Pirbright Combined Medical Practice

Pirbright Medical Centre- Alexander Barracks, Surrey, GU24 0QQ
Windsor Medical Centre - Combermere Barracks, Windsor, SL4 3DN.

Defence Medical Services inspection

This report describes our judgement of the quality of care at Pirbright Combined Medical Practice. 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	Good	
Are services safe?	Requires improvement	
Are services effective	Good	
Are service caring?	Good	
Are services responsive to people's needs?	Good	
Are services well-led?	Good	

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Summary

About this inspection

We carried out this announced comprehensive inspection on 11,12 and 25th September 2024. We visited both Pirbright and Windsor practices over the course of 3 days. As a result of this inspection the practice is rated as good 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? – good
Are services responsive? – good
Are services well-led? – good

The 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:

There was an effective approach to care that was responsive to the needs of a differing population group including civilians.

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.

There were good lines of communication with the unit, welfare team the local NHS and the Department of Community Mental Health (DCMH) to ensure the wellbeing of service personnel.

The arrangements for managing medicines, including the management of medicines given under Patient Group Directives (PGDs) and high-risk medicines (HRMs) were good.

Mandated training for staff was not up-to-date, including paediatric Basic Life Support (BLS) training, safeguarding and Infection Prevention and Control (IPC).

There was evidence of clinical audit based on patient population and national guidance.

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

There was a process in place for the management of referrals but this was not failsafe and required review.

Patients received effective care reflected in the timeliness of access to appointments, reviews, and screening/vaccination data.

The combined medical practice benefitted from an inclusive leadership style, such that staff felt valued and able to contribute to improved ways of working. An inclusive whole-team approach was supported by all staff who worked collaboratively to provide a consistent and sustainable patient-centred service.

Notable Practice

As a result of new guidance regarding concussion management, an audit was completed by one of the doctors and a physiotherapist. The audit found there were inconsistencies with recording correct codes and using the correct templates. As a result some work had been completed by the Regimental Medical Officer at Windsor who had put together a template using a scoring system that covered everything. This had been finalised and was going to be pushed out to other Phase 1 establishments for them to adopt.

Prescribers reviewed inhaler use and the effect on the carbon footprint and as a result developed the Pirbright Greener Quick Inhaler Guide encouraging the use of dry powder inhalers where possible. Often giving better asthma control, these inhalers also had a considerably lower carbon footprint.

A case load management tool was developed by the Primary Care Rehabilitation Team (PCRF) team as a method of tracking the active caseload for the whole PCRF, which enabled the Officer in Command (OC) to have oversight of the total caseload at any time. For example, how many ankle injuries or shoulder injuries were on the caseload. This then linked into the Patient Reported Outcome Measures providing a rich database which could be used to monitor the effectiveness of the PCRF through clinical audit.

The Chief Inspector recommends to the practice:

A review of the staff training programme needs to be undertaken to ensure staff have the up-to-date skills and knowledge to deliver effective care and treatment. This should include safeguarding training, IPC and paediatric basic life support.

Ensure all staff complete training in recognising the deteriorating patient/sepsis relevant to their role.

Ensure all staff participate in urgent care moulage training including scenarios pertinent to the sick child.

Ensure vulnerable patients, including carers and care leavers have the appropriate code and alerts on their clinical records.

Ensure the process of managing external referrals is reviewed, including the management of those patients requiring urgent referral (2 week waits).

Formalise support for medics, including notes audits.

Consider a review of the management of long-term conditions across both practices to ensure consistency.

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

Review the DPHC policy requirement for emergency life support to ensure that all clinical staff who might need to deliver care to children have received training in paediatric immediate life support.

Co-ordinate with the recruitment team to ensure that new cadets' notes are summarised prior to arrival at Pirbright Combined Medical Practice.

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

Review the suitability of other departments working out of the same building as the Windsor Medical Practice ensuring patients' privacy is upheld at all times.

Review the policy that depicts searches for sodium valproate to include all registered patients not just service personnel.

