Abbey Wood Medical Centre

Abbey Wood, Filton, Bristol, BS34 8JH

Defence Medical Services inspection

This report describes our judgement of the quality of care at Abbey Wood 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	**Requires improvement**	
Are services safe?	**Requires improvement**	
Are services effective	**Inadequate**	
Are service caring?	**Good**	
Are services responsive to people's needs?	**Good**	
Are services well-led?	**Requires improvement**	

Contents

Summary

About this inspection

We carried out this announced comprehensive inspection on 20 June 2023.

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

The key questions are rated as:

Are services safe? – requires improvement
Are services effective? – inadequate.
Are services caring? – good.
Are services responsive? – good.
Are services well-led? – requires improvement.

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.

The practice had good lines of communication with the unit, welfare team and the Department of Community Mental Health (DCMH) to ensure the wellbeing of service personnel.

The arrangements for managing medicines, including the management of medicines given under Patient Group Directives (PGDs) and High-Risk Medicines (HRMs) required improvement, including the management of Shared Care Agreements.

Mandated training for staff was not up to date, including Basic Life Support (BLS) training.

There was evidence of some clinical audit based on patient population need/or based on national guidance. However, this required further development.

The programme in place to manage patients with long-term conditions was not robust, with no proactive recalls and no register in place.

All staff knew how to raise and report an incident and were fully supported to do so. The systems and management of significant events were good.

The management of referrals was good, with a robust process in place for monitoring.

Patients found it easy to make an appointment and urgent appointments were available the same day.

Not all governance systems were effective with not all relevant information captured to monitor service performance.

The medical centre benefitted from an 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.

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 Chief Inspector recommends to the medical centre:

The undertaking of a comprehensive review of the current service level agreement in place between contracted GPs and Defence Medical Services, to ensure this provides oversight and administrative time to fully support staff and patients of the practice. The rating of inadequate in the key questions of effective, and rating of requires improvement for the key question of safe and well-led demonstrate the impact of the insufficiency of the current service level agreement.

The medical team must review patients who are deemed to be vulnerable to ensure that their needs are being met.

Ensure all staff are aware of Abbey Wood processes with regard to safeguarding arrangements.

Medicines management requires immediate review, particularly the management of PGDs and High-Risk Medicines (HRMs), including Shared Care Agreements, and ensuring patients receiving repeat medications are reviewed.

Agree structured processes to ensure that clinicians come together to review clinical guidance and updates with a view to enabling evidence based best practice in line with national guidance and Defence Primary Healthcare (DPHC) policy.

A review of the staff training programme needs to be undertaken to ensure staff have the up-to-date skills and knowledge to deliver effective care and treatment. This should include thermal injury training. Best practice dictates that one staff member has received STIF training.

The recall of patients diagnosed with a long-term condition should be reviewed to ensure the process is effective and patients are recalled in line with DPHC policy.

Continue to develop the audit programme ensuring it drives improvement in services for patients.

Continue to improve the completion rates of and follow up to audiometric testing on eligible patients.

Ensure all staff have Terms of Reference (ToRs) for their roles, and clear roles and responsibilities for all assigned secondary/lead roles.

Adopt a consistent approach to clinical coding for vulnerable patients to ensure the management of these patients through clinical searches is fully effective.

Ensure the risk register is in accordance with DPHC policy and captures all risks for the practice. Support risk resolution through escalation where local solutions cannot be found.

The Chief Inspector recommends to DPHC

The medical centre should gain assurance that all electrical safety checks and water safety checks are complete and that there is no outstanding action.

Review the infrastructure of Abbey Wood Medical Centre and take actions to ensure it meets the needs of the patients and meets with infection control requirements. This should include the replacement of carpet in the consulting room and upgrading the sink to ensure compliance.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Healthcare

Our inspection team

The inspection team was led by a CQC inspector. The team included specialist advisors including a primary care doctor, a nurse and a practice manager. Defence Medical services (DMS) had not been able to resource a physiotherapy advisor and so we were unable to inspect the Primary Care Rehabilitation Facility (PCRF). In addition, a new nurse specialist advisor shadowed this inspection.

