Warminster Medical Centre

Waterloo Lines, Warminster, Wiltshire, BA12 0DJ

Defence Medical Services inspection

This report describes our judgement of the quality of care at Warminster 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 inspection

We carried out this announced comprehensive inspection on 29 June 2023.

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

The key questions are rated as:

Are services safe? – good?
Are services effective? – good?
Are services caring? – good?
Are services responsive? – good?
Are services well-led? – good?

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 DMS.

At this inspection we found:

Patient feedback about the service was positive. It showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment. Patients told us they received appointments at a time that suited them.

Effective safeguarding arrangements were in place and the practice had introduced a validated screening tool to identify, support and refer patients who disclosed domestic violence and abuse. The practice had good lines of communication with the units and welfare team to ensure the wellbeing of service personnel.

Staff induction and training processes were complete and up-to-date.

Medicines management was good. Consideration needs to be given to ensuring access to the dispensary in accordance with Defence Primary Healthcare guidance. To allow a full and accountable transaction of Patient Group Directives, a review of this process was needed.

There was an effective programme in place to manage patients with long-term conditions. Patients received effective care reflected in the timeliness of access to appointments, reviews, and screening/vaccination data. The care provided for children and families was accessible and effective.

The medical centre had good lines of communication with the unit, welfare team, local NHS, social services, and the Department of Community Mental Health to ensure the wellbeing of service personnel.

All staff knew how to raise and report an incident and were fully supported to do so.

Patients found it easy to make an appointment and urgent and routine appointments were available within a few days.

The medical centre benefitted from a strong and inclusive leadership style, such that staff felt valued and able to contribute to improved ways of working. An inclusive whole-team approach was supported by all staff who worked collaboratively to provide a consistent and sustainable patient-centred service.

The team were committed to delivering the best care through a culture of constant learning and improvement. The medical practice was an approved training practice and had a well-established training ethos.

A programme of quality improvement activity was in place and this was driving improvement in services for patients.

Staff were aware of the requirements of the duty of candour, (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). Examples we reviewed showed the medical centre complied with these requirements.

The governance systems were effective with all relevant information captured to monitor service performance.

The Chief Inspector recommends to the medical centre:

The process for the management of significant events should be reviewed to ensure it includes all events and how lessons learnt are shared and recorded.

Where possible offer patients with a caring responsibility the opportunity to access a healthcare review and to received protective vaccinations, as per DPHC policy.

Ensure that the medical centre strengthens the processes with regard to access arrangements for the dispensary and the storage and allocation of some medicines.

In line with recent DPHC policy, ensure there is a risk assessment in place for the emergency trolley and the medicines within it.

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

Our inspection team

The inspection team was led by a CQC inspector. The team of specialist advisors included a primary care doctor, a practice manager, a senior pharmacist technician (undertaken

remotely), a physiotherapist (also undertaken remotely) and a nurse. In addition, a new nurse specialist advisor shadowed this inspection.

Background to Warminster Medical Centre

Warminster Primary Healthcare Centre (WPHC) is a military medical treatment facility based in Waterloo Lines, Warminster, Wiltshire. WPHC is contained in a stand-alone purpose-built facility which was opened in 2004. It provides primary healthcare services for the entitled population of approaching 1500 patients, of which about 1/3 are civilian dependents resident in the local area. The Primary Care Rehabilitation Facility (PCRF) is co-located and part of the medical centre management structure.

The medical centre has a mixture of uniformed and civilian staff who provide a range of core primary healthcare services, along with rehabilitation and occupational medicine. In addition to the DPHC staff members, a team of medical staff from the resident major military unit, the Royal Dragoon Guards, work alongside permanent staff. At the time of our inspection, the practice had approximately 1059 patients registered, of which approximately 459 were civilians; of the civilian patients, 168 were aged 18 years and under. The practice also supports military personnel working out of area on training courses.

The staff team.

Senior Medical Officer (SMO)	1
Civilian Medical Practitioner	2
Medical Officers	1
Practice manager	1
Nurse	2
Health Care Assistant	1
Exercise Rehabilitation Instructors (ERI)	1
Physiotherapists	3 (part time)
Administrator	3
Combat Medical Technicians* (CMTs)	12

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

Are services safe?

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

Safety systems and processes

The Senior Medical Officer (SMO) was the lead for safeguarding. All staff had received up-to-date safeguarding training at a level appropriate to their role. A safeguarding adult/child policy was held by the medical centre and was reviewed in February 2023. The policy included contact addresses and telephone numbers for the local safeguarding teams, and these were displayed throughout the medical centre in the waiting areas and in the clinical rooms. Any change to the policy was emailed to all staff members for awareness and raised during the monthly practice and healthcare governance meeting which was attended by all staff.

The welfare team within the garrison consisted of 4 welfare representatives for the 4 main units based at Warminster. Welfare meetings were held on a monthly basis and attended by the SMO, welfare lead (Warrant Officer 2) and the Commanding Officer.

