







Cosford Medical Centre

Wolverhampton, WV7 3EX

Defence Medical Services inspection report

This report describes our judgement of the quality of care at Cosford 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	Outstanding	
Are services safe?	Good	
Are services effective	Good	
Are service caring?	Good	
Are services responsive to people's needs?	Outstanding	
Are services well-led?	Outstanding	

Contents

Summary	3
Are services safe?.....	7
Are services effective?	15
Are services caring?	22
Are services responsive to people's needs?	24
Are services well-led?	27

Summary

About this inspection

We carried out an announced comprehensive inspection at Cosford Medical Centre on 26 September 2023. The 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. The primary care rehabilitation facility was not inspected as part of this inspection due to there not being a physiotherapist specialist advisor available.

This inspection is one of a programme of inspections that 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:

- A person centred culture was embedded to ensure patients received quality and compassionate care to meet their individual needs.
- Patients received effective care reflected in the timeliness of access to appointments, reviews and screening/vaccination data. A successful catch up programme had recently been completed.
- The practice had forged close working relationships within military healthcare, with NHS organisations and with the local community in planning how services were provided to ensure that they meet patients' needs.
- Multidisciplinary team meetings were held in the medical centre on a monthly basis, and care plans for complex patients drawn up jointly with other professionals to ensure the best care was provided.
- Processes were in place to identify patients who were considered vulnerable and coding was applied on the patient record. Staff had completed safeguarding training appropriate to their role.
- There was a safe system for the management of specimens and referrals.
- We identified minor deficiencies in the medicines management processes, most were rectified on the day of inspection.
- The practice had suitable health and safety arrangements in place to ensure a safe service could be delivered.
- Risks to the service were recognised by the leadership team. The main risks outside of the practice's control had been escalated and workarounds implemented. A range of risk assessments were in place for the practice.

- Facilities and equipment at the medical centre were sufficient to treat patients and meet their needs.
- Staff were aware of the requirements of the duty of candour and monitored compliance. Examples we reviewed showed the practice complied with these requirements.

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

- The practice had an extensive and comprehensive approach to the induction and continuing professional development of clinical staff. This included a forum of doctors that conducted peer review and notes audits as part of the assurance process for new and locum staff. This approach was supported by a no blame, supportive culture in which staff could grow and develop.
- The staffing and governance structure consistently combined to provide resilience and promote a safe environment. Of note, leads and deputy roles were spread throughout the team, supported by training and covered all key areas. The referral tracking system was both extensive and comprehensive whilst being easy to follow and use. The significant events and complaint audits were in depth and provided a clear focus on continuous improvement.
- The appointment system had been meticulously configured to maximise the delivery of primary care. It had provided resilience when prioritisation of appointments was required. It also took account for personal, professional and cultural needs whilst simultaneously providing quick access to see a clinician.
- Leadership at the practice consistently received praise from patients, colleagues and external stakeholders. This included medical staff's contributions to Station Personnel Support Committee activity and positive feedback received from the station welfare team.
 - One of the doctors who was the musculoskeletal (MSK) lead had developed close working relationships with Stanford Hall, the MSK service in Telford and set up referral pathways with the Robert Jones and Agnes Hunt Orthopaedic Hospital in Oswestry where there was a veteran centre and military consultant. We were given an example of when the doctor had worked closely with Stanford Hall to facilitate the transition of a patient with disabilities and complex medical needs to transition to a local NHS practice. Stanford Hall is the Defence and National rehabilitation Centre based in Nottinghamshire. Quality improvement work was extensive and made a positive impact on patient care. Following the identification of a root cause in respiratory problems, the practice facilitated the identification of a non-hazardous solder flux (a substance used to form a strong bond between parts of electronics or wires) material and the reduced the burden on surveillance spirometry (breathing test). This had freed up nursing hours and had a positive impact on patient care highlighted by the force protection statistics and long-term condition monitoring and outcome data.
 - In addition, a mental health support leaflet and a service leaver's guide had been designed by the medical centre team and both been adopted by the region. A number of quality improvement projects had been developed including

improved access for school children, cervical screening and sexual health appointments.

- The practice took steps to protect the environment through recycling and repurposing.

Dr Sean O’Kelly BSc MB ChB MSc DCH FRCA

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

Our inspection team

The inspection team was led by a CQC inspector. The team comprised specialist advisors including a primary care doctor, a practice manager, a primary care nurse and a pharmacist. One specialist advisor new to the CQC and two colleagues from DMSR were also in attendance as observers.

Background to Cosford Medical Centre

Located in Shropshire, Cosford Medical Centre provides routine primary care and occupational health care service to a patient population of 2,144 military personnel. Families living within a 5 mile radius of the station boundary were also able to register as patients. The station houses the Defence School of Aeronautical Engineering, No1 radio School, Defence School of Photography, RAF School of Physical Training as well as musicians, international students (engineering and language) and the University of Birmingham Air Squadron. A Primary Care Rehabilitation Facility (PCRF) situated in the building is an integral part of the medical centre and provides personnel with a physiotherapy and rehabilitation service. The medical centre also has its own dispensary.

The medical centre is open from 08:00 to 17:00 hours Monday to Friday. Wednesday afternoons are protected for training but patients can still access services by telephone and urgent patients can be seen. The medical centre was staffed by a duty RAF medic at lunch times and between the hours of 17:00 and 18:30 on weekdays. Outside of these hours, patients are signposted to the NHS111 service or 999 service. Due to it being a flying station, medical cover is provided 24/7 by a duty medic. Medics triage any call and signpost patients or book them in for an appointment at the medical centre. The duty phone number was detailed in the patient information leaflet and held in the guard room that was manned 24/7.

The staff team

Doctors	1 Senior Medical Officer (SMO) 1 Deputy Senior Medical Officer (DSMO)
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	1 Unit Medical Officer (UMO) 3 Civilian Medical Practitioners (CMP) 1.9 whole time equivalent (WTE)
Nurses	2 military nurses (Band 7) 3 civilian nurses 2.6 WTE (Band 6) 1 healthcare assistant
RAF medics	10 (DPHC assets, not unit)
PCRF	5 civilian physiotherapists 3.8 WTE 3 exercise rehabilitation instructors (ERI) 1 PCRF administration support
Pharmacy technicians	2
Environmental health technician	1
Practice manager	1
Administrators	3 E1 administrators 2.4 WTE 1 E2 administrator

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

Are services safe?

