Care Quality Commission

Boulmer Medical Centre

Longhoughton, Alnwick, Northumberland NE66 3JF

Defence Medical Services inspection report

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information given to us by the practice and patient feedback about 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 inspection

We carried out this announced comprehensive inspection on 6 and 8 June 2023.

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

Are services safe? – good

Are services effective? – good

Are services caring? – good

Are services responsive to people's needs? – good

Are services well-led? – good

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 the CQC will complete at the invitation of the DMSR in its role as the military healthcare regulator for the DMS.

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

It was identified that patients were reluctant to be discharged from physiotherapy and upgraded as they were concerned about passing the fitness test. The Exercise Rehabilitation Instructor explored this issue and, with reference to policy, noted there was a chit providing a 3-month grace period following upgrade. This chit has since been used and forwarded to physical training instructors to allow a delay in testing. Since then patients have been less anxious about being discharged. This piece of work was identified as a quality improvement project.

At this inspection we found:

- Feedback showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.
- The practice was well-led and the leadership team demonstrated they had the vision, capability and commitment to provide a patient-focused service and consistently sought ways to develop and improve.

- The practice was in the early stages of developing a ‘network’ with Newcastle Medical Centre. Both practices had started to collaborate to promote better service for patients.
- There was an open and transparent approach to safety. An effective system was in place for managing significant events and staff knew how to report and record using this system.
- The practice worked collaboratively with internal and external stakeholders, and shared best practice to promote better health outcomes for patients.
- There was an open and transparent approach to safety. An effective system was in place for managing significant events and staff knew how to report and record using this system.
- The arrangements for managing medicines minimised risks to patient safety. A process was in place to monitor patients prescribed high risk medicines.
- The practice team had effective working relationships with internal and external stakeholders.
- Quality improvement activity was embedded in practice and was used to drive improvements in patient care.

No recommendations were identified for the practice:

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

Our inspection team

The inspection was led by a CQC inspector and a team of specialist advisors, including a primary care doctor, practice nurse, pharmacist and practice manager. The physiotherapist specialist advisor inspected the Primary Care Rehabilitation Unit (PCRF) on 8 June 2023.

Background to Boulmer Medical Centre

Located near the town of Alnwick in Northumberland, Boulmer Medical Centre provides primary care, occupational health and a rehabilitation service to patient population of approximately 600 service personnel, including a small number of Phase 2 trainees. Families and dependants are not registered at the practice and are signposted to local NHS practices.

The practice is open Monday, Tuesday and Thursday from 08:00 to 16:30 hours, Wednesday from 08:00 to 12:00 hours and Friday from 08:00 to 16:00 hours. Out-of-hours medical cover is provided by Catterick Garrison Medical Centre. From 18:30 hours weekdays, at weekends and for public holidays, patients are advised to use NHS 111. Patients requiring urgent care out-of-hours are also signposted to the minor injuries unit in Alnwick, walk-in-services at Wansbeck Hospital and emergency care at Northumbria Specialist Emergency Care Hospital.

The staff team

Doctors	Senior Medical Officer Civilian medical practitioner – 3 days per week
Practice management	Practice manager – civilian Deputy practice manager – military (post vacant)
Nurse	One – civilian
Administrative officer	Two – civilian
PCRF	One physiotherapist – civilian Exercise Rehabilitation Instructor - military

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

The Senior Medical Officer (SMO and practice nurse were the leads for adult and children safeguarding. Staff had completed safeguarding training at a level appropriate to their role. A local safeguarding standard operating procedure (SOP) and quick reference guide was in place and staff we spoke with knew how to access these documents. The SMO had developed a relationship with the Northumberland safeguarding team and had previously attended the Northumberland safeguarding team meetings. In addition, the SMO participated in the regional safeguarding meeting. At the time of the inspection, there were 13 Phase 2 trainees and there were no patients under the age of 18 registered at the practice.

A safeguarding/vulnerable patient register was in place. Vulnerable patients were identified during consultations, DMICP (electronic patient record system) searches and from referrals from other units, such as the welfare team. Specific clinical codes were used and alerts added to the patient's record. Vulnerable patients and safeguarding concerns were discussed at the care and concern meetings. A search of DMICP was undertaken prior to the meeting to ensure the register was up-to-date. A unit-based meeting was held each month with the chain of command to discuss non-clinical issues in relation to vulnerable patients. We were given an example of how a safeguarding concern was effectively managed in conjunction with the patient and the Chain of Command.

