Shawbury Medical Centre

Wem Road, Shawbury, Shropshire, SY4 4DZ

Defence Medical Services Follow Up inspection

This report describes our judgement of the quality of care at Shawbury 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 Shawbury Medical Centre on 27 April 2023. 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 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.
- We identified deficiencies in the medicines management processes some of which were rectified on the day of inspection.
- 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 infrastructure and staffing 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.

- 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 and the shortage of key individuals due to unfilled posts had been overcome.
- Staff worked well as a team and said they were well supported and included in discussions about the development of the service.

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

- The doctors had audited the wait time for patients to access the Department of Community Mental Health (DCMH) and considered this to be a risk. They developed a 'DCMH waitlist spreadsheet' to monitor and maintain those waiting to be seen for anxiety and low level depression. The medical centre had made use of the 12 free counselling sessions offered by the RAF benevolent fund to further mitigate the risk. As a result of this, we saw that patients were able to gain quicker access to psychological therapies**.**

The Chief Inspector recommends to the practice:

- Contact the regional team to discuss what support can be provided with the medicines management procedures and processes.
- Improve the prescription tracking system to ensure full traceability.
- Include details of action taken as part of the safety alert management process.
- Improve the arrangements for communicating updates on clinical guidelines to ensure they are acted on in a timely manner.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

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, a physiotherapist and an exercise rehabilitation instructor. Three specialist advisors new to the CQC were also in attendance as observers.

Background to Shawbury Medical Centre

Located in Shropshire, Shawbury Medical Centre provides routine primary care and occupational health care service to a patient population of 1,783 military personnel and their families (if living within a 5 mile radius). The station is a flying training school and trains aircrew and air traffic controllers. In addition the medical centre looks after an infantry regiment based at Tern Hill Barracks (the medical centre at Tern Hill does not have suitable facilities to provide the full range of services). The future of Tern Hill Barracks was under discussion and this inspection did not include a visit to view the facilities, some of which were being used to provide services. A Primary Care Rehabilitation Facility (PCRF) situated in a nearby building is an integral part of the medical centre and provides personnel with a physiotherapy and rehabilitation service. The medical centre is open from 08:00 to 18:30 hours Monday to Friday. Thursday afternoons are protected for training but patients can still access services by telephone and urgent patients can be seen. Outside of these hours, patients are signposted to the NHS111 service or 999 service. Due to it being a flying station, medical cover is provided 24/7 by a duty medic. Medics triage any call and signpost patients or book them in for an appointment at the medical centre. The duty phone number was detailed in the patient information leaflet and held in the guard room that was manned 24/7.

The staff team

Doctors	One Senior Medical Officer (SMO) One Deputy Senior Medical Officer (DSMO) One General Duties Medical Officer (GDMO) Two Civilian Medical Practitioners (CMP) 1 position currently job shared
Regimental Medical Officer (RMO)	One (unit asset non DPHC, assigned to a unit based at Tern Hill Barracks)
Practice manager Deputy practice manager	One One
Nurses	One senior nurse (Band 7) One nurse (Band 6) One locum nurse (Band 6)
PCRF	Three physiotherapists (one officer in command referred to as OCPCRF, one B7 and one B6)

	One exercise rehabilitation instructor (ERI) locum
Administrators	Two
RAF medics	Seven (DPHC assets, not unit)

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

Are services safe?

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

Safety systems and processes

The medical centre worked to the Defence Primary Care Healthcare (DPHC) Tri-Service safeguarding policies. There was also a vulnerable person register policy, child safeguarding, adult safeguarding and a domestic violence and abuse policy. The policies included contact addresses and telephone numbers for the local safeguarding teams (both in hours and out of hours), and these were displayed 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 policies and knew how to report a safeguarding concern. An electronic library had been set up in the healthcare governance workbook (HcG Wb), a system that brings together a comprehensive range of governance activities) so all staff had access to essential information including internal and external safeguarding contact details. Most of the doctors also had the safeguarding app downloaded to their personal devices which provided another resource for local safeguarding information. Families and dependants who lived within 5 mile radius of the medical centre were able to register, those who lived further that 5 miles away were signposted to register at an NHS practice. In addition to these policies, there was also the 'Station Supervisory Care Directive' for any concerns relating to trainees including those under the age of 18. A letter had been sent out to local practices where dependents may be registered making them aware of the potential for service family members and the additional welfare support that available for families.

