mission Ready Training Centre held a ‘Communicable Disease Outbreak Management Plan’ for the unit which was last reviewed in August 2021. The medical centre did not hold an individual plan for communicable diseases or pandemic outbreaks. The practice did not have a policy on what actions to undertake in the event of an outbreak.

Appropriate and accurate information

- Quality and operational information was used to ensure and improve performance. The DPHC electronic health assurance framework (referred to as eHAF) was used to monitor performance. The eHAF is an internal quality assurance governance tool to assure standards of health care delivery within defence healthcare.
- There were arrangements at the medical centre in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. This extended to the PCRF.

Engagement with patients, the public, staff and external partners

- Due to an oversight when the Bassingbourn practice re-opened, the DPHC central audit SharePoint which collated patient surveys did not recognise Bassingbourn. This was checked during the visit and the practice was still omitted from the list. In the interim, the practice had been utilising their own comment books to obtain feedback which resulted in 3 actions that were documented on the ‘You Said, We Did’ board. These included the erection of a tent for patients to wait in whilst awaiting military transport and a request for water to be made available in the waiting area which had now been provided.
- The PCRF had acted on responses to their own patient survey. Wimbish patients had highlighted the challenges with and frustration at having to travel to Bassingbourn for class therapy. In response, a weekly rehabilitation class was started at Wimbish. A number of requests for a squat rack had been made to enable rehabilitation programmes to be fully completed in the PCRF. A business case had been submitted to secure the rack and weights.
- Good and effective links were established with internal and external organisations including the Welfare Officer, Regional Rehabilitation Unit, Department of Community Mental Health and local health services.

Continuous improvement and innovation

We identified that the medical centre had been productive with their time available due to the delayed opening and whilst waiting for patient numbers to increase. A comprehensive framework had been set up in readiness through the optimal use of SharePoint. Of note:

- the development of a comprehensive guidance pack for clinical staff;

    - the development of a detailed and effective welcome pack and appraisal programme for new joiners.

- The nursing team had been involved with a number of quality improvement projects (QIPs) that resulted in an improved crash trolley kit being standardised and a more robust check list (included expiry dates and nominated checkers) and results spreadsheet that improved local practice.
- Service improvement projects that had taken place in the PCRF were not recorded as QIPS. We identified the responses to patient feedback as good examples of where a QIP could be recoded. The PTI training delivered following the reconditioning process review had been recorded as a QIP.