Background to Abbey Wood Medical Centre

Abbey Wood Medical Treatment Facility is a tri-Service Medical Centre based in Bristol. It provides primary care to a practice population of 1,323. Military personnel work alongside civil servants within an office-based environment, providing equipment and support for current and future operations. They are a contracted civilian practice, with the practice team all working for Hanham Health, a local GP Practice.

There is no dispensary at the practice, instead a local contract is in place for prescriptions to be dispensed by a pharmacy near to Abbey Wood.

The practice is open from 08:00hrs to 12:00hrs and 13:00hrs to 16:30hrs Monday to Friday. From 16:30hrs until 18:30hrs patients can contact Hanham Health which has a surgery located a few miles away. Outside of Practice hours patients contact the NHS 111 service.

The staff team

Senior Medical Officer (SMO)	1
Civilian Medical Practitioners	3
Practice Manager	1
Nurse Practitioner	1
Nurses	1Senior Nurse 1 Practice Nurse
Healthcare assistants/ Senior Medical Administrator	2
Administrators	1
Receptionist	1
Physiotherapists	2

Are services safe?

We rated the medical centre as requires improvement for providing safe services.

Safety systems and processes

The Senior Medical Officer (SMO) was the lead for safeguarding although there were no Terms of Reference (ToRs) nor a list of roles and responsibilities in place to reflect this. All staff had received up-to-date safeguarding training at a level appropriate to their role. The medical centre had child and young adult safeguarding policies in place that included contacts for local safeguarding teams, this was last reviewed in September 2022. The policy did not cover internal processes. In addition, the medical centre also had a vulnerable patient policy. This included how to manage vulnerable patients including getting written consent from the patient for inclusion on the register.

A vulnerable adults register was in place and we were told was updated monthly by the administrative team. We reviewed the notes of 5 of the patients on the register. All had been reviewed by a doctor within the past month. We noted that 4 of the 5 had an alert on the system in line with policy. However, the medical centre staff were not using the Defence Primary Healthcare (DPHC) mandated code, instead they were using the code 'on the supportive care register'.

We conducted a search for patients who had previously been coded as vulnerable and were now working at Abbey Wood. There were 6 identified and only 2 had an alert in place (both appeared to have been added after the inspection and one was for a patient who should be reviewed due to there being no evidence of their current vulnerability). One was on the practice local 'supportive care register' and another previously had been, with evidence that this had been rescinded (although the removal of the code was a long time after the condition had resolved). No evidence was seen from this review that patients had been actively reviewed by the medical centre or that the code was rescinded when the condition had resolved. Patients on unfit live arms limitation were reviewed monthly with both the welfare and administrative team to ensure the review was up to date. All patients who did not respond to a recall were referred back into the welfare team. Department of Community Mental health (DCMH) patients were recorded on a separate register to ensure that they were being reviewed regularly while awaiting the DCMH appointment. New patient questionnaires were reviewed to identify vulnerable patients.

Safeguarding concerns were discussed at the monthly Unit Welfare meetings. The SMO attended along with Soldiers' Sailors and Airmen's Families Association (SSAFA), the welfare team, padre, unit welfare officers and community support officer. Senior leaders for Abbey Wood attended twice a year. The medical centre also met weekly with the welfare team. We spoke with the welfare team who confirmed the medical centre were very responsive to helping with any patient who needed to be seen urgently.

We saw a safeguarding audit had been completed in May 2023. This looked at the confidence of the team with regard to safeguarding procedures. All staff agreed that safeguarding was everyone's concern and all knew who the lead was and felt confident in identifying safeguarding concerns. However, the team were less confident in applying

Abbey Wood processes for reporting concerns. As result, this has been added to the practice meeting agenda to keep staff updated with educational information to inform continued discussion.

