Care Quality Commission

St Athan Medical Centre

MOD St Athan, Barry, Vale of Glamorgan, CF62 4WA

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 18 and 19 July 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.

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.
- A process was in place to identify and support vulnerable patients, including a safeguarding policy for children and adults.
- The practice was well-led and the leadership team demonstrated they had the vision, capability and commitment to provide a patient-focused service and consistently sought ways to develop and improve.
- The healthcare governance workbook was well-developed and captured a wide-range of information to illustrate how the practice was performing.
- The practice worked collaboratively with internal and external stakeholders, and shared best practice to promote better health outcomes for patients.
- There was an open and transparent approach to safety. An effective system was in place for managing significant events and staff knew how to report and record using this system.

- The arrangements for managing medicines minimised risks to patient safety. A process was in place to monitor patients prescribed high risk medicines.
- Quality improvement activity was embedded in practice and was used to drive improvements in patient care.

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

The lead for chronic conditions had developed a detailed practice standard operating procedure (SOP) for the recall of patients (SOP 05-01-13). In addition to chronic conditions, it covered routine medicals, health checks, health screening and child immunisations. The SOP provided clear guidance for searches to identify patients without a recall date and to highlight patients who required a review in the preceding 30 days. This SOP provided a comprehensive practical guide for staff to follow when undertaking searches and reviews, and it provided consistency in how searches were carried out. Equally, the tracker to record searches was structured and clearly illustrated each monthly search, including colour coding to indicate the status of standards and other pertinent information.

An Aseptic Non-Touch Technique (ANTT) audit was undertaken for all clinical staff. This was introduced initially for new staff with the reduction of face-to-face contact following COVID-19 step down procedures. The outcome of the audit resulted in additional training for staff and enhanced monitoring of IPC management. All staff have been subject to an ANTT audit, including those that work from home.

Baby massage classes were offered by one of the practice nurses with the relevant training. Staff advised us that it had been well received by parents. It also provided an opportunity for further health promotion and early identification of any issues that a new parent might be experiencing.

The Chief Inspector recommends to the practice:

- Continue to follow up on the environmental cleaning contract with the aim to include enhanced cleaning in the contract.
- To ensure improvements have been made with the quality of clinicians' record keeping including consistency with the use of clinical coding, consider undertaking a follow up audit within the next 6 months.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Healthcare

Our inspection team

The inspection was led by a CQC inspector. Along with a team of specialist advisors including a primary care doctor, practice nurse and practice manager the practice was inspected on 18 July 2023. The pharmacist specialist advisor inspected the practice remotely on 19 July 2023. We were unable to secure a physiotherapist specialist advisor, so the Primary Care Rehabilitation Facility (PCRF) service was not included in the inspection.

Background to At Athan Medical Centre

St Athan Medical Treatment Centre provides a primary care service for service personnel and their families. An occupational health service is available for service personnel and reservists. At the time of inspection, approximately 1,197 patients were registered at the practice comprising 985 service personnel and 212 civilians. In addition, minor surgical procedures, rehabilitation services and childhood vaccinations are provided. All facilities are at ground floor level and accessible to people with limited mobility or those who use mobility aids.

The practice is open 08:00 to 17:00 hours Monday to Friday. A duty medic provides urgent telephone advice from 17:00 to 18:30 hours Monday to Friday. A doctor provided cover for the region from 17:00 to 18:30 hours Monday to Friday. Outside of these hours and during weekends and public holidays, patients were directed to contact NHS 111.

The staff team

Doctors	Senior Medical Officer (SMO) – long term absence Deputy SMO – post vacant Regional SMO – providing cover in the absence of the SMO Civilian medical practitioner – 3 days per week
Practice management and administration	Practice manager – military Deputy practice manager – military Medics x 3 Administrators x 2
Nurses	Band 7 Band 6 Band 5 Military nurse Health care assistant
PCRF	Senior physiotherapist – civilian Physiotherapist Exercise rehabilitation instructor – civilian
Dispensary	Pharmacy technicians x 2

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

The Senior Medical Officer (SMO) and Band 7 practice nurse were the leads for adult and children safeguarding. Staff had completed safeguarding training at a level appropriate to their role. A child and adult safeguarding policy was in place and reviewed in January 2023. Contact details for the local children and adults safeguarding teams were displayed.

