Care Quality Commission

Valley Medical Centre

The Rimon Than Healthcare Facility, RAF Valley, Holyhead, Anglesey, LL65 3NY

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 20 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:

The practice had particularly good access to dermatology services. The Senior Medical Officer had a specialist interest in dermatology and regularly facilitated dermatology clinics in secondary care. The practice had built upon this and, through established links with the local dermatology department, had access to consultant-led advice so could expedite patient appointments as a result.

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.

- 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.
- There were gaps in the governance arrangements for the management of medicines. The practice had identified this and were taking action to ensure improvements were made.
- Although clinical coding was not always consistent, clinical record keeping was of a high standard.
- 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 service delivery and patient care.
- The leadership team was pro-active with addressing issues that could impact the positive team dynamics.

The Chief Inspector recommends to the practice:

- The governance systems to maximise the safety of how medicines are managed should be reviewed to ensure adherence with organisational policy. A further regional-led review of the management of medicines should be undertaken to ensure the required improvements have been made.
- Reduce the large quantity of emergency medicines held at the practice.
- Ensure regular supervision is provided for the non-medical prescriber.
- Review the use of clinical coding (Read codes) to ensure consistency with coding, both with the application of coding and range of codes used by clinicians.

Dr Sean O’Kelly BSc MB ChB MSc DCH FRCA

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

Our inspection team

The inspection was led by a CQC inspector and a team of specialist advisors, including a primary care doctor, practice nurse, pharmacist and practice manager. A physiotherapist specialist advisor was not available so the Primary Care Rehabilitation Facility (PCRF) was not included in this inspection.

Background to Valley Medical Centre

Co-located with the dental centre, Valley Medical Centre provides primary care, occupational health and a rehabilitation service to patient population of approximately 565 comprising 335 service personnel, 222 dependents and 8 patients receiving occupational health only. The population includes a large cohort of Phase 2 training students. In addition to primary care, physiotherapy/rehabilitation and occupational health is provided. The practice facilitates emergency medical cover for all air operations at RAF Valley and a nearby airfield (RAF Mona).

The practice is open Monday to Friday 08:00 to 18:30 hours. NHS 111 is accessible to patients out-of-hours, including weekends and public holidays

The staff team

Doctors	Civilian Medical Practitioner – acting SMO (covering for the SMO on long term leave) Deputy SMO - deployed Locum GP
Practice management	Practice manager – military Deputy practice manager – military (currently on extended leave)
Nurse	Band 7 – civilian Military nurse – post vacant
Receptionist	Post vacant
PCRF	Two physiotherapists (job share) – civilian Exercise rehabilitation instructor – military
Medics	Seven

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 and terms of reference were in place to support these roles. All staff had completed safeguarding training at a level appropriate to their role. Local safeguarding polices were in place, including for child/adult safeguarding and domestic abuse. Contact details for local safeguarding services were available in all consulting rooms. If appropriate, staff attended the local NHS safeguarding meetings.

The safeguarding/vulnerable patient register was held on DMICP (electronic patient record system) and managed by SMO and practice nurse. Vulnerable patients were identified when first registering at the practice, during consultations, DMICP searches and through referrals from other units, such as the welfare team. In addition, welfare meetings were held each month, attended by the SMO, the Padre and a representative from SSAFA (Armed Forces charity).

We reviewed several DMICP patient records and noted that relevant alerts and 'vulnerable adult' clinical coding had not been added to some records. In addition, a record of vulnerable patients discussed at clinical meetings had not been added to the patients' DMICP record. Promptly after the inspection, the SMO reviewed the records and confirmed coding and alerts had since been added. Vulnerable patients were discussed at the clinical meeting and a summary of the discussion along with the patient's DMICP number was recorded in the meeting minutes. If any change was made to the plan of care, then an entry was made in the patient's record.

Practice staff had links with both internal and external teams to support patients who were vulnerable or where there was a safeguarding concern. We were given an example of when a potentially vulnerable patient was discussed with the local safeguarding service including the action taken and subsequent follow up.

Chaperone information was clearly displayed in all patient areas. The practice nurse facilitated update chaperone training for the team in June 2023. A list of trained personnel was in place. A chaperone audit had been undertaken.