Vulnerable patients (VP) were mainly identified during consultation, DMICP (clinical system) searches and on referral from another department such as the welfare team. As VPs were coded on DMICP, a search was performed monthly to identify all patients with the assigned code and the results were then cross-referred against the VP registers held on SharePoint within a limited and restricted area to ensure all patients were identified. The VP caseload was discussed at the monthly vulnerable adults/child meeting which was attended by all doctors, nurses, pharmacy technician and the health visitor. Patients were identified by their DMICP number on the meeting minutes and their DMICP record was updated during the meeting following each review. The SMO attended the monthly Unit Health Committee meeting with the designated welfare team.

Clinicians used HARK, a validated screening tool for domestic violence and abuse (DVA). DVA posters were displayed in most clinical areas.

Due to the delays with ‘low risk’ patients obtaining initial Department of Community Mental Health (DCMH) appointments, the medical centre had adopted a system whereby patients waiting for their treatment to commence with DCMH were individually reviewed each month during the vulnerable adults/child meeting.

Chaperone training was conducted in March 2023 and ad hoc training sessions would be provided throughout the year for new staff members. There were 14 staff members (8 male / 6 female) deemed competent to fulfil the role of a chaperone and all these individuals were in date with their DBS certificates. Lists of trained chaperones were displayed in the waiting area and in each clinical room (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The medical centre staff database contained a list of all members of staff who are required to hold a professional registration. The practice manager was responsible for reviewing this database at the beginning of each month and informed the relevant staff member if

their registration was due for review. On review of the staff database, all personnel were in date with their professional registration. For locum staff, the competency pack was reviewed to ensure all the necessary recruitment checks were in place prior to commencing work. All DBS certificates were checked for compliance and updated onto the staff database. At the time of the visit, all staff were in date with their DBS certificates. All medical centre staff were covered by crown indemnity.

There was an acupuncture risk assessment listed on the risk assessment register, alongside this there was a Standard Operating Procedure (SOP) in place and consent form. Evidence was provided that showed the servicing of equipment within the Primary Care Rehabilitation Facility (PCRF) was in date and was the responsibility of the exercise rehabilitation instructor (ERI).

There was a dedicated lead for infection prevention and control (IPC), and they had completed the IPC link training. Annual IPC audits were undertaken and actions taken as required.

The practice manager monitored the cleanliness standards on a weekly basis and updated a check sheet within the cleaning management folder. A schedule for the cleaning contract was also held within the cleaning management folder. The cleaning management team last conducted a spot check inspection in May 2023 and the report was seen, no observations were raised in the report and no issues had been raised by the practice manager. The cleaning management team conducted ad hoc inspections throughout the year, usually on a quarterly basis. The last deep clean of the medical centre was undertaken in April 2023.

The practice manager was responsible for the management of the healthcare clinical waste, the SOP for this was last reviewed in April 2023. Clinical waste was monitored and emptied if required by the duty medic on a daily basis and all yellow bags containing waste were secured, labelled, and locked away securely in containers as per DPHC policy. The duty medic recorded the number of bags they placed in the clinical waste collection bins on the clinical waste register. On collection the number of bags taken was always cross referenced against the register to ensure accuracy. Clinical waste was collected on a weekly basis by an outside company. There have been no concerns raised over the contract and the company has always collected as scheduled. The last annual healthcare waste audit was conducted in September 2022 and no issues were identified. Consignment notes were emailed directly to the group mailbox and the practice manager was responsible for ensuring the quantity corresponded to the register. Once confirmed, the consignment note was filed in the clinical waste register. The pre-acceptance waste audit was last conducted in April 2023 and no observations were raised.

The medical centre had a good system in place to distribute Medicines and Healthcare Products Regulatory Agency Alerts, we noted that Field Safety Notices (FSNs) had not been recorded, this was put into place following the inspection. Alerts were discussed and minuted in practice meetings.

Risks to patients

There was a good balance of civilian and military staff which afforded continuity of care. Looking forward, the medical centre had already highlighted a risk regarding staffing due to the Regimental Medical Officer post scheduled to be gapped for 1 year which would impact occupational grading reviews. A locum request has been submitted to cover this shortfall and to ensure the medical centre could sustain the additional workload. Within the PCRF the staffing levels were currently good, but this was due to change as the ERI was being posted and there was no replacement planned. This was not on the risk register but following discussion was added on the day.

The PCRF ensured it was safe to conduct physical activity (wet globe bulb test monitoring) and took measures if unsafe, this included looking at clothing, hydration and using other areas to exercise. There was an email sent to the practice manager every morning with the wet globe bulb test reading. If there was any change to this reading then a tannoy message was sent from the front gate to the whole of the garrison.

There was a good skill mix within the nursing team. However, we noted that the senior nurse was the only individual who could give child immunisations, which could lead to delays in vaccination clinics.

All new members of staff were required to complete the DPHC mandated induction programme which had been amended accordingly to include information relevant to the unit and further adapted for physiotherapists and locums.

We reviewed the medicines on the emergency trolley and found they were appropriate and in date. Defibrillators were located in the medical centre and also in the gym. Oxygen was held and was accessible. There was appropriate signage in place.

All staff had completed basic life support, sepsis, anaphylaxis and defibrillator training. Information about sepsis was displayed in various areas of the medical centre. Clinical staff had received training in climatic illness. Some emergency scenario training took place in May simulating a heat injury and collapse at the front door. Due to no doctors or nurses being available, the medics had to respond to the incident which involved transiting the patient to the treatment room, conducting an assessment, and treating the patient.