The status of safeguarding and vulnerable patients was discussed regularly with the welfare team. In addition to informal discussion, the needs of vulnerable patients were discussed at the Service Personnel Support Committee meeting which formed part of the monthly clinical meetings. Vulnerable patients were also discussed at the monthly Unit Health Committee meetings at both Ternhill and Shawbury attended by the Senior Medical Officer (SMO), Deputy Senior Medical Officer (DSMO) or Regimental Medical Officer (RMO). 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 and housing issues. They confirmed they had a good relationship with the medical centre and communication between the two was good. The practice had also established external links with the NHS Shropshire, Telford and Wrekin safeguarding team.

One of the Civilian Medical Practitioners (CMPs) was the safeguarding lead with the nurse manager acting as deputy. Both were trained to safeguarding adults and children level 3. All other staff had completed safeguarding training appropriate for their role. The practice safeguarding policy stated that the safeguarding lead should be trained to Level 4. This was not a DPHC policy requirement, and the safeguarding lead was no longer in-date to level 4, but was in date level 3 as per the requirements. We were assured that the local policy would be updated to reflect this.

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 health visitors and Padre. The medical centre worked closely with Department of Community Mental Health (DCMH) and the 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. The coding process was outlined in the vulnerable persons register policy and a review of 5 records showed all were coded appropriately.

Chaperone training was captured on induction of new staff and the practice manager monitored the staff database on a monthly basis and informed personnel if their training was due to expire or had expired. Lists of trained chaperones were displayed in patient areas throughout the building. A copy of all trained chaperones was also held within the HcG Wb.

The full range of recruitment records for permanent staff was held centrally. However, the medical centre could demonstrate that relevant safety checks had taken place for the staff, at the point of recruitment, including a DBS check to ensure staff were suitable to work with vulnerable adults and young people. An electronic record identified when each member of staff was required to renew their registration.

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 a practice nurse who had completed specific training for the role, accessed the DPHC IPC compendium for support and attended the quarterly IPC link forum led by the DPHC IPC lead. IPC training was included for all staff as part of induction. Additional internal training was delivered by the link nurse; for example, a refresher course to remind staff of the correct handwashing procedure.

Regular IPC audits were carried out including the DPHC mandated audits that were scheduled into a monthly rolling programme. All of the audits we reviewed were in-date. These included the patient area audit from November 2022. An action plan was raised to address issues identified. Minutes from the practice meetings evidenced that discussion did take place but we suggested IPC could be included as a standing agenda item. Issues raised were placed on the nurse’s IPC issues log, held on the HcG Wb. The outstanding issues related to infrastructure and a review of the issues log showed they were escalated and managed appropriately by the practice manager.

Environmental cleaning was provided by an external contractor. A written cleaning schedule was in place for each room and we saw that these were signed off to confirm that cleaning tasks had been completed in line with the agreed frequency. Weekly spot checks were conducted by the IPC lead and documented in the HcG Wb. At the time of inspection, the medical centre appeared to be clean and staff spoke of a good relationship with the contractor. Additional requests such as high-level cleaning had been completed when required. Arrangements were in place for deep cleaning, the last had been carried in December 2022.

Healthcare waste was appropriately managed and disposed of with one of the medics named as the responsible individual. 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 carried out in October 2022 showed full compliance.

One staff member was currently providing acupuncture to patients. There was an acupuncture standard operating procedure and risk assessment in place and this had been reviewed regularly and all staff were aware of. Written consent was gained and scanned onto DMICP. Staff we interviewed were aware of the impact of acupuncture for flying crew (they should not fly for 12 hours after acupuncture).

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. Facilities at Tern Hill were being used for rehabilitation. Equipment in the Tern Hill gym was managed by the physiotherapist based at the station. The equipment was not seen but reported as appropriate for their needs and in good order. All items were checked by the PCRF team before and after treating a patient.