Vulnerable patients were identified during consultations, DMICP (electronic patient record system) searches and from referrals from units and teams, such as the welfare team. Specific clinical codes were used and alerts added to clinical records to ensure patients were identified as vulnerable. The practice was represented at the monthly Station welfare meetings and the Unit Health Committee meetings. A safeguarding/vulnerable patient register was established. At the time of the inspection, 18 patients were identified on the register. Although no service personnel under the age of 18 were registered at the practice, 121 children were registered.

The chaperone protocol was displayed. A notice including a list of trained chaperones was displayed on clinic room doors. The availability of a chaperone was outlined in the patient information leaflet. Chaperone training for the team was provided in February 2023.

Although the full range of recruitment records for permanent staff was held centrally, the practice could demonstrate that relevant safety checks had taken place at the point of recruitment, including Disclosure and Barring Service (DBS) checks to ensure staff were suitable to work with vulnerable adults and young people. DBS checks and the professional registration of staff was checked each month. The practice nurse team held and monitored the vaccination status of clinical staff.

An infection prevention and control (IPC) policy was in place. One of the practice nurses was the lead for IPC and had completed the required training for the role. The annual IPC audit was completed in May 2023 and a management action plan developed. All actions had been completed.

An Aseptic Non-Touch Technique (ANTT) audit was undertaken for all clinical staff, resulting in additional training and monitoring of IPC management. Training was monitored by the IPC lead. All staff have been subject to an ANTT audit, including those that work from home.

The IPC lead monitored the cleaning. Although a formal contract was in place for environmental cleaning, it did not include arrangements for the provision enhanced or deep cleaning. This matter was subject to ongoing discussion. A local cleaning standard operating procedure had been developed to ensure staff were aware of steps to take should an enhanced clean be required. Deep cleaning was carried out by the nurses every 6 months. We identified no concerns with the cleanliness of the premises.

The lead for the clinical waste was based in the medical centre and one of the co-located dental team was the deputy lead. Supported by a waste disposal policy, the management of clinical waste included a waste log and consignment notes. Tags were used to track

waste, which was stored in a secure area of the building. The annual clinical waste identified the practice was fully compliant.

Risks to patients

The patients who provided feedback indicated they could secure an appointment with a clinician in a timely way. At the time of the inspection, doctors' hours were reduced due to the ongoing absence of the SMO. To address the gaps in doctors' hours, the regional SMO (RSMO) regularly provided clinics and covered out-of-hours remotely. After the inspection, we were advised that an SMO had started at the practice to provide cover for the next 6 months. In addition, a deputy SMO was due to start mid-September 2023 and a locum doctor had been secured to start for 6 weeks from the beginning of August 2023. The nursing team confirmed they were sufficiently staffed to meet the needs of the patient population. The deputy practice manager post was due to be disbanded at the beginning of August 2023.

The medical emergency trolley and medicines were checked daily and monthly or if the trolley had been opened/used. All the items we checked were in-date. Oxygen was available and it was full and in-date. Full and empty gas cylinders were stored appropriately in an area away from the building.

The staff team was up-to-date with training in emergency procedures, including basic life support and the use of an automated external defibrillator. Although not DPHC mandated training, a funding application had been submitted for the Band 6 nurse to undertake Paediatric Immediate Life Support training. Scenario based training was facilitated by the station in June 2022, including an airfield crash incident which practice staff were actively involved with. In addition, practice staff participated in scenarios involving mass casualties led by one of the units. Practice staff completed sepsis training in April 2022 and thermal injury training in July 2023

Information to deliver safe care and treatment

Staff advised that there were regular issues with accessing DMICP. The use of WiFi dongles has improved WIFI access in areas of the building with intermittent signal. In the event of a MODNET network outage, the practice had access to WiFi in the rooms with internet connection. With an outage, the practice followed the business continuity plan (BCP) and provided emergency appointments only. The BCP and a contingency pack containing relevant forms was held at reception. If paper documentation was used it was later coded and scanned to the patient's record. Other medical centres in the South Wales Group had access to St Athan DMICP so could view the clinic lists.

The Band 7 practice nurse was the lead for summarisation and searches were undertaken each month. At the time of the inspection, 99% of patients' records had been summarised.

Arrangements were in place for the regular auditing of doctors' and nurses' record keeping. Auditing of records had taken place shortly before the inspection. The military nurse was due to start a programme of auditing the record keeping of medics. We reviewed a range of DMICP records and noted gaps and inconsistencies with the standard

of doctors' record keeping, in particularly the use of clinical coding. Similar issues had been identified with the internal annual audit of the doctors' record keeping in May 2023. The outcome of the audit was discussed with each individual doctor and it was planned to discuss the overall findings more broadly at the next practice meeting. Overall, the nurses' records we reviewed were detailed in terms of history taking, clinical examination and recording the offer and use of a chaperone. For completeness, the records would benefit from inclusion of information given to the patient in the event of their condition worsening or not improving.

