Sandhurst Medical Centre

Haig Road
Camberley
Surrey
GU15 4PQ

Defence Medical Services inspection

This report describes our judgement of the quality of care at Royal Military Academy Sandhurst 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 services.

Overall rating for this service	**Requires improvement**	
Are services safe?	**Requires improvement**	
Are services effective	**Good**	
Are service caring?	**Requires improvement**	
Are services responsive to people's needs?	**Good**	
Are services well-led?	**Good**	

Contents

Summary

About this inspection

We carried out this announced comprehensive inspection on 29 July 2024.
As a result of this inspection the practice is rated as requires improvement in accordance with the Care Quality Commission's (CQC) inspection framework.

The key questions are rated as:

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

The Care Quality Commission (CQC) does not have the same statutory powers with regard to improvement action for Defence delivered healthcare under the Health and Social Care Act 2008, which also means that Defence delivered healthcare 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 Defence delivered healthcare. DMSR is committed to improving patient and staff safety and will take appropriate action against CQC's observations and recommendations.

This inspection is one of a programme of inspections that the CQC will complete at the invitation of the DMSR in their role as the military healthcare regulator for the DMS.

At this inspection we found:

The medical centre worked collaboratively with internal units and departments to enhance the safety, welfare and wellbeing of personnel and their families.

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

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.

Medicines management processes were good. However, we identified 2 areas that required strengthening including a review of written processes and improved temperature control of the upstairs emergency trolley.

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

Facilities and equipment at the medical centre were sufficient to treat patients and meet their needs.

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

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

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

An inclusive whole-team approach was supported by all staff who worked collaboratively to provide a consistent and sustainable patient-centred service.

Quality improvement activity was embedded both within the medical centre, primary care rehabilitation facility (PCRF) and the rehabilitation Platoon (Lucknow Platoon), including various approaches to monitor outputs and outcomes used to drive improvements in patient care.

Governance systems were in place but required review to ensure all relevant information is up to date and captured to monitor service performance.

Notable Practice

Technology was used to support patients. A health promotion Padlet (an online bulletin board that included videos, websites and information) was developed and supported by the academy, for promoting self-health management and signposting. This could be accessed from any smart phone, computer or device. Also Smart Boards were initiated by a GP trainee working at the medical centre. These were virtual notice boards in the medical centre and the PCRF that used interactive communication to push out information for patients. Information included a rotating ‘meet the staff’ photo board, eConsult link, out of hours information, weather and the academy and medical centre diary for the week.

The PCRF introduced an injuries tracker that staff had developed and was an excellent tool for tracking trends in line with the training courses. An example of this was when cadets presented with similar injuries that were identified as relating to a particular exercise causing spikes in injuries. Evidence collated led to changes in the exercise and a reduction in the load carrying requirement, this had led to significant reductions in injuries.

A Lucknow Platoon board was in the rehabilitation office. This had enabled clinicians to see at a glance exactly where individuals were on their recovery pathway and included a specific checklist of objective markers (taken from research). Cadets said they found it very useful to understand where they needed to be on the pathway to recovery, and clinicians found it useful as an overview.

A prompt was put in place on DMICP (electronic patient record system) that ensured the full range of screening questions would be checked at an early stage in a patient’s assessment, meaning that inflammatory conditions (which can often delay diagnosis) were identified earlier.

The Chief Inspector recommends to Royal Military Academy Sandhurst Medical Practice

Review the Standard Operating Procedures to support the safe management of medicines.

Ensure the emergency medicines trolley is kept within the correct temperature range.

Make more effective use of the risk register, medical centre management action plan (MAP), and issues log within the healthcare governance framework to achieve improvements more efficiently.

Review the management of the peer review programme for physiotherapists and exercise rehabilitation instructors (ERIs).

Ensure all alarms are made available and tested regularly within the PCRF.

Improve patient privacy within the PCRF.

The Chief Inspector recommends to Defence Primary Healthcare (DPHC) and the wider organisation:

Review the DPHC policy requirement for emergency life support considering whether all clinical staff working in families practices should have training in Paediatric Immediate Life Support.

Coordinate with the recruitment team to ensure that new cadets notes are summarised prior to arrival at Royal Military Academy Sandhurst (RMAS).

Continue to support the PCRF to improve the infrastructure so that suitable facilities are available to patients undergoing rehabilitation.

Chris Dzikiti

Interim Chief Inspector of Healthcare

Our inspection team

The inspection team was led by a CQC inspector. The team of specialist advisors including a primary care doctor, a pharmacist, a practice manager, a physiotherapist, an exercise rehabilitation instructor and a nurse.

Background to Sandhurst Medical Centre

Sandhurst Medical Centre is the British Army Officer Phase 1 training establishment. The medical centre provides primary and occupational healthcare to around 1480 service personnel and 530 entitled civilian patients.

The services provided include routine nurse, doctor and Combat Medical Technician (CMT) medic clinics, eConsult nurse triage, duty doctor triage/consultation, adult and child immunisations, well woman clinics, fitness to deploy medical screening, routine occupational medicals and a dispensing pharmacy. The primary care rehabilitation facility (PCRF) provides routine and urgent physiotherapy to service personnel, along with exercise rehabilitation support to military patients and entitled civilian patients are referred to Frimley Park Hospital.

The camp has a highly transient population which includes foreign national cadets and personnel. The officer training cadet population has a thrice yearly outflow of approximately 225, in April, August and December. There is a thrice yearly inflow in January, May and September as well as 3 yearly short course for professionally qualified officers/interns and reserves.

The staff team

Senior Medical Officer (SMO)	One
Deputy Senior Medical Officer (DSMO)	One (vacant until September)
Practice Manager	One
Civilian Medical Practitioners	One
Senior Nursing Officer	One
Medical officers	One Regimental Medical Officer
Nurses	Seven (two posts vacant)
Pharmacy technician	One
Exercise rehabilitation instructors (ERI)	One
Physiotherapists	One Officer Command (OC) Three physiotherapists
Administrators	Five
Medics	Five (non-Defence Primary Healthcare)

Are services safe?