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

Safety systems and processes

The medical centre worked to the Defence Primary Care Healthcare (DPHC) Tri-Service safeguarding policies. There was also a domestic violence and abuse policy and a vulnerable person register policy supported with a standard operating procedure (SOP). All were linked through the electronic health assurance framework (eHAF) and had been reviewed in the last 12 months. The child safeguarding and adult safeguarding policies were separate, both had a clear process and flow chart to guide on how concerns should be escalated. The policies included contact addresses and telephone numbers for the local safeguarding teams (both in hours and out of hours), and these were displayed in the waiting areas and clinical rooms. Staff interviewed during the inspection were fully aware of the policies and knew how to report a safeguarding concern. Following a review of the safeguarding policies, the revised versions were communicated to all staff. On completion, all staff were required to sign the governance mandated orders proforma and these were held in their personal folders. Families and immediate family who lived within 5 mile radius of the medical centre were able to register, those who lived further than 5 miles away were signposted to register at an NHS practice. In addition to these policies, there was also the 'Station Supervisory Care Directive' for any concerns relating to trainees including those under the age of 18.

The status of safeguarding and vulnerable patients was discussed regularly with the welfare team. In addition to informal discussion and the monthly clinical meeting, the needs of vulnerable patients were discussed at the monthly Unit Health Committee meetings attended by a Medical Officer and one of the practice managers. We contacted the Welfare Officer for the camp who told us they provided a welfare service to some vulnerable young individuals. They praised the communication with both administrative and clinical staff. Informal communication took place daily and the medical centre team made valuable contributions to the monthly Station Personnel Support Committee (unit welfare meeting). We were told that urgent appointment requests had always been accommodated. The practice had also established external links with safeguarding agencies in Shropshire. A letter had been sent out to local safeguarding teams and to local practices where immediate family members may be registered. This letter provided key contacts at Cosford as well as making them aware of the potential for service family members and the additional welfare support that available for families.

One of the Civilian Medical Practitioners (CMPs) was the safeguarding lead with the Deputy Senior Medical Officer acting as deputy. Both were trained to safeguarding adults and children level 3. All other staff had completed safeguarding training appropriate for their role (all clinical staff were level 3 trained). The Warrant Officer was the safeguarding administrator. Training was delivered through a combination of 'elearning for healthcare' and live online training courses.

The team made regular contact with all military personnel considered vulnerable. The team had a network of contacts with internal and external services such as the health

visitors and Padre. The medical centre worked closely with the Department of Community Mental Health (DCMH) and the welfare services. We contacted the welfare team and padre as part of this inspection to hear that strong links existed with the medical centre staff, communication was excellent and access to urgent appointments were always accommodated.

Vulnerable patients were identified during consultation, DMICP (clinical operating system) searches and on referral from another department such as the welfare team. Coding was applied to clinical records to identify patients considered vulnerable and urgent appointments were offered. A 'patients of concern' register was maintained on DMICP and included vulnerable patients and those with safeguarding or welfare concerns. Patients on the register were reviewed monthly by the safeguarding lead and discussed in the monthly clinical meeting (attended by all clinicians). The safeguarding lead was responsible for updating DMICP with any new information following the meeting. Any new concerns raised would be reviewed sooner and communicated to relevant personnel so information was shared in advance of the next meeting.

Phase 2 students who were downgraded often required a case conference to discuss their retention in service. This was coordinated by the Training Pipeline and Risk Management cell. To best support the patients and improve their chances of being retained, the practice recognised the requirement for confidential information to be shared and discussed. A quality improvement project (QIP) was undertaken to introduce a bespoke consent form to enable the patients to be fully informed when giving their consent.

Chaperone training was captured on induction. The practice manager monitored the staff database on a monthly basis and informed personnel when their refresher training was due to expire. Lists of trained chaperones were displayed in each consultation room and in reception. We noted that there was a good mix of male and female chaperones available. In addition, the chaperone poster had been translated into Arabic for overseas patients. The chaperone policy was included in the patient information leaflet and displayed on the practice's SharePoint communications page.

The full range of recruitment records for permanent staff was held centrally. However, the practice could demonstrate that relevant safety checks had taken place for the staff, at the point of recruitment, including a DBS check to ensure staff were suitable to work with vulnerable adults and young people. An electronic record identified when each member of staff was required to renew their registration.

Staff were up-to-date with their Hepatitis B vaccination and there was a Hepatitis B register available to view.

A process was in place to manage infection prevention and control (IPC). The current IPC lead was a practice nurse who had completed specific training for the role (the 2 day link practitioner course), accessed the DPHC IPC compendium for support and attended the quarterly IPC link forum led by the DPHC IPC lead. There was a named deputy lead who had completed role-specific training (the level 7 module). IPC training was included for all staff as part of induction. Additional internal face-to-face training was delivered by the IPC lead nurse as part of the trade training programme. All staff were currently in-date with training.

Regular IPC audits were carried out including the DPHC mandated audits that were scheduled into a monthly rolling programme. All of the audits we reviewed were in-date. These included the annual audit in 2023 that showed full compliance. An action plan was raised to address issues identified. Minutes from the healthcare governance meetings evidenced that discussion did take place and IPC was included as a standing agenda item. There were no outstanding issues that had not been actioned.

Environmental cleaning was provided by an external contractor. A written cleaning schedule was in place for each room and these were signed off to confirm that cleaning tasks had been completed in line with the required frequency. There was a named cleaning lead and deputy for the practice. Any issues identified were discussed with the cleaning contractor. Staff spoke of a strong working relationship with any issues quickly rectified. Weekly spot checks were conducted by the practice manager and documented in the healthcare governance (HcG) workbook. These were complimented by a monthly walk round by the cleaning company's supervisor. The cleaner felt very much part of the team and was highly thought of by staff. This was reflected in the cleanliness of the facility. Arrangements were in place for deep cleaning, the last one had been carried in April 2023.

Healthcare waste was appropriately managed and disposed of with the environmental health technician (EH Tech) named as the responsible individual. 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. Waste transfer was recorded by email with paper copies held. Consignment notes were retained by the practice and an annual waste audit carried out in August 2023 showed full compliance. There were two lockable external waste bins firmly secured with keys held by EH Tech. Signed disposal certificates were retained and seen on the visit.

Risks to patients

The management team believed that the establishment of the practice was adequate for the patient list size. Vacant posts had been filled with locum staff whilst recruitment took place or to cover detachments of military staff. Locum staff included a Medical Officer, pharmacy technician and nurse, secured in order to meet the needs of patients while vacant posts were being recruited for. Recruitment was underway to appoint permanent staff into vacant roles.

We found that access to appointments was good and a system was in place which facilitated same day face to face appointments with a doctor when needed. The SMO had an extended role and acted as the SMO for 5 medical centres within the region. Cosford also provided clinical support up to 18:30 (referred to as shoulder cover) for 4 medical centres in the region. The practice had agreed that whenever possible, they would avoid dropping below a minimum of 3 doctors in clinic at any one time in order to maintain a manageable workload. If this happened for more than 3 days, then care would be prioritised in accordance with DPHC's priorities and regional assistance would be requested.