Referrals were managed by the administration team. A new system for managing referrals had been introduced in April 2023. The process had been simplified and included colour coding to indicate the status of each referral. Referrals were checked each week, including 2-week-wait referrals. Staff followed up with the relevant hospital if there were delays with receiving an appointment date. Once the outcome letter was received, it was scanned to the patient's record and the doctor tasked to review it. A separate log was maintained for internal referrals.

A process was established for the management of samples, including a log of all specimens sent to the pathology laboratory. The practice had a laptop that was compatible with local NHS services so was used for reviewing pathology, imaging and medical correspondence. The duty nurse checked Path Links (NHS clinical pathology network) each day. The duty nurse checked the specimen log to ensure results were received. The laboratory was contacted if there was any delay with the return of results. The duty doctor checked the pathology results daily and actioned them accordingly.

Safe and appropriate use of medicines

The SMO was the lead for medicines management. In their absence the RSMO and regional pharmacist were providing support. The 2 pharmacy technicians had shared responsibility for the day-to-day management of the dispensary.

Dispensary and stock management was undertaken in accordance with the DPHC SOP. Ambient temperatures of the dispensary were checked and recorded twice a day. Vaccines were in-date and were routinely rotated in the fridge. There was sufficient space around the vaccine packages for air to circulate. The temperature of the fridges was monitored twice a day.

Prescriptions were stored in a locked cabinet in the main office which was alarmed. Access was limited to doctors, nurses and the pharmacy technicians. The key was held in a key safe and staff recorded the sign-out of the key in a register. The code to the key safe had not been changed for some time. A log of prescriptions taken and by whom was maintained. An audit by the regional pharmacist July 2023 noted prescription audits were not routinely carried out. Since then, the technicians have been auditing prescriptions once a week. The practice or deputy manager carried out spot checks on prescribed and dispensed prescriptions in the dispensary.

A safe system was in place for repeat prescriptions. If the repeat prescription was agreed through remote consultation, then the doctor sent a task or called the dispensary. The prescription was printed and signed by a doctor before dispensing. Patients could also request a repeat prescription through email. A secure repeat prescription deposit box was

located outside the dispensary for patients to drop off requests. A display outside the dispensary advised patients about the importance of medication reviews and how repeat prescriptions could not be issued if the patient's medication review had expired.

Accountable and controlled drugs (medicines with a potential for misuse) were held securely in the controlled drug (CD) cabinet. The CD keys were kept in a key safe box in the dispensary. Only the practice manager, doctors and pharmacy technicians had the code to access the CD keys.

Patient Group Directions (PGD), which authorise practice nurses to administer medicines in line with legislation, had been authorised by the SMO. The practice nurses had completed the required PGD training. A PGD folder was held by individual nurses and PGD stock was stored in the nurses' rooms, including creams, nicotine replacement therapy and vaccines. A PGD audit was completed in May 2023. Occasionally, Patient Specific Directions were used by the medics for one of the units and these were appropriately managed and administered.

The NHS-compatible laptop was used by the administrative team to download all letters from secondary care and these were then disseminated to the doctors. The pharmacy technicians were advised by the doctor of the medicines recommended by secondary care and these were ordered for the patient.

The arrangements for monitoring patients prescribed high risk medicines (HRM) differed from that outlined in the DPHC SOP. The pharmacy technicians advised there was no set list of HRMs as the doctors previously decided there were too many HRMs identified in the SOP that needed to be included in the searches. For example, patients on ramipril (medicine for high blood pressure) should be on the HRM register according to the SOP but the practice did not include ramipril in the search as patients prescribed this medicine were included on the long term condition (LTC) register and in the routine LTC searches so any monitoring requirements would be identified through these processes.

The pharmacy technicians maintained a register on SharePoint of what the practice agreed were HRMs and weekly HRM searches were carried out. The pharmacy technicians advised that HRM searches were undertaken for any medicine with a secondary care shared care agreement (SCA), all red or amber drugs as determined by the NHS Hospital Trust (noting the practice covers at least 3 trusts and the Wales red/amber drugs differ from England) and any medicine determined to be on the list by the doctors as discussed at the 2 weekly HRM multi-disciplinary team meetings. Every time there has been a new SMO, the practice reviewed if this way of monitoring HRMs remained safe and acceptable. We checked a range of patients on the high risk register and appropriately signed and easily accessible SCAs were in place. In addition, an alert documenting the consultation/date when the agreement was put in place was attached. A HRM prescribing audit was undertaken June 2023 and discussed at the clinical meeting.