Risks to patients

The management team believed that the establishment of the practice was adequate for the patient list size. Vacant posts had been identified as a risk. However, the support of locum staff had been secured in order to meet the needs of patients. Recruitment was underway to appoint a new receptionist, band 6 nurse and an exercise rehabilitation instructor. The vacant posts were not leading to any clinical risk but preventing the practice from progressing future plans such as the provision of minor surgery.

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, staff had identified the provision of Annual Periodic Medical Examinations (APME) would increase capacity and would reduce wait times (at the time of inspection, wait times to see a doctor for an APME were approximately 6 weeks).

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 these were regularly checked. We identified a number of minor issues that did not present a risk to patients and were rectified on the day. In addition, we checked the ambulance vehicle that would be used to transport patients from the airfield to the medical centre. Again, we highlighted some minor issues that were rectified on the day.

The staff team was suitably trained in emergency procedures, including basic life support (BLS), automated external defibrillator (AED) sepsis and anaphylaxis. Annual refresher training in BLS, AED and the use of emergency equipment was mandated for all staff and was provided in-house by clinicians trained in advanced life support. All RAF Medics were in-date for 3 yearly Immediate Emergency Care Provider (IECP) which included responding to medical emergencies, the management of thermal injuries and dealing with

suspected spinal injuries. Emergency training courses completed by staff online had been supplemented by face to face training delivered by the clinical team.

Clinical staff had completed their hot/cold injury mandatory training. A practical session was conducted in April 2023. Sepsis training had been completed and was last refreshed in November 2022.

A closed circuit television system (CCTV) in the waiting room allowed patients to be observed whilst waiting. The monitors covered all of the cameras situated in the waiting area and it was the responsibility of the designated receptionist to monitor the CCTV.

Wet Bulb Globe Temperature (WBGT), used to indicate the likelihood of heat stress, was carried out in the unit's gym, and led by the physical training instructors (PTIs). PCRF staff were aware of actions to take in accordance with WBGT monitoring The unit PTIs monitored and recorded temperature readings and adapted activity for patients when needed.

The Officer in Charge was the PCRF lead for risk assessments (RAs) and had completed an appropriate risk assessment course. The SMO and PCRF staff were aware of the RAs and knew where to access them.

Information to deliver safe care and treatment

The DPHC standard operating procedure (SOP) was followed for the summarisation of patients' notes. The process for summarising and scrutinising notes was incorporated into the arrival process for patients. This process included conducting the 3 yearly review of patient notes. A DMICP audit was used to provide oversight of notes that required summary or review. A monthly search identified what work was outstanding and this was divided amongst the nurses. We found that no paper notes were awaiting summarisation and there was a small number of recently arrived electronic notes to be completed.

A peer review programme of doctors' DMICP consultation records was in place. The SMO and DSMO had conducted peer assurance in 2023. CMPs had not yet completed peer assurance but it was scheduled (the delay for this was because they wished to conduct it in person). The peer review of notes for the nurses was carried out at 6-month intervals with the most recent being November 2022.

There was a peer review process in place for all PCRF staff whereby each clinician was formally reviewed at regular intervals. The exercise rehabilitation instructor (ERI) had established links with the regional rehabilitation unit (Cosford) and attended the unit approximately once a month.

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 at the clinical meeting and monthly at the practice meeting and the monthly Health Assurance Framework meeting. At the monthly practice meeting, the staff members responsible for the tracker presented the statistics. Urgent referrals were highlighted and prioritised. The administration team monitored the referral tracker daily and all staff granted access could view the document. Referrals remained on the

tracker until the report had been returned and actioned. Any appointment not attended by a military patient was followed with a request to reschedule and contact with the patient and the provider. Staff had identified that attendance from Tern Hill patients was impacted due to frequency of deployment and issues with patients not receiving electronic correspondence. A system was implemented where each referral was handed to the patient in person unless they had a confirmed address for the patient. A six monthly audit was carried out on 'did not attend appointment' which monitored attendance for medical centre appointments. The staff told us that attendance had been impacted by the addition of patients from Tern Hill but this had now improved. An audit was done on 2 week wait referrals and all but 2 were complaint (the 2 exceptions were sent within the timescales but had not initially been put on the correct form having been made during the Christmas shutdown when DPHC wide duty doctors provided medical cover). The audit confirmed processes caried out by Shawbury Medical Centre staff were in line with policy (processed within 24 hours of the referral being made by the referring doctor and a summary put onto the patient's record to confirm that it has been sent and received).