Arrangements were in place to check and monitor the stock levels and expiry dates of emergency medicines. We saw evidence to show that an appropriately equipped medical emergency kit and trolley was in place and regularly checked. We identified a number of

minor issues that did not present a risk to patients and were rectified on the day. There was a medic response car that could be used to transport patients from the airfield. In the event of an ambulance being required, an NHS ambulance would attend alongside staff from the practice. However, there had been no requirement to use the vehicle as an Air Ambulance station based within the airfield would respond to any incident (dependant on the ambulance being manned as it was not a 24 hour service). The incorrect control solution was being used for the blood glucose monitors but this was rectified on the day.

The staff team was suitably trained in emergency procedures, including basic life support (BLS), automated external defibrillator (AED) sepsis and anaphylaxis. Annual refresher training in BLS, AED and the use of emergency equipment was mandated for all staff. All RAF Medics were in-date for 3 yearly Immediate Emergency Care Provider (IECP) which included responding to medical emergencies, the management of thermal injuries and dealing with suspected spinal injuries. Emergency training courses completed by staff online had all been supplemented by face-to-face training delivered by the clinical team and by a visiting paramedic.

Clinical staff had completed their hot/cold injury mandatory training, last refreshed in July 2023. Sepsis training had been completed and was also last refreshed in July 2023. The 3 Medical Officers were trained in aviation medicine and the SMO was a Flight Medical Officer (held a diploma in and taught aviation medicine). The SMO was involved with the Aeromedical Evacuation Control Centre at Tactical Medical Wing and frequently deputised at the Authorising Officer for all tri-service Aeromed requests.

A closed circuit television system (CCTV) in the waiting room allowed patients to be observed whilst waiting. The monitors covered all of the cameras situated in the waiting area and it was the responsibility of the designated receptionist to monitor the CCTV. However, this had been temporarily disconnected due to security issues. To mitigate the switch off of the CCTV, the deputy practice manager created a timed walkaround poster to ensure each of the waiting areas were checked by a member of staff every half hour.

Information to deliver safe care and treatment

The DPHC SOP was followed for the summarisation of patients' notes. The process for summarising and scrutinising notes was incorporated into the arrival process for patients. This process also included the 3 yearly review of patient notes. DMICP searches to provide oversight of notes that required summary or review were used by both the practice manager and nursing manager. A total of 91% of notes were summarised and those awaiting summarisation were not overdue. Obtaining civilian notes was prioritised as military patients who joined would already have notes available in DMICP. Medics contacted LaSCA (an agency that provided administration support to the healthcare industry) who in turn would contact NHS GP surgeries to request NHS records. A tracker of requests was maintained and records chased up when not received in a timely manner.

A peer review programme of doctors' DMICP consultation records was in place. The doctors all reviewed 10 sets of notes for an individual and graded them against a check-sheet. A doctor's meeting was then held to review the notes and discuss their findings. The consensus of opinion was recorded on a score sheet and then given to the doctors who undertook the consultations (for them to reflect upon any point of note and to use in

their annual appraisal). The peer review of notes for the nurses was carried out as part of the induction for new staff and locums in order to complete assurance. Permanent nurses had annual reviews carried out on their records with feedback given anonymously. There was a feedback template on the HcG workbook that provided a clear structure to support staff with the process. Medics did not undertake any routine consultations other than recording basic patient information onto templates. Any medics that did consult with a patient would receive ad-hoc feedback from the duty doctor and this was highlighted within the duty doctor and duty medic orders.

Co-ordinated by the administration team, a comprehensive and effective system was in place for the management of both internal and external referrals. Each referral was added to a tracker and this was reviewed monthly at the practice meeting. Urgent referrals were highlighted and prioritised. The administration team monitored the referral tracker daily and all staff granted access could view the document. Referrals remained on the tracker until the report had been returned and actioned and the patient discharged. Any appointment not attended by a patient was followed up. The referral tracker included an index of useful documents and contacts as well as an instruction guide on how to use the tracker. A RAG (red, amber, green) system was used to give clear visibility of the status for each referral. Any 'advice and guidance' discussion between clinicians could be made into a referral and these were also included on the tracker. Internal referrals including those made by the primary care rehabilitation facility were managed as part of the process.

An effective process was in place for the management of specimens and this was supported by an SOP. Specimens were requested electronically and the clinician discussed with the patient at the time of request how they would like to receive the results (text, face to face or email). This was clearly documented on records. Samples taken were recorded on an online spreadsheet and results were returned via the PathLinks (electronic link between the pathology laboratory and healthcare professionals) inbox. These were then reviewed by the nursing team who updated the spreadsheet to confirm receipt before allocating to the requesting doctor for action. Results were also reviewed by the duty doctor as a failsafe. Nurses were given protected time in clinics to complete the tasks involved with the management of samples. At the end of the week, the spreadsheet was reviewed and any tests that remained outstanding were chased up. This review included a check by the nursing team on the inbox of any absent doctor. If any results were awaiting review, they were immediately moved to the inbox of the duty doctor. The duty doctor reviewed and filed all results for doctors that were out of office for longer than 7 days. Filed results could then be left in the requesting doctor's inbox for review, action and archiving as appropriate.

DMICP outages and system freezes were not an issue at Cosford. There was Wi-Fi in the building and because all staff had laptops, they could be used to connect to DMICP when the local area network was down. If the outage was widespread, the practice would refer to their business resilience plan (BRP) and reduce to seeing emergency patients only. Packs of paper forms were available to document clinical notes manually for scanning onto DMICP at the soonest opportunity. The practice also held paper ASER and safeguarding referral forms and clinics were routinely printed for the following day.

Safe and appropriate use of medicines

There were systems in place for the safe handling of medicines. A number of minor issues were raised during the inspection. Most of these were rectified on the day and did not create any risk to patients. Those not actioned on the day were where the practice had previously identified and work was ongoing to address the issue; for example, signage for vehicles that carried medical gases was awaiting a response from military transport.

The Unit Medical Officer (UMO) was the named lead for medicines management and a pharmacy technician named as deputy. This was reflected in their terms of reference (TORs). The day-to-day management was delegated to the pharmacy technicians and this was reflected in their TORs.

Arrangements were in place for the safe management of controlled drugs (CD), including destruction of unused CDs. We saw that monthly checks had been completed; the CD specimen signature list was complete. The CD cabinet was compliant and access controlled. Destruction certificates had been completed and although witnessed, these were destroyed in the presence of practice staff. We highlighted that the destruction of all CDs must occur in the witness of an individual external to the practice.

Emergency medicines were easily accessible to staff in a secure area of the medical centre and all staff knew of their location. The storage of oxygen and Entonox (an inhaled gas used for pain relief) cylinders was safe and the area was clear of clutter. Appropriate signage was displayed on the doors of rooms containing medical gases. There was no signage on the vehicle used to transport medical gases but this had been forbidden by military transport. We discussed potential workarounds which the practice planned to follow up on.

Medication requiring refrigeration was monitored twice a day to ensure it was stored within the correct temperature range. Storage arrangements for the vaccinations were secure and all stock was found to be in-date.