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

An antibiotic prescribing audit was undertaken in December 2022.

Track record on safety

We spoke with the lead for health and safety who was also the building custodian and lead for Control of Substances Hazardous to Health (COSHH), fire and equipment care. A risk register for the practice was maintained and a separate register for the station was also in place. The practice could transfer risks they were not in a position to address to either the station or region. The risk register was reviewed each month. Health and safety was a standing agenda item at practice meetings.

A register of up-to-date risk assessments covering all aspects of patient/staff safety was in place, including COSHH risk assessments. Any change to the assessments or underpinning policies were communicated to staff via email and discussed at the practice meeting. COSHH data sheets were held by dispensary staff and were reviewed 6 monthly. COSHH products were stored appropriately.

The fire risk assessment for the premises was undertaken in September 2020. The contractor checked the fire system and firefighting equipment each week. Fire drills were held every 6 months with the most recent taking place in March 2023.

Although the legionella risk assessment was held by the unit, evidence was in place to confirm the contractor carried out water safety checks each month. Taps were run each Monday. An annual gas check was undertaken in November 2022 and the 5-yearly electrical safety check in February 2020.

An equipment assessment (referred to as a LEA) was undertaken in March 2023 and the practice was in the process of addressing the minor recommendations. The unit was responsible for the testing of portable electrical appliances. A schedule was in place for an external contractor to monitor medical equipment.

There was a fixed audible alarm system for most rooms in the building. For those without access to the system, handheld alarms were available. Alarms were checked monthly but not recorded. The health and safety lead said they would start to record these checks. A statement of need had been submitted for the installation of an alarm system in all rooms. A lone working SOP was in place, although lone working in the building rarely happened as 2 clinicians were usually on duty.

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 Band 7 practice nurse was the lead for ASER and an ASER register was maintained. ASER was a standing agenda item at the practice meetings.

From interviews with staff and evidence provided, it was clear there was a culture of reporting incidents. Staff we spoke with gave examples of incidents reported through the ASER system including the improvements made following the outcome of investigations. For example, an ASER relating to the management of blood samples was thoroughly reviewed, discussed with the team and improvements made to the process. An ASER trend analysis completed in 2022.

All National Patient Safety Alerts for medicines and medical devices from the Central Alerting System were sent to the pharmacy technicians from region. Alerts were added to the regional spreadsheet on SharePoint and the technicians recorded the action taken. They also maintained a practice spreadsheet for the alerts. Alerts were discussed at healthcare governance meetings and forwarded to clinicians if relevant to the practice.

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, clinical pathways, legislation and standards. One of the nurses checked for NICE updates and updated the NICE register. NICE and other guidance was a standing agenda item at the fortnightly multi-disciplinary team (MDT) meetings. In addition, staff were kept informed of clinical and medicines updates through the Defence Primary Healthcare (DPHC) newsletter circulated each month. Vulnerable patients and patients with complex needs were discussed at the MDT meeting, which the local health visitor and school nurse were invited to attend. Entries in patients' records confirmed these discussions took place and were recorded.

Step 1 of the mental health intervention programme was undertaken at the practice. Two community psychiatric nurses (CPN) from the Department of Community Mental Health (DCMH) Bulford were based in the building so were easily accessible for advice, support and continuity of patient care. The DCMH team had streamlined a referral pathway for 1 of the units with specific operational needs to expedite care and determine fitness for deployment. Patients with mental health needs were discussed at the MDT meetings. In addition, patients could be referred to the welfare team, SSAFA (Armed Forces charity) and the Padre for additional support. We reviewed a small number of patients records which showed appropriate evidence-based management including assessment, diagnosis and intervention.

A visiting surgeon from University Hospital of Wales provided a minor surgery clinic. A treatment room with the necessary equipment was specifically set up to facilitate this activity. The health care assistant assisted the surgeon with procedures.