An effective process was in place for the management of specimens and detailed in an SOP. A record of each request was held at reception. Results were returned electronically via PathLinks and dealt with by a nurse if normal, or by the duty medical officer if abnormal. The reception team noted when results were returned and made a follow up call to the laboratory when results were considered overdue.

DMICP outages and system freezes were frequent. The reception staff printed off the next day clinic lists each night in case of a potential outage. In the event of an outage, paper notes would be made (then scanned onto DMICP once the system was accessible), 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 Cosford Medical Centre.

Safe and appropriate use of medicines

There were systems in place for the safe handling of medicines. A number of minor issues were raised during the inspection. Most of these were rectified on the day and did not create any risk to patients. Evidence was sent within a week of the inspection to show that all other actions had been completed.

The DSMO was the named lead for medicines management and this was reflected in their terms of reference (TORs). The day to day management was delegated to the medics and this was reflected in their TORs.

Areas of improvement were identified in the arrangements for the safe management of controlled drugs (CD), including destruction of unused CDs. We saw that some monthly checks had not been completed, the CD specimen signature list was not complete, destruction certificates had not been completed and there was a gap between individual entries on the register. The SMO responded after the inspection to confirm that checks were now complete (the gaps had occurred during times of being very short staffed), specimen signatures were now available for all those issuing or checking CDs and the gap

in the register had been rectified (an entry had been recorded but it was made on an old form and needed to be transferred onto the register).

Emergency medicines were easily accessible to staff in a secure area of the medical centre and all staff knew of their location. A number of minor issues were identified and all were rectified on the day of inspection.

The storage of oxygen and Entonox (an inhaled gas used for pain relief) cylinders required improvement to minimise the risk of damage and conform to promote safety. The store was not clean and lacked signage. The practice responded after the inspection to confirm that a clean of the storage area had been arranged and signs ordered.

Medication requiring refrigeration was monitored twice a day to ensure it was stored within the correct temperature range. Storge arrangements for the vaccinations were secure and all stock was found to be in-date.

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. However, this record of receipt had no indicator of who the prescription numbers had been received by. This impacted the system as prescriptions could not be traced to the individual 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. Patient Specific Directions were not used at the practice.

Requests for repeat prescriptions were managed in person or by e-Consult, in line with policy. Requests were received into the group email inbox, printed by medics and signed by a doctor. Medics did not issue medicines if the medication review date had expired, and instead, were referred to the prescriber. 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.

The 7 patients on repeat medication we checked had all been managed appropriately. We saw evidence to show that patients' medicines were reviewed regularly and the doctor's notes in DMICP around medication changes were comprehensive.

The review of patients prescribed with antibiotics was overdue (last completed in March 2022). However, the General Duties Medical Officer had commenced an audit for the previous 12 months antibiotic prescribing.

A process was established for the management 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 and saw that all had been coded, monitored within recommended timescales and had shared care agreements in place.

Track record on safety

Measures to ensure the safety of facilities and equipment were in place. Electrical and gas safety checks were in-date. Water safety measures were regularly carried out with a legionella inspection undertaken in April 2023. 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 monitoring and recording the servicing of all clinical/non-clinical equipment was established, this included equipment in the PCRF.

Staff had adopted the current risk template as per DPHC guideline and used the 4Ts (treat, tolerate, transfer or terminate) to manage risk. 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 reviewed regularly with risk management being 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 for home visits. Staff informed us that lone working rarely occurred, but if it did, the duty medic was informed and staff would regularly check-in with colleagues. Lone working was taking place at Tern Hill where the staff member contacted the Officer in Charge when they arrived and again when they left.

The station major incident plan, last updated in December 2022, was held in the medical centre and was comprehensive in covering the most likely causes of a major incident. The plan made reference to the role of the medical centre in the event of a major incident. A station crash exercise involving the medical centre had taken place in May 2023.

The medical centre had a fixed alarm system that was tested regularly for both serviceability and response. The PCRF had an alarm system that linked to all clinical rooms within the medical centre.