Opportunistic screening was undertaken to screen for domestic violence. The SMO had plans to develop a domestic violence, coercion/control awareness session for the patient population.

The chaperone policy was displayed and outlined in the patient information leaflet. The practice nurse facilitated update chaperone training for the team in May 2023.

Although the full range of recruitment records for permanent staff was held centrally, the practice could demonstrate that relevant safety checks had taken place at the point of recruitment, including Disclosure and Barring Service (DBS) checks to ensure staff were suitable to work with vulnerable adults and young people. A process was in place to monitor the professional registration and vaccination status of staff. All relevant staff had indemnity insurance.

An infection prevention and control (IPC) policy was in place. The practice nurse was the lead for IPC and had completed the required training for the role and attended the regional IPC forum. The IPC audit completed in March 2023 showed the practice was fully compliant. The practice nurse facilitated an annual IPC workshop for the team that included a handwashing presentation. Training records showed that non-clinical staff were not up-to-date with annual IPC training. After the inspection the practice manager confirmed training had been arranged for the end of June 2023.

As the physiotherapist provided acupuncture, an SOP was in place to support its safe provision.

A contract and schedule was in place for environmental cleaning. The practice manager monitored the cleaning and liaised regularly with the cleaning contractor. Deep cleaning was carried out during the Christmas period when the practice was closed. The practice could request additional deep cleans if required.

The practice nurse was the lead for clinical waste. Supported by a waste disposal policy, the management of clinical waste included a waste log and consignment notes. Clinical waste segregation posters were displayed. The clinical waste was stored in a secure shed in the grounds of the building. A clinical waste audit in March 2023 identified the practice was fully compliant.

Risks to patients

The SMO indicated that available doctor hours were sufficient to meet the needs of the patient population. Nursing hours had been supported by the deputy practice manager (DPM) who was also a medic. The military DPM post became vacant shorty before the inspection. A replacement DPM was being sourced as a priority. The practice was in the process of forming a network with Newcastle Medical Centre that had a recent uplift in nursing hours. The network arrangement provided for Boulmer Medical Centre to access additional nursing hours. In addition, funding had been approved for a locum healthcare assistant.

An arrangement was in place for the physiotherapist at Newcastle Medical Centre to provide cover for patients with an urgent need. The exercise rehabilitation instructor (ERI) was deployed until November 2023 and a locum ERI was due to start at the beginning of July 2023. In the interim, the physiotherapist was providing patients with extra exercise programmes as rehabilitation classes were not taking place.

The medical emergency trolley and medicines were checked each month or if the trolley had been opened/used. Tags were in place with a list of expiry dates held. We checked all items and they were in-date. Oxygen was held with the trolley and it was full and in-date. Full and empty gas cylinders were stored appropriately in an area away from the building.

The staff team was up-to-date with training in emergency procedures, including basic life support and the use of an automated external defibrillator (AED). Anaphylaxis training had only been completed by the clinical members of the team. In accordance with Defence Primary Healthcare policy all staff were required to complete this training. Shortly after the inspection the practice manager confirmed anaphylaxis training had been arranged for the staff who needed to complete it. The mandated heat injury prevention course had been completed by all military staff working at the practice. All staff completed sepsis training in September 2022.

When in post, the ERI worked with patients at the unit gym. There was a significant distance from the gym to the nearest AED. The physiotherapist and practice manager had discussed the matter. It was added to the risk register and discussed further with station command that an AED should be provided if the ERI is to continue working from the gym. Since then, the gym has been moved and is nearer to an AED.

Wet Bulb Globe Temperature checks to indicate the likelihood of heat stress were undertaken by the unit physical training instructors and then relayed to the physiotherapist.

Information to deliver safe care and treatment

In the event of an IT outage impacting DMICP access, staff referred to the business continuity plan. Staff advised that there were occasional issues with accessing DMICP, but it did not impact patient care. A process was in place to use paper documentation as a contingency which was later coded and scanned to the patient's record.

All new personnel assigned to the station were issued with a medical centre registration form. Administration staff reviewed the completed form and took necessary action, including contact with the medical board desk if required. Each month the practice manager checked to identify new personnel assigned or departing from the station. They also undertook a summarising search and assigned records requiring summarisation to the 3 clinicians. Eighteen percent of the records required summarising and we were advised this back log would be addressed when a DPM and locum HCA were appointed.