There was no evidence of chaperone training on the training log, nor a list of trained staff, but we were told that staff had received training from the local practice. Staff confirmed they had received training and were confident in their roles. In reception, a notice advised what staff would provide cover for the day. Following the inspection the practice manager put together a list of trained staff and added this to the Healthcare Governance workbook (HcG WB).

Staff who acted as chaperones had received a Disclosure and Barring Service (DBS) check. 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. All staff were employed by the NHS and contracted to Defence Primary Healthcare (DPHC). All professional indemnity was held on the staff database and monitored by the practice manager.

There was a dedicated lead and deputy in place for infection prevention and control (IPC) and they both had completed the IPC link training and other IPC training at Hanham Health (NHS). Annual IPC audits were undertaken and actions taken as required. Outstanding issues included carpet in the consulting room and a non-compliant sink, these issues were known to the DPHC infrastructure team and meetings were being held to resolve them.

Environmental cleaning was provided by an external contractor. A written cleaning schedule was in place and this was signed off to confirm that cleaning tasks had been completed in line with the agreed frequency. Cleaning standards were monitored by the practice manager and at the time of inspection, the medical centre was clean. Arrangements were in place for deep cleaning, the last had been carried out in June 2023.

Healthcare waste was appropriately managed and disposed of. Clinical waste was monitored daily and, when required, yellow bags containing waste were secured, labelled and locked in containers awaiting collection. Clinical waste was collected weekly and an annual waste audit carried out in May 2023 showed full compliance.

Risks to patients

Abbey Wood Medical Centre was providing 10 clinical sessions per week between doctors and the nurse practitioner as agreed through the NHS contract. We found there was a good clinical skill mix. For example, there was a nurse practitioner who undertook daily triage and a member of the administrative staff who was also a trained healthcare assistant. The administrative staff had a wide range of transferable skills which was demonstrated daily when tasks were distributed to all staff. For example, the operations manager readily supported covering reception when required. All staff worked very closely with each other and could easily step into their role should there be unplanned or planned absences.

As staff were contracted to DPHC to provide a service, there was continuity of staff to ensure the safe running of the practice from Hanham Health (HH).

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

Records showed not all staff had completed updated basic life support training, following the inspection we received confirmation this had been competed and all staff were up to date. We noted, whilst not mandatory, emergency scenario training had not been conducted/recorded.

There were leaflets in the waiting room about sepsis and all staff had received training. Clinical staff had not received training in climatic illness. Administrative staff were able to describe what they would do if a patient became ill whilst in the medical centre and there was guide for staff to refer to.

Waiting patients could be observed at all times by staff working on the front desk.

Information to deliver safe care and treatment.

New patients due to arrive at Abbey Wood were emailed a new patient questionnaire. When completed, this was submitted to the nursing team for scrutiny and summarising. A folder was held by practice manager that showed 22 sets of patient notes were outstanding at time of inspection. However, following a search on the clinical system on the day, we found 52 sets of notes had not been summarised, with 43 of these being over 3 years old. When notes are not summarised, there is a risk that active conditions are not captured or coded correctly and systems to monitor patients may not be effective.

A process was in place for the management of specimens. All samples sent were logged Any result returned that was out of range was referred to the doctor.

Peer review of doctors DMICP (electronic patient record system) consultation records had previously been undertaken in September 2020 and included a notes audit, these were between the doctors and the nurse practitioner, there was no evidence of an audit on the clinical notes made by the nurses. The doctors had a weekly meeting at HH NHS practice, some remote meetings and also doctors meetings were held a few times a year at Abbey Wood.

The management of referrals was clear, comprehensive and active. The majority of external referrals were made via the NHS electronic referral system (eRS). A referrals tracker with restricted 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. The register included both internal and external (secondary care) referrals.

Tabletop instructions were available to all staff, for example, on how to manage referrals, raising work services and raising business cases.

Staff confirmed that access to patient records was only occasionally a concern but did not pose a significant risk to continuity of patient care. In the event of a DPHC-wide outage, the medical centre would revert to seeing emergency patients only. Appointments were printed out at the end of each day for the following day and hard copy forms were held for use in this scenario and documentation would be scanned onto DMICP.