A process was in place for the management of specimens. All samples sent were logged Any result retuned that was out of range was referred to the duty medical officer.

The reception desk was always covered by a member of staff, and the waiting area could be observed from reception at all times, there were a few ‘blind spots’ identified within the waiting area and a mirror had been positioned to enable full visibility. A business case had been submitted for CCTV to be installed.

Information to deliver safe care and treatment.

The process for scrutinising and summarising records of new patients to the medical centre and conducting the 3 yearly review was managed by the practice manager. A monthly search was conducted and forwarded to the nursing staff to review. A

summarising protocol was in place and was recently reviewed in June, the nurses had allocated protected time on a Friday to conduct summarising.

Peer review of doctors DMICP consultation records was undertaken regularly and a consistent methodology was used. Nurses' and physiotherapists records were also peer reviewed, this took place regularly and outcomes were discussed at meetings.

Every day at 10:30 a short meeting was held between all staff, this was an opportunity to discuss the day ahead and share any information, allowing a smooth running of the day over a coffee. Staff told us they appreciated this time an felt it was beneficial to everyone.

The Business Resilience Plan (BRP) was last reviewed in May 2023. Within the plan there was a section for actions to be carried out in the event of IT outages. The reception staff printed off the next day clinic lists each night in case of a potential outage and as per the BRP, hard copies of consultation paperwork and clinic templates were held in the continuity pack-ups. In the event of an outage the hard copies would be utilised and scanned onto DMICP once the system was serviceable. In the event of an outage each clinic would be reviewed, and non-urgent appointments would be re-scheduled accordingly and only essential/urgent patients only would be seen during this period. Any outage related to DMICP issues was reported accordingly. If DMICP was compromised for several days, the medical centre could provide a telephone consultation service working remotely and if required the SMO could consider the option to relocate to Larkhill Medical Centre to hold clinics. Sister practices such as Tidworth and Bulford could also be called upon for assistance.

The management of referrals was good. The majority of external referrals were made via the NHS electronic referral system (eRS). A referrals tracker with limited access was maintained and 2 week wait and urgent referrals were highlighted so were easily visible. The referrals register was held in a limited access folder on SharePoint and was password protected.

Safe and appropriate use of medicines

The SMO was the lead for medicines management with another doctor the lead for medicines audits. The dispensary was well managed by the pharmacy technician. They were part of the medicines management meetings, the monthly vulnerable adults meeting and the Unit Health Committee meetings, was a good use of their knowledge and expertise. The healthcare assistant was interested in training in some dispensary work, this would help as second checker in the dispensary.

Patient Group Directions (PGDs) had been signed off to allow appropriately trained staff to administer medicines in line with legislation. The PGDs were current, signed off by the authoriser and had been audited in June 2023. We discussed how vaccines, PGDs and Medics Issuing Protocols were accounted for on DMICP and issued onto patients records by nurses/medics. To allow a full and accountable transaction of this, a review of the process was needed.

The PGDs were stored in a cupboard within the treatment room. They were secured and controlled. We noted the storage space was not big enough to meet DPHC medicine

management policy. It was recommended that a Statement of Need was put in place to create a larger secured storage space in the treatment room.

PGDs were issued to the treatment room from the dispensary and controlled by the nursing team. Although this is not incorrect by policy, we discussed the medical centre should consider creating stock locations to allow for auditable transactions in issuing and the ability to run assured stock checks for out-of-date medicines.

Although the access to the dispensary was safe, a review was needed so that only necessary staff had access. The review should include detailed instructions signed by SMO for who can had permission to access and for what purpose.

We saw evidence to show that patients medicines were reviewed regularly. The doctor's notes in DMICP were comprehensive. The pharmacy technician demonstrated good awareness of the requirements for monitoring and was clearly familiar with the patients on the register. They regularly checked when patients needed a review and arranged for these to be done before repeat medications were issued. An antibiotic prescribing audit had been undertaken to assess prescribing and showed positive results.

Arrangements were established for the safe management of controlled drugs (CD), including destruction of unused CDs were in place. An audit had been completed and a plan to audit opiates was in place.

Emergency medicines were easily accessible to staff in a secure area of the medical centre and all staff knew of their location. Medication requiring refrigeration was monitored twice a day to ensure it was stored within the correct temperature range. We saw a piece of equipment called an ISocket this allowed an alert to be sent to regional staff if the power went off.

The emergency crash trolley was checked daily. The trolley did include equipment in line with DPHC policy. However, there was a lot of equipment included on the trolley that was not needed. The paperwork for checking was not clear and had multiple months of checks that had not been removed and archived. The trolley did not have the appropriate risk assessments for core medications as per DPHC policy.

All staff who administered vaccines had received the immunisation training as well as the mandatory anaphylaxis training.

Prescription pads were stored securely. There was a system to track their issue and usage so all prescription numbers could be traced to the prescriber.

Requests for repeat prescriptions were managed in person or by email in line with policy. A process was in place to update DMICP if changes to a patient's medication was made by secondary care or an out-of-hours service. The repeat prescription process was detailed in the medical centre leaflet. A red label was used to remind patients that the maximum number of repeat prescriptions had been issued, this was a good way to communicate to patients and remind them they need to contact a clinician for review before more were issued.