Chris Dzikiti

Interim Chief Inspector of Healthcare

Our inspection team

The inspection team was led by a CQC inspector. The team of specialist advisors included a primary care doctor, a practice manager, a pharmacist, 2 physiotherapists, 2 nurses and an exercise rehabilitation instructor. We visited both Pirbright and Windsor practices. Two new specialist advisors also attended in a shadow capacity.

Background to Pirbright Combined Medical Practice

Pirbright Combined Medical Centre provides primary care to Phase 1 trainees, permanent members of staff including families and a number of development courses. As a combined practice, care is provided across two sites, Pirbright and Windsor Combermere, but also delivers care for Victoria Barracks (via Combermere Barracks). Since May 2024, Defence

Primary Healthcare (DPHC) has formally recognised the service as a group practice arrangement. Families and dependents of military personnel are also registered at the practice but are only seen in Pirbright Medical Centre.

In addition to routine primary care services, the practice provides a range of other services including, vaccinations, sexual health, smoking cessation, cervical cytology, over 40's health screening, chronic disease management and aviation medicals. A PCRF is located at both sites and the dispensary is located at Pirbright.

Pirbright Combined Medical Centre at Combermere Barracks (Windsor) offers primary healthcare and occupational health to military personnel. The main focus is to provide primary healthcare to maintain operational effectiveness and maintain force health protection.

Pirbright Combined Medical Centre is open Monday to Friday 08:00 to 18:30. After this, patients are referred to local out of hours services/emergency department.

The staff team

Senior Medical Officer (SMO)	Vacant
Civilian Medical Practitioner	Two Two (Part time)
Deputy Senior Medical Officer	One
Regimental Medical Officer (RMO)	One
Group Practice manager	One
Senior Nursing Officer (SNO)	One
Nurses	Deputy Senior Nursing Officer (DSNO) (Vacant) Three Band 6 in post and 3 vacant posts One Band 5 in post and 2 vacant posts One Band 5 (part time)
Health Care Assistants	Two (1 military and 1 civilian) in post plus 2 vacant posts.
Pharmacy Technician	Two (1 military and 1 civilian)
Physiotherapists	One Officer Command (OC) One Band 7 One Band 7 (Part time)

Exercise Rehabilitation Instructors (ERI)	One Band 6 Physio in post and 2 vacant posts One Band 6 (part time) Two Exercise Rehabilitation Instructors (ERI) and 1 post vacant
Administrators	One office manager Three administrators in post and 1 post vacant.
Combat Medical Technicians* (CMTs)	Nine

Windsor Branch

Medical officers (Non DPHC)	One Welsh Guards RMO One Coldstream Guards RMO
Practice manager	One Branch Manager
Nurse	One Band 6
Physiotherapists Exercise Rehabilitation Instructors (ERI)	Two Band 6 One ERI
Administrator	Two
Combat Medical Technicians* (CMTs) Non DPHC	19

Are services safe?

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

Safety systems and processes

Pirbright provided care to families and Windsor provided care for service personnel only. All the staff we spoke with had access to the safeguarding standard operating procedures (SOPs) and understood what would be considered a safeguarding concern. The SOPs for both adult and child safeguarding had been reviewed and included contact details for local safeguarding teams.

Both practices worked to the Defence Primary Care Healthcare (DPHC) Tri-Service safeguarding policies. Records indicated that not all staff had received updated safeguarding training at a level appropriate to their role, it was unclear whether this was a recording issue or if staff were out-of-date for refresher training. The group practice manager confirmed they would give this prompt attention.

The Primary Care Rehabilitation Facility (PCRF) had all safeguarding policies on their SharePoint page and displayed throughout the department, they included links to the safeguarding lead and the safeguarding policy team site.

Safeguarding concerns were discussed at monthly meetings. Vulnerable person registers, including patients under the age of 18, care leavers and carers were maintained and a search of DMICP (electronic patient record system) was undertaken monthly. One of the doctors also attended meetings at local schools alongside social workers and teachers.

A primary healthcare team meeting was held monthly where any safeguarding concerns were discussed, this was attended by the camp welfare representatives, a doctor, the Senior Nursing Officer (SNO), a physiotherapist, health visitor, representatives from schools and a midwife.