Arrangements were in place for the auditing of clinician's record keeping. Practice meeting minutes for May 2023 indicated recently completed audits were discussed. Improving clinical coding was the main theme identified and shared with the staff team. We reviewed a wide range of DMICP records and found record keeping was of a good standard.

Due to the recent departure of the DPM, one of the administrators had been assigned the lead for managing referrals. An effective system was in place to manage referrals, including colour coding to indicate the status of each referral. Referrals were checked each week. The physiotherapist had a separate system for recording and monitoring referrals. Other staff had access to this system so could monitor referrals in the absence of the physiotherapist.

A process was established for the management of samples. All clinicians took samples with the practice nurse overseeing the register and checking weekly the status of all results. The laboratory was contacted if there was any delay with the return of results. Requesting clinicians reviewed results through Path Links (NHS clinical pathology network). All patients received their results direct from the requesting clinician.

Safe and appropriate use of medicines

The SMO was the lead for medicines management. As there was no dispensary at the practice, a Local Agreement Pharmacy (LAP) was established at Shilbottle, approximately a 10-minute drive from the practice. Either the prescription was taken to the LAP by the patient or emailed to the pharmacy in advance. The patient could collect the prescription from the pharmacy or they could be delivered to the medical centre. LAPs do not charge patients for prescriptions. Patients also had the choice to take the prescription to any community pharmacy. With this option, there is a charge at private prescription rate but the cost could be claimed back.

Prescription forms were effectively managed. Prescriptions and related documentation were locked in a filing cabinet in the DPM's office. Access was via a key safe in the administrator's office. A register for prescriptions for controlled drugs (medicines with a potential for misuse) was maintained and the prescriptions were kept in the safe. All details were recorded as specified in the controlled drug (CD) book for receipt and issue. A check showed that the running total correlated with the physical balance. The keycode for the

safe was reset in the last 2 weeks. The main key for the key safe was held in another key safe. Access was limited to certain staff. The password was reset every 6 months.

Minimal medicines were stored at the practice. They included vaccines, emergency medicines and Patient Group Directions (PGD) medicines so the practice nurse could administer medicines in line with legislation. Over labelled medicine was available if needed but had not been used so far.

Dispensed prescriptions containing CDs were locked in a cabinet if delivered back from LAP. Generally, patients collected CDs from LAP in person. An annual CD audit had been completed and a self-declaration was in place. Quarterly and annual CD returns had been completed.

Vaccines were ordered by the pharmacy technician at Newcastle Medical Centre. Orders were delivered direct to the practice and the stock recorded on DMICP by the practice nurse. Fridge temperature checks were undertaken in accordance with policy. The datalogger lights were checked daily and recorded on temperature chart. The nurse was aware of actions to take if temperature excursion occurred. The administrators know to monitor temperatures in the absence of the nurse and the action to take if temperature excursion occurred. Stock was in-date and stored according to expiry dates. Stock was well spaced in the fridge to allow air flow. The fridge was locked, and the key held by the practice nurse.

A safe system was in place for repeat prescriptions; email only or through a direct request to the prescriber during consultation. An electronic log of items sent to LAP for dispensing was maintained. No telephone, postal or right-hand side of prescription requests were accepted.

A process was in place for medication reviews. Prescription and treatment reviews were undertaken at the same time; every 6 months. The practice manager carried out searches to identify patients due a review and informed the doctor. In addition, the SMO carried out reviews opportunistically.

The practice nurse had completed the required PGD training. PGDs were in-date and had been appropriately authorised by the SMO. A PGD protocol was in place and the PGD website was referred to; no printed PGDs were kept. An annual PGD audit had been completed.

Any recommended medication change advised by secondary care was actioned as soon as the matter was brought to the attention of the doctor. A prescription was issued and the patient referred to LAP or other community pharmacy.

An effective process was in place for high risk medicines (HRM) that required monitoring. An HRM register was in place. Records we reviewed showed appropriate alerts were used and monitoring arrangements were in place. Shared care agreements with secondary care services were in place if indicated. An unlicensed and off-label prescribing register was established and up-to-date.

Regular searches were undertaken for patients prescribed valproate (medicine to treat epilepsy and bipolar disorder). At the time of the inspection, no females were prescribed this medicine.