We saw evidence to show that patients' medicines were reviewed regularly and the doctor's notes in DMICP around medication changes were comprehensive. A process was

established for the management of and monitoring of patients prescribed high risk medicines (HRM). The register of HRMs used at the medical centre was held on DMCIP and all doctors and relevant clinicians had access to this. We looked at a sample of patient records and saw that all had been coded or had shared care agreements were in place.

Track record on safety

There was a designated health and safety lead for the practice. Electrical safety checks of the premises had been completed in April 2023 and the report stated that the inspection was unsatisfactory. There was no electrical safety certificate available stating that the facility was safe and due review in 5 years. The practice manager had contacted the contractors to confirm whether the necessary faults had been rectified, however the individual that he needed to speak with was unavailable. The medical centre were trying to gain assurance from the contractors stating that the faults had been rectified. We had clarification following the inspection that was in place and all electrical safety checks had previously been signed off as safe.

Water safety checks were regularly carried out and a full legionella risk assessment was carried out in December 2022. A fire risk assessment of the building was undertaken annually. Firefighting equipment tests were current. Staff were up-to-date with fire safety training and were aware of the evacuation plan.

An active and retired risk register was held on the Healthcare Governance (HcG) Workbook and adopted the 4 Ts approach to risk management. The risk register contained both clinical and non-clinical risks and all risks were reviewed each month by the practice manager and discussed during the monthly practice and Healthcare Governance meeting. All risks were recently reviewed (June 2023).

The medical centre held a lone worker policy which was recently reviewed in March 2023, which stipulated that in the event someone is required to work out of hours, the duty medic or the practice manager would remain in the building to ensure there were always two individuals in the building at all times. The lone worker policy also stated if there is a requirement in the future, a risk assessment is to be raised. The practice manager has completed the necessary courses to conduct risk assessments and all risk assessments were in-date at the time of the inspection.

There were alarms in all rooms with exception of the dispensary (one was going to be ordered). There was a record in place to record that alarm checks had been completed.

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. All incidents reported were logged through the ASER system. The ASER tracker was located within the HcG Workbook. According to the tracker there was only 1 ASER outstanding completion that had been forwarded to Regional Headquarters to investigate further,
this was regarding the receipt of outsourced prescription whereby on receipt of the medication from the pharmacy it had already time expired.

The ASERs were discussed at the practice meeting but there was limited information added to the minutes on what has been discussed or implemented. The medical centre had an ASER log which had basic information on it.

The PCRF staff reported that most ASERs had been added by the medical centre as opposed to adding themselves. No ASERS had been submitted showing good positive work (purple ASERS) despite there being many examples.

The pharmacy technician oversaw the Medicines and Healthcare products Regulatory Agency (MHRA) and the Central Alerting System (CAS) and added them to the alert register which was held within the HcG Workbook. The register included details of actions taken by the medical centre in response to each alert. Alerts pertinent to the medical centre were distributed to all staff and discussed at the monthly Practice and Healthcare Governance meeting. We saw an example whereby an alert was raised for a medicine in May 2023, this was immediately reviewed. The alerts register fully documented that the necessary actions had been undertaken and that the DMICP search showed no patients were identified as being on this medication.

Are services effective?

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

Effective needs assessment, care, and treatment

Clinical staff had a forum to keep up-to-date with national clinical guidance, including National Institute for Health and Care Excellence (NICE) and the Scottish Intercollegiate Guidelines Network (SIGN) guidance. The NICE guidelines were discussed during the doctors meeting every Tuesday and shared with the medical centre during the monthly Practice and Healthcare Governance meeting. At the Practice and Healthcare Governance meeting in April 2023, it was documented that the NICE Update for Primary Care / March 2023 had been discussed.

The Defence Primary Healthcare (DPHC) team produced a newsletter that was circulated to clinicians providing further information and a summary of relevant safety updates. The regional nursing advisor sent out weekly updates that included any new guidelines.

Primary Care Rehabilitation Facility (PCRF) staff were familiar with Department of Defence Rehabilitation Guidance and provided examples of treatment provided based on evidence-based guidelines and care pathways. The PCRF used the MSK-HQ (musculoskeletal health questionnaire) as well as injury specific measures, using individual questionnaires. The MSK-HQ was used via the DMICP template.

The exercise rehabilitation instructor (ERI) made effective use of objective outcome measures when planning and progressing patient care. This was measured at the start of treatment, reviewed every four to six weeks and measured again on completion of rehabilitation. There was clear evidence of using objective markers from best practice guidelines.

A patient document was attached to patients' DMICP notes to record prescribed exercises. It included a Rehab Guru (a comprehensive exercise programme) clinical code that can be used to access full details of the programme.

Clinicians had opportunities to attend regional forums, such as regional governance meetings and nurse development forums. Practice meetings were held jointly with the healthcare governance meeting every month in order to discuss practice issues. Records of these meetings were seen with evidence clearly visible and links of all updates contained within meeting minutes.

Monitoring care and treatment

We found that chronic conditions were managed well. Standard operating procedures (SOPs) outlining the management and monitoring arrangements of long-term conditions were in place.

There were 12 adult patients on the diabetic register and their care indicated positive control of both cholesterol and blood pressure. We looked at the notes of 3 patients with diabetes, they had received eye screening that demonstrated they had retinopathy but two had been incorrectly coded in their records.