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 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. All IPC audits were uploaded to SharePoint and the latest audit was completed within the last 6 months. The audit showed compliance in all areas with a small number of actions. The practice nurse reviewed and updated the action log each month. As there was no sluice, the practice had

a designated room for samples. Fluid absorbent granules were used to solidify urine samples and they were disposed of correctly.

A contract and schedule was in place for environmental cleaning. Cleaning took place twice a day, in the morning and at lunchtime. The practice nurse and practice manager carried out weekly spot checks of the cleaning standards. Annual deep cleans were undertaken with the last one in December 2022.

An equipment cleaning sign off sheet was in place for clinicians to confirm they had cleaned equipment in their clinical area. The IPC audit indicated not all clinicians were consistently doing so and this had been raised at practice meetings.

A lead was identified 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. The annual clinical waste audit was completed in August 2022.

Risks to patients

Despite gaps, staff indicated the staffing levels were sufficient to meet the needs of the patient population. The Senior Medical Officer (SMO) was on long term leave. The deputy SMO (DSMO) was deployed and cover was being provided by an experienced locum familiar with the service. The Civilian Medical Practitioner was acting in the role of SMO. The doctors interviewed felt the workload was manageable and they had sufficient administration time to complete any necessary work. The SMO described little difficulty covering periods of staff absence. The military nurse post was vacant and, in the planned absence of the civilian nurse, both medics and doctors could cover the work. Planned staff absence enabled clinics to be modified to meet urgent and routine demand, and continued requests for routine medical examinations. The practice had a close working relationship with Cosford and Shawbury medical centres with staff cover sometimes being provided between the services.

The staffing levels were predicted to improve as the deputy practice manager and DSMO were due to return in July 2023. In addition, a locum healthcare assistant was due to start and an administrator had been recruited.

The practice has an extensive locum induction pack in place. Locum staff on the day were aware of safeguarding procedures within the practice and provided evidence of appropriate training. In addition, locum staff were included in the team and attended both practice and clinical meetings when safeguarding concerns were discussed.

The medical emergency trolley was secured with a serialised tag and there was a log for access to the trolley. All staff knew where the emergency medicines were located and records showed medicines in the emergency trolley had been checked monthly. A stock check of the trolley and kits found all medicines and medical consumables were in date. A blood glucose monitor was held on the trolley. The oxygen cylinder was full and in date. Records showed that the ambient temperature was being monitored in accordance with the Defence Primary Healthcare (DPHC) standard operating procedure (SOP) for temperature monitoring.

We identified that an unnecessary quantity of emergency medicines was held in the dispensary. There was no clear explanation provided for this excessive stock. After the inspection, we were informed the regional pharmacist had a plan in process to distribute additional quantities of emergency medicines to other medical centres within the region but this could not be confirmed.

Despite asking various staff during the inspection, we were not provided with evidence to demonstrate that an emergency medicines risk assessment had been completed in accordance with the DPHC SOP. After the inspection, we received the risk assessment which had been signed off by the SMO in April 2023 and sent to the regional pharmacist.

The staff team was up-to-date with training in emergency procedures, including basic life support, anaphylaxis and the use of an automated external defibrillator. Records showed all staff had completed the heat injury prevention mandated training and the attended DPHC non-freezing cold injury training in December 2022. A sepsis training session was held for the team in June 2023 that included the National Early Warning Score 2 (referred to as NEWS2). Sepsis information was displayed on staff notice board and in patient area and clinical rooms.

Comprehensive in-service (trade) training covered emergency topics including ejection seat, crash response and spinal injuries. An annual station crash exercise was conducted with civilian emergency services with the last live exercise held in May 2023. The doctors had previously completed Battlefield Advanced Trauma Life Support (referred to as BATLS) and the Military Pre-hospital emergency Care course (referred to as MPHEC). Two of the medics were in date for BATLS. The practice nurse was trained in intermediate life support and had applied for the paediatric immediate life support course.

Information to deliver safe care and treatment

Staff described how previously MODNET across the station was insufficient resulting in the late running of clinics and impacting the completion of administrative tasks. Since the practice received Wi-Fi routers MODNET access had improved. In the event of an 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. The appointment list was printed out by reception each evening in case of an outage.