We rated the practice as requires improvement for providing safe services.

Safety systems and processes

The medical centre worked to the Defence Primary Care Healthcare (DPHC) safeguarding policies. All staff within the medical centre had received up-to-date safeguarding training at a level appropriate to their role. The standard operating procedures (SOPs) for adult and child safeguarding had been reviewed and included contact details for local safeguarding teams. Sandhurst sat on the boundary of 3 counties and dependant on where patients lived depended on where safeguarding referrals were sent. Staff had a single point of contact into the Child and Family Consultation Service this alleviated any delays.

We saw a good example of a potential safeguarding concern that was identified by PCRF staff, escalated to Officer Command (OC) and then the Senior Medical officer (SMO) for support. On further investigation there was no further concern or action required but the process was clearly followed and staff were confident in asking for advice.

A primary healthcare team meeting was held monthly where any safeguarding concerns were discussed, this was attended by the camp welfare representatives, all doctors, the senior nurse, an administrator, 2 health visitors and a midwife. Vulnerable person registers, including patients under the age of 18 and care leavers were maintained and a search of DMICP (electronic patient record system) was undertaken monthly.

All doctors had information given to them with regard to safeguarding arrangements and this was included in their induction pack. Information regarding safeguarding was displayed in every clinical room and on the notice board for patients to read.

The medical centre had a mix of male and female staff who acted as chaperones. An electronic list of trained staff was available for the clinicians to use but there was no list of staff in the consulting rooms for clinicians to refer to. This was implemented the day after the inspection. All trained chaperones were in date their Disclosure and Barring Service (DBS) check. Chaperone training was last conducted in July 2024

The full range of recruitment records for permanent staff was held centrally. However, the medical centre 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.

Clinicians that had professional registrations had their pin numbers recorded in the staff data base and the record of registration checks were held within the Healthcare Governance (HCG) workbook, we noted this was not fully completed and that the practice manager had no oversight of these. Following the inspection, all checks were completed and it was confirmed all clinicians were up to date and the records had been updated.

All staff had completed training in infection prevention and control (IPC), there was a member of staff who was the dedicated lead and they had completed the link training

along with one other nurse. IPC audits were conducted regularly with any shortfalls discussed at practice meetings and managed on an action plan. A hand washing audit had also been completed and there were posters up in each clinical room.

There were measures in place to minimise the spread of infectious diseases. Staff attended IPC forums and updates that kept them informed of any trends, or new training requirements. Personal protective equipment was available in all clinical areas. Hand gel was available throughout for staff and patients in all areas.

Delivered by an external contractor, an environmental cleaning contract and schedule was in place. Each room was colour coded and a written cleaning schedule was in place. These were signed off to confirm that cleaning tasks had been completed in line with the required frequency. The premises was deep cleaned in July 2023 when cadets were on leave. We visited the medical centre and the PCRF and all were clean and tidy throughout.

The management of healthcare waste was in line with policy. Clinical waste was bagged, secured and marked with the medical centre code before being recorded in a waste log and held in a dry store. Consignment notes were held and were cross referenced and an annual waste audit was completed.

Staff within the PCRF provided acupuncture to patients. There was an acupuncture SOP and risk assessment in place and this had been reviewed regularly and that all staff were aware of. Verbal consent was obtained and documented using the appropriate read coding and synonym, in line with DPHC policy. Continuous professional development involved departmental sessions and a full day update training course with an external tutor.

Gym equipment in the PCRF treatment area was maintained, serviced and monitored. Checks on equipment were completed daily. All rehabilitation equipment was in excellent condition, some of which was new, meeting the needs of the patient population. A recent installation of gym matting had provided improvements, allowing safe and effective progressive of exercise, whilst improving the patient experience. The PCRF were well supported from a wider Equipment Care Management (ECM) perspective and had been subject to regional headquarters unannounced inspections and internal DPHC Directives.

Valproate (medicine to treat epilepsy and bipolar disorder) searches were regularly undertaken. One patient was currently taking this medicine and we saw good communication between the pharmacy technician and the family about the sourcing of the correct brand, this was ongoing.

Risks to patients

There was a good balance of well-trained civilian and military staff which afforded continuity of care. The medical centre had a weekly diary meeting looking at the following 2 weeks' workload. They discussed factors that impacted on care delivery for example leave and new courses due to arrive. The doctor's rota was managed by the civilian doctor with the other departments managing their own rotas, this included the PCRF, the nurses and the medics (non-DPHC) for the academy. Locums were requested to cover gaps, long leave periods and deployments.

The PCRF had effective staffing and management processes in place to meet demands. Temporary healthcare workers had been employed when needed to fill vacancies. There was a locum physiotherapist employed at the time of the inspection to cover an extended period of leave and the PCRF was fully staffed.

The risk register highlighted the risks of having 1 person in post in the dispensary. The dispensary shut if the pharmacy technician was absent and seeking locums was challenging. Cadets cannot leave camp during the working day and not at all during their first 5 weeks. Every attempt was made to provide pharmacy cover liaising with Pirbright. When this was not possible there was a collection service available to them. Recruits could collect their medication from the medical centre in the afternoon, there was a tracker in place to support this. Permanent staff and families were able use using Pirbright and Aldershot DPHC dispensary.

The PCRF infrastructure risks were held on the medical centre HCG workbook. Some elements of this had been escalated and were held by the Regional Headquarters (RHQ).

A Disability Access Audit had been completed and some issues were identified including ramps and handrails not extensive enough and problems with the front door. Approval was gained from Historic England and planning permission was in place along with funding, they were just waiting for action from the Quarter Masters department. There was a clear action plan in place with DPHC headquarters infrastructure and the health and safety advisor. There was regular oversight from RHQ and the residual risk regularly updated.