An antibiotic audit was undertaken recently and identified antibiotic use had increased during winter. Further medicine audits were planned.

Track record on safety

The health and safety representative for the building (practice manager) and station were displayed on the safety board. Also displayed were the fire risk assessment, fire orders for the building and management plan. One of the staff team was identified as the fire safety representative. Staff advised us that regular fire drills were conducted.

Evidence was in place to confirm the contractor carried out water safety checks. An annual gas check was undertaken in August 2022 and the 5-yearly electrical safety check in September 2020.

A lead and deputy for equipment care were identified. An equipment assessment (referred to as a LEA) was undertaken in November 2022 and the minor recommendations had since been completed. Testing of portable appliances was carried out in May 2023. Some rehabilitation equipment was out-of-date for servicing and was clearly signed to indicate it was not in use. The physiotherapist was following this up and it had been discussed at the practice meeting.

The practice manager was the designated lead for risk management and had completed the managing safety course. The SMO was the nominated deputy. A register of up-to-date risk assessments covering all aspects of patient/staff safety was in place, including lifting/handling assessments, lone working and Control of Substances Hazardous to Health (COSHH) risk assessments. Any change to the assessments or underpinning policies were communicated to staff via email and discussed at the practice meeting. COSHH products were stored appropriately.

The risk register identified 5 active risks managed by the practice to either ‘treat’ or ‘tolerate’. The practice manager reviewed the risk register each month and updated the staff team accordingly at the monthly practice/governance meeting at which risk was a standing agenda item.

There was a fixed audible alarm system with warning lights outside each of the clinical rooms. It was linked to a main dashboard alongside the reception desk to indicate activation. We tested the system during the inspection and staff promptly responded. The physiotherapy room alarm was not connected to the dashboard. However, the alarm when activated displayed a warning light outside the door. In addition, the room was directly opposite the reception area which was always staffed.

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. An ASER register was maintained and ASER was a standing agenda item at the practice/governance meetings.

From interviews with staff and evidence provided, it was clear there was a culture of reporting incidents. All staff we spoke with gave examples of incidents reported through

the ASER system including the improvements made following the outcome of investigations. For example, an ASER relating to a delayed diagnosis of an unusual clinical presentation was thoroughly reviewed and the case presented to other doctors for their learning.

Patient safety alerts were up-to-date. Two of the staff had access to the Central Alerting System (CAS). Alerts were sent to the individual dealing with CAS on that day who then forwarded them to the clinicians. Alerts were a standing agenda item at the practice meetings.

Are services effective?

We rated the practice as good for providing effective services.

Effective needs assessment, care and treatment

Processes were in place to support staff to keep up-to-date with clinical developments including NICE guidance, the Scottish Intercollegiate Guidelines Network, clinical pathways, current legislation, standards and other practice guidance. New or updated guidance was discussed at the practice meetings. In addition, a clinical update meeting was held each month.

Staff were kept informed of clinical and medicines updates through the Defence Primary Healthcare (DPHC) newsletter circulated each month. Patients with vulnerabilities and/or complex needs were discussed at the monthly care and concern meetings.

Patients with mental health needs were managed and supported in line with standard practice. The Department of Community Mental Health (DCMH) had provided doctors with training in Step 1 of the mental health intervention programme. Standardised clinical codes were applied and patients were regularly reviewed. The chain of command was involved if appropriate and the DCMH was available for additional advice and guidance. If referred to the DCMH, the patient had an initial assessment within 2 weeks or on the same day if urgent. Patients could also be signposted to an established mindfulness/meditation service, SSAFA (Armed Forces Charity) and to the welfare team. Our review of records for patients with a mental health need showed they were appropriately supported and managed. Consistent clinical coding was used.

The primary care rehabilitation facility (PCRF) had the necessary equipment and space needed to deliver an effective service. Patients were assessed by physiotherapist in the PCRF and referred to exercise rehabilitation instructor (ERI) in main gym.

The physiotherapist referred to the Department of Defence Rehabilitation to ensure best practice guidance was being followed. The musculoskeletal health questionnaire (MSK-HQ) was routinely used and relevant clinical coding applied for audit purposes. Twenty five percent of care pathways were missing an MSK-HQ score. This result was not unusual as absent discharge scores often are due to non-attendance and patients not responding to requests or telephone appointments.