Safe and appropriate use of medicines

Systems were in place to ensure doctors signed repeat prescriptions before the medicines were dispensed and handed out to patients. There was no full time, fully operational dispensary at Abbey Wood Medical Centre. Arrangements were in place to send all prescriptions to a local community pharmacy. We were not made aware of any delays in patients receiving medication. We reviewed the notes of patients on repeat medicines and through a search found 55% had not had a recorded review.

There was inconsistency in the system and procedures for the review of high-risk medicines. Following review of the practice notes, we found there was inconsistency in coding, alerting, recording of drugs as hospital only, and evidence of missing Shared Care Agreements (SCA) with no evidence the medical centre had chased the missing ones. We found that medicines that required critical monitoring requirements were not always being completed in line with guidance. These issues presented a risk to patient safety.

We conducted a search for all patients who had been coded as requiring high-risk drug monitoring, some of whom may have required Shared Care Agreements with secondary care. We found 27 patients using this search (compared to 9 on register). The notes of 5 patients were reviewed from this search and we found one that did not have a SCA in place.

There was an Amber drugs register kept in the practice, (Amber drugs are specialist drugs initiated by secondary care prescribers, but with the potential to transfer prescribing to primary care with written SCAs and according to the agreed process for the transfer of care). This was maintained by the senior administrator and covered whether there was a SCA in place, what monitoring was needed, how often and the date of last review/bloods. There were 9 on the register and we reviewed the notes of 5 patients. There was clear SCA amber drugs for 1 patient – all aspects for this patient were in line with DPHC policy. Three patients had clear red specialist/hospital only drugs. Two patients had this clearly marked on their prescription. One was outside policy for recording this on the prescription screen. Only one of the 3 had an alert in place. All 3 were appropriately coded as requiring high-risk drug monitoring. A 5th patient had an SCA in place but the monitoring was incomplete.

The regional pharmacist carried out a management audit in May 2023 and initial verbal feedback had been given, this had yet to be formally written up. Following the inspection we were informed that the medical centre was found to be fully compliant with the exception of the segregation of Controlled Drugs to be destroyed. This had since been resolved.

Blank prescription forms and pads were securely stored and there were systems to monitor their use. Records showed that staff recorded fridge and room temperatures; this

made sure medicines were stored at the appropriate temperature. Staff were aware of the procedure to follow in the event of a fridge failure. The practice did not hold any controlled drugs (medicines that require extra checks and special storage because of their potential misuse). We saw evidence that medicines were disposed of correctly and the correct sharps container was used.

Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. However, when we reviewed these we found that not all had been appropriately reviewed and signed off by the SMO. The medical centre could not evidence that all nurses had completed their training. Following the inspection, the medical centre confirmed to us that training certificates were in place and all staff had previously received training and this was in-date. Individual PGD audits were planned in the next 3 months.

The staff had access to emergency medicines and equipment in the medical facility. The emergency trolley was checked regularly and was suitable for use.

Track record on safety

There was a designated health and safety lead within the medical centre. We were told all electrical safety checks and water safety check were regularly carried out including a full legionella risk assessment by an outside agency. However, these certificates had not been made available to the medical centre. 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.

We looked at the practice's arrangements for the provision of a safe service. A risk register was maintained but did not take account of the 'four T's' (transfer, tolerate, treat, terminate) to clearly indicate where and how risks were being managed. Risk was discussed as part of the healthcare governance meetings which were held every 3 months. There were only 2 risk assessments in place for the medical centre, and 2 issues, not all risks had been assessed and no risks had been transferred for example, the carpeting in the clinical rooms and non- compliant wash hand basins.

There were handheld mobile alarms in all rooms. There was a record in place to record that alarm checks had been completed. There were also alarms installed in clinical rooms but these were not audible, instead lights flashed outside of the room when an alarm was made.