There were 30 patients recorded as having high blood pressure. Thirty were recorded as having a blood pressure check in the past 9 months.

There were 32 patients with a diagnosis of asthma and all had an asthma review in the preceding 12 months.

Audiology statistics showed 71% of patients had received an audiometric assessment within the last 2 years.

Through 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 talking therapies, charities and with the Department of Community Mental Health. The medical centre played a key and effective role in safeguarding young and vulnerable patients.

A comprehensive quality improvement programme was in place which had been designed for optimal relevance to the patient population. We saw many audits were in place spanning clinical, administrative, and managerial topics. More than one cycle had been undertaken and in many instances there was evidence of positive outcomes for patients. For example, audits were undertaken in chronic diseases, childhood vaccinations, mental health, referrals, medicines audits and notes audits.

Effective staffing

All staff were required to complete the bespoke Defence Primary Healthcare (DPHC) mandated induction programme which had been amended accordingly to include information relevant to the unit and further adapted for physiotherapists and locums. On completion, the staff database was updated accordingly. On review of the staff database, only one member of staff had not completed the induction programme and was currently unable to due to being deployed on operations. As part of the induction process all new members of staff were assigned a mentor.

The locum induction pack was based upon the DPHC mandated induction programme but had been adapted to include relevant information pertinent to the unit and also included other pertinent DPHC guidance. Links to the tabletop instructions were contained within the induction programme. There were also 2 folders containing hard copies of all the tabletop instructions located in the conference room and the main administration office.

All staff including locums were invited to attend the monthly Practice and Healthcare Governance meeting and other meetings depending on their specific skill set.

The training register was held on the Healthcare Governance (HcG) Workbook with a detailed forecasted programme for all members of staff to attend. The practice manager monitored the staff database and ensured that mandated training courses were included within the training register. Staff were encouraged to actively monitor the staff database to ensure they remain compliant. Mandatory training was also a standing agenda item at the

monthly Practice and Healthcare Governance meeting and staff were informed when courses were due to expire. Staff had protected time to complete their training on allocated Continual Professional Development (CPD) days and following the mandated meetings.

All staff received mid-term and annual appraisals which provided assurances on their performance and guidance on any areas for development as well as potential CPD opportunities. The SMO was responsible for the management of the appraisal spreadsheet and on review, all military and civilian staff were in date with the mid-term and annual appraisals. The medical centre provided opportunities for staff to conduct CPD activities 1-2 times a month. CPD for the doctors was also undertaken during the weekly doctor meetings where they discussed topics such as NICE guidelines. During and following clinics, there was also clinical and managerial supervision in place for medics to discuss cases, have time for reflection and receive mentorship. We saw peer reviews had been undertaken by the doctors in March 2023 and the nurses in May 2023.

Staff had access to role specific training, for example, the practice manager had completed the practice managers course and had completed health & safety courses to enable him to undertake risk management and complete risk assessments. All staff were regularly informed by the Regional Headquarters that they could apply for funding for external courses.

Coordinating care and treatment

The medical centre staff met with welfare teams and line managers to discuss vulnerable patients. Staff told us that they had forged some good links with other stakeholders, including the local NHS, social services, and voluntary organisations. The nurses had regular, arranged telephone calls with the health visitor on the first and last Friday of every month.

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 and electronic notes were sent to the NHS practice. If the patient was deemed vulnerable, the medical centre staff worked with them and the welfare department to help them register and access the NHS services they needed.

Patients who were considered vulnerable were discussed at least monthly in multi-disciplinary meetings. Monthly vulnerable adult searches were cross checked with the vulnerable adults register to highlight any patients who had deregistered with the medical centre to identify any who might have been missed.

Referrals from the PCRF were sent to Regional Rehabilitation Unit (RRU) or local NHS as required. Waiting times for rehabilitation courses at the RRU was 50 working days. The average wait for multi-disciplinary injury assessment clinic was 26 working days.

Helping patients to live healthier lives.

One of the nurses was the lead for health promotion. We saw information leaflets were available in the treatment rooms. There was a good amount of information leaflets

available for patients, examples of topics covered included pregnancy screening, vaping, sepsis, smoking, alcohol, cervical screening and breast cancer. There was also a large display board in the waiting area showing what travel vaccinations were required for each country and information on each disease.

There were Quick reference (QR) codes displayed in the waiting room that gave patients a direct link into some NHS initiatives, for example Couch to 5K, weight loss and Active 10'.

There was a unit health fair arranged for the following week, and the medical centre were attending. Weight management had been found to be of higher instance within the community so weight management clinics were being offered, one of the nurses was trained in treating/managing obesity.

A doctor and nurse had the appropriate sexual health training and provided sexual health support and advice. There was sexual health information available throughout the practice, including chlamydia self-testing in the toilets and condoms were available. Patients were signposted to local sexual health services for procedures not undertaken at the medical centre.

There was a lead doctor who specialised in women's health. Clinics were run every week and covered all aspects of women's health including contraception, pre- and post-natal care and the menopause. The physiotherapist liaised closely with the doctor and together they put together care plans for the patient.

The PCRF had put together a comprehensive patient information leaflet for patients to refer to and this included what services the PCRF offered and how to access the service.