The physiotherapist used Rehab Guru (software for rehabilitation exercise therapy), which provided patients with injury prevention information and templates. A power point had been created by the ERI regarding injury prevention in running. The ERI worked part time as an ERI and part time as a physical training instructor which worked well as it facilitated taking patients right through the process from injury and downgrade to upgrade, back to full fitness and passing fitness test.

The PCRF was consistently meeting all of its key performance indicators.

Monitoring care and treatment

One of the doctors was the lead for chronic conditions and the practice nurse deputised. A chronic disease meeting was held every 10 weeks. A register for patients diagnosed with a chronic condition was in place. System searches were undertaken regularly by the practice nurse to ensure the register was current and to check annual review dates. In relation to the annual review, up to 2 reminder letters were sent to the patient. If no response was received then the doctor contacted the patient by telephone. If there was still no response, then the practice manager contacted the patient.

There were low numbers of patients with a chronic condition including asthma, diabetes and high blood pressure. Our review of a range of patient records showed these patients were recalled and monitored in a timely way appropriate to their needs. Methods of identifying patients at risk to developing diabetes included opportunistic screening, risk assessments and new patient screening. Any patients found to be at risk were offered annual blood tests, check-ups and health promotion advice.

Audiology statistics showed 95% of patients had received an audiometric assessment within the last 2 years. The uptake was high as the unit promoted audiometric assessments due to the ‘air critical’ nature of job role for personnel. Joint Medical Employment Standards (referred to as JMES) were appropriately managed.

The audit register clearly demonstrated that quality improvement was embedded in the practice. All staff actively engaged with audit activity and the register indicated a balanced range of data searches, mandated audits and clinical audits. For example, an asthma audit and vitamin B12 audit were undertaken to ensure conformance with local national guidance.

The physiotherapist had completed a range of clinical audits including for a 2-yearly acupuncture audit, the use of MSK-HQ and the start back questionnaire for lower back pain. It was identified that patients were reluctant to be discharged from physiotherapy and upgraded as they were concerned about passing the fitness test. The ERI explored this issue and, with reference to policy, noted there was a chit providing a 3-month grace period following upgrade. This chit has since been used and forwarded to physical training instructors to allow a delay in testing. Since then patients have been less anxious about being discharged. This piece of work was identified as a quality improvement project.

Effective staffing

Staff had received an appropriate induction and appraisal. All new members of staff were required to complete the DPHC mandated induction which had been modified to include role specific elements and information relevant to the unit.

The Senior Medical Officer (SMO) was the lead for staff training and the practice manager deputised. The practice manager monitored the mandatory training on a monthly basis and informed staff via email and at the monthly practice meeting of any outstanding training that required completion. Some mandatory training had not been completed as the practice manager had been misinformed that it was not mandated for civilian staff. Since the inspection, we received confirmation from the practice manager that this training had been scheduled.

Clinicians had the appropriate qualifications to meet the needs of the patient population. For example, the physiotherapist was trained to provide acupuncture and kept up-to-date through continuing professional development (10 hours over 2 years as recommended). The SMO was a Military Aviation Medical Examiner. Opportunities were available for staff to pursue special interests that would benefit the needs of the patient population. For example, the physiotherapist completed the Defence Health and Wellbeing Advisor Course for enhanced treatment or to run Defence DOFit courses.

There was an active in-service (trade) training programme in place which supported staff with continuing professional development (CPD). A CPD session was held every 5 weeks. In addition, opportunities were available for staff to engage, discuss policy updates and share best practice with regional colleagues. The SMO participated in the 3-monthly regional clinical management meetings, which involved case discussion, peer review and review of latest guidelines. In addition, they attended the monthly 'Problem Based Small Group Learning' meetings with other doctors within the region.

Because the practice nurse was currently working as a standalone nurse, they completed peer mentorship/clinical supervision with the nurses at Newcastle Medical Centre. This initiative demonstrated positive collaborative working and a good example of 'networking' with a local DPHC practice. The practice nurse also attended the regional infection prevention and control (IPC) forum with other IPC leads within region. In addition the practice nurse completed external training on the new ECG machine at Catterick Medical Centre.

Clinicians were responsible for maintaining their own CPD portfolio. Appraisal and revalidation were in-date for all clinical staff.