Lessons learned and improvements made

All staff had access to the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events and incidents. The medical centre carried out a thorough analysis of the significant events that had been reported. Staff understood their roles in discussing, analysing, and learning from incidents and events. We reviewed safety records, incident reports and national patient safety alerts. We saw that there were regular practice meetings where these were discussed. We saw that learning from the reported

significant events was shared to make sure action was taken to improve safety in the practice. When there were unintended or unexpected safety incidents, we were told patients received reasonable support, truthful information, and an apology and were told about any actions to improve processes to prevent the same thing happening again.

From interviews with staff and evidence provided, it was clear there was a culture of reporting incidents. Both clinical and non-clinical staff gave examples of incidents reported through the ASER system including the improvements made as a result of the outcome of investigations. For example, improving patient confidentiality in the waiting room.

The medical centre had a system in place to distribute alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). Discussion took place at clinical meetings and was recorded in the minutes.

Are services effective?

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

Effective needs assessment, care, and treatment

Clinicians had access through various channels to relevant and current evidence-based guidance and standards, including National Institute for Health and Care Excellence (NICE) and the Scottish Intercollegiate Guidelines Network (SIGN) guidance. Due to time constraints and clinician availability, there was no regular or structured processes within Abbey Wood to review updates or discuss these with clinical colleagues to ensure evidence based best practice was updated in line with amendments and Defence Primary Healthcare (DPHC) policy. Weekly meetings were held at Hanham Health (HH) that some staff could attend depending on their availability. The most recent meeting held at Abbey Wood showed clinical discussions were had about aircrew medicine and another about the controlled drugs policy.

The DPHC team produced a newsletter that was circulated to clinicians providing further information and a summary of relevant safety updates.

Monitoring care and treatment

The nursing team monitored patients with long-term conditions (LTC). The population manager facility (referred to as ‘POPMAN’) was used to identify patients with a LTC on the day of the inspection. At the time of the inspection, the medical centre did not have an LTC register, the medical centre have since notified us that there is now one in place. Where chronic disease reviews had been undertaken, they were of good quality and the appropriate templates had been used. There was some evidence of recalls from the notes of active management of chronic disease, but this was not consistent. Conditions not represented on POPMAN but which needed active recall (e.g. pre-Diabetes and Hypothyroidism) did not appear to be actively managed or recalled. There was limited use of reminders/recall dates for some conditions leading to some missed opportunities to manage conditions and reduce long-term risks.

We searched the clinical system and it identified 26 patients coded as diagnosed with asthma. Only 15 of these patients were coded as having been reviewed in the past 12 months (58% compared to the target of 70%).

Eighty patients were coded as having high blood pressure. Of these patients, 72% had a blood pressure reading of 150/90 or less (compared to the target of 80%)

Those patients diagnosed with Atrial Fibrillation had been reviewed, 100% of these patients had had been assessed for the risk of stroke (CHA2DS2-VASc score) and those indicated were on anti-coagulation therapy (blood thinning medicines).

There were 6 patients coded as having coronary heart disease. All (100%) of these had a blood pressure reading of 150/90 or less and all were taking aspirin or equivalent.

Patients presenting with a mild to moderate anxiety or low mood were assessed in accordance with the pathway and treated initially at the practice (step 1) or referred to the Department of Community Mental Health (DCMH) team if their clinical need was assessed as greater than what step 1 could provide. There were 30 patients coded as diagnosed with depression, none were coded as receiving a review between 10-56 days following diagnosis. We saw 4 patients were coded with a significant mental health issue, none had been coded as having a care plan agreed, 50% had a blood pressure reading recorded (target 90%) and only 25% had their alcohol intake recorded (target 90%).

There were 17 patients coded as diagnosed with diabetes. We saw that 82% had a blood pressure reading of 150/90 or less (the target is 93%) and those with a blood pressure reading of 140/80 was 35% (target is 78%).