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 business continuity plan 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 meetings. 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.

PCRF staff had a clear understanding of the ASER process and had completed training. ASERs were discussed with the wider practice team at the clinical governance meetings. We saw examples of when the process had been followed effectively; for example, an ASER that prompted improvement in the servicing of PCRF equipment.

Annual ASER audits were completed with the most recent undertaken in November 2022. The audit highlighted the main trends as being communication issues with the pathology laboratory and fridge temperatures falling outside of the recommended temperature range. Resultant actions taken included the installation of new fridges and additional temperature checks added to the end of each day.

A system was in place for managing patient safety alerts. All alerts were received from region by the medics who then checked if there was any stock of the affected item/s. A regional database was then populated and the alert forwarded all clinicians. Safety alerts were a standing item on the agenda at the practice meetings. We highlighted that the regional database did not include a section to include details of action taken by the practice in response to each alert meaning there was not a complete audit trail.

Are services effective?

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

Effective needs assessment, care and treatment

Arrangements in place to ensure staff had a forum to keep up-to-date with developments in clinical care and guidance included monthly clinical and healthcare governance meetings. 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). However, we highlighted that two recent updates in clinical guidelines were not noted on the meetings of the minutes and did not appear to have been understood. We acknowledged this was in part due to preparation for our inspection but the leadership team felt these meetings could be long and tiring due to the broad scope of what needed to be covered. More regular but shorter meetings were being considered.

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 and we saw an example where a holistic approach had been taken when an injury needed wider clinical input.

Monitoring care and treatment

Long-Term Conditions (LTCs) were managed by the nursing team with an appointed lead and 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 69% of patients had received an audiometric assessment within the last two years. The performance was lower than expected levels but a catch up programme identified the majority of overdue assessments were required by Tern Hill patients and phase 1 trainees (audiology assessments had been paused during COVID).

Through a 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). The doctors had captured the DCMH wait time as a risk and developed a 'DCMH waitlist spreadsheet' to monitor and maintain those waiting to be seen. The medical centre had made use of the 12 free counselling sessions offered by the RAF benevolent fund to further mitigate the risk.

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.

Wait times for referrals were generally good. However, staff reported persistent problems with the local X-ray department with both wait times and administrative errors.

An audit calendar was in place and this extended to the PCRF where the audit programme was integrated. Clinical audits was seen to be an integral part of quality improvement. We saw good examples on the day that included a depression audit that had been carried out comprehensively and identified useful improvement points.

Effective staffing

There was an induction pack for all new staff that included role specific sections. All staff new to DPHC completed the online DPHC induction. The PCRF had a separate induction programme which was held on the healthcare governance workbook (HcG Wb). We found on exception which was that the Regimental Medical Officer from Tern Hill had not been given an induction, the medical centre confirmed that this had been done immediately after the inspection.

On arrival, locum staff completed 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.

There was a training calendar and a record of mandatory training. The training lead monitored the status for all staff and discussed required training activity in the practice meetings. Time was available to staff every Thursday afternoon to complete training and compliance was good across the team.

The meeting schedule supported continued professional development and revalidation requirements through clinical updates, guideline reviews, safeguarding updates and RAF/Defence Medical Services (DMS) specific training. Clinicians were supported by reception staff to undertake 360 degree feedback in order to meet revalidation requirements.

There was role-specific training for relevant staff. For example, the practice manager had attended the DMS Lead Healthcare Governance course and the deputy practice manager had attended the Institution of Occupational Safety and Health course and was a manual handling instructor.

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 Senior Medical Officer, Deputy Senior Medical Officer and Regimental Medical Officer attended the Unit Health Committee meetings at which the health and care of vulnerable and downgraded patients was reviewed. Links were being actively set up again after having lapsed during COVID. In particular, links with the health visiting team had been re-established as well as the setting up a new referral pathway for FIT testing. The practice had linked in with a high-tech simulation laboratory to assist with moulage (simulation) training.

The PCRF communicated well with the medical centre both in person and electronically, they told us this worked well. PCRF staff attended the aircrew and MDT meetings as well as the monthly practice clinical meetings. As part of the referral's tracker, there was a log for recording referrals to the Regional Rehabilitation Unit 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 copy of service leavers policy which included signposting to veterans' services both locally and nationally.