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

Prescription pads were stored securely in the dispensary. There was a system to track their issue and usage to the individual prescriber.

Patient Group Directions (PGDs) had been signed off to allow appropriately trained staff to administer medicines in line with legislation. The PGDs were current and signed off by the authoriser. Medicines that had been supplied or administered under PGDs were in-date. Patient Specific Directions were not used at the practice.

Requests for repeat prescriptions were managed in person, email or by e-Consult, in line with policy. Requests were received into the group email inbox, managed by the pharmacy technicians and signed by a doctor. Repeat prescriptions were issued by the pharmacy technicians if in-date for a review and up-to-date with blood tests. Queries and issues that could not be dealt with by the pharmacy technicians were passed to the doctors. Medics did not issue medicines if the medication review date had expired, and instead, referred the request to the prescriber. A process was in place to update DMICP if changes to a

patient's medication was made by secondary care or an out-of-hours service. The repeat prescription process was detailed in the practice leaflet and in a poster displayed at the dispensary hatch.

The 5 patients on repeat medication we checked had all been managed appropriately. We saw evidence to show that patients' medicines were reviewed regularly and the doctor's notes in DMICP around medication changes were comprehensive. The practice was aware of the backlog of patients on repeat medication overdue a review and had formulated a catch-up plan.

Regular reviews of patients prescribed with antibiotics were conducted internally and by the regional team.

A process was established for the management and monitoring of patients prescribed high risk medicines (HRM). The register of HRMs used at the medical centre was held on DMICP and all doctors and relevant clinicians had access to this. We looked at a sample of patient records and saw that all had been coded, monitored within recommended timescales and had shared care agreements in place. Monthly internal audits of HRMs were conducted and assured by a quarterly regional audit.

Track record on safety

Measures to ensure the safety of facilities and equipment were in place. Electrical and gas safety checks were in-date. Water safety measures were regularly carried out with a legionella inspection conducted in June 2023. 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. A land equipment audit completed in March 2023 achieved full compliance with two minor observations.

A system for monitoring and recording the servicing of all clinical/non-clinical equipment was established, this included equipment in the PCRf.

Staff had adopted the current risk template as per DPHC guideline and used the 4Ts (treat, tolerate, transfer or terminate) to manage risk. The practice manager and the deputy practice manager had completed the necessary courses to conduct risk assessments and all risk assessments were in-date at the time of the inspection.

The HcG workbook contained active and retired risk registers. The active risk register was reviewed regularly with risk management being a standing agenda item at the monthly practice and HcG meetings.

The business resilience plan (BRP) for the station, last updated in February 2023, was held in the medical centre comprehensive in covering the most likely causes of a major incident. The plan referred to the role of the medical centre in the event of a major incident and had hyperlinks to the business continuity plan, risk management matrix and outbreak and control plan. The BRP included a list of key personnel together with their contact details. These included the IT service centre, the Station Commander and members of the regional team. A station crash exercise involving the medical centre had taken place in April 2023.

The medical centre had a fixed alarm system that was tested regularly for both serviceability and response.

Staff had the information they needed to deliver safe care and treatment to patients. If there was an unplanned DMICP outage, the medical centre would use laptops and Wi-Fi if it was a local network server issue. The business continuity plan detailed workaround steps should problems with connectivity continue.

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 ASER lead was the practice manager who was deputised by the deputy practice manager, this was reflected in their TORs. The staff database showed that all staff had completed ASER training and discussion around learning took place at the monthly practice management and HcG meetings. A record of ASERs was maintained by the practice manager and we saw these had been completed in a timely manner and included a completion date, whether or not the ASER had been added to the risk/issues log and a note of any lessons learnt.

From interviews with staff and evidence provided, it was clear there was a culture of reporting incidents for all staff. 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. An ASER log was maintained on the HcG workbook and included any resultant changes made.

Annual ASER audits were completed twice a year. The most recent audits highlighted the main trends as being a reduced staffing of the doctors and nurses, the referral process, repeat medications and IT issues, specifically DMICP. The staffing issue had been rectified and the nurses had a robust practice development plan for their department. DMICP was due to be replaced by the new CORTISONE system. The referral process had been developed and was seen to be highly effective and robust.

A system was in place for managing patient safety alerts. This was previously tracked by the pharmacy technicians and distributed in-house. However, this had recently been changed to a centralised DPHC function. Although the DPHC template was populated and submitted, the practice continued to use their own system as an addition to maintain records of actions taken. All prescribers were encouraged to register to receive MHRA and CAS into their personal e-mail inboxes in addition to receiving the DPHC emails. The pharmacy technicians continued to send out emails when the practice received an alert (from MHRA or DPHC). We were given a recent example of an alert on the underdosing of a medication (calcium gluconate) in the treatment of hyperkalaemia (high levels of potassium in the blood). Alerts was also a standing agenda item for the monthly HcG meeting.

Are services effective?

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

Effective needs assessment, care and treatment

Arrangements in place to ensure staff had a forum to keep up-to-date with developments in clinical care and guidance included monthly clinical and healthcare governance (HcG) meetings. The formal meetings incorporated an agenda item to discuss national clinical guidance, including NICE (National Institute for Health and Care Excellence) and the Scottish Intercollegiate Guidelines Network (SIGN). The Unit Medical Officer (UMO) reviewed the updated NICE guidance in the previous month and sent a summary to the clinicians. Those relevant to primary health care and those that required a more thorough discussion/review were distributed to doctors to summarise and discuss at subsequent meetings. The Senior Medical Officer (SMO) told us that many informal discussions occurred in relation to patients/cases of interest in the crew room. An informal discussion in the crew room led to the circulation of the 'Red Whale' summary on testosterone testing and replacement.

Our review of clinical records demonstrated that clinicians carried out assessments and provided care and treatment in line with national standards and guidance, supported by clear clinical pathways and protocols.

Staff were kept abreast of clinical and medicines updates through the Defence Primary Healthcare (DPHC) newsletter circulated to individual staff and to the medical centre each month. Participation with regional events and forums also provided an opportunity for clinicians to keep up-to-date.

Monitoring care and treatment

Long-Term Conditions (LTCs) were managed by the nursing team within which there was an appointed lead and deputy. DPHC standard operating procedures (SOPs) outlining the management and monitoring arrangements for LTCs reflected current management at practice level. We looked at a sample of patients' notes, they were comprehensive and in good order. The medical centre provided us with the following data:

- The small number of patients on the diabetic register were regularly monitored in accordance with best medical practice guidance. Processes were in place to identify and monitor patients at risk of developing diabetes.
- There were 33 patients on the hypertension register who were regularly monitored in accordance with best medical practice guidance. All 33 patients had a record of their blood pressure taken in the past 12 months and 23 had a blood pressure reading of 150/90 or less.
- There were a total of 60 patients with a diagnosis of asthma, 52 had received an asthma review in the preceding 12 months using the asthma review template.