The PCRF building was joined to the main gym which has a Wet Bulb Globe Temperature machine (used to monitor the environmental heat accounting for air temperature, humidity, radiant heat and air movement). Readings were constantly monitored, and control measures were put in place. Staff had a comprehensive understanding of the necessary actions and work/rest plans

All but 1 staff member was up-to-date with Basic Life Support training (BLS), anaphylaxis and the use of an automated external defibrillator (AED). The SMO and nurses were trained in Immediate Life Support. The medical centre had considered the needs of the population and as a result the 2 military nurses and the Senior Nursing Officer had completed Paediatric Immediate Life Support (PILS) training, the remainder of the military nurses had applications in progress. Last year as a group the medical centre commissioned a 2 day paediatric study period for the civilian nurses, delivered by an outside agency, to mitigate this gap in paediatric training. They used a grant available for civilian staff to purchase this.

Both clinical and non-clinical staff we spoke with were aware of the signs and symptoms of the deteriorating patient that included symptoms of sepsis. Training records showed sepsis training was undertaken for all staff in October 2023. Reception staff confirmed they had received training in sepsis and said they would refer to the duty doctor with any concerns about a patient. Sepsis recognition and awareness posters were displayed throughout the medical centre.

Regular scenario-based training or ‘moulages’ were evident with the last sessions taking place in June and July 2024 which demonstrated the effects of heat illness. Following each

training session, staff undertook a learning account to identify what went well and where improvements could be made. A spinal emergency moulage was planned for the autumn.

The PCRF had an SOP for 'Actions on Medical Emergency' including an agreement with the medical centre who had a grab bag to respond to any emergency in the PCRF, but without delaying calling for an ambulance. The PCRF had requested to run a moulage with the medical centre and this was planned for future. There was an AED in the PCRF, this was checked daily.

The waiting room was not visible from reception with staff being unable to see if any patient became acutely unwell whilst waiting for their appointment. There was no CCTV in place, so to mitigate this, the medical centre purchased a baby monitor with the screen that was held in reception. All other waiting areas were in line of sight of staff.

All staff undertaking vaccinations received training annually. Information and medicines were in all clinical areas for management of anaphylaxis for adults and paediatrics

Unplanned admissions to hospital were managed well, including effective communication and monitoring between the medical centre and the hospital itself. Upon discharge from hospital the patient was given a follow up appointment with a doctor.

All staff knew where the emergency medicines were located. We found all medicines on the emergency trolley were appropriate and in-date and a risk assessment was in place. There was an AED on the emergency trolley that could be used for paediatrics. Each emergency trolley had laminated paediatric algorithms for BLS, Advanced Life Support (ALS) and anaphylaxis. Laminated copies for paediatric temperature and blood pressure parameters, the paediatric early screening tool and the sepsis screening tool for 0-5 years and 5-11 years old were also evident. Additionally in treatment room 1 (the main receiving clinical room), there was a paediatric cupboard with paediatric pulse oximeter, peak flow, paediatric volumatic spacer for asthma sufferers as well as fluids and various guidelines for burns, there was a range of paediatric airways and masks available.

Oxygen was held and was accessible with appropriate signage in place. All clinical staff has received training in medical gases usage.

Information to deliver safe care and treatment.

The medical centre including the PCRF had moved to OneNote to communicate to all staff, they found this useful to record and disseminate information. This system allowed retrospective information to be available for new staff so they could see previous posts, not just those after their start date. Physiotherapists also had a twice weekly Microsoft Teams slot available with the SMO to discuss cases, a regular meeting to discuss patients with the Regional Rehabilitation Unit and regular multi-disciplinary team meetings.

The physiotherapist completed an annual notes audit using the DMICP template, the last being in 2023 with a re-audit planned for the summer. We noted that the exercise rehabilitation instructors (ERI) notes were not included in this process.

Doctors had regular case discussion between themselves and medics were supported by the duty doctor during morning triage clinics. Every morning there was daily team coffee where cases were discussed by any members of the multi-disciplinary team (notes were not physically reviewed). On a Wednesday doctors held case based discussions meeting (this was extended to any members of the nursing team who wished to attend, all cases discussed were recorded and doctors records were reviewed by their peers. At the monthly PHCT meeting peer reviews of all DMICP entries for patients coded as vulnerable patients was undertaken. A formal routine audit of medical records was last undertaken in May 2024.

Peer review for nurses took place quarterly with nurses reviewing 5 sets of each other's notes. Alongside this the nurses had a monthly meeting where they had the opportunity to discuss any issues, they also met every morning to discuss and plan for the day and twice weekly had coffee together for informal discussions. There was no formal process in place for the physiotherapists or ERIs to receive formalised peer review, clinical supervision and mentoring on musculoskeletal assessment skills. Joint appointments did happen informally and the physiotherapists and ERIs planned to record and plan this more formally.

The medical centre experienced issues with accessing connectivity and access to DMICP similar to other Defence-wide medical centres. The operational capability of the medical centre had been compromised recently when a vaccination clinic had to be cancelled due to no connectivity. The practice manager had submitted a business case for SIM cards to see if this would improve access. Also, to minimise the risk associated with connectivity issues, the Business Resilience Plan outlined the action to take. Clinic lists were printed at the end of each day in the event of a DMICP outage the following morning. Hard copy consultation forms were available for use during an outage and records scanned onto the system at a later point.

The medical centre used different ways to get information out to patients, these included the use of Padlet (an online bulletin board that includes videos, websites and information, and a SMART Boards (virtual notice boards).

Processes were in place for the summarisation of civilian and permanent staff's records. A clinical code applied to DMICP records confirmed summarisation had been completed. At the time of the inspection, 100% of civilian records and permanent staff had been summarised. New cadets coming through were found to not have had their notes summarised by the recruitment team, the last intake showed approximately a third that had not been summarised, this had been raised as a concern and was recorded on the risk register. This presented a potential risk with the medical centre being unaware when receiving patients with a condition that may require treatment.

An effective system was in place for managing both internal and external referrals including urgent 2-week-wait (2WW) referrals. There were 2 civilian administrators responsible for referral management included internal and external referrals for hospital appointments, urgent and non-urgent. Staff were able to describe the process in detail. Details were uploaded onto the portfolio spreadsheet tracker and showed when the referral was made and the date of when to review progress, this was checked weekly. The doctors made referrals to Department of Community Mental Health and kept oversight of these. Follow up appointments were booked with the patient whilst attending their initial and ongoing appointments to ensure weekly or 2 weekly reviews were in the diary.