The summarising of service personnel health records was coordinated by the practice nurse. Medics tasked the nurse to notify of new patients arriving at the unit. In addition, the nurse summarised existing patients' records every 3 years in line with DPHC Guidance Note 02. Medics managed the records for families registered at the practice. A first cycle summarising audit completed in June 2023 identified a backlog of summarising family records with 26 outstanding. The practice had worked hard to reduce the back log and just 9 records were awaiting summarising at the time of the inspection. We were advised there was a backlog/delay in receiving families records. Although it was evident summarising was taking place, 2 members of the inspection team reviewed summarisation resulting in different outputs. This was likely related to the use of different clinical codes to confirm summarisation had taken place.

Arrangements were in place for the auditing of doctors' record keeping. Evidence was provided of regular peer-to-peer review of doctor's notes performed at approximately 6 monthly intervals and submitted for the purpose of appraisal. The practice nurse's record keeping had been audited in June 2023. In the absence of another nurse at the practice, the practice nurse planned to link with the nurses at Chester Medical Centre for peer review. We reviewed a wide range of DMICP records and found record keeping was of a good standard.

A comprehensive system was in place to manage both internal and external referrals, including colour coding to indicate the status of each referral. Referrals were checked each week. We reviewed a range of patient records and they showed referrals were appropriately actioned and followed up, including urgent 2-week wait referrals. Evidence was in place indicating the practice had also pursued other means to access fast track access to secondary care for patients.

Supported by an SOP, a process was established for the management of samples, including a pathology specimen log, use of internal tasking to recall patients. All samples were recorded in the log prior to being sent to laboratory. Results were received electronically and checked by the nurse against the log. The duty doctor reviewed the global box on a daily basis and actioned anything urgent or for doctors who were absent. Otherwise, results were left for requesting doctor to review. Results not received within a week were followed up. On the day of the inspection, there were no outstanding pathology specimens unchecked.

Safe and appropriate use of medicines

The Senior Medical Officer (SMO) was the lead for medicines management and the medical account holder. Terms of reference (TOR) were in place for this role. For clarity, the SMOs TOR should outline which member of staff the dispensary activities are delegated to.

Safe processes were in place for the issuing of prescriptions as they were issued by serial number. Prescriptions (FMed296) were stored securely in the dispensary. Rather than the required bound book with page numbers, prescriptions were accounted for on loose sheets of paper. We identified unopened boxes of FMed296 forms that were not recorded on the FMed296 log as required. For the supply of FMed296 prescriptions, the log should detail the signature/name of the person the FMed296 was issued to, date of supply, quantity supplied, running total, signature or initials of persons issuing the FMed296.

Feedback from patients suggested there was confusion about the process for repeat prescription as requests were being made by telephone, email and in person. As a result of this feedback, the practice changed to an email request system and patients were satisfied with this initiative. From our discussions with staff and review of patient records it was evident that the repeat prescription SOP was being followed correctly. A spot check of the dispensed repeat prescriptions demonstrated that all repeat prescriptions had been dispensed within 8 weeks indicating that patients were effectively informed when their prescriptions were ready for collection. The process for issuing prescriptions to patients was discussed, witnessed and was in-line with the DPHC SOP on handing out a prescription.

The practice nurse used Patient Group Directions (PGD) so they could administer medicines in line with legislation. The PGDs had been authorised by the SMO. The nurse was in-date for PGD training and had access to the published Defence Medical Services PGDs on SharePoint. The authorisation for administration of the yellow fever vaccine was out-of-date and was rectified on the day. A review of DMICP consultations confirmed the PGD template was being used in line with policy. A spot check of the PGD over-labelled medicines identified all medicines were in-date and correctly accounted for on DMICP. A PGD audit was completed in April 2023. Full compliance with the standards was achieved.

The practice nurse was a non-medical prescriber (NMP) and had been authorised to prescribe by DPHC HQ. Their NMP status was in-date. The practice nurse had completed multiple clinical courses to expand prescribing competency and maintain clinical currency.