Monitoring care and treatment

One of the practice nurses was the lead for chronic conditions. They had developed a detailed practice standard operating procedure (SOP) for the recall of patients (SOP 05-01-13). It covered chronic conditions, routine medicals, health checks, health screening and child immunisations. The SOP provided clear guidance for searches to identify patients without a recall date and to highlight patients who required a review in the preceding 30 days. This SOP was a comprehensive practical guide for staff to follow when undertaking reviews and it provided consistency in how searches were carried out. Equally, the tracker to record searches was structured clearly illustrating each monthly search, including colour coding to indicate the status of standards and other pertinent information. The tracker was formatted to indicate when a patient was due to go out-of-

date with any relevant screening or recall. This facilitated timely invites for medicine reviews and chronic condition monitoring or vaccinations.

Text, letter and telephone calls were used to recall patients. Additional contact was made with patients who did not respond. Our review of a range of records showed patients diagnosed with a chronic disease were recalled and monitored in a timely way appropriate to their needs.

A low number of patients were diagnosed with diabetes and they were well managed. Searches were used to identify patients with previous raised blood sugar levels including during pregnancy and those patients were invited for an annual review. There were 19 patients with a diagnosis of asthma. Fifteen had been reviewed in the last year and 4 had been invited for review.

There were 15 patients recorded as having hypertension (high blood pressure). Twelve of these patients had a record for their blood pressure taken in the past 12 months and 4 patients had a blood pressure reading of 150/90 or less. A system was in place to follow up on all patients with any previous raised blood pressure (>140/90). If the patient’s blood pressure returned to normal then they were followed up within 5 years (timeframe dependant on previous recordings). All patients diagnosed with ambulatory hypertension were followed up with annual monitoring in accordance with NICE guidance.

Audiology statistics showed 72% of patients had received an audiometric assessment within the last 2 years. Joint Medical Employment Standards (referred to as JMES) were appropriately managed.

The audit register demonstrated the practice pro-actively engaged with quality improvement activity. The register included a link to the actual audit and frequency of when the audit was to be repeated. The register indicated a balanced range of data searches, mandated audits and some clinical audits. Population-based outcome audits were limited as the focus was on mandated audits as outlined in the DPHC Healthcare Audits SOP (9-6-1). We looked at 2 first cycle clinical audits in detail (bowel and sexual health) and noted inconsistencies in the approach. One did not have a clear structure, such as explicit criteria, standards identified and methodology. It also lacked sufficient detail, such as inclusion of clinical codes. Using a structured audit approach enhances reliability and validity particularly when undertaking further audit cycles.

Effective staffing

Staff had received an appropriate induction and appraisal. All new members of staff were required to complete the DPHC mandated induction which had been modified to include role specific elements and information relevant to the units. A member of staff new to the practice described a thorough induction including shadowing staff for 2 weeks. Locum staff were required to complete an induction and DPHC mandated training.

The practice manager monitored mandatory training on a monthly basis and informed staff via email and at the governance meetings of any outstanding training that required completion. Protected time was given to staff to complete mandatory training.

Clinicians had the appropriate qualifications to meet the needs of the patient population. At the time of the inspection, none of the doctors were qualified as a Military Aviation Medical

Examiner so Cosford Medical Centre were providing aviation medical cover. The practice nurse who was lead for infection prevention and control (IPC) attended the regional IPC forum. In addition, the Band 7 nurse was a non-medical prescriber and had a weekly meeting with the RSMO for support and feedback about their prescribing in the preceding week and for ongoing development/discussion. Led by the regional pharmacist, the pharmacy technicians attended quarterly meetings with technicians from the other medical centres.

A weekly in-service (trade) training programme was in place which aimed to keep the staff up-to-date in terms of knowledge and skills, and to support staff with continuing professional development (CPD). Staff could suggest training topics to be included in the programme. In addition, opportunities were available for staff to engage, discuss policy updates and share best practice with regional colleagues. For example, a weekly meeting was held between the 5 primary care practices in the region (South Wales and neighbouring English counties). Practice managers, doctors and the regional SMO (RSMO) attended the meetings which were chaired by the Area Manager. This forum provided opportunities for practice staff to engage with peer support, shared learning and clinical development within the region.

Staff visited the University of Wales Air Squadron in 2022 with the aim to gain a more in-depth understanding of aviation and to enhance management of patients, including awareness of occupational elements The visit included training about the Royal Air Force training school and cultural awareness relating to the international trainees.

Clinicians were responsible for maintaining their own CPD portfolio. Some staff highlighted they had been unable to take CPD days due to the shortage of staff and work pressure. Appraisal and revalidation were in-date for all clinical staff.