The nursing team oversaw the process for the management of samples. A specimen register was maintained and a 100% check of samples was conducted at the end of every week. Both the nurse and duty doctor checked Path Links (system used to manage samples) daily for results, following which the specimen register and patient's record were updated accordingly. Results were also reviewed by the doctor who requested the specimen.

Safe and appropriate use of medicines

The SMO was the lead for medicines management and the day-to-day tasks were delegated to the pharmacy technician. This was reflected in the Terms of Reference (ToRs). The ToRs were signed electronically and were in-date.

Arrangements were established for the safe management of controlled drugs (CDs), including destruction of unused CDs. All internal and external quarterly checks were being completed in line with policy. A CD audit and the annual declaration had been completed and submitted to headquarters. The CD keys were kept separate from the dispensary keys. There were processes in place for the access to CDs out of hours. However, the written processes required review to match the practiced actions. A review of the most recent destruction certificate confirmed that accountable and controlled drugs were being destroyed in accordance with policy.

There was one practising non-medical prescriber in the medical centre. Patient Group Directions (PGDs), which authorise practice nurses to administer medicines in line with legislation had been signed off by the doctor and this was monitored by the pharmacy technician. Nurses had completed the required training and a PGD audit was completed in June 2024. Patient Specific Directions were not used.

The medical emergency trolley and medicines were checked daily and monthly or if the trolley had been opened/used. Tags were in place with a list of expiry dates held. We checked all the emergency medicines and kit and these were in-date, including medical gases, which were at sufficient capacity and appropriate signage was in place. The trolley held a laminated picture showing the drawer lay out and both trolleys matched each other so that items can be found easily. The emergency trolley upstairs was kept in the corridor which was not temperature controlled. We noted that the temperatures recoded showed the maximum temperature in which to store medicines had been exceeded parameters (above 25 degrees) but no actions had been taken to move the trolley to a cooler location. The trolley downstairs was located in the treatment room, which was temperature controlled.

An effective process was in place for the management and action of Medicines and Healthcare products Regulatory Agency (MHRA) and National Patient Safety alerts. The electronic MHRA alert register was current and a system was in place to ensure the practice received, disseminated, and actioned all alerts and information relevant to them. Current meeting minutes showed that alerts were discussed.

Clinical guidance regarding monitoring the quality of prescribing and implementation was shared through the use of a OneNote system so all staff could refer to it.

Medication requiring refrigeration was monitored twice a day to ensure it was stored within the correct temperature range. Fridges were locked in the treatment rooms. 'Golden hour' temperature controlled boxes were used if movement of vaccines to other facilities was required.

Protocols to access the dispensary were unclear. The SOP stated that any doctor plus one other member of staff could access the dispensary. The pharmacy technician was clear that the door code was only known to the relevant personnel and access was restricted. The SOP stated that out of hours stock for administration in the treatment room could be taken in absence of pharmacy technician as long as the prescription was left and that payment was taken if required. This was conflicting as payment was not required for emergency treatment and access was limited to only eligible staff. We discussed the need to for SOP to be updated.

Through discussion and review of DMICP records, it was evident that there was a clear audit trail for the request of repeat medication. There process for the management of information about changes to patient's medicines received from other services was clear.

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

The high-risk medicines (HRMs) register supported the management of patients prescribed HRMs. An audit had been completed in May 2024. Appropriate HRMs and shared care agreement alerts were raised on patient's DMICP records.

Track record on safety

There was a designated health and safety lead and a board was displayed which was regularly externally audited. Measures to ensure the safety of facilities and equipment were in place. External inspections were completed. Electrical and gas safety checks were up to date and a legionella risk assessment had been completed in January 2021.

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

Both active and retired risk and issues registers were in place. However, the 4 Ts—(transfer, tolerate, treat, and terminate) were absent from the register, leading to some ambiguity regarding their definitions in the context of risk. Upon examination of the register, it was noted that some entries had been recently reviewed, whilst others, which encompassed both clinical and non-clinical issues, were still pending review. Additionally, a separate issue register was identified that also necessitated a comprehensive review. Risks were addressed during the practice meeting. Furthermore, risk assessments pertaining to individual products that pose health hazards, known as COSHH, were established.

The fixed panic alarms throughout the medical centre were not in good working order and the medical centre was waiting for funding to replace the whole system. This was on the risk register and was mitigated with single issue panic alarms, these could not be heard throughout the whole building and were not regularly tested. Following the inspection all alarms were checked and the results recorded in the HCG workbook. There was no emergency alarm system in the PCRF.

Lessons learned and improvements made

The medical centre worked to the DPHC policy for reporting and managing significant events, incidents and near-misses, which were recorded on the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events and incidents. The staff database showed all staff within the medical centre, with the exception of one, who was waiting for an account, had access to the system. Three members of staff in the PCRF did not have their training recorded on the medical centre training data base, we were informed following the inspection that this was recorded separately on the PCRF tracker. All staff we spoke with knew how to report an incident. ASERs were discussed at the monthly practice meetings.

Are services effective?

We rated the practice as good for providing effective services.

Effective needs assessment, care, and treatment

Processes were in place for clinical staff to keep up-to-date with developments in clinical care including National Institute for Health and Care Excellence (NICE) guidance, the Scottish Intercollegiate Guidelines Network, clinical pathways, current legislation, standards and other practice guidance. Staff were kept informed of clinical and medicines updates through the Defence Primary Healthcare (DPHC) newsletter circulated to staff each month. Clinical updates were discussed at practice and clinical meetings. The most recent example was the updated guidance in treating heat illness casualties.

The Primary Care Rehabilitation facility (PCRF) staff attended monthly meetings to share and discuss evidence-based guidance, including NICE & SIGN. They also had a 2 weekly continuing professional development (CPD) sessions. The PCRF staff also attended the multi-disciplinary team (MDT) clinical meeting, and they had representation at practice meetings.