Our review of 3 of the NMPs diabetic consultations showed comprehensive documentation and efficient follow up based on abnormal blood results. Through discussion, it was evident the NMP was confident to refer patients outside their scope of practice. We identified that there was no formal clinical supervisor/mentorship in place to support the NMP.

Although a local working policy detailing the management of prescribing requests from other services was not in place, a process was established for the management of information about changes to a patient’s medicines. Staff confirmed that any notification of changes to a patient's medicines from other services such as out-of-hours, hospital discharge letters and out-patient appointments were scanned onto the patient’s notes and the nominated doctor tasked to action or review the patient. If notifications or changes were urgent, the patient was given an appointment to see a doctor for a medical review.

It was evident that the high risk medicines (HRM) register supported the safe and comprehensive management of patients prescribed these medicines. Appropriate HRM and shared care alerts were in place for the 3 patient records we reviewed. The records also showed timely blood monitoring had been undertaken. DMICP searches were regularly run to identify new patients prescribed an HRM. The last search was completed in June 2023. An HRM audit was completed in March 2023 and discussed at the clinical meeting.

Controlled and accountable drugs (potentially addictive and harmful medicines subject to regulation) were kept in the dispensary in a controlled drug (CD) cabinet. The CD keys were kept separate from the dispensary keys. Although out-of-date, a local working policy for access to the CD cupboard was in place. A log for entry into the CD cupboard was maintained. We undertook a spot check of the physical stock and it was in accordance with the documentation/register (BMed12). Documentation in the BMed12 was clear and legible and in accordance with policy. The specimen signature log in the BMed12 had been completed accurately by all practice staff involved in the accounting of CDs and accountable drugs (AD). The WP10 (prescription forms used to prescribe CDs) were being accounted for and held in a hardback bound book as required.

Internal monthly CD checks had been completed but the checks for November 2022, December 2022 and February 2023 had not been undertaken in accordance with organisational policy. Quarterly external CD checks had been completed, but there was a period from August 2022 to March 2023 whereby no external CD checks had been conducted. An annual CD audit had been completed and an action plan developed. A spot check of destruction certificates found all CDs and ADs destroyed had been documented

in the BMed12 and the destruction certificates had been completed in accordance with policy.

The practice procured the CD, Fentanyl (strong painkiller), for the Mountain Rescue Service. In accordance with the DPHC SOP for the supply of medicines to the Mountain Rescue Service, we were not provided with evidence during the inspection that a receipt for Fentanyl (FMed573) and issue voucher had been obtained. After the inspection, we were sent the receipt. The practice acknowledged that no issue voucher had been generated.

All vaccines were in date and evidence the vaccines were being correctly rotated in the pharmaceutical fridge. There was sufficient space around the vaccine packages for air to circulate. No food or specimens were held in the pharmacy fridges. Twice daily monitoring of the fridges took place and the external thermometers were in date.

Stock was not safely accounted for on DMICP. A stock check of 3 vaccines showed errors in the accounting of all. One vaccine that arrived on 13 June 2023 had not been added to DMICP. It had been in the fridge for 5 working days.

Transaction reports showed vaccine stock was periodically being stock adjusted down with justifications stating, 'issued to the treatment room'. All vaccines administered to patients via PGDs should be added to the dispensing queue and stock adjusted down individually so that the vaccine batch number and expiry can be linked to the DMICP record. In the event of a vaccine recall, a DMICP search can be run to identify the patients affected. In addition, the management of time expired medicines, including vaccines, was not effective as time expired medicines were being missed.

Valproate (medicine to treat epilepsy and bipolar disorder) searches were undertaken to check if women of childbearing age were prescribed this medicine. The search in June 2023 identified that no patients were prescribed valproate.

A comprehensive antibiotic audit and a CD audit had been completed. The audits had been discussed with the clinical team for shared learning purposes.

A regional-led review of medicines management was undertaken in May 2023. We reviewed the report from the visit and it did not identify the deficits we found with how medicines were managed. Despite this, leaders of the practice had recognised that governance processes for managing medicines were not being followed. The actions taken included raising a significant event in relation to the CDs (June 2023), staff re-training and enhanced monitoring of how medicines were being managed. Since the inspection, the practice manager confirmed that a more senior member of staff had taken over responsibilities for the governance of medicines.