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. Links were established with NHS GP surgeries where dependants of serving personnel were registered.

Helping patients to live healthier lives

The medical centre had a nurse as the named lead and a medic as the deputy for health promotion. The nurses were aware of the location of key resources, cross referenced the NHS health promotion calendar and represented the practice as Health and Wellbeing Committee representatives. There was a structured programme of health promotion activity with a yearly planner and calendar on the HcG Wb. The health promotion boards were rotated monthly, these included a paediatric health promotion board. At the time of inspection, there was a highly illustrated and colourful display to raise awareness and provide prevention advice on skin cancers. The medical centre staff has been involved in supporting health fairs and linked in with station health promotion work.

A nurse with specific training (STIF) took the lead on sexual health training and provided sexual health support and advise. Patients were signposted to local sexual health services for procedures not undertaken at the medical centre. Quick Review or QR codes were on the front door and toilet doors to signpost patients to local sexual health clinics. Condoms and chlamydia screening kits were placed in the toilets to promote privacy and confidentiality.

The PCRF staff participated in unit health fairs to advise on both treatment and prevention. There had been a station wide piece of work in utilising the rotary aircrew conditioning program. This had resulted from recognising the demands on the body from travelling by helicopter. In addition, wider funding had been sought in order to develop a gym closer to the training wing for patients to complete this conditioning program. Having it closer would ensure it was completed regularly. The PCRF had provided clinical expertise and advised on what equipment would be needed for the gym area. We encouraged PCRF staff to write these up as QIPs and also as purple ASERS (recognise positive events).

The number of eligible women whose notes recorded that a cervical smear had been performed in the last 3-5 years was 161 which represented an achievement of 90%. 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. Force protection performance was high with vaccination statistics identified as follows:

- 96% of patients were in-date for vaccination against polio.
- 76% of patients were in-date for vaccination against hepatitis B. *
- 95% of patients were in-date for vaccination against hepatitis A.
- 96% of patients were in-date for vaccination against tetanus.
- 99% of patients were in-date for vaccination against MMR.
- 99% of patients were in-date for vaccination against meningitis.

- 96% of patients were in-date with vaccination against diphtheria.

*The hepatitis B is lower due to phase 1 trainees being registered but yet to commence the schedule of vaccinations.

Child Immunisation

The practice had a system in place to contact the parents or guardians of children who were due to have childhood immunisations. The practice has exceeded the WHO based national target of 95% (the recommended standard for achieving herd immunity) for three childhood immunisation uptake indicators. For the one indicator where the national target was unmet, the practice could explain that this was down to awaiting essential information about two children's vaccination history. Results are below:

Child Immunisation	**Practice %**	**Comparison to WHO target of 95%**
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB)	78%	WHO target not met. Practice taking appropriate action.
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster)	100%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster)	100%	Met 95% WHO based target

The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR)	100%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR)	95%	Met 95% WHO based target

Consent to care and treatment

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw evidence that showed verbal consent was recorded and coded appropriately on DMICP. Written consent forms were used for implant insertion and removal. Consent recording formed part of peer review and audits were carried out. The chaperone training module included a section on obtaining and recording consent.

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 3 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 and staff although the feedback made reference to how the service had been impacted during times when a number of posts had been unfilled.

Patients could access the welfare team and various support networks for assistance and guidance. Information regarding these services was available in the waiting areas and the clinical staff were fully aware of these services to signpost patients if required.

Involvement in decisions about care and treatment

Patients with caring responsibilities and cared for patients were identified through the new patient registration form and at new patient medicals. New patients identified as carers were given an initial appointment with the nurse. Patients identified as having a caring responsibility had an alert on their notes and were captured on a DMICP register. Information to support carers was available in the patient waiting area.

There was a carer's lead and deputy for the practice who had put together an internal training programme and delivered it to all staff.

A dedicated carer's noticeboard situated in the waiting area named the leads for the practice and provided contact details for support staff and services including the chaplain, nursery for childcare and the Hive. As well as new patient checks where the specific needs were discussed, carers were recalled for annual flu jabs and annual carer health checks. Details of this were documented in the practice leaflet. A carer's pack containing relevant information and signposting was available at reception.