The range of PCRF clinical records we looked at showed evidence of MDT discussion. The Musculoskeletal Health Questionnaire (MSK-HQ) was the standardised outcome measure for patients to report their symptoms and quality of life. Rehab Guru (software for rehabilitation exercise therapy) was in use to monitor individual patient progress. The use of the MSK-HQ was clinically coded via the DMICP template. There was a structure for those patients in the rehabilitation platoon (Lucknow Platoon) to progress through weight-bearing stages, to plyometrics (a form of exercise that uses fast powerful movements to improve a persons speed and power) to impact training and then onto load carrying. This was documented in the rehabilitation office so all staff looking after the Lucknow Platoon were aware where everyone was on the pathway. There were detailed printed programmes for each stage of progression.

Within the PCRF, clinical audits that encompassed Best Practice Guidelines were limited. An audit had been completed that looked at the physiotherapy referrals made to the exercise rehabilitation instructors (ERIs) to ensure that they gave clear handovers and ensured patients were referred electronically and that administration lists were accurate, the results were positive. We also saw some data regarding anterior knee pain, this was a service evaluation rather than audit with the main points being injury trend analysis.

The PCRF ensured that it took a holistic view of patients, including mood, sleep and lifestyle. They had delivered presentations to cadets on topics such as sleep, and the effect of the menstrual cycle during training. They had an excellent awareness of the demands and structure of the courses their patients were on whilst under rehabilitation.

Monitoring care and treatment

The nursing staff had recognised the need for the management of chronic disease to become more streamlined and had begun some work around this. There was a chronic disease register in place but this was being reviewed. A new chronic disease register was being collated aligning the nurse who was trained in each specific condition. The nursing team had created condition specific clinics to be offered moving forward as currently patients were seen on a more ad hoc basis. They also recognised over-lap of some conditions so implementing a merged register was being worked on to reduce number of attendances to medical centre and improve the patient experience.

The nurses carried out the DMICP searches and recalled patients via text message for bloods and other tests. If there was no response, a follow up phone call was made and then if needed, a letter was sent. Interpreters were used if English was identified as not the first language. We reviewed a random sample of patient records and both recall and monitoring were sufficiently documented.

We conducted searches to identify patients with LTCs on the day of the inspection. Reviews were of good quality and the appropriate templates had been used.

There were 14 adult patients on the diabetic register. For all 14 patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For 13 patients with diabetes, the last blood pressure reading was 150/90 or less which is an indicator of good blood pressure control.

There were 49 patients on the hypertension register and 46 of these had had their blood pressure taken in the past 12 months. Of these, 35 patients had a blood pressure reading of 150/90 or less.

There were 31 patients with a diagnosis of asthma. Of these, 20 had received a review in the past 12 months. Of the 11 that had not had a review, 6 were new patients and/or were newly diagnosed.

On arrival, patients over 40 were offered the over 40s health screening. Searches were run to capture over 40’s and a check of their records was completed to ensure they have been offered the service.

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.

There was active management of children’s immunisation status. Currently, staff relied on Child Health Immunisation Service (CHIS) to send them a list of children who were due or outstanding various childhood immunisation. The medical centre had systems in place that gave assurance that the children registered had been recalled or had an appointment booked at the appropriate time.

Routine vaccination and audiometric recalls were managed by the nurses. Audiometric recall for the cadets were managed by the medics. Audiology statistics showed 96 % of patients had received an audiometric assessment within the last 2 years.

We saw that referrals to the Regional Rehabilitation Units (RRU) and Multi-Disciplinary Injury Assessment Clinics (MIAC) were made promptly with manageable wait times for the patients. The PCRF had regular meetings with the MIAC clinicians to discuss potential referrals. All referrals were added to a list held on SharePoint, and this was managed by the clinicians.

One of the doctors was the leads for audit. Quality improvement activity included clinical audit, DPHC mandated audits and data searches. An audit calendar was in place for 2024/2025, although this required a review to ensure clarity. We looked at a range of audits including medical records and high risk medicines. Other audits undertaken by the nursing team included childhood immunisations, cytology, diabetes, Infection Prevention and Control (IPC), and Patient Group Directives (PGDs). We noted an antimicrobial audit had not been undertaken.

Effective staffing

There was an induction programme in place, with a separate induction for locum staff. DPHC induction and workplace induction were recorded on the staff database. Prior to the inspection, the previous practice manager held inductions electronically, but there was no evidence of these. The practice manager had recognised this and implemented a hard copy induction folder, where they would keep all staff inductions and would also include electronic copies.

Within the PCRF staff reported an effective induction process, including the locum physiotherapist who reported significantly more time and effort being given to delivering an effective induction than they had experienced anywhere else. There were both PCRF and medical centre elements to the induction programme, which was documented and recorded by the Band 7 physiotherapist.

The Staff Sergeant monitored the mandated training and followed up with individuals whose training was due to expire. Staff were given protected time to complete this required training. The training programme, was organised around the academy terms and encouraged all members of staff to take training sessions that they may have an interest in. There was good compliance with mandated training with mitigating circumstances for staff who were out-of-date. A register of in-service training (referred to as trade training) was maintained, including a programme of planned training for 2024.

The medical centre understood their responsibilities of the patients who may have a learning disability or autism. They had not undertaken specific training yet but was partly covered within DPHC mandatory training under Diversity and Inclusion and active Bystander training. In addition, they had held 2 medical centre (all staff) training sessions on communication and coaching which included neuro diversity and personality type with regard to using a variety of platforms for communication/understanding and learning as well as training on the Mental Capacity Act. They had also developed different platforms to push out information on their services and improve accessibility (digital, hard copy,

translation services). They recognised this was an area for development and there was formal training already planned for the autumn, more specifically, on neurodiversity and the accessibility of services, this was to be delivered by one of the doctors. The medical centre also supported the Hidden Disabilities Sunflower scheme, to identify and support those individuals with a hidden disability.