Dedicated clinics were allocated for asthma reviews to ensure they were conducted by appropriately trained clinicians.

- Audiology statistics showed 75% of permanent patients and 63% of trainees had received an audiometric assessment within the last two years. The nursing team closely monitored the status of trainees and permanent patients. An effective recall process was in place.

Through a review of clinical records and discussions with the doctors, we were assured that the care of patients with a mental illness and/or depressive symptoms was being effectively and safely managed, often in conjunction with the Department of Community Mental Health (DCMH). The practice followed the DPHC guidance and provided step 1 interventions and immediate referral for appropriate diagnoses. Doctors had different preferred sources of step 1 intervention. However, a QIP resulted in the production of 'Mental Health Resources Cosford Patient Information Leaflet' which was shared with all doctors, regional headquarters (RHQ) and the station. The station distributed it to the local schools and the RHQ shared it within the region.

We saw that referrals to the Regional Rehabilitation Units and minor injury assessment clinics were made promptly with manageable wait times for the patients.

Wait times for referrals were generally good. However, staff reported long wait times for first appointments with the DCMH. Those patients waiting were assessed by DCMH to prioritise when deemed necessary and monitored by the doctors whilst awaiting the appointment.

An audit calendar was in place and this extended to and integrated with the primary care rehabilitation facility (PCRF). The practice was engaged with the DPHC RHQ audit programme and this was tracked in the healthcare governance (HcG) workbook. Clinical audits were an integral part of quality improvement. We saw good examples on the day that included a multiple cycle gout audit (repeated to monitor and drive improvement).

Effective staffing

There was an induction pack for all new staff that included role specific sections. All staff new to DPHC completed the online DPHC induction. All new doctors underwent the practice's own standard induction which was coordinated by the practice management. A tailored package was then provided dependent on previous experience and needs. For example, the new civilian medical practitioner (CMP) had never worked for the Ministry of Defence previously so was given time shadowing each department. GP trainees and General Duties Medical Officers underwent an induction that included supervisory and educational support from an experienced doctor together with shadowing opportunities. New doctors received similar support, depending on their previous experience. Role specific inductions were provided to new nurses. This was seen to be a comprehensive induction pack used in conjunction with the DPHC process. Peer review of notes was also completed as part of the process and the same induction was completed by locum nurses. It was recommended this submitted as a 'purple' ASER and shared with wider DPHC as good practice (purple ASERs are used to highlight good practice). The nurses were not routinely involved with triage of any patients, including children. They did not assess and

treat children, the only paediatric contact they had was for immunisations. The nurse manager had completed the Royal College of Paediatrics and Child Health 'Spotting the Sick Child' learning course and a health assessment course which incorporated children and felt confident in the assessment of sick children. However, they were not independently assessing nor treating them.

On arrival, locum staff completed the DPHC mandated locum induction programme which has been amended accordingly to include cadres specific elements and information relevant to the unit. According to the staff database, all locums had completed their induction programme and evidence of this was shown at the time of the visit.

There was a training calendar and a record of mandatory training. The training lead monitored the status for staff and discussed required training activity in the practice meetings. Protected time was afforded to staff every Wednesday afternoon to complete training. Compliance levels for training were high across the team. All clinicians were encouraged to engage in continued professional development (CPD) and were supported in taking study leave. This was monitored via the appraisal system for doctors and nurses. GP training was provided at Cosford and the SMO was enrolled onto the GP trainer's course as well as being an appraiser (the previous GP trainer had recently left the practice).

The meeting schedule supported CPD and revalidation requirements through clinical updates, guideline reviews, safeguarding updates and RAF/Defence Medical Services (DMS) specific training.

There was role-specific training for relevant staff. For example, the practice manager had attended the joint practice manager's course and had applied for the Institution of Occupational Safety and Health course (IOSH). The deputy practice manager was IOSH trained and had an MSc degree in healthcare management.

Staff administering vaccines had received specific training which included an assessment of competence. Vaccinators could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to online resources and discussion at nurses' meetings.

Coordinating care and treatment

The practice manager, and when available a doctor, attended the Unit Health Committee meetings (held monthly) at which the health and care of vulnerable and downgraded patients was reviewed (consent from the patient was gained in advance). A doctor attended the welfare meetings when requested or if clinical capacity allowed. Case conferences were also attended by a doctor and consent was gained in advance to enable the doctor to discuss the case prior to the meeting.

Although we did not inspect the PCRf as part of this inspection, it was clear that they were an integral part of the practice. The practice communicated well with staff in the PCRf, meetings were inclusive and governance structures integrated.

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 to give to the receiving doctor, and a letter if the patient was mid-way through an episode of care. In addition to this, the practice had adapted the documentation for leavers to include a patient information leaflet with lots of information on how they could register with an NHS GP and dentist, and how to utilise the NHS and the services available to veterans. This formed a quality improvement project (QIP) which the regional headquarters had shared with other medical centres in the region.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred or after they were discharged from hospital. Information was shared between services and we saw that a full copy of findings from investigations and any further treatment requirements were sent to the medical centre to update the patient's records. Links were established with NHS GP surgeries where family members of serving personnel were registered. One of the doctors who was the musculoskeletal (MSK) lead had developed close working relationships with Stanford Hall, the MSK service in Telford and set up referral pathways with the Robert Jones and Agnes Hunt Orthopaedic Hospital in Oswestry where there was a veteran centre and military consultant. We were given an example of when the doctor had worked closely with Stanford Hall to facilitate the transition of a patient with disabilities and complex medical needs to transition to a local NHS practice. Stanford Hall is the Defence and National rehabilitation Centre based in Nottinghamshire.

Helping patients to live healthier lives

The practice had a named lead and deputy for health promotion. There was a structured programme of health promotion activity with a yearly planner and calendar on the HcG workbook. The health promotion displays were comprehensive, clear and positioned strategically to target the most relevant cohort of patients. For example, well man and well woman health promotion information was displayed in the respective male and female toilets. Paediatric health promotion was displayed in the waiting area on a dedicated noticeboard. At the time of inspection, there was a travel health promotion and the paediatric health promotion noticeboard had a highly illustrated and colourful display to raise awareness of allergies. Staff has been involved in supporting health fairs and linked in with station health promotion work. The practice team participated in a region wide approach to health promotion, staff members from each practice formed a working group and would take the lead on sourcing material and compiling health promotion boards.

A nurse with specific training (STIF) took the lead on sexual health training and provided sexual health support and advice. All nurses were STIF foundation level trained and offered a confidential sexual health advice and screening service. Patients were signposted to a local NHS sexual health clinic for procedures not undertaken at the medical centre. In addition to appointments offered during the day, an evening walk in clinic was provided monthly. Patients could obtain a self-test kit online and condoms were available from the practice. Some of the doctors were STIF trained and clinical staff could reach out to the regional sexual health lead through the MASHH (multiagency

safeguarding and support hub) service. Health fairs were used to target sexual health screening and provide educational help and advice.