We were advised that 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. Patients with caring responsibilities 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 that there had been no requirement to use the service in recent years but there was a translation standard operating procedure to refer to which included the access code and relevant links.

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 (PTI) led fitness sessions. In addition, there was clear evidence of collaborative working between PCRF staff and PTIs.

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 building to the medical centre with clinical rooms that provided privacy for patients. Patients were informed about confidentiality issues in the gym and given an option to request privacy. A radio was used in the gym and waiting area to minimise the risk of conversation being overheard.

The reception area was separate to the waiting area meaning 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. This was supported by a sign at the reception hatch. Telephone consultations were undertaken in private to maximise patient confidentiality.

The staff team were still in-date with their Defence Information Management Passport to ensure awareness when handling personal information.

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. Doctors had access to video conferencing facilities but these were not routinely offered.

As Shawbury was the nearest medical centre with aviation trained doctors, services were extended to include patients from Woodvale (Formby) where there were mainly reservists who worked on an airfield.

An access audit as defined in the Equality Act 2010 had been completed for the premises in October 2022. Actions identified in the audit had been completed. The PCRF facilities at Tern Hill were included in the audit and deemed unsuitable for patients in wheelchairs or with severely restricted mobility. Military transport was available to bring these patients to Shawbury.

A hearing induction loop was available at reception although staff reported that there had been no need. Crutches and a wheelchair was available 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 provided by the duty doctor or nurse manager who would triage any request to carry out a visit in circumstances when the patient was unable to travel to the medical centre. Information on this was provided in the patient information leaflet. Staff reported that requests for home visits were rare and any undertaken would be recorded on the healthcare governance workbook.

The practice manager was the designated diversity and inclusion (D&I) lead for the practice with the Officer in Charge of the PCRF as deputy. The D&I board was situated in the staff room and could easily be accessed by all members of staff. There were also a D&I poster displayed in the waiting area.

A direct access physiotherapy (DAP) service (through self-referral) provided patients with the choice of a direct referral. However, this had been temporarily suspended and it was planned to reintroduce once the team returned to the full establishment.

Fit to fly aviation slots were provided each morning to minimise disruption to training.

A boxing medical clinic was laid on to support the annual boxing tournament held at Tern Hill.

Timely access to care and treatment

The medical centre was open Monday to Friday 08:00-18:30 hours. On a Thursday afternoon, the practice protected time for training but would see any urgent patients and they duty medic phone provided a line of communication for patients. Outside of these hours, patients were signposted to the NHS111 service or 999 service. Due to it being a flying station, medical cover was provided 24/7 by a duty medic. Medics would triage any call and signpost patients or book them in for an appointment at the medical centre. The duty phone number was also held in the guard room that was manned 24/7.

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. Home visits to patients on the base were occasionally undertaken and a standard operating procedure in place.

There was good availability of appointments for all clinicians. For example, urgent slots with a doctor were available on the day and routine appointments within 3 working days. To accommodate aircrew and pilots, a good number of same day appointments were available. An appointment with the nurse could be secured the same day. Bloods were prioritised for the morning as they were collected around midday. Routine and follow up physiotherapy appointments were available within two days. Due to the PCRF being short of a staff member, urgent appointment requests would be seen by a doctor first and referred to the PCRF when required. New patient and follow up appointments were available the next day to see an exercise rehabilitation instructor.

Appointments were protected outside of school hours for ease of access to families with children.

Listening and learning from concerns and complaints

The practice manager was the lead for complaints and managed them 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 was undertaken annually with the most recent carried out in November 2022.

We reviewed the two complaints received by the practice in the last 12 months. They were handled appropriately and in a timely manner with confirmed actions taken within the timescales stipulated in the policy.

The PCRF had not received any complaints in the last 12 months. Staff in the PCRF were aware of the complaints procedure and attended practice meetings where complaints would be discussed.

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 displayed throughout the practice.

Shawbury Medical Centre had written their own mission statement which was specific to their role on station and had been reviewed following the addition of the regiment based at Tern Hill. This was ‘supporting our patients to deliver the outputs of RAF Shawbury and 1 Royal Irish.’