Coordinating care and treatment

Discussions with staff indicated the practice had well developed links with internal teams and services, including the units and welfare team. In addition, relationships were established with local health and social care services. For example, The Band 7 practice nurse maintained links with the safeguarding teams and local social workers. The CPNs based in the premises provided a link to the DCMH. The practice was in the early stages of a plan to de-register dependents of service personnel and the practice manager was the main link for liaison with local primary care practices.

Service personnel leaving the military were provided with a release medical form to give to the doctor at the practice they planned to register with. The form confirmed the patient was a veteran and explained how the NHS GP could obtain a full copy of the patient’s military health care record. For patients with complex needs, a formal hand over was given to the GP taking over their care. Patients were made aware of the Veterans Health Service and, if appropriate, the Veterans Mental Health Transition, Intervention and Liaison Service (TILS).

Helping patients to live healthier lives

The health care assistant was the lead for health promotion. A detailed health promotion strategy was in place for the practices within the region which aligned with national initiatives. It also took account of the patient population needs and seasonal influences. The health promotion programme was refreshed on a monthly basis. Health and lifestyle information was communicated through a range of health promotion displays and leaflets in the patient waiting area. For example, there were displays regarding heat illness and travel health. Health promotion was extended to the wider station with display boards available in the mess and educational centre.

The Band 7 practice nurse was the lead for sexual health and had completed appropriate training for the role. Patients could make an appointment for a sexual health matter at a time that suited them. The SOP for the recall of patients (SOP 05-01-13) included searches for patients with human immunodeficiency virus or HIV. Doctors had the option to refer patients to the Military Advice and Sexual Health/HIV (MASHH) service at Birmingham for complex sexual health needs that could not be treated at the practice.

In accordance with the SOP for the recall of patients, monthly searches were undertaken for bowel, breast and abdominal aortic aneurysm screening in line with national programmes. Appropriate action was taken to prompt patients to uptake screening if eligible. Ninety-five per cent of eligible women had had a cervical smear in the last 3-5 years. The NHS target is 80%.

A small number of parents declined the vaccination for their children. The following was the status of childhood vaccinations at the time of the inspection:

- 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 87%
- The percentage of children aged 2 who had received their booster immunisation for Pneumococcal infection was 87%
- 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 87%
- The percentage of children aged 2 who had received immunisation for measles, mumps and rubella (one dose of MMR) was 87%

  The percentage of children aged 5 who had received immunisation for measles, mumps and rubella (two doses of MMR) was 87%

The status of vaccinations for service personnel was:

- 96% of patients were in-date for vaccination against diphtheria.
- 96% of patients were in-date for vaccination against polio
- 99% of patients were in-date for vaccination against hepatitis B
- 99% of patients were in-date for vaccination against hepatitis A.
- 96% of patients were in-date for vaccination against tetanus.

- 92% of patients were in-date for vaccination against meningitis.
- 71% of patients were in-date for vaccination against mumps, measles and rubella.

Service personnel were not actively recalled for the meningitis vaccination but were vaccinated opportunistically.

Consent to care and treatment

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. Written consent was taken for minor surgery and a log maintained of consent taken. Signed consent forms were scanned and uploaded to the patient's record. Implied consent was taken for non-invasive examinations. A consent audit was undertaken in October 2022 and due again in October 2023.The clinical records we looked at showed consent was consistently obtained from patients where required.

Clinicians understood the Mental Capacity Act (2005) and how it would apply to the patient population group. The senior nurse at Brecon Medical Centre had facilitated mental capacity training for the team in October 2022. We were provided with an appropriate example of when a mental capacity assessment had been undertaken.

Clinicians had received training in relation to 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).

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

Thirty-eight patients provided written feedback as part of the inspection process and we spoke with 4 patients during the inspection. All respondents indicated staff treated patients with kindness, respect and compassion. We were given examples of when practice staff had gone ‘the extra mile’ to provide compassionate and supportive care and to patients.

Patients were asked about their preferred pronouns. A record of the patient’s religion was held on DMICP to facilitate the provision of appropriate vaccines, such as non-animal product based vaccines.

One of the practice team attended the unit introduction briefing for new intakes of service personnel to promote available services provided at the practice.

Details about how to access the HIVE Information Centre was available through the practice communications page and the practice information leaflet. Patients could also access the station welfare advisor and one of the units had its own welfare network. Welfare services were advertised in the waiting room.