All eligible female patients are on the national cervical screening database and were recalled by the nurse. The latest data confirmed an 89% uptake, 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. Alerts were added to their DMICP record which allowed for opportunistic discussion with a health professional. DMICP searches had been created for all national screening.

An effective process was in place to recall patients for their vaccinations. Vaccination statistics were identified as follows:

91% of patients were in-date for vaccination against diphtheria.

91% of patients were in-date for vaccination against polio.

96% of patients were in-date for vaccination against hepatitis B.

97% of patients were in-date for vaccination against hepatitis A.

91% of patients were in-date for vaccination against tetanus.

99% of patients were in-date for vaccination against MMR.

99% of patients were in-date for vaccination against meningitis.

Child Immunisation

The percentage of children aged 1 who had 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/Hepatitis B) was. 100%.

The percentage of children aged 2 who had received their booster immunisation. for Pneumococcal infection (i.e., received Pneumococcal booster) (PCV booster) was 93%.

Consent to care and treatment

Staff had a good understanding of the Mental Capacity Act (2005) and how it would apply to the patient population, all staff had received training in the Mental Capacity Act.

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. Clinicians advised us that implied consent was accepted for basic procedures such as the taking of blood pressure. Written consent was taken for more intimate examinations and this was regularly audited with the last being 4 weeks ago, showing 100% compliance.

Are services caring?

We rated the medical centre as good providing caring services.

Kindness, respect, and compassion

In advance of the inspection, patient feedback cards were sent to the medical centre. A total of 17 patients responded and feedback was positive about the care and kindness shown. One example was of a patient who needed some help competing a particular form, a member of staff spent 2 hours helping them to fill it out then post it for them. We also observed staff being courteous and respectful to patients in person and on the telephone.

We received feedback from 10 patients who had received care from the Primary Care Rehabilitation facility (PCRF), feedback was 100% positive with comments made about the exemplary care they had received from the physiotherapists and from the exercise rehabilitation instructor.

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. We spoke with one member of the welfare service, who spoke highly of the responsiveness of all the team when help was needed. They described the service as ‘awesome’.

Involvement in decisions about care and treatment

The clinicians and staff at the medical centre recognised that the personnel receiving care and treatment could be making health care decisions that could have a major impact on their military career. Staff demonstrated how they gauged the level of understanding of patients, gave clear explanations of diagnoses and treatment, and encouraged and empowered patients to make decisions based on evidence-based guidance and clinical facts.

Patients identified with a caring responsibility were captured on a DMICP register. We searched the system and found there were 6 patients identified with caring responsibilities, of these 4 had not been coded as having a review or been offered a flu vaccination as per DPHC policy. Following the inspection this was followed up and actions made to address this. There was a practice leaflet which included information for carers and extensive information in the waiting area which included details of outside agencies.

Staff explained that they occasionally saw patients who spoke English as a second language. They could access a translation service if they needed it and information about this was available in the waiting room. Practice leaflets were also available in different languages and these were made available through a quick access code also in the waiting area.

Privacy and dignity

Consultations took place in clinic rooms with the door closed. Patients were offered a private area if they wanted to discuss something in private or appeared distressed. The waiting area was away from the reception desk so conversations could not be overheard and there was a television on to mask any conversations held at the reception desk.

All staff had completed the Defence Information Management Passport training which incorporated the Caldicott principles.

The mix of male and female staff allowed the medical centre to facilitate patients who wished to see a doctor or nurse of a specific gender. Currently only female physiotherapists were available, initially a chaperone of the specific sex would be offered, if this was not acceptable, they would utilise another PCRF within the region, for example Larkhill.

Are services responsive to people's needs?

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

Responding to and meeting people's needs

Patients were offered a range of bespoke services to support the population group. Examples included diving medicals, family planning, childhood immunisation clinics and women's health clinics.

The practice manager was the lead for diversity and inclusion. There was good communication with the garrison leads and nominated leads within the medical centre. An Equality Access Audit as defined in the Equality Act 2010 was completed for individual sites within the past year. Any points identified were discussed and put onto the risk register. There was information and contact details for patients in the main waiting area and throughout the medical centre.

There was a designated Diversity and Inclusion lead within the Regional Headquarters if any member of staff wished to approach someone from outside of the facility. On review of the staff database, all personnel had completed the relevant courses and an operational inclusion advisor was also scheduled to deliver further training in July for the medical centre.

A policy was in place to guide staff in exploring the care pathway for patients transitioning gender. Despite the policy for 'Medical Administration of Transgender Patients within DPHC' currently still in draft format, the medical centre had been proactive in developing their own 'Transgender guidance for Warminster' policy. Their policy was reviewed in March 2023. The medical centre had also activity engaged with the 'Pride in Practice' programme which worked with GP practices to ensure that all lesbian, gay, bisexual and transgender people had access to inclusive healthcare that understood and met their needs. The Pride in Practice team were scheduled to visit the medical centre in August.

Timely access to care and treatment

Details of how patients could access the doctor when the medical centre was closed were available through the garrison helpline. Details of the NHS 111 out of hours service was outlined in the practice information leaflet. Shoulder cover was provided on a duty rota by the region until 18:30 hours, then patients were directed to the NHS 111 service.