Staff administering vaccines had received specific training which included an assessment of competence. Staff who administered vaccines could demonstrate how they kept 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 medical centre staff met with welfare teams and line managers to discuss vulnerable patients. Staff told us that they had forged some good links with other stakeholders, including the local NHS Midwifery and Health Visiting service, multi-agency safeguarding hub (MASHH), child health community teams, sexual health services (Kingston, Aldershot and Basingstoke) local safeguarding teams, NaTHNaC (travel advice), SSAFA, padres, welfare and camp executives.

It was clear that the PCRF was an integral part of the medical centre. There were good streams of communication with staff in the PCRF, meetings were inclusive and governance structures integrated.

The ERI reported regular case discussions were held the physiotherapist but they were not part of the wider MDT meetings. Every Tuesday morning a meeting was held for cadets that may be or were in Lucknow Platoon where timeframes and occupational issues were discussed. Following the meeting, the physiotherapist met with one of the doctors to discuss the patient's clinical needs. This was documented on DMICP.

The physiotherapists had specified times where the RRU clinicians (Band 7 and podiatrist) were available for case discussion. There were 2 fixed sessions in place each week where the SMO was available for clinical discussion, via Teams, (which enabled this to continue even if the SMO was deployed).

For patients leaving the military, pre-release and final medicals were offered. During the pre-release phase, all patients received a summary of their healthcare record, including immunisations and medication and information on how to obtain a full copy of their records. Service leavers also received a patient information leaflet detailing how to register with an NHS GP, how to find a dentist and information about the Armed Forces Compensation Scheme.

Helping patients to live healthier lives

Health promotion was run from the NHS promotion calendar with information posters displayed. The health promotion displays at the medical centre were comprehensive, clear and positioned strategically to target the most relevant cohort of patients. One of the

nurses was the designated lead, and co-ordinated the health promotion boards throughout medical centre and the wider camp.

One doctor and 2 nurses were trained in sexual health (referred to as STIF). One of the nurses was the lead for sexual health and advice and contraception were provided. Condoms and chlamydia self-testing kits were available in the toilets, and local NHS sexual health screening clinics were advertised.

All eligible female patients are on the national cervical screening database were recalled by the nurse. The latest data confirmed a 92% uptake, the NHS target was 80%. Regular searches were undertaken to identify patients who required screening for bowel, breast, and abdominal aortic aneurysm in line with national programmes. Alerts were added to their DMICP record which allowed for opportunistic discussion with a health professional. DMICP searches had been created for all national screening.

Vaccination statistics were identified as follows:

82% of patients were in-date for vaccination against diphtheria.

82 of patients were in-date for vaccination against polio.

84% of patients were in-date for vaccination against hepatitis B.

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

82% of patients were in-date for vaccination against tetanus.

93% of patients were in-date for vaccination against MMR.

Child Immunisation

The percentage of children aged 1 who had completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) (i.e., three doses of DTaP/IPV/Hib/Hepatitis B) was 99%.

The percentage of children aged 2 who had received their booster immunisation for Pneumococcal infection (i.e., received Pneumococcal booster) (PCV booster) was 99%.

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 99%.

The percentage of children aged 2 who had received immunisation for measles, mumps and rubella (one dose of MMR) was 99%.

The percentage of children aged 5 who had received immunisation for measles, mumps and rubella (two doses of MMR) was 97%.

Consent to care and treatment

Staff had previously had training in the Mental Capacity Act (2005) and how it would apply to the patient population, this was due to be delivered again. Clinicians understood the Mental Capacity Act (2005) and how it would be applied to the patient group.

Clinicians were aware of both Gillick competence (young people under 16 with capacity to decide) and Fraser guidelines (advice/treatment focused on a young person's sexual health). Clinicians advised us that implied consent was accepted for basic procedures such as the taking of blood pressure. Written consent was taken for more intimate examinations.

Are services caring?

We rated the practice as requires improvement for providing caring services.

Kindness, respect, and compassion

The last patient survey, undertaken by the medical centre between September and October 2023, showed 96% (of applicable patients) said they were satisfied with their healthcare provision. We spoke with 6 patients on the day and they were happy the care they had received. They described the staff as helpful and kind.

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.

Involvement in decisions about care and treatment

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

Patients identified with a caring responsibility were captured on a DMICP. There was a medical centre ‘Padlet’ which included information for carers. Alerts were made on individual patient’s notes to ensure that longer appointments were given if needed. There was a carers poster on display in the waiting area.

There was an SOP in place for the care of patients who were care leavers. All care leavers were asked to identify themselves in the eRegistration process and they were offered further support if required. One of the administrative staff was a ‘carers champion’ and one of the nurses was designated to monitor young people and carers. There was information for carers of the medical centre information boards.

Privacy and dignity

Patient feedback showed patients were confident information kept about them would remain confidential. Consultations took place in clinic rooms with the door closed. The reception area was separate to the waiting room meaning that conversations between patients and reception would not be overheard. If patients wished to discuss sensitive issues or appeared distressed at reception, they were offered a private room to discuss their needs.

Patients could request clinicians of a specific gender or a second opinion. Patients were offered alternative appointments if there is not an appropriate clinician on any given day.

The physiotherapist assessment and treatment area within the Primary Care Rehabilitation Facility had curtained cubicles. There was an ‘open curtain’ policy in the treatment area, and cadets and training staff were treated in the same area at the same times, conversations could be clearly overheard, there was mitigation in place by having a radio playing but this was playing at a level too quiet to be heard at the time of inspection. The open curtain policy meant that at the time of inspection a patient was having their shoulder assessed, with their top off, in view of the inspectors. There was a poster that detailed the ‘open curtain’ policy in place and we were told that patients consent was gained before treatment.

Clinicians reported they could use the rehabilitation office for confidential conversations, but 3 members of staff were based in that office so it was unclear how realistic this was. Staff said that no patients had ever asked for a confidential space, but the Officer Command (OC) would often use the office for seeing those in Lucknow Platoon (for conversations not assessment).