Involvement in decisions about care and treatment

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

The Band 7 practice nurse was the lead for carers. Patients with a caring responsibility were managed in accordance with the carer’s standard operating procedure including identification through the patient registration process, use of coding on DMICP and inclusion on the carer’s register. Carers were offered additional services, such as the flu vaccination and annual health checks. Information for carers was displayed in the ‘carers corner’ of the waiting area and included details about local support services. A comprehensive practice leaflet was sent to all new joiners to the practice, which highlighted local and national support for carers. The needs of carers were discussed at the multi-disciplinary team meetings and, if appropriate, at the unit health committee meetings.

An interpretation service was available for patients who did not have English as a first language. Information about this service was displayed in the premises.

Privacy and dignity

There was a clear process for enhancing privacy and confidentiality for patients at reception. Patients were required to stand back until called forward. A television and radio

in the waiting area provided background sound to minimise conversations being overheard. Privacy rooms were available if patients wished to discuss a matter in private. 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.

All staff had completed the mandated Healthcare Governance and Assurance training.

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 responsive services.

Responding to and meeting people's needs

The service was responsive based on the needs of the patient population. For example, one of the units operated at a high tempo and was a rapidly deploying sub-section of the Armed Forces. The staff team was very pro-active and flexible to accommodate the needs and short notice deployability of this cohort of patients, including provision of short notice lunchtime and evening clinics. Children were not triaged by telephone and face-to-face appointments were offered as the practice considered this the safest option. Urgent appointments were available for children after school hours.

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 and trained diversity and inclusion advisors were available. An Equality Access Audit for the premises was completed in November 2021. Issues identified in the audit had been added to the issues log. A hearing loop was available at reception. A statement of need had been submitted for automatic opening doors.

Clinicians were aware of the organisational policy for the management of transgender personnel to ensure they received appropriate clinical care, support and early referral. The standard operating procedure (SOP) for the recall of patients (SOP 05-01-13) included searches for patients undergoing gender reassignment to ensure they were invited for appropriate screening.

A private facility was available if a patient wished to breast feed their baby in private. A baby changing and baby massage room was also available.

Baby massage classes were offered by one of the practice nurses with the relevant training. Staff advised us that it had been well received by parents. It also provided an opportunity for further health promotion and early identification of any issues that a new parent might be experiencing.

Timely access to care and treatment

Feedback from patients confirmed they received an appointment promptly and at their preferred time. Requests for medical advice and appointments could be arranged by telephone or via eConsult. Patients had a choice of telephone or face-to-face consultations. Urgent appointments with a doctor, nurse or physiotherapist could be facilitated on the same day. A routine appointment with a doctor or nurse was available within 2 days. Although home visits could be accommodated, none had been requested or required since 2021. A basic home visit register was in place with a more detailed register held on DMICP.

The practice provided a service to all its patients between 08:00 to 17:00 hours Monday to Friday. A duty medic provided urgent telephone advice from 17:00 to 18:30 hours Monday

to Friday. A doctor provided cover for the region from 17:00 to 18:30 hours Monday to Friday. Outside of these hours and during weekends and public holidays, patients were directed to contact NHS 111.

Listening and learning from concerns and complaints

The practice manager and deputy practice manager were the leads for complaints. Complaints were managed in accordance with Defence Primary Healthcare (DPHC) 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 DPHC governance webpage. There had been 1 complaint in the last 2 years and it had since been resolved. Complaints was a standing agenda item at the practice meetings.

Are services well-led?

We rated the practice as good for providing well-led 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 mission for the practice was:

"To deliver safe and effective Primary Health Care, aviation and occupational medicine to our practice population to enhance and sustain the operational effectiveness of Mod St Athan."

Similar to other medical centres in the region, (South Wales and neighbouring English counties), the practice had experienced disrupted staffing levels, particularly for staff in leadership positions. To maximise resilience, a remote practice support network was developed for the region in 2020 with a regional Senior Medical Officer (RSMO) central to the network. Objectives of the network included strengthening resilience for all practices during times of staff shortage, sharing best practice and the use of collaboration to promote collective development.

The building St Athan Medical Centre is located in is planned to close and the medical centre will move to a new location. As the families and dependents of service personnel will be unable to access the new location, the practice manager was engaged with local NHS practices regarding the transfer of their care. Stakeholder engagement has been taking place to ensure a streamlined process within a timescale agreeable to everyone concerned.