There was good availability of appointments for all clinicians. Urgent doctor and nurse appointments were available on the day. Routine doctor appointments were available within 4 working days. Routine appointments to see a nurse were available the next day. Text messaging was used to remind patients of their appointments.

The Primary Care Rehabilitation Facility (PCRF) offered direct access to appointments. A new patient or routine physiotherapy appointment was available within 14 working days. There was capacity to see patients urgently on the same day if required. Appointments to

see the exercise rehabilitation instructor (ERI) or a new or routine appointment were available within 3 days. There was no waiting list for rehabilitation classes. Originally patients did not know they could self-refer and this was identified via feedback, as a result the referral process was added to the PCRF information leaflet and this was now being handed out to patients in the medical centre.

The medical centre provided a daily medic led sick parade and the nurses performed a triage clinic every day. Following a review of their clinics and mandated outputs it was identified that there was a low attendance for the woman's health clinics. Whilst identifying the cause, a decision was made to move the clinic to another day which resulted in an improvement in attendance and overall statistics. eConsult and telephone consultations were provided by the medical centre which captures individuals struggling to attend the medical centre for appointments.

Listening and learning from concerns and complaints

The practice manager was the lead who handled all complaints in the practice. The practice had implemented a process to manage complaints in accordance with the Defence Primary Healthcare complaints policy and procedure, no complaints had been recorded within the past 12 months.

Information was available to help patients understand the complaints system, including in the patient information leaflet and a complaints leaflet. Alongside these there was also a book in the waiting room that people could use to write any concerns or compliments, each one had been addressed and answered by the practice manager.

Are services well-led?

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

Vision and strategy

Staff we spoke with were clear that their remit was to support patients to benefit from the best possible healthcare outcomes which, in turn, supported operational capability.

The medical centre worked to Defence Primary Healthcare's (DPHC) mission statement. 'To provide safe and effective healthcare, which meets the needs of our patients and the chain of command, to support force generation and sustain the physical and moral components of Fighting Power.'

In addition, the team had also created their own vision statement:

'Working together to improve the physical health and mental wellbeing of our patients and supported units through a high quality of primary care services throughout Warminster Garrison'.

Leadership, capacity, and capability

The balance of civilian and military clinical input provided continuity for patients. The practice had a strong leadership strategy and vision that all staff championed. There was adequate management capacity, skill and experience within the medical centre to cover any shortfalls. The medical centre had civilian employed staff who were experienced ex-military personnel previously employed in DPHC managerial roles. Therefore, in the event of military personnel being absent there was enough managerial capacity to ensure business continuity.

The team were committed to delivering the best care through a culture of constant learning and improvement. The medical practice was an approved training practice and had a well-established training ethos. It supported learners in a variety of trade groups including doctors, nurses and medics/paramedics which ensured teaching and learning was always a high priority.

The medical centre had a practice development plan held within the Healthcare Governance Workbook which was based on the 5 domains of the Health Assurance Framework (HAF). Following a full review of the HAF prior to the CQC inspection, all outstanding actions relevant to driving the medical centre forward and improving the overall standard of healthcare provided were added to the practice development plan and the HAF actions spreadsheet within the workbook, these were reviewed by the practice manager each month.

Every day at 10:30 a meeting was held between all heads of departments, this was an opportunity to discuss the day ahead and share any information, allowing a smooth running of the day. On Wednesday afternoons the medical centre was closed, and this time was used for practice meetings and in-service training. This protected time allowed

for training within specialties, all staff we spoke with had a positive attitude towards learning.

Culture

A responsive and patient-centred focus was clearly evident with this ethos embedded in practice. Staff continually looked at ways to improve the service for patients.

All staff described an approachable and supportive leadership team that was committed to ensuring cohesion, equality, and inclusion. It was clear from discussions with staff that their contributions to the development of the service were valued. All staff attended the practice meetings where they could put forward suggestions or raise concerns.

Staff knew how to access a Freedom to Speak Up Guardian, they told us the culture was inclusive with an open-door policy with everyone having an equal voice, regardless of rank or grade. All were familiar with the whistleblowing policy and said they would feel comfortable raising any concerns. We interviewed a cross section of staff, and all told us that it was a happy place to work and that they could rely on their work team to discuss and mitigate any concerns they faced. They spoke about colleagues who were supportive, compassionate, and caring.

It was evident that the Regional Headquarters were highly thought of, supportive and held in high regard. Whilst the medical centre were implementing the HAF, the regional governance lead provided training and assistance for the entire medical centre. This ensured the framework to be effectively utilised to ensure governance compliancy and highlight any observations to continue to drive the medical centre forward.

The medical centre were fully aware who to contact if they are encountering any concerns and if there are any issues out of hours there is also a duty regional officer who is contactable by phone. The regional team had all visited the medical centre recently and the area manager visits on a monthly basis.

The practice manager said they felt respected, supported and valued within the medical centre. When they were new in post, the practice manager distributed a climate survey within the medical centre to obtain an understanding of the staff experiences and perception of equality, diversity and inclusion within the medical centre. The overall results of the survey were good and enabled the team to address any shortfalls raised.