Audiology statistics showed 40% of patients had received an audiometric assessment within the last 2 years. The medical centre told us that getting up-to-date with the audiometry testing had always been a challenge, and during the height of the recent pandemic they had been put on hold in line with DPHC direction. In order to improve, the medical centre ran a pilot running the first booth-less hearing event in collaboration with the regional headquarters. While they were awaiting calibration of the booth-less equipment they were running a regular weekly audiometry clinic to improve the uptake.

We ran searches on audiometry and hearing results management and we found evidence that 2 patients who had a hearing impairment but had not been graded in line with policy. We raised this with the medical centre as a matter of urgency and they took prompt actions to recall and raise the issue as a significant event (ASER). We noted that 497 patients had not had an audiometry test within the past 2 years.

A register was in place of quality improvement activity of (QIA). We saw the most recent audits included, cytology, safeguarding and infection prevention and control. Clinical audits were limited, we saw a Hypothyroidism audit was undertaken in June 2023 and an Atrial Fibrillation audit in December 2022. There was a plan in place with a focus on the audit calendar being re-invigorated to include a larger range of clinical and administrative audits.

Effective staffing

Doctor's hours allocated to provide patient care required review. There was insufficient time allocated for doctors to complete other clinical leadership work and essential administrative tasks.

The medical centre had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. There were some desk top instructions in place for new doctors to refer to.

The staff database showed that not all staff had completed their mandatory training, for example one member of staff had not received updated Basic Life Support training and staff had not completed training in climatic illness. Following the inspection evidence was submitted showed all staff were up to date with BLS training.

Although staff were allowed half a day a month protected time for mandatory training administrative staff told us that they often undertook training at home as there was not enough time to complete all that was required. No training plan was maintained to forecast and prepare for upcoming training needs. We saw the practice manager had written on a whiteboard in the office training to be undertaken for the month of July.

The doctors and nurses had the appropriate skills for their role and were working within their scope of practice, for example 1 of the doctors was Military Aviation Medical Examiner (MAME) trained and 3 were trained to undertake diving medicals. Clinical staff kept up-to-date with their own continual professional development and revalidation. Performance appraisals were conducted by line managers for all staff. All doctors were in date for appraisal and all doctors and nurses had completed timely revalidation.

Staff were encouraged to manage their own personal development and were helped and encouraged to do so. For example, the senior administrator had trained to be a health care assistant and was trained in phlebotomy.

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.

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. Hanham Health was a Veterans Friendly practice and the Senior Medical Officer was the veterans link person and had good knowledge of resources and patient's entitlements. There was a useful leaflet 'Leaving the Armed Forces, Support for your future Health and Wellbeing available to patients.

Helping patients to live healthier lives

All of the nurses shared the lead for health promotion. We saw information leaflets were available in the treatment rooms. There were notice boards located in reception; some example topics covered included sepsis, smoking and cancer. There were opportunities offered to patients' partners to join them in the consultation for health care advise, for example nutritional advice for a pre-diabetic patient.

None of the nurses had specific sexual health training but were able to provide general sexual health support and advice. Patients were signposted to local sexual health services for procedures not undertaken at the medical centre.

All eligible female patients were on the national cervical screening database and had been recalled by the nurse. The latest data confirmed a 97% 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.

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

94% of patients were in-date for vaccination against diphtheria.

94% of patients were in-date for vaccination against polio.

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

98% of patients were in-date for vaccination against hepatitis A.

94% of patients were in-date for vaccination against tetanus.

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

90% of patients were in-date for vaccination against meningitis.

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.

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 and the helpfulness of staff.

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 3 members of the welfare service, all spoke highly of the responsive care provided by the medical centre.

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. There was a practice leaflet which included information for carers and information on the notice board. Hanham Health facilitated a carers forum and patients of Abbey Wood were able to use this too if they chose to.

The medical centre staff were a friendly and open team who treated everyone with the same level of respect. Patients identified as needing extra support to access the medical centre, for example, any patient with a phobia, had an alert on their notes to highlight to staff that they had special support requirements. There was information about the Lesbian, Gay Bisexual and Transgender community (LGTB) outside the waiting room for patients to refer to.