The number of eligible women whose notes recorded that a cervical smear had been performed in the last 3-5 years was 216 which represented an achievement of 92%. 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. At the time of the inspection there were a small number of patients identified that met the criteria for screening. A recall system was in place that monitored uptake and those eligible were in-date for screening.

Patients due a vaccination were identified when summarising patient notes. The units were responsible for ensuring their individuals booked in for their own vaccines. Force protection performance was high with vaccination statistics identified as follows:

- 91% of patients were in-date for vaccination against polio.
- 88% of patients were in-date for vaccination against hepatitis B.
- 85% of patients were in-date for vaccination against hepatitis A.
- 91% of patients were in-date for vaccination against tetanus.
- 84% of patients were in-date for vaccination against MMR.
- 67% of patients were in-date for vaccination against meningitis. *
- 90% of patients were in-date with vaccination against diphtheria.

* there was no requirement for the medical centre to undertake a pro-active catch up programme for permanent staff. However, they did a periodic vaccine recall and push in line with NHS guidance.

The vaccination statistics were lower for phase 2 trainees as they were recently registered and were part way through their schedule of vaccinations. However, the practice could demonstrate that an effective patient recall system was in place. All trainees were timetabled in for vaccinations as part of their training timetable for their service travel vaccines (Hep A, Hep B and yellow fever) so were not included in the recall. The following data for trainees was provided by the practice:

- 96% of patients were in-date for vaccination against polio.
- 22% of patients were in-date for vaccination against hepatitis B.
- 24% of patients were in-date for vaccination against hepatitis A.
- 96% of patients were in-date for vaccination against tetanus.
- 99% of patients were in-date for vaccination against MMR.
- 99% of patients were in-date for vaccination against meningitis.
- 96% of patients were in-date with vaccination against diphtheria.

Child Immunisation

The practice had a system in place to contact the parents or guardians of children who were due to have childhood immunisations. The practice has exceeded the WHO based national target of 95% (the recommended standard for achieving herd immunity) for two childhood immunisation uptake indicators. For the three indicators where the national target was unmet, the practice could explain that this was down to awaiting essential information about a newly registered child's vaccination history. Results are below:

Child Immunisation	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB)	100%	WHO target met.
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster)	90%	WHO target of 95% not met. There was 1 of the 10 patients newly registered with no vaccination data. This data had been requested.
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster)	90%	As above.
The percentage of children aged 2 who have received immunisation for measles,	90%	As above

mumps and rubella (one dose of MMR)		
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR)	100%	Met 95% WHO based target

Consent to care and treatment

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. A review of patient notes evidenced that verbal consent was recorded and coded appropriately on DMICP. Written consent forms were to be used for minor operations once commenced (due to be carried out by the new civilian medical practitioner). Consent recording formed part of peer review and audits were carried out. The chaperone training module included a section on obtaining and recording consent.

Clinicians had a good understanding of the Mental Capacity Act (2005) and how it would apply to the population group. All staff received training as part of their in-house programme. In addition, the SMO had delivered face to face training in July 2023. The clinicians stated that they had not had any recent examples of seeing a patient who lacked capacity but mental capacity was assessed for all patients when consulting to ensure they had the capacity to make their own decisions and participate in discussion around their treatment and care.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

In advance of the inspection, patients were invited to give feedback using comments cards. A total of 16 patients responded and feedback was positive. We also observed staff being courteous and respectful to patients in person and on the telephone. The overriding theme was that staff were caring and professional.

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.

A continuous patient questionnaire had returned 228 responses in 2023. Included in these were 70 comments that praised the service provided or offered suggestions. It was clear that the practice reviewed these in detail, fed back to the wider team and made any changes as a result.

Involvement in decisions about care and treatment

Patients with caring responsibilities and cared for patients were identified through the new patient registration form and at new patient medicals. New patients identified as carers were given an initial appointment with the nurse where the carer requirements were discussed. Patients identified as having a caring responsibility had an alert on their notes and were captured on a DMICP register. Priority appointments were given to patients with caring responsibilities when required.

There was a carer's lead and deputy for the practice. Staff had access to a carers' policy and carers' register standard operating procedure. These included how to identify a carer, Read codes and support measures such as annual flu vaccinations. The carers' register was held within the vulnerable adult and child register.

A dedicated carer's noticeboard situated in the waiting area named the carers' champion for the practice and provided contact details for support staff and services including the chaplain, local support services and national helplines. A carer's pack containing relevant information and signposting was available at reception. Information on the patient information leaflet included the Shropshire Carers helpline, informed patients of the Carers Emergency Card and detailed discounts to various services. In addition, there was a definition of the term 'carer' to assist patients with caring responsibilities recognise themselves as carers and to encourage them to make the practice aware.

Staff could access 'The Big Word' translation service if they needed it. There was a sign to inform patients of the translation service. Staff told us that there had been no requirement

to use the service in recent years but some information had been translated into Arabic to support visiting personnel.

Privacy and dignity

Screening was provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. Clinic room doors were closed during consultations.

The primary care rehabilitation facility (PCRF) is located within the main medical centre building. The PCRF gymnasium was located in a separate building (adjacent to the station gymnasium) with clinical rooms that provided privacy for patients.

The reception area was separate to the waiting area meaning that conversations between patients and reception would unlikely be overheard. If patients wished to discuss sensitive issues or appeared distressed at reception, they were offered a private room to discuss their needs. This was supported by clear signage at the reception hatch. Telephone consultations were undertaken in private to maximise patient confidentiality (a glass screen could be closed when a telephone call was taken at the reception desk). There was a television in the waiting area that provided background noise to promote privacy. There was a radio in dispensary and a sign that requested patients to stand back from the hatch.

The staff team were still in-date with their Defence Information Management Passport to ensure awareness when handling personal information.

The mix of male and female staff allowed the medical centre to facilitate patients who wished to see a clinician of a specific gender. This included patients booking into the PCRF. There was no male nurse nor female exercise rehabilitation instructor but requests could be accommodated by signposting patients to an alternative military medical centre in the region.

Are services responsive to people's needs?

We rated the practice as outstanding for providing responsive services.

Responding to and meeting people's needs

The practice used an appointment system where patients could be seen in person or by phone. Home visits were provided in rare circumstances when a patient was house bound through ill health but was not in need of emergency treatment. The details around home visiting were detailed in the patient information leaflet. Requests for a home visit would be assessed by a doctor on a case-to-case basis. The eConsult service was used to provide more convenient access to information and advice whilst prioritised patients in need of urgent care could be seen in person.

An access audit as defined in the Equality Act 2010 had been completed for the premises in September 2022. Actions identified in the audit had been completed. These included the addition of high backed chairs in the waiting area. The building and surrounding area including the car park supported access for those with reduced mobility. There were disabled parking spaces close to the entrance, a dropped kerb and automatic opening front doors. Inside the building, there was an accessible toilet and baby changing facilities.