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

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 Senior Medical Officer (SMO) and the staff team were acutely aware of the battle rhythm (schedule of activities) of the college intakes and their ongoing needs and requirements. As such, they were aware of when to expect issues pre and post exercise, when there will be a surge of individuals seeking routine vaccinations and times when sick parade (walk in on the day clinics) would need to be bolstered. All of this allowed for planning, upsurging of staffing and ultimately provided the patients with an improved journey and enhanced service when needed.

The medical centre had a highly flexible approach to the management of appointments to meet patients' needs. This flexibility was enhanced as the duty doctor was available until 18:30 hours. Protected appointments were in place for the administration of eConsults, children and 'book on the day' appointments. Longer appointments could be accommodated for patients with complex needs. Vaccination clinics were often coordinated at short notice to ensure readiness for operational deployment.

An Equality Access Audit as defined in the Equality Act 2010 was completed in June 2024. Any points identified were discussed and put onto the issues register. The audit completed for the Primary Care Rehabilitation Facility (PCRF) identified several issues:

Chairs for patients did not have arms should these be required to push up to from a seated to a standing position.

There were ramps in the department (which were very steep for anyone, particularly those on crutches) and a handrail that was shorter than the ramp. Another issue with the building was the lack of accessible toilets for those with disabilities, patients were advised to use the accessible toilet in the medical centre but this was some distance away. This had been looked at by the camp but no actions or solutions were made.

A fire exit was being used as the main entrance to the department – this meant that the fire exit was constantly open. The other entrance to the department was not suitable for use as had steps to access only. The department had engaged with Historic England to get permission to change the doors to an electronic access door.

Within the PCRF changes had been made based on patient feedback. For example, patients reported poor lighting in the waiting area so a works request was initiated for the installation of extra lights. Also there was feedback on the lack of equipment in the gym, this also resulted in a business case and subsequent additional equipment being purchased.

Timely access to care and treatment

The medical centre had a flexible approach to the management of appointments to meet patients' needs. The primary point of contact for patients was through eConsult. A recent survey showed that 100% of patients found it easy to access healthcare.

The medical centre was open 6 days a week (08:00-13:00 on Saturdays only in 'term' time, no Saturday service during recess periods). There was a daily walk in clinic, referred to as 'sick parade', available for urgent appointments, led by medics with support and guidance provided by a nurse/doctor. From 16:30 until 18:30 'shoulder cover' was provided for any urgent case by nurse triage and duty doctor cover. Outside of these hours, a 24-hour NHS advice line was available by dialling NHS 111. The nearest general NHS hospital was located at Frimley Park.

The nurses triaged eConsults and would refer anything out of their scope of practice to the duty doctor on the day. This could be by means of a face to face appointment or by telephone. If a child required an appointment this was sent to the duty doctor.

An urgent appointment with a doctor, nurse or medic could be accommodated on the same day. Routine appointments with these clinicians could be facilitated within 48 hours. Nurses could book double appointments or longer if required. There was a women's health clinic and a specific child immunisation clinic in place.

Direct Access Physiotherapy (DAP), a DPHC requirement to support patient choice, was available to permanent staff, all referrals for cadets had to go through a doctor first.

Urgent physiotherapy appointments were available within 1-2 days, a routine new patient physiotherapy appointment and follow up appointment was available within a week. Cadets could be seen sooner if required.

Waiting times for a new patient appointment to see the exercise rehabilitation instructor was within 1 week and a follow up appointment was available within a few days. There was no wait for rehabilitation classes.

Listening and learning from concerns and complaints

The practice manager was the lead who handled complaints. The medical centre had implemented a process to manage complaints in accordance with the DPHC complaints policy and procedure. An example given of a recent complaint was with an overseas soldier and their family who were registered at the medical centre. They had various interactions with the doctors and ultimately felt they were not being listened to and were dissatisfied with the care they had been receiving. A formal complaint was therefore submitted. The SMO investigated this complaint, reviewed the medical record and found there had been no mismanagement of the care given. However, it became evident that there were cultural issues surrounding the family and that communication was of concern. The SMO invited the family into the medical centre and spent time listening to their concerns and explaining the referral process and the complicated nature of NHS intervention in this area. It was apparent that communication had been the problem with

the patient not fully understanding, once the processes had been explained, the family were relieved and satisfied with the outcome.

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

Are services well-led?

We rated the practice as good for providing well-led services.

Vision and strategy

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

The medical centre worked to 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’.

Sandhurst Medical Centre also worked to its own mission statement which was;

‘Sandhurst Medical Centre will provide a psychologically safe environment with the welfare and development of staff at its core, and in so doing safeguard the delivery of high quality care to entitled patients and support to RMAS training outputs’.

Care was delivered to patients through an integrated multi-disciplinary approach. There was clear engagement and support from the medical centre to support the Primary Care Rehabilitation Facility (PCRF) priorities. Staff were proactive in health promotion support, lifestyle advice and access to mental health provision. However, on the day of the inspection, there was no evidence of a practice development plan or management action plan (MAP). The PCRF had their own MAP in place with tasks assigned to individuals to action.

The medical centre were working hard to improve the protection of the environment and they actively promoted the need to recycle and there were many recycling bins around the building. They were also trying to reduce paper wastage within the medical centre where possible by using electronic records and laminating templates.

Leadership, capacity, and capability

The staff spoke of a good working relationship with the regional team, the Senior Medical Officer (SMO) and management team had regular dialogue with the Regional Clinical Director and Regional Headquarters.

Over the past 7 years the SMO had been a cornerstone of the medical centre, offering stability and continuity in patient care. Their sustained presence had ensured patients received consistent, high quality care. Their understanding of the workings at Sandhurst and the operational requirements had greatly contributed to enhanced patient outcomes and supported the overall development of the care provided.

The staff team at medical centre worked hard to deliver the best possible care to patients. All staff we spoke with described a committed and able leadership team. There was an established civilian doctor who had been in post for many years who was integral to the medical centre governance and leadership team.