There was a formal practice development plan with a focus on developing the practice through additional services, formal engagement with patients and aspirations to become a ‘green practice’. The future plans for Ternhill Medical Centre included integration of Ternhill medical staff and outreach clinics to provide more services from there.

The Primary Care Rehabilitation Facility (PCRF) had developed their own vision which was: ‘to be a rehabilitation facility that delivers holistic and evidence-based rehabilitation that contributes to the fighting power by enabling a timely return to operational fitness’.

Leadership, capacity and capability

The practice had taken over the patient list from Tern Hill Medical Practice and had been through a time when a number of positions in the established team were not filled. This had impacted service delivery in the preceding 12 months. However, we found a team who had gained resilience and had focussed on providing the core services to keep patients safe whilst postponing plans to develop ideas for the future.

Leaders within the medical centre provided direction, decision making and structure. Practice meetings took place regularly and minutes were provided to team members who were unable to attend.

We identified that the practice could benefit from further support from the regional team, in particular with medicines management due there not being a pharmacy technician.

The Senior Medical Officer (SMO) and the Deputy Senior Medical Officer (DSMO) 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. There had been issues with unfilled posts which resulted in a reliance on locum doctors. At the time of inspection, these issues had been resolved.

The practice manager was on a 5 year assignment to provide consistency and protection from regular changes in leadership.

Job descriptions and terms of reference were in place for all members of staff. There was a list of roles and responsibilities which involved a wide range of staff and each lead had an appointed deputy.

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. This extended to locum staff who felt they were treated as equals to the full-time staff. 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 felt involved in decisions made and were comfortable in raising any concerns or issues within their department. Group team building exercises were held regularly.

Working arrangements had been tailored where possible to support staff. These included family friendly hours, working from home and supporting staff to pursue sporting and recreational activities.

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 in 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.

An audit programme was in place and the PCRF 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:

- Full practice meetings held monthly.
- Clinical meetings held monthly.
- Nurse meetings held monthly.
- PCRF meetings held weekly.
- Welfare meetings held monthly (both Shawbury and Ternhill).
- In-house training held (protected time allocated weekly).

However, the leadership team was accepting that there may be a need to review the meeting schedules and agenda to make the meetings shorter and more focussed to ensure key messages were disseminated effectively.

Managing risks, issues and performance

Processes were in place to monitor national and local safety alerts and incidents. To make fully effective, action taken needed to be added to the records.

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. There was a proactive approach to risk mitigation.

The main risks identified had not been transferred to regional headquarters. We discussed whether this would be more appropriate for some of the larger risks; for example, infrastructure including digital and staffing.

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 reviewed six monthly, the last review took place in January 2023.

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

The practice had been utilising their patient feedback to produce actions that were documented on the 'You Said, We Did' board. These included the introduction of a text messaging service for appointment reminders, commencement of ERI and vaccination clinics at Ternhill (to negate the requirement for patients to travel to Shawbury) and the provision of eConsult as an alternative to contacting the practice by telephone or face to face for medical advice.

The PCRF did not conduct their own patient survey but did link in to the one for the medical centre as a whole.

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 a comprehensive and effective audit programme that was integral in driving improvement. A total of 6 quality improvement projects (QIPs) had been recorded on the DPHC national SharePoint for Shawbury Medical Centre. Of note:

- The introduction of metabolic screening for patients identified as high risk for metabolic syndrome (a combination of diabetes, high blood pressure and obesity) which included ethnic origin coding (the prevalence for some ethnic groups is higher than others).
- Following the identification of a trend in MSK injuries for the crew operating in helicopters, the PCRF team had adapted the 'Aircrew Conditioning Programme' for rotary crew to the rear crew and implemented it to reduce injury.
- The 'exercise prescription form' had been adapted in response to patients experiencing fatigue from downloading exercise apps. The form was adapted to simplify and ensure consistency and accuracy of the exercises to follow.

- An improvement in the recording of consent which had resulted in an audit score of 100% for the correct coding and recording of consent.
- A ‘red card’ system at reception to promote privacy by giving patients a non-verbal sign to the receptionists when asking for a private space to talk. This system had been extended to the PCRF.