Track record on safety

The practice manager was the designated lead for risk management and the risk register. A log 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. Risk was a standing agenda item for discussion at the practice meetings. Any change/updates to the register, assessments or

underpinning policies were shared with staff at the practice meeting. COSHH products were stored appropriately.

Arrangements were in place to ensure the risk of fire was minimised, including a dedicated fire representative, fire risk assessment and fire orders for the building. Firefighting equipment was regularly checked. Staff advised us that 6-monthly fire drills were conducted.

Evidence was in place to confirm water safety checks were regularly undertaken, including a legionella risk assessment in April 2023. An annual gas check was undertaken in July 2022 and the 5-yearly electrical safety check in May 2919.

A lead for equipment care was identified. An equipment assessment (referred to as a LEA) had been completed and a management action plan developed. Testing of portable appliances was in-date. It was the responsibility of each clinician to check the equipment in their clinical room. The lead identified this was not consistently happening and had been identified on the last LEA. Staff had been reminded at the practice meeting of the requirement to regularly check equipment. Equipment in the ambulances was checked daily.

The building was fitted with an integrated alarm system, which was tested weekly. In addition, each clinical room had a handheld panic alarm. Patients in the waiting area could be observed by reception.

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 meetings. All significant events were discussed at the meeting with lessons learnt and shared with the team before the ASER was closed off.

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 action taken and improvements made following the outcome of an investigation. In response to a sentinel event, the practice recalled a cohort of patients to discuss individually with each patient their treatment and future monitoring.

There were effective processes in places for the management and action of alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) and from the Central Alerting System. Evidence was seen of an in-date electronic MHRA alert register. Once received, alerts were disseminated and actioned. Alerts were discussed at practice meetings and a link added to the MHRA alert log was included in the minutes.

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 National Institute for Health and Care Excellence (NICE) guidance, military guidance, clinical pathways, current legislation, standards and other practice guidance. NICE guidance was a standing agenda item at the clinical meetings. Recent topics presented and discussed included management of metastatic carcinoma with an unknown primary, cardiovascular disease and risk modification. In addition, interesting and/or patients with complex needs were discussed including patients diagnosed with cancer, vulnerable patients and patients with mental health needs. Clinicians also met regularly with the Primary Care Rehabilitation Facility (PCRF) staff to discuss patients and these discussions were recorded on DMICP.

Staff were kept informed of clinical and medicines updates through the Defence Primary Healthcare (DPHC) newsletter circulated each month.

Patients with mental health needs were managed and supported in line with standard practice. Step 1 of the mental health intervention programme was provided at practice level, mainly in relation to anxiety and depression. This included use of assessment tools such as Generalised Anxiety Disorder Assessment (referred to as GAD) and the Patient Health Questionnaire-9 (referred to as PHQ-9) for depression. In terms of clinical coding, individual clinicians select a code from the wide selection available on DMICP which meant there was limited consistency across the practice.

Patients were regularly signposted to SSAFA for support and the RAF Benevolent Fund which provides counselling. The practice described a good relationship with the Department of Community Mental Health (DCMH). The timeframe from referral to assessment was between 3 and 6 weeks. Patients were reviewed regularly by a clinician whilst awaiting a DCMH assessment, although clinical coding to acknowledge this was not always used. Our review of records for patients with a mental health need showed they were appropriately supported and managed.

Monitoring care and treatment

The practice nurse was the lead for chronic conditions. The nurse managed the clinical element of chronic conditions and the doctors managed patients' occupational needs associated with their condition. A register for patients diagnosed with a chronic condition was in place and maintained by the nurse. System searches were undertaken regularly to ensure the register was current and to check annual review dates.

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 the patients

were in-date for recall. However, it was unclear how they had been recalled as clinical coding was not always consistent or accurate.

The medics recalled patients for their audiology assessment. Audiology statistics showed 87% of patients had received an audiometric assessment within the last 2 years. Joint Medical Employment Standards (referred to as JMES) were appropriately managed.