Staff explained that they occasionally saw patients who spoke English as a second language. They could access a translation service if they needed it.

Privacy and dignity

Consultations took place in clinical rooms with the door closed. Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.

Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed, they could offer them a private room to discuss their needs. There was a radio playing to provide a sound barrier, phone calls regarding patients were only made in the closed office. 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 clinician of a specific gender.

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

Appointment slots were organised to meet the needs of specific population groups. For example, the staff team reviewed the way that clinics were set up, meeting together to discuss how improvements could be made to make the process more efficient. This included a daily clinic co-ordinator who checked that all paperwork was correct and in place prior to the appointment. Forms were sent by email to the patient, in advance if appropriate, for the patient to complete before their appointment to save them waiting.

Patients were able to receive travel vaccines when required. The practice was a yellow fever centre.

Eye care and spectacles vouchers were available to service personnel from the medical facility.

The practice manager was the lead for diversity and inclusion. There was good communication with the Chain of Command and nominated leads within the medical centre. An Equality Access Audit as defined in the Equality Act 2010 had been completed within the past year. There was a notice board with information and contact details for patients in reception.

Dependant on the patient's clinical need, the option of a telephone or face-to-face appointment or eConsult could be offered. Telephone requests were added to a doctor's routine clinic as appropriate. Home visits were rare but could be accommodated if required.

Timely access to care and treatment

Details of how patients could access the doctor when the medical centre was closed were available through the station helpline, put out on unit orders and on the answer phone message. A brief was given by Senior Medical Officer to the team at Hanham Health (HH) prior to prolonged periods of leave to remind them of protocols. If a patient was seen at HH they would try and get the patient seen by a clinician who worked at Abbey Wood. The team at HH could refer to Department of Community Mental Health (DCMH) and had all the packs of all paperwork required. DCMH would accept email referrals from HH if needed due to no DMICP access.

Details of the NHS 111 out of hours service was outlined in the practice information leaflet. Shoulder cover was provided by HH until 18:30 hours, then patients were directed to the NHS 111 service.

Urgent doctor and nurse appointments were available on the day. Routine doctor appointments were available within 2 weeks. Routine appointments to see a nurse were available within a few days.

Listening and learning from concerns and complaints

The practice manager was the lead who handled all complaints in the practice, although they had no written role or responsibilities or any Terms of Reference in place to support this. The practice had implemented a process to manage complaints in accordance with the Defence Primary Healthcare complaints policy and procedure, one complaint had been recorded within the past 12 months and we saw this had been handled well and the patient given an apology.

Information was available to help patients understand the complaints system, including in the patient information leaflet and in the waiting room.

Are services well-led?

We rated the medical centre as requires improvement 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 overall medical centre mission statement was;

‘The aim of Hanham Health as a General Medical Practice (Community) is to provide the best possible health care for our patients while promoting better physical and mental health by offering a planned programme of health promotion and preventative care based on local and national guidelines’.

The medical centre also had their vision statement-

- To provide the best possible health care for our patients.
- To promote better physical and mental health by offering a planned programme of health promotion and preventative care based on local and national guidelines.
- To provide a comprehensive range of services both within the practice and by referral to other agencies.
- To ensure that the services are easily accessible, efficient and responsive to the needs of patients.
- To provide a professional, pleasant, safe, supportive and efficient working environment for everyone in the practice. To include all members of the team in planning and decision making by encouraging teamwork and good communication.
- To maximise the profitability of the organisation to ensure the best possible service to patients and fair remuneration to all members of the practice team.

Leadership, capacity, and capability

The practice had a supportive leadership strategy and vision that all staff championed. Staff reported feeling supported within their roles and listened to when suggesting change or raising concerns.

The staff team felt well supported by the regional team with the Senior Medical Officer (SMO) meeting monthly with them. They reported having good relationships and links with the Regional Clinical Director, the operations manager and the healthcare governance manager who were described as approachable and contactable. The practice manager had regular meetings with the area manager.