Coordinating care and treatment

Discussions with staff indicated the practice had well developed links with internal teams and services. For example, the practice was represented at the Service Personnel Support Committee meeting and unit health committee meeting. The practice had developed good links with Newcastle Medical Centre and the SMO aimed to strengthen and build on the relationship over the next year. In addition, the practice had effective communication with other regional practices. Relationships were established with external health services, such as the Northumberland Safeguarding team and local services providing a sexual health service.

The practice provided release medicals for service personnel leaving the military. Following the release medical, the patient was issued with the appropriate paperwork, provided with sufficient medicines and the process for NHS registration was explained. Patients were also made aware of the Veterans Health Service and, if appropriate, the Veterans Mental Health Transition, Intervention and Liaison Service (TILS).

Helping patients to live healthier lives

Clinical records we reviewed showed that supporting patients with healthy lifestyle options was routine to consultations where appropriate. The practice nurse was the lead for health

promotion. A detailed health promotion strategy was in place that took account of Public Health England and the NHS approach to health promotion. Health and lifestyle information was displayed through the television screen in the waiting area where a range of varied health promotion displays and leaflets were available. For example, there was a display specific to men's health. The practice participated in unit-led health and wellbeing days. The last one was held in May 2023.

One of the doctors was the lead for contraception and sexual health. Patients could self-refer to the local NHS sexual health service, which staff described as a good service. In addition, there was the option to refer patients to the Military Advice and Sexual Health/HIV (MASHH) service at Birmingham for more complex sexual health needs. Chlamydia testing kits and information was available in the patient toilets.

The ERI had facilitated presentations on injury prevention in running delivered as part of 'lunch and learn' at the station for service personnel. In addition, the ERI provided patients with Rehab Guru injury prevention guides for further educational purposes.

Monthly searches were undertaken for bowel, breast and abdominal aortic aneurysm screening in line with national programmes. Appropriate action was taken to prompt patients to uptake screening if eligible. Ninety-six per cent of eligible women had had a cervical smear in the last 3-5 years. The NHS target is 80%. A cervical screening audit had been undertaken. Given the small numbers of eligible women, no major learning points were identified.

The practice nurse was the lead for travel medicine and one of the nurses at Newcastle Medical Centre deputised. Recall for vaccinations was driven by service need when deploying. Vaccination statistics were identified as follows:

- 96% of patients were in-date for vaccination against diphtheria.
- 96% of patients were in-date for vaccination against polio.
- 100% of patients were in-date for vaccination against hepatitis B.
- 98% of patients were in-date for vaccination against hepatitis A.
- 96% of patients were in-date for vaccination against tetanus.
- 100% of patients were in-date for vaccination against meningitis.
- 77% of patients were in-date for vaccination against mumps, measles and rubella.

Consent to care and treatment

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. Implied consent was mainly used. The clinical records we looked at showed consent was consistently obtained from patients where required, including for acupuncture. Written consent was taken for invasive procedures and implied consent for non-invasive examinations. Consent was considered as part of the audit of clinicians' record keeping.

Clinicians understood the Mental Capacity Act (2005) and how it would apply to the patient population group. Staff training in mental capacity had been incorporated as part of the chaperone training. We were provided with an appropriate example of when a mental capacity assessment had been undertaken.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

We referred to a variety of methods to establish patients' views of the service provided at Boulmer Medical Centre. These included the Defence Primary Healthcare (DPHC) patient survey (263 responses received from October 2021 to May 2023), the primary Care Rehabilitation Facility patient feedback survey and the feedback cards issued to the practice ahead of the inspection. All respondents indicated staff treated patients with kindness, respect and compassion. We were provided with various examples of when practice staff had gone 'the extra mile' to support patients, including home visits for additional support.

The practice signposted patients in need of additional emotional and social support to the padre, SSAFA and/or the personal services team.

Involvement in decisions about care and treatment

Our review of clinical records and feedback about the practice demonstrated that patients were involved in planning their treatment and care.

The Senior Medical Officer was the lead for patients with a caring responsibility. Carers were identified either during the registration process, DMICP searches, via the welfare team or through self-identification. A carers display and leaflets was situated in the waiting area. It identified the additional services available to patients, such as the flu vaccination and annual carer health checks. The practice leaflet and television screen in the waiting area also advertised what the practice offered to carers.

Clinical codes and alerts were added to carers' records and a DMICP search is conducted each month to ensure all carers were identified. Carers were discussed at the care and concern meetings.