A comprehensive rolling schedule of audit was in place, which was administered by the practice manager and Senior Medical Officer (SMO). The schedule included both mandatory audits and audits chosen because of their particular benefit to the patient population. Examples of these population-based audits included the management of hypothyroidism and psoriasis. For both of these audits, at least 2 cycles of audit were evident. Learning was shared with staff at team meetings. The audits we reviewed were of a good standard.

Effective staffing

Staff had received an appropriate induction and appraisal. All new members of staff were required to complete the DPHC mandated induction and the practice induction that included role specific elements.

The staff training database allowed staff to check/monitor when their training was due. The database was reviewed by the training lead at the practice meetings. In addition, the training programme was displayed in the training room and updated each month. Protected time was allocated for mandatory training and, if there were significant deficiencies identified, staff had time blocked out to allow completion.

In-service or trade training was coordinated by a dedicated lead. Topics for training sessions were identified by staff suggesting topics to support their training needs, mandated requirements and changes in policy. An attendance record was maintained for each training session.

The clinical team were highly experienced and collectively had a diverse range of skills/experience to support the patient population. This included significant time spent in NHS primary care, aviation medicine and a wide range of military occupational medicine experience. The SMO worked in a local NHS dermatology clinic once a week to maintain their skills in this specialist area. The practice nurse was trained in sexual health. Furthermore, the practice nurse had an interest in menopause and had booked a training course in this area with the aim to set up a menopause café. Regular engagement and peer review took place between the doctors and PCRF staff and there were plans to start looking at a joint research programme soon. Clinicians were part of the local NHS trainers' group and attended the meetings. In addition, the practice manager attended the NHS practice managers' meetings for Anglesey.

The doctors all completed regular appraisal and revalidation. The practice nurse completed their revalidation with the Band 7 Nurse at Chester Medical Centre. All clinicians were aware of the continuing professional development requirements and used clinical meetings, mandatory training, and practice meetings to support with meeting this requirement.

Coordinating care and treatment

Discussions with staff indicated the practice had well developed links with internal units and teams including participation in unit and welfare meetings. Good links were established with local hospitals and local safeguarding groups.

The practice demonstrated adherence to the Defence Medical Services policy for the transfer of medical records when military patients left the service and moved to NHS care. In addition to providing the 'medical history on release from HM forces' form, the practice developed information pack for those leaving military service. The pack included information about accessing support and assistance from the various charities available to veterans. This initiative was identified as a quality improvement project.

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 a member of the DPHC health promotion network. Each practice within the network takes it in turn to put together a health promotion display board and shares it with other practices. A health promotion calendar for the practice was in place. Unit-led health and wellbeing days were held annually.

Health and lifestyle information was available throughout the patient areas of the building. Displays included cervical cancer awareness, men's health, travel health and women's health. A range of information leaflets and booklets in the waiting area covered topics such as mental health, screening, diabetes and various cancers. The practice had set up a Facebook page which was used to disseminate health promotion advice from the local health boards.

The practice nurse was trained in sexual health (STIF, levels 1 and 2) so took the lead in the area. They provided sexual health advice to patients. Patients could self-refer or clinicians could refer patients to the local sexual health clinic. The local clinic details were displayed on notice boards, in the patient toilet and in consulting rooms. 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. Condoms were available in the patient toilet.

In line with national screening programmes, regular screening searches were undertaken for bowel (18 eligible patients; 11 screened and 7 awaiting test kit), breast (9 eligible patients; 8 screened and 1 non responder) and abdominal aortic aneurysm (no eligible patients). Appropriate action was taken to prompt eligible patients to participate in screening. Eighty-six per cent of eligible women had had a cervical smear in the last 3-5 years. The NHS target is 80%. Processes were in place to ensure patients were notified of their eligibility for screening.

The practice nurse carried out quarterly vaccination searches or vaccinated opportunistically when a patient presented at the practice.