A hearing induction loop was available at reception although staff reported that there had been no need to make use of it. Crutches and a wheelchair were available for any patient that may need support due to limited mobility.

Dependant on the patient's clinical need, the option of a telephone or face-to-face appointment or e-mail reply could be offered. The practice found this system to be highly effective for patients to gain access to appointments so had continued once COVID-19 restrictions relaxed. Telephone consultations had become commonplace, a doctor's routine daily clinic was a mix of face to face and telephone conversations. Aircrew specific medicals were provided. Diving and boxing medicals were available but prioritised against occupation requirement.

The practice had a designated diversity and inclusion (D&I) lead and there was a dedicated noticeboard situated in the patient waiting area. The noticeboard included the D&I network directors and a 'QR' or quick review code to report any unacceptable behaviour to the service discipline team. The D&I lead sent regular emails to all staff to ensure awareness and highlight areas of good practice. Staff were aware of the new Defence Primary Healthcare (DPHC) transgender standard operating procedure and accommodated cultural requirements such as the implications of fasting on physical training and rehabilitation appointments. A transgender policy was in place and the in addition, the practice had considered and adapted their appointment system to account of the 8 additional protected characteristics. The meetings with welfare included a D&I section to discuss any disclosure of work related issues regarding discrimination of a protected characteristic.

The practice had taken a number of measures to have a positive impact on the environment. Electronic registration , text and emails were used with the deliberate aim to

reduce the use of paper, The cardboard middles of blue paper rolls were used for craft and gardening activities, recycling bins were placed around the building and glass coffee jars were collected separately. Posters were displayed to encourage lights to be switched off and the pharmacy technician had spoken with the team about how inhalers release greenhouse gases. An audit was planned to target moving patients to inhalers that were less harmful to the environment.

Timely access to care and treatment

The practice opened Monday to Friday 08:00-12:00 hours and 13:00 to 17:00. On a Wednesday afternoon, the practice protected time for training but would see any urgent patients. A duty doctor was available each day between 08:00 and 18:30. A duty medic provided cover between 12:00 and 13:00 and between 17:00 and 18:30. This was for emergency patients and airfield cover only (due to it being a flying station, medical cover was provided 24/7 by a duty medic). Medics would triage any call and signpost patients or book them in for an appointment at the practice. The duty phone number was also held in the guard room that was staffed 24/7. The dispensary opened each weekday morning from 08:30 to 10:00 and 10:30 to 12:00. Afternoon opening hours varied and the dispensary closed on a Wednesday afternoon.

Details of how patients could access the doctor when the practice was closed were available through the patient information leaflet, on the main entrance to the building and on the recorded message relayed when the practice was closed. Details of the NHS 111 out-of-hours service was in the patient information leaflet and instructions were displayed on the doors at the main entrance so could be seen when the practice was closed.

There was good availability of appointments for all clinicians. For example, urgent slots with a doctor were available on the day and routine appointments within 3 working days. To accommodate urgent requests, a good number of same day appointments were available. An appointment with the nurse could be secured the same day and a routine appointment within 3 days. Bloods were prioritised for the morning as they were collected around midday. Urgent samples were delivered to hospital by military transport. New patient appointments were available the next day to see a physiotherapist.

Appointments were protected outside of school hours for ease of access to families with children. In addition, dedicated appointments for school children were part of the duty doctor's clinic. The nurses liaised and obtained timetables from the numerous training schools in order to adapt their clinics around the availability of trainees. Evening clinics dedicated to cervical screening were offered and had helped improve the uptake. In addition, the nursing team allocated clinics to specific primary care duties in order to prioritise and target specific cohorts of patients. Examples included vaccinations for trainees, formal medical screening (over 45 health check), an ear syringe clinic and chronic disease. This had been successful in catching up on outstanding work post COVID and following a recent period of being short staffed. To ensure all trainees and permanent staff instructors received their respective flu vaccines, the lead nurse liaised with the schools and booked a whole day for vaccinations at a larger location to increase capacity. This same approach had been used for COVID vaccinations. Station training days were also used as an opportunity to vaccinate patients.

Listening and learning from concerns and complaints

There was a named lead (practice manager) and deputy (deputy practice manager) for the management of complaints. The process followed was in accordance with the (DPHC) complaints policy and procedure. Written and verbal complaints were recorded and discussed at the monthly practice meetings together with any compliments that had been received. There had been an insufficient number of complaints to trigger an audit but the lead was aware of the threshold. A historic (backdated to 2020) review of complaints was completed in February 2023 and no trends were identified.

We reviewed the single complaint received by the practice in the last 12 months. The patient was contacted and provided with information and this was done in a timely manner and within the timescales detailed in the policy.

Information on the complaints process was displayed on posters around the medical centre and included on station standing orders, the online communication page and on interactive boards around the station.

Are services well-led?

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

Vision and strategy

The medical centre worked to the Defence Primary Healthcare (DPHC) mission statement which was: 'DPHC is to provide safe, effective healthcare to meet the needs of our patients and the chain of command to support force generation and sustain the physical and moral components of fighting power'.

Cosford Medical Centre had written their own mission statement which was specific to their role on station. This was 'supporting our patients to deliver the Station output and Defence Mission.'

There was a formal practice development plan included in the healthcare governance (HcG) workbook. Aspirations were reviewed monthly and included improvements in infrastructure, follow up to consultants when new shared care agreements were required and the recommencement of formal medical screenings with recall completed by the medics.

Leadership, capacity and capability

The practice had been through a time when a number of positions in the established team were not filled. This had impacted service delivery in the preceding 12 months. However, we found a team who had gained resilience and had focussed on providing the core services to keep patients safe whilst providing support to other medical centres within the region. An effective catch up programme for vaccinations and long-term conditions had been implemented and completed. This was in part due to the effective appointment system that had been tailored and adapted to best meet the needs of the patient population. Strong links had been developed between the training schools and the nursing team to maximise the patient recall system and encourage high levels of attendance. The Senior Medical Officer (SMO) praised the whole team for their supportive and cohesive approach.

Leaders within the medical centre provided direction, decision making and structure. The SMO had an extended role supporting other medical centres in the region. There was a comprehensive meeting structure that underpinned the governance structure and promoted an inclusive leadership approach. Staff we spoke with consistently praised the leadership and this was echoed in the feedback from affiliated staff and patients. It was apparent from walking round the medical centre and discussions with staff that there was a high level of respect and support across all levels/ roles and professions within the team.

The SMO and the Deputy Senior Medical Officer (DSMO) covered each other as the clinical leads during periods of leave, deployments, and other absences. The practice manager and deputy deconflicted their leave to ensure there was always a constant managerial presence within the practice.

Job descriptions and terms of reference were in place for all members of staff. There was a list of roles and responsibilities which involved a wide range of staff and each lead had an appointed deputy.