Leadership, capacity and capability

Despite the challenges with inconsistent staffing levels, staff indicated there was sufficient management/leadership capacity at the practice to meet the needs of the practice and patient population. The RSMO was providing clinical leadership oversight in the absence of the SMO and also covering clinics in the absence of sufficient doctor hours. Levels were due to improve with the appointment of a Senior Medical Officer (SMO) for 6 months and recruitment of a deputy SMO. A locum doctor was also due to start. The deputy practice manager was due to be disbanded shortly after the inspection. It was too early to determine the impact this would have on leadership capacity.

Staff described effective support from the RSMO and regional team. The area manager worked from St Athan Medical Centre 2 days a week and was visible and available to the team.

Culture

It was clear from patient feedback and how practice staff responded to patient and the occupational needs of units that 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.

An Internal Assurance Review (IAR) in 2022 indicated a fluctuating morale within the staff team. Staff indicated morale was influenced by staff shortages, fatigue and unnecessary changes being introduced. We were told a lack of administrative staff continued to impact the morale of the medics. Although morale had continued to fluctuate, staff we spoke with described how the team worked well together supported by an inclusive and approachable leadership team. Staff were looking forward to stability with the imminent arrangement to increase staffing levels. The RSMO suggested that the effective working relationship between the SMO and practice manager had led to improvements in morale since the last IAR.

Staff told us they felt respected, supported and valued by the leadership team. Everyone had an equal voice, regardless of rank or grade. Both formal and informal opportunities were in place so staff could contribute their views and ideas about how to develop the practice. The leadership team promoted an open-door policy and encouraged staff to share their views at meetings. Staff said they would feel comfortable raising any concerns and were familiar with the whistleblowing policy. They were familiar with the Freedom to Speak Up (FTSU) policy and were aware of how to access FTSU representatives.

Initiatives were in place to enhance staff morale and wellbeing. For example, sport at lunch time for military staff was encouraged. ‘White space’ activities were taking place. Social activities included BBQs in the central garden area. ‘Toastie Tuesdays’ had been introduced whereby the team get together at break time.

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 effectively managed, including the patient being informed.

Governance arrangements

There was a clear staff reporting structure in place and all staff were aware of their line management arrangements. Equally, staff were aware of their roles and responsibilities, including secondary lead roles for specific areas. Terms of reference were established for those with secondary roles. A comprehensive rolling 5-weekly meeting structure was in place. To ensure effective weekly planning and oversight, a diary meeting attended by all staff was held each Monday followed by a meeting for administrative staff. Clinicians attended the 2-weekly multi-disciplinary team meeting. Practice, heads of department and team building meetings were held each month. Both a continuing professional development and all-staff governance meeting took place bi-monthly.

The Band 7 practice nurse was the healthcare governance (HCG) lead. A clear and comprehensive healthcare governance workbook was maintained which brought together in one document the wide range of practice governance activities. These included the risk register, tasks and checks, audit, health and safety and quality improvement. Staff had access to meeting minutes through links added to the workbook.

The range of policies and standard operating procedures (SOP) were identified on the healthcare governance workbook. Each included a link to the policy SOP, date of review and member of staff responsible for the review.

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 business continuity plan was reviewed in January 2023. It took account of all the likely generic system failures and had clear guidance for the need to relocate if required.

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

The leadership team was familiar with the policy and processes for managing staff performance. Although not a concern that was indicated, the leadership team was familiar with the range of processes to manage performance including the 'supporting attendance' approach.

Appropriate and accurate information

The DPHC electronic health assurance framework (referred to as HAF) was used to monitor performance. The HAF is an internal quality assurance governance tool to assure standards of health care delivery within defence healthcare. The practice manager used the HAF as a management tool. All staff had access and each department updated the HAF for their department.

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. A quick response or QR code was available for patients to leave feedback and this was reflected in the organisational-wide patient survey (referred to as GPAQ) patient experience questionnaire results available on the DPHC

Governance SharePoint page. A ‘You said, we did’ board captured the changes made based on patient feedback. Feedback was discussed as a standing agenda item at the monthly practice meetings.

Good and effective links were established with internal and external organisations including the welfare team, units, Department of Community Mental Health and local health and social care services.

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 audit calendar was in line with the current DPHC audit schedule. Quality improvement activity, including individual audits, were discussed at the healthcare governance 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. The QIPs practice staff highlighted included the provision of a baby nursing/massage room, the NHS-compatible laptop for reviewing pathology, imaging and medical correspondence and an aseptic non-touch technique to improve wound care. Although unclear whether the SOP for the recall of patients (SOP 05-01-13) had been raised as a QIP, we identified that raising it as a QIP would benefit other practices.