The status of childhood vaccinations was:

- 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 (i.e., 3 doses of DTaP/IPV/Hib/Hepatitis B) was 100%
- The percentage of children aged 2 who had received their booster immunisation for Pneumococcal infection was 100%
- The percentage of children aged 2 who had received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e., received Hib/MenC booster) was 100%
- The percentage of children aged 2 who had received immunisation for measles, mumps and rubella (one dose of MMR) was 100%
- The percentage of children aged 5 who had received immunisation for measles, mumps and rubella (two doses of MMR) was 100%

The status of service personnel vaccinations was:

- 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 – first vaccine
- 99% of patients were in-date for vaccination against hepatitis B – second vaccine
- 98% of patients were in-date for vaccination against hepatitis B – third vaccine
- 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 obtained from patients where required. Written consent was taken for invasive procedures and implied consent for non-invasive examinations. A consent and chaperone audit had been undertaken in June 2023. It showed consent was documented in 80% of all consultations, 100% for cytology and wound care consultations, and 92% of phlebotomy contacts.

Clinicians understood the Mental Capacity Act (2005) and how it would apply to the patient population group. They had received training recently in mental capacity. Clinicians were aware of both Gillick competence (young people under 16 with capacity to make a decision) and Fraser guidelines (advice/treatment focussed on a young person's sexual health). Given the current patient population, there were no recent examples of when these guidelines had been applied.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

Nineteen patients provided feedback about the service as part 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.

A display was available in the practice with details about how service personnel and families could access the HIVE Information Centre. Patients also had access to welfare services, the Padre and charities, such as the RAF Benevolent fund and SAFA.

Involvement in decisions about care and treatment

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

A small number of patients with a caring responsibility were identified. Alerts were added to their records to facilitate prompt and flexible access to medical care. Carers were identified either during the registration process, DMICP searches, via the welfare team or through self-identification. A carer's display with a variety of information was available in the waiting area, including the contact details for support services in Wales.

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 notice in reception advised patients that could speak with someone in a private area if confidentiality was required. All staff had completed the mandated Healthcare Governance and Assurance training as part of their induction.

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 co-ordinated the service to respond to the needs of patients. For example, 'Fit to Fly' aviation appointments were available every morning. Aircrew had rapid direct access to physiotherapy. Afterschool appointments were available for children and childhood immunisation clinics were held. The practice supported breast feeding and provided a quiet area if a patient wished to breast feed in private.

The practice was committed to meeting the principles of the Equality Act 2010, including safeguarding people with protected characteristics. Staff were trained in equality and diversity. Clinicians were aware of the 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. As it was a new build, the premises was fully accessible for people with mobility needs. A hearing loop was available at reception.

Timely access to care and treatment

Through the inspection feedback cards, a small number of patients indicated it was difficult to get an appointment. Staff said this had been issue but had improved with the appointment of a locum doctor. 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. Same day appointments were available with a doctor or nurse for both urgent and routine requests. An appointment with physiotherapist could be facilitated within 2 to 3 days. Access to the exercise rehabilitation Instructor was at the request of the physiotherapist. Although uncommon, home visits were available and recorded in the home visit register.

The wait for an aviation medical was usually less than 4 weeks. The practice could be flexible with appointments to ensure personnel did not lose their currency to fly.

Out-of-hours access to medical care was detailed in the practice leaflet and displayed on the front door of the practice Emergency out-of-hours cover midweek was provided by a medic and doctor from 17:00 to 18:30 hours. Patients had access to the NHS111 from 18:30 hours on weekdays, at weekends and on public holidays.

The practice had particularly good access to dermatology services, driven by the SMO with a specialist interest in dermatology and who regular facilitated dermatology clinics in secondary care. The practice had built upon this and, through established links with the local dermatology department, had access to consultant-led advice and could expedite patient appointments as a result.

Listening and learning from concerns and complaints

The practice manager was 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. The last recorded complaint was in December 2021 and it had been resolved to the satisfaction of the complainant. Complaints was a standing agenda item at the practice meetings.

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 aim of the practice was:

"To always do our best to support our patients on every occasion."

Leadership, capacity and capability

Although there were staffing gaps at the time of the inspection, staff advised that there was sufficient management/leadership capacity to meet the needs of the practice and patient population. The Senior Medical Officer (SMO) was on long term leave and the deputy SMO was deployed. The civilian medical practitioner was acting into the role of SMO.

Staff we spent time with spoke highly of the inclusive leadership approach, including the visibility and support provided by the SMO and practice manager.

The leadership team described excellent support from the regional team particularly as region acted swiftly to provide support and address any concerns the practice had. Two weekly meetings were held with the Regional Clinical Director.