An interpretation service was available for patients who did not have English as a first language. We were advised it had not needed to be used.

Privacy and dignity

Consultations took place in clinic rooms with the doors closed. Privacy curtains were used when patients were being examined. Telephone consultations were undertaken using headsets to maximise patient confidentiality. A radio playing minimised conversations being overheard at reception.

A privacy sign was displayed behind the reception desk to inform patients that if they require to speak to a member of staff in confidence, they should ask the receptionist. All

telephones calls of a private/confidential nature received at reception were automatically transferred to the main admin office to prevent any information being overheard in the main waiting area. There was a television next to the reception desk and a radio situated at the back of the waiting area which supported with minimising conversations being overheard. All staff had completed the mandated Healthcare Governance and Assurance training at the time of the visit.

In the event that a clinician of a preferred gender was not available patients could attend an alternative medical centre within the region.

Are services responsive to people's needs?

We rated the practice as good for providing caring services.

Responding to and meeting people's needs

The practice had made changes to respond to the needs of patients. For example, early morning appointments at 07:45 hours and afternoon specific clinics had been introduced to accommodate shift workers on unit. The afternoon clinic was also more convenient for patients living out of area who required deployment preparation. When the Local Agreement pharmacy arrangement was set up it took into account minimising travel time for patients.

The practice was committed to meeting the principles of the Equality Act 2010, including safeguarding people with protected characteristics. Clinicians worked in accordance with organisational policy for the management of transgender personnel to ensure they received appropriate clinical care, support and early referral. An Equality Access Audit for the premises was completed in January 2023. The building was accessible for people with mobility needs. A hearing loop was not required based on the current needs of people who used or accessed the building. The patient information leaflet was available in larger print.

Timely access to care and treatment

Feedback from patients confirmed they received an appointment promptly and at their preferred time. Requests for medical advice and appointments could be arranged by telephone or via eConsult. Patients had a choice of telephone or face-to-face consultations. Urgent appointments with a doctor, nurse or physiotherapist could be facilitated on the same day. A routine appointment with a doctor was available within 2 days and 1 day with the nurse. There was a wait of a week for a specialist medical.

Patients could refer directly to physiotherapy and approximately 80% of referrals were direct access. An urgent appointment could be accommodated the next day and both a routine and follow up appointments within a week. In the temporary absence of an exercise rehabilitation instructor, the physiotherapist had arranged for patients to have enhanced access to regional rehabilitation unit (RRU) courses if they were assessed as needing exercise therapy.

Since COVID-19, waiting times for referrals to secondary care had increased. This was managed by the doctor regularly reviewing the patient. There was no significant wait for patients referred to a RRU as the physiotherapist could refer to any RRU. Patients referred to the Multidisciplinary Injury Assessment Clinic were seen within 4 weeks.

Out-of-hours access to medical care was detailed in the practice leaflet, displayed on the front door of the practice and also outlined on the answering machine message. Emergency out-of-hours cover midweek was provided by Garrison Medical Centre from 16:30 to 18:00 hours. Patients had access to the NHS111 from 18:00 hours on weekdays, at weekends and on public holidays.

Listening and learning from concerns and complaints

The practice manager and Senior Medical Officer were the leads for complaints. Complaints were managed in accordance with Defence Primary Healthcare policy complaints policy and local procedure. The complaints procedure was displayed in the practice leaflet and on the patient information board in the waiting area.

Complaints were recorded on the centralised Defence Primary Healthcare governance webpage. There was 1 complaint from October 2022 recorded and it had since been resolved. Complaints was a standing agenda item at the monthly practice meeting.

Are services well-led?

We rated the practice as good for providing caring services.

Vision and strategy

The practice worked to the Defence Primary Healthcare (DPHC) mission statement defined as:

"To provide and commission safe and effective healthcare which meets the needs of the patient and the Chain of Command in order to contribute to Fighting Power."

The practice was in the early stages of developing a 'network' with Newcastle Medical Centre, to be finalised in September 2023. It was perceived that this initiative would provide resilience to cover staff absences and to support clinicians working in isolation from other colleagues within the same discipline, such as the practice nurse and physiotherapist. The 2 practices had already started working together by supporting with staff shortages, peer review/supervision and governance matters.