Staff felt well supported by some members of the regional team. However, it was felt that additional benefits to patient care could be achieved by more productive working relationships with all members of the regional team.

Culture

Staff were consistent in their view that the practice was patient-centred in its focus.

We heard from staff that the culture was inclusive with an open-door policy and 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. The practice manager had recently implemented an electronic form that staff could use to feedback with anonymity.

The monthly meetings were inclusive with all staff encouraged to attend. Staff felt involved in decisions made and were comfortable in raising any concerns or issues within their department. Group team building exercises were held regularly. Staff welfare was seen as a priority. A member of the team provided lunchtime yoga sessions and those who wished to do physical training at lunch times were afforded extra time.

On being posted to Cosford Medical Centre, the SMO met with all staff members to get to know them and to invite them to approach with any concerns and/or support needs. Staff were specifically asked on how the SMO could best make a difference for them. This feedback was collated and used to influence decisions. In addition, the SMO had utilised the Health and Safety Executive (HSE) Management Standards Indicator Tool to collect data about stress at work amongst the team. There had been 2 rounds of data collection. The SMO planned to utilise the HSE's analysis tool to analyse and compare the data, then feed this back to the staff and discuss a plan with the Senior leadership team to address any areas of concern.

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

A comprehensive understanding of the performance of the practice was maintained. The system took account of medicals, vaccinations, cytology, summarising and non-attendance. The last Healthcare Governance Assurance Inspection took place in May 2022 and an overall grading of 'substantial assurance' was achieved. The eHAF (electronic health assurance framework) was used to document and evidence governance

activity and had been extensively populated by the practice management and other key staff members. Many of these had now been superseded by DPHC's direction to utilise registers on SharePoint (complaints, quality improvement projects, alerts). The provision of care was monitored through an ongoing programme of QIA.

There was a clear staffing structure in place and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. Terms of reference (ToR) were in place to support job roles, including staff who had lead roles for specific areas. Resilience was provided by appointed leads having named deputies who were sufficiently trained to deputise.

All staff had access to the HcG workbook which included various registers and links such as the risk register, ASER tracker, duty of candour log, IT faults and cleaning issues log. A range of information was accessible through quick links from the HcG workbook. These included risk assessments, TORs, and the standard operating procedure index. The workbook was continually being developed and was managed by the practice manager and deputy practice manager.

An audit programme was in place and the primary care rehabilitation facility (PCRF) was integrated with this.

A range of meetings with defined topics for discussion were held to ensure a communication flow within the team. The practice had a designated meeting matrix in place which included the following:

- Executives meeting held weekly.
- Full practice meetings held monthly.
- Clinical and development meetings held monthly.
- Healthcare governance meetings held monthly.
- PCRF meetings held weekly (staff, multidisciplinary team, trainee caseload, permanent caseload).
- Welfare meetings held monthly).
- In-house training held (protected time allocated weekly).

Staff told us that these formal meetings were supplemented by a daily huddle and regular ad hoc conversations to share information. Items that required urgent communication in between formal meetings were circulated by email.

Managing risks, issues and performance

Processes were in place to monitor national and local safety alerts and incidents. The practice had continued to use their own system in addition to the regional system in order to ensure there was a record of action.

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 the practice meetings. There was a proactive approach to risk mitigation. For example, staff were briefed before the annual Cosford Air Show and simulation training was conducted.

Risks were actively monitored and managed in line with DPHC policy and through the ongoing review and revision of a risk register. Risks were escalated as appropriate to DPHC and beyond. Where relevant/applicable, risks were raised by the SMO with the Station Commander/executives and if needed, were added to the station's risk register. The risk register was discussed at the monthly healthcare governance meeting.

Appraisal was in-date for all staff. Although there had not been a need to use, the leadership team was familiar with the policy and processes for managing under-performance and ensured staff were supported in an inclusive and sensitive way taking account of their wellbeing. The management favoured an approach of an initial conversation to understand personal issues and create a resolution plan when possible. A new training programme would be put in place and the member of staff allocated a mentor.

A business continuity and major incident plan was in place and reviewed annually as a minimum, the last review took place in February 2023. The plan was available for remote access and to all staff through inclusion on the HcG workbook. The plan had been enacted in 2023 following a suspected gas leak. Clinical staff successfully relocated to work from a space within the station gym.

Appropriate and accurate information

Quality and operational information was used to ensure and improve performance. The DPHC electronic health assurance framework (referred to as eHAF) was used to monitor performance. The eHAF is an internal quality assurance governance tool to assure standards of health care delivery within defence healthcare.

There were arrangements at the medical centre 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

The practice had been utilising their patient feedback to produce actions that were documented on the 'You Said, We Did' board. These included the signposting of patients to Donnington Medical Centre when items were out of stock and opening the doors earlier in the morning at 07:50 to allow waiting patients to enter the building. Continued work was ongoing to establish an active patient participation group but attendance had been minimal. The practice planned to move the frequency of meeting to quarterly to encourage better attendance. A poster was clearly displayed in the waiting area and patients were invited to meet with practice staff. Messages that requested patient feedback were sent

out daily (25 each day) and there was a 'QR' or quick review code (that could be scanned to give feedback) within the waiting rooms, clinical rooms and patient information leaflet. The same QR code was included as part of the station communication page and provided to the training schools for students to provide feedback.

The practice used the Governance, Performance, Assurance and Quality (GPAQ) questionnaire to obtain and correlate patient feedback. There had been 122 responses in 2023 that included comments that praised the service provided and the staff who delivered it.

The PCRF conducted their own patient survey and had their own suggestion box.

Good and effective links were established with internal and external organisations including the Welfare Officer, Regional Rehabilitation Unit, Department of Community Mental Health and local health services. In addition the staff had forged strong working relationships with external healthcare providers that had resulted in the development of referral pathways as well as in the continuity of care. Safeguarding links were in place with local teams and local NHS GP practices.

Continuous improvement and innovation

We identified that the medical centre had a comprehensive and effective audit programme that was integral in driving improvement. A total of 4 quality improvement projects (QIPs) had been recorded on the DPHC national SharePoint for Cosford Medical Centre and there were 9 on the practice's internal register. Of note:

- The introduction of a service leavers guide that had been adopted and shared by regional headquarters.
- Following the identification of a root cause in respiratory problems, the practice facilitated the identification of a non-hazardous solder flux (a substance used to form a strong bond between parts of electronics or wires) material and the reduced the burden on surveillance spirometry (breathing test). This had freed up nursing hours and had a positive impact on patient care highlighted by the force protection statistics and long-term condition monitoring and outcome data.
- The 'mental health leaflet' developed by the practice had been adopted by the station and shared with local schools.
- An improvement in the recording of consent for students facing a Training Pipeline and Risk Management Board (TPRM). Trainees could only be downgraded for 6 months after which if not recovered or likely to recover, a process is started of which the TPRM is part of.
- A number of QIPS that related to improved access for school children, cervical screening and sexual health appointments.