The practice manager was new in post and it was their first DPHC practice management post. Whilst still learning they showed an abundance of passion, drive, and motivation. They had the respect of the staff and team cohesion was evident.

All the staff we interviewed spoke highly about how medical centre was led and how the whole staff team felt valued. They described how the leadership style was inclusive which encouraged them to want to be part of developing the service. PCRF staff said they felt part of the team despite working in a separate building. They were very complimentary about the culture and atmosphere that has been created by the senior leadership team.

The team were committed to delivering the best care through a culture of constant learning and improvement. The medical centre was an approved training practice and had a well-established training ethos that considered the population it provided care for. There was protected time for practice meetings and training. Staff we spoke with had a positive attitude towards learning.

The SMO was the wellbeing lead as part of the Royal Military Academy Sandhurst (RMAS) Cultural Change strategy. Work had been undertaken by the RMAS Organisational Culture Strategy over the course of the last year. This led to a more fundamental look at the workplace systems and behaviours as a determinant of wellbeing. The focus was how the wellbeing of staff overall and within the medical centre directly impacted of the care of the cadets. This was therefore a staff focussed initiative with the cadets the indirect beneficiaries of a cultural shift. It was launched at the start of the current intake of cadets and taken on by subdepartments within the academy to start to reflect on and implement positive change. This work was ongoing.

Culture

It was clear from patient feedback, interviews with staff and quality improvement activity that the needs of patients were central to the ethos of the medical centre. Staff felt that their contributions to the development of the service were valued. All staff attended the practice meetings where they could put forward suggestions or raise concerns.

Staff said they would feel comfortable raising any concerns and were familiar with the whistleblowing policy. The practice has introduced an anonymous whistleblowing portal with quick reference codes displayed throughout the building.

The staff team was cohesive and worked well together with the collective aim to provide patients with a good standard of care. Staff described an open and transparent culture and were confident any concerns they raised would be addressed without judgement. The team enjoyed many social events together including a golf day, a pottery day fitness and meals out.

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.

Governance arrangements

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 (ToRs) 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 healthcare governance (HCG) workbook which included various registers and links such the ASER tracker, duty of candour log, IT faults and cleaning issues log.

An audit programme was in place and we saw examples of clinical audits where repeat cycles were carried out to monitor standards and quality. However the audit calendar needed review to be clear of the forecast of audit activity moving forward.

A range of meetings with defined topics for discussion were held to ensure a communication flow within the team. The medical centre had a designated meeting matrix in place.

An internal assurance review was undertaken of the PCRF in September 2023 and where concerns were identified actions were taken. For example, there was no way of tracking referrals so a referrals tracker had since been implemented and further added safety measures were put in place for when acupuncture was being undertaken.

Managing risks, issues and performance

There was a current and retired risk register on the HCG workbook along with a record of current and retired issues. Whilst the register articulated some main risks identified by the team, some required review. The issues register also required review.

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

The Business Resilience Plan was in place and this had been tested in July 2024, and due for review in July 2025. It clearly detailed the action to be taken in the event of loss of any services.

Appropriate and accurate information

The HAF (health assurance framework) commonly used in DPHC services to monitor performance is an internal quality assurance governance assurance tool to assure

standards of health care delivery within defence healthcare. The senior leadership team of the medical centre and the PCRF were predominantly the main authors of the HAF, responsible for the documentation of what was happening within the department. All staff attended the monthly practice meetings which informed the compliance with the HAF command requirements. Staff members we talked with during the inspection recognised their responsibilities in managing the governance and assurance framework.

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

Various options were available to prompt patients to provide feedback on the service and the medical centre acted on feedback received, including the DPHC online survey.

There was a Patient Participation Group (PPG) in place with the last meeting being in June 2024. Attendance was small but did include some cadets which was encouraging for the medical centre as they were always striving to gain feedback and instigate improvements if needed and most importantly to celebrate success.

A patients survey had been adapted specifically for cadets in Lucknow Platoon to capture their specific experience of receiving fulltime rehabilitation and collect any specific trends from this population. The aim was to make improvements to the patient pathway, this work was ongoing.

Continuous improvement and innovation

There was much evidence of continuous improvement across the medical centre and PCRF.

A health promotion Padlet (an online bulletin board that included videos, websites and information) was developed and supported by the academy, for promoting self-health management and signposting. This could be accessed from any from any smart phone, computer or device.

A metabolic register was being developed to align those patients with co-morbidities to have annual medication and chronic disease reviews coordinated into a single visit.

Smart Boards were initiated by a GP trainee working at the medical centre. These were virtual notice boards, in the medical centre and the PCRF, that used interactive communication to push out information for patients. Information included a rotating ‘meet the staff’ photo board, eConsult link, out of hours information, weather and the academy and medical centre diary for the week.

A new practice leaflet had been developed that included quick reference codes allowing access to the appointment booking system, eConsult, and the PPG.

A piece of work has been completed to look at bone stress injuries and some of the risk factors involved. There were plans to implement practice as a result of this. This work was ongoing.

The PCRF introduced an injuries tracker that staff had developed and was an excellent tool for tracking trends in line with the training courses. An example of this was when cadets presented with similar injuries, this was identified as relating to a particular exercise causing spikes in injuries. Evidence collated led to changes in the exercise and a reduction in the load carrying requirement, this made significant reductions in injuries.

A patient survey was adapted specifically for cadets in Lucknow Platoon to capture their specific experience of receiving fulltime rehabilitation and collect any specific trends from this population. The aim was to make improvements to the patient pathway, this work was ongoing.

A Lucknow Platoon board was in the rehabilitation office. This had enabled clinicians to see at a glance exactly where individuals were on their recovery pathway and included a specific checklist of objective markers (taken from research). Cadets said they found it really useful to understand where they need to be and the pathway to recovery, and clinicians found it useful as an overview.

A prompt was put in place on DMICP (electronic patient record system) that ensured the full range of screening questions would be checked at an early stage in a patients assessment, meaning that inflammatory conditions, that often delayed diagnosis, were identified earlier.