Culture

It was clear 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.

Overall, staff told us they were supported, respected and valued by the leadership team. For example, senior staff members had on occasions covered the duty rota for junior staff so they could have a weekend off. However, disharmony within the staff team had been identified by practice leaders. To address the issue, the practice manager had arranged for the Padre to mediate and facilitate a training session on conflict management. In addition, a staff survey was undertaken in May 2023, the results of which were used to determine the needs of the team and develop a plan of action. The results were also discussed at a staff meeting. A 'morale board' had been set up in the staff room and staff were encouraged to write positive comments about colleagues. Communication workshops had been held to encourage a healthy team culture. 'White space' events and social/team

building events were regularly organised and regular team physical training sessions had been introduced by exercise rehabilitation instructor.

Staff told us that everyone in the team 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. We were given an example of when the leadership team listened and promptly acted when staff recently raised concerns. Staff 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. Not all staff were fully aware of the secondary roles they had been assigned. Terms of reference were established for those with secondary roles. Staff with lead roles had protected time to carry out their additional duties. Due to staff gaps, it had not been possible to always identify deputies for lead roles.

The practice nurse had recently been assigned the lead role for healthcare governance (HCG). Protected time had been agreed for governance activity. A range of meetings were held to ensure effective communication and information sharing across the staff team, including a weekly diary planning meeting and a meeting for junior ranks. All staff had access to the meeting minutes via the HCG workbook. The workbook is an overarching system used to bring together a range of governance activities, including the risk register, audit, health and safety and quality improvement. The workbook was clear and comprehensive. Staff had access to it and provided input at the practice meetings in order to improve patient care and practice efficiency.

The last internal assurance review took place in June 2022. The practice achieved full assurance in the caring domain and substantial assurance in all other domains. The most recent regional-led review of medicines took place in May 2023. However, it did not identify the gaps we noted with the governance processes for medicines management. Prior to our inspection, the practice had identified the problems and had taken action.

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 risk was an agenda item at the practice meetings.

The business continuity plan was comprehensive and provided all the likely generic system failures in the event of a disruption to service. Arrangements were in place for patients to access care at Chester or Shawbury medical centres should the need arise. The practice team was routinely involved in major incident planning and participated in scenarios (tabletop and practical) with the station executive team. A station crash exercise was undertaken in conjunction with civilian emergency services in May 2023.

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. They had initiated the process to address underperformance activating a range of options to support the process in a positive way, including re-training and support from the welfare team.

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 were involved with updating the HAF and meetings were held twice weekly between the SMO, practice nurse and practice manager to review how the HAF was progressing and the associated management action plan.

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, including the DPHC online survey. The quick response or QR code was displayed in the patient waiting area. Patient could also complete a patient experience questionnaire available at reception. Patient feedback was recorded in the HCG workbook and discussed at staff meetings. A patient participation group held in June 2022 did not attract any participants. The practice planned to try this option again.

Changes made as a result of feedback included appointments offered after school hours, early morning aviation medicals and improved access through eConsult and telephone consultations.

Good and effective links were established with internal units and services including the welfare team, Department of Community Mental Health and the units. The practice was represented at the station executive meetings and at the Service Personnel Support Committee, and the SMO met with the station commander each month.

The safeguarding lead and deputy had links with the local safeguarding team secretary for the West and all staff attended local safeguarding training. The practice manager was the First Response Team Co-Ordinator for the Welsh Ambulance Service that currently has 6 trained co-ordinators, 2 of which are RAF medics. The ambulance service provides accelerated healthcare, not just for the RAF, but to the civilian population outside the station.

Options were available for staff to provide both formal and informal about the service.

Continuous improvement and innovation

A quality improvement programme was in place. The audit register clearly demonstrated that the practice actively engaged with audit activity. The practice nurse was the lead for audit and the practice manager was the deputy. The audit calendar was in line with the current DPHC audit schedule. Quality improvement activity, including individual audits, were discussed at the clinical and/or practice meetings, confirmed by a review of meeting minutes. Quality improvement projects (QIP) carried out by the practice were held on the DPHC Healthcare Governance webpage and 3 QIPs were logged.