The monthly meetings demonstrated an inclusive culture, whereby all medical centre staff attend and have the opportunity to raise any concerns or issues within their department. ‘Thank you’ and ‘In year’ bonuses were available for all civilian staff. Staff reported there is a no-blame culture, events such as complaints/ASERs/feedback were discussed at the monthly meetings and seen as an opportunity to learn and make quality improvements.

The medical centre have social functions throughout the calendar year and often arranged food tasting afternoons for the whole team.

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

Communication across the practice was strong and an appropriate meeting structure and healthcare governance approach was in place. This included regular clinical, practice, healthcare governance and unit healthcare committee meetings, safeguarding and Primary Care Rehabilitation Facility (PCRF) meetings. The PCRF was operating as a fully integrated part of the medical centre team.

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. Staff had lead/deputy roles and responsibilities with some having multiple associated duties due to their particular expertise and skill sets.

The medical centre had worked hard to create and maintain the Healthcare Governance (HcG) Workbook so that it was easy to use for all staff. The workbook contained a Standard Operating Procedures (SOP) spreadsheet that had linked to all the various policies and SOPs used by the medical centre and these were regularly reviewed. New updates from DPHC were discussed at the monthly meetings and incorporated into the workbook as required. Any new updates to policies were distributed via email to all staff to ensure information has been shared throughout the team.

The senior nurse was the nominated audit lead for the medical centre and the practice manager was the designated deputy. The medical centre had adopted the revised DPHC audit cycle and all mandated audits for January to March had been completed and there was only the ASER analysis audit that needed to be completed for April to June.

On review of the QIP register it was noted that there had been 9 raised in 2023 (7 medical centre and 2 PCRF). However, on review of the QIP register both QIPs had been submitted by the PCRF, but no QIPs had been raised by the medical centre. As per DPHC guidelines, all QIPs were to be registered centrally for analysis, to enable DPHC to share good practice with other facilities. The practice manager agreed to act on this promptly.

Managing risks, issues and performance

There was a current and retired risk register on the workbook along with current and retired issues. The register articulated some of the main risks identified by the practice team but some key issues were not included such as staffing in the PCRF. The registers were regularly reviewed. There were risk assessments in place including both clinical and non-clinical risks. An issue log and retired issue log was held within the workbook and reviewed by the practice manager on a monthly basis. Issues were a standing agenda item at the monthly Practice and Healthcare Governance meeting. According to the issue register there were 2 ongoing issue as follows:

- Submitted business case for the flooring in 2 x consultation rooms to be changed to laminate flooring.

- Staffing issues - the Regimental Medical Officer post for the Royal Dragoon Guards being gapped for 1 year.

Both of these issues were also recorded on the risk register.

Staff who were not performing would be supported initially to identify any underlying cause and implement support structures. If performance did not improve then formal performance management processes, military or civilian, would be followed.

All staff were in date for ‘defence information passport’ and ‘data security awareness’ training. When a member of staff left, smart cards were returned to the guard room and they were removed from having access.

The business continuity plan (BCP) had been reviewed and was exercised to ensure that staff knew what to do in an emergency. The BCP covered all the main risks to the service. The practice had a major incident plan which supported all units and had been agreed by unit commanders. The Communicable Disease Outbreak Management Plan for the medical centre was reviewed in April 2023.

Appropriate and accurate information

The eHAF commonly used in DPHC services to monitor performance is an internal quality assurance governance assurance tool to assure standards of health care delivery within defence healthcare. The entire eHAF was recently reviewed utilising all subject matter experts within the medical centre. On completion of the review, the actions raised were transferred onto the workbook, were reviewed each month and discussed during the Practice and Healthcare Governance meeting.

National quality and operational information were used to ensure and improve performance.

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

Options were in place for patients to leave feedback about the service including information in the practice leaflet. All feedback was collated and discussed at the practice meetings every month. Patient questionnaires were continually distributed by the medical centre and patients could fill these in via quick Reference (QR) codes or paper copies. The medical centre provided feedback to patients via the ‘You said, We Did’’ board held in the reception area which included patient’s comments. The medical centre held a patient participation group twice a year. Prior to the scheduled meetings the practice manager asked for volunteers to attend via the practice newsletter.

Patients were also able to provide feedback by filling in slips in the waiting area and posting them in the suggestion box. The practice manager checked these on a monthly

basis and discussed them during the scheduled Practice and Healthcare Governance meeting. All staff were aware they could provide feedback on the service via a staff suggestion box located in the staff room.

The medical centre has a good working relationship with the liaison officer from the Salisbury NHS Foundation Trust and received updates via emails regarding the local hospitals, invites to various meetings for all specialities and training opportunities.

Continuous improvement and innovation

There was much evidence of continuous improvement in the medical centre.

The medical centre held a practice development plan within the workbook with recommendations and projects on how they want to drive the business forward by promoting continuous improvement and innovation. Areas for further development included LGBT working group, improving quality improvement projects and enhancing the training program. Two noticeable improvements within the practice development plan were the significant increase in patient questionnaires responses and introduction of the thank you bonuses and ‘in year’ award scheme to reward staff performing above and beyond their roles.

The PCRF had several initiatives in place, including the development of quality improvement in women’s health integrated with the medical centre.

The PCRF offered Pilates classes to complement patient’s treatment plans.

The ERI had developed some booklets in order to monitor and improve compliance with patient programmes.