We saw that leaders recognised the challenges they faced in delivering a high-quality service to all patients at Abbey Wood. Although there was a clear leadership structure and

staff felt supported by management, the SMO did not have enough dedicated time to pursue the additional duties required which could not be delegated to other staff at the practice. For example, there were very limited examples of formal clinical meetings between the nurses and the doctors.

Culture

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.

We heard from staff that 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.

Staff wellbeing was given a high priority at the medical centre and several initiatives had been put into pace to support this. For example, a lunchtime walk and gym groups were organised on a frequent basis 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

We found gaps and shortfalls across the governance structure, including clinical and non-clinical processes, which have been highlighted throughout the report. The healthcare governance workbook (HcG Wb) was the overarching system used to bring together a range of governance activities, including the risk register, staff database and standard operating procedures. Complaints and the quality improvement activity (QIA) were held on the DPHC SharePoint page in lists as mandated by DPHC HQ.

A quality improvement activity (QIA) programme had been established for 2022/23. This included further clinical audits in key areas that had not yet competed including antibiotic prescribing and a notes audit.

Staff told us the practice leaders were approachable and took the time to listen to all members of staff. All staff were involved in discussions about how to run and develop the medical centre. Staff told us there were regular meetings and there was an open culture within the medical centre where they had the opportunity to raise any issues and talk

openly. We noted that not all staff were invited to the Healthcare Governance meetings and that there was no set agenda. Following the inspection we were told this had been recognised and resolved.

There was a clear staffing structure in place and staff had their own job descriptions (NHS). However, Terms of Reference (ToRs) were not in place to support job roles, including staff who had lead roles for specific areas, there was no staff roles and responsibilities list.

A meeting schedule was established, and this included 3 monthly healthcare governance, safeguarding, practice and Unit Health Committee meetings. Quarterly meetings were held with Defence Primary Healthcare (DPHC) Headquarters. Discussion at each meeting was recorded and made available to those unable to attend.

Managing risks, issues and performance

There was a current and retired risk register on the HcG Wb along with current and retired issues. The register articulated some of the main risks identified by the practice team but we noted that there was no transferred risks such as the need to replace carpets in clinical rooms, infection prevention and infection control non-compliance (basins), and the infrastructure. The risk/issues register held minimal information.

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, would be followed. This was provided by an external human resources company.

All staff were in date for ‘defence information management passport’ and ‘data security awareness’ training.

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.

Appropriate and accurate information

The HAF 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. All feedback following reports from audits or inspection were highlighted in the eHAF Management Action Plan to capture oversights and target areas for quality improvements and mapping actions were reviewed for each domain. Following on from feedback on the day, the leadership team had already addressed several issues which had been documented with action/timelines in place.

Engagement with patients, the public, staff and external partners

There were a few options in place to encourage patients to provide feedback on the service and contribute to the development of the service. These included a patient experience survey via a QR (quick reference) code on all emails and a patient experience survey that was undertaken throughout the year. The last survey was undertaken between October 2022 and December 2022, the results were very positive about all aspects of care delivered by the medical centre.

Continuous improvement and innovation

The staff team actively had the motto “How Can We Do Better”. Staff worked closely which each other and ensured all administrative staff had the skills to cover other staff absences. A tasking list was held within the main administrative office which was distributed amongst the team each day which ensured all responsibilities were covered. At 11:45 each day, all staff come together and checked that jobs had been completed and if not, staff worked together to get these completed. Clearly the staff cared about the medical centre and the patients, some of the staff had worked there for many years and were adaptable to changes/improvements to working practices. Following this inspection, the team immediately commenced with an action plan for improvement.

We saw a safeguarding audit had been completed in May 2023 this looked at the confidence of the team with safeguarding procedures. All the staff agreed that safeguarding was everyone’s concern and all knew who the lead was and felt confident in identifying safeguarding concerns but were less confident in the Abbey Wood processes for reporting of adult of child concerns. As result this has been added to the practice meeting agenda to keep updated staff to safeguarding issues and some educational information included to inform continued discussion.