Leadership, capacity and capability

Staff advised us that there was sufficient management/leadership capacity at the practice to meet the needs of the practice and patient population. Staff gaps were efficiently and effectively addressed so continuity of service provision was not compromised. All the staff we spent time with spoke highly of the inclusive leadership approach, including the visibility and support provided by the Senior Medical Officer (SMO) and practice manager.

The leadership team described how the support from the regional management team was good, particularly as region acted swiftly to address staffing gaps.

Culture

It was clear from the initial presentation at the beginning of the inspection, from patient feedback and interviews with staff that the needs of patients were central to the ethos of the practice. Staff understood the specific needs of the patient population and tailored the service to meet those needs. For example, holding a clinic at 07:45 hours to accommodate shift workers.

Staff spoke highly of the culture and strong collaborative teamwork. They felt respected, supported and valued. Everyone had an equal voice, regardless of rank or grade. Both formal and informal opportunities were in place so staff could contribute their views and ideas about how to develop the practice. The leadership team promoted an open-door policy and encouraged staff to share their views at meetings. Staff said they would feel comfortable raising any concerns and were familiar with the whistleblowing policy. They

were familiar with the Freedom to Speak Up (FTSU) policy and were aware of how to access FTSU representatives.

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. A duty of candour log was maintained and we were given an example of how duty of candour breach had been effective management, including the patient being informed.

Governance arrangements

There was a clear staff reporting structure in place. Staff were aware of their roles and responsibilities, including secondary lead roles for specific areas. Terms of reference were established for those with secondary roles. These were reviewed in May 2023 to ensure they were current. A range of meetings were held to ensure effective communication and information sharing with the staff team.

The practice nurse was the healthcare governance (HCG) lead and the practice manager the deputy. An HCG meeting was held every 5 weeks between the heads of departments. Any observations raised relevant to other staff were discussed further at the monthly practice meetings. All staff had access to the meeting minutes via the healthcare governance workbook. The workbook is overarching system used to bring together a range of governance activities, including the risk register, audit, health and safety and quality improvement.

Managing risks, issues and performance

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 meetings. The practice manager reviewed the risk register each month and it was then discussed at the HCG meetings.

The business continuity plan (BCP) was reviewed in August 2022. It took account of all the likely generic system failures and had clear guidance for the need to relocate if required. The plan was activated on the in August 2022 as a result of no access to the building due to a lock malfunction at the entrance to the premises. A post BCP activation report was completed and the lessons identified/recommendations were identified.

Processes were in place to monitor national and local safety alerts, incidents, and complaints. This information was used to improve performance.

The leadership team was familiar with the policy and processes for managing staff performance. Although not a concern that was indicated, the practice manager was familiar with the range of processes to manage performance including welfare support, re-training, appraisal and disciplinary processes.

Appropriate and accurate information

The DPHC electronic health assurance framework (referred to as HAF) was used in to monitor performance. The HAF is an internal quality assurance governance tool to assure standards of health care delivery within defence healthcare. All staff had access to the HAF.

The practice recently performed a 6-monthly self-assessment as evidenced on the overall grading tabs of the HAF. Each of the domains were reviewed with the input of all the team any actions that required individual input were referred to by the HCG lead. We reviewed the HAF 'Management Action Plan' and noted that just 1 action had been raised since the HAF was introduced in December 2021; this had since been closed. The HAF was a standing agenda item for discussion at the HCG meetings.

There were arrangements at the practice in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

Various options were available to prompt patients to provide feedback on the service and the practice acted on feedback received.

Good and effective links were established with internal and external organisations including the Welfare Officer, Department of Community Mental Health and local health services. One of the doctors attended both the Station Personnel Support Committee meetings and the quarterly station health and wellbeing meetings. The SMO liaised with the Alnwick Medical Group in relation to safeguarding matters.

Continuous improvement and innovation

One of the doctors was the lead for quality improvement and a register of quality improvement projects (QIP) was maintained.

The audit register clearly demonstrated that the practice actively engaged with audit activity. Meeting minutes showed the outcome of audits were discussed at the practice meetings. The practice manager was in the process of modifying the audit programme to accommodate the revised DPHC standard operating procedure for audit released in March 2023.

The practice manager organised 6-monthly meetings with the staff team to capture any potential QIPs. Although recorded locally, we noted the QIPs had not been transferred to the DPHC Healthcare Governance webpage to showcase positive performance at the practice and also to enable the sharing of good practice with other DPHC facilities. This oversight was addressed promptly after the inspection.