Early access appointments were available for carers enabling them to see a doctor at the earliest convenience. Doctors had a good understanding and knowledge of the multiple grants available from the local authority that could be offered to carers and support was offered to access these.

We undertook a search of DMICP and found that there were 30 carers registered and 13 care leavers. Whilst we found these had the appropriate coding attached to their records, not all had alerts in place. We also noted that not all patients recorded as vulnerable had been recorded as having been discussed at a multi-disciplinary meeting.

All doctors had information given to them with regard to safeguarding arrangements and this was included in their induction pack. There was safeguarding information in every room including how to refer to safeguarding for both children and adults.

Notices advising patients of the chaperone service were displayed in each room, in the practice leaflet and in the reception area at both sites. There was a list of trained chaperones and chaperone training was held regularly. The SNO had recognised that

more male chaperones were required and had a plan in place to support this. Staff who acted as chaperones had received a Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

The full range of recruitment records for permanent staff was held centrally. 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. There were a small number of staff that did not have a DBS recorded either because they were new in post, were on long-term sick leave or because they had expired; for those, we saw evidence showing a replacement had been requested, it had been added to the risk register and an appropriate risk assessment was in place. There were 2 administrative staff that had a legacy contract where a DBS was not a requirement and they were unwilling to obtain one; this risk had been transferred to regional headquarters. All staff had crown indemnity and all clinical staff held a professional registration which was recorded on the staff database.

There was a dedicated lead for infection prevention and control (IPC), they were yet to gain their link practitioner qualification, although they had applied for this and had a date for a training course in October 2024. They were well supported by a physiotherapist who had completed the required training. The training log showed that 70% of other staff had not completed or recorded their IPC training. Regular audits of IPC were undertaken across both practices.

There were measures in place to minimise the spread of infectious diseases. Staff received updates that kept them informed of any trends, or new training requirements. Personal protective equipment and hand gel was readily available throughout.

Environmental cleaning was provided by an external contractor twice daily. We visited both practices and both PCRFs and all were clean and tidy throughout. Arrangements were in place for deep cleaning.

The management of healthcare waste was in line with policy. Clinical waste was bagged, secured and marked with the practice code before being recorded in a waste log held in a dry store. Consignment notes were held at both sites but were not always being cross referenced to the waste log, this was rectified during the inspection. An annual waste audit was completed, the last had been carried in November 2023.

Staff across both PCRFs provided acupuncture to patients. There was an acupuncture SOP and risk assessments in place. These had been reviewed regularly and all staff were aware them. All patients were given an information leaflet and written consent was gained and scanned onto DMICP. The delivery of acupuncture was audited and some actions for improvement were identified with note keeping, this was being actioned and a re-audit planned.

Gym equipment in both PCRF treatment areas was maintained, serviced and monitored this included weekly cleaning and checks to ensure all equipment was in good working order. If any issues were found these were reported and repair/service arranged.

Risks to patients

There was a good balance of well-trained civilian and military staff which afforded continuity of care. However, staffing levels were depleted across both practices. Currently there were 52 established posts and 19 were vacant, 13 of these were filled with temporary healthcare workers. There was a challenge in providing doctor cover to the Windsor practice if the Regimental Medical Officer was away. When this happened, patients wanting to see a doctor would travel to Pirbright and Windsor provided a nurse led service only. To ensure safety a clinical rota was in place, this was well managed and ensured suitable qualified staff were covering across both sites. There was also a weekly diary meeting where this was discussed and any issues addressed.

There were multiple nursing vacancies which were covered by locum staff. Staff said vacancies were covered quickly by regional headquarters providing authority to obtain agency nurses. The SNO planned to undertake a workforce review to consider supporting uplifting/regrading some nurses to offer better continuity.

Nursing staff currently provided routine and out of hours care to patients including children. The current workforce were predominantly ward based staff previously and they were covering out of hours provision at Pirbright between 1630 and 1830 hours Monday to Friday supported by the duty doctor (by telephone). These staff had been supported in the uplifting of their skills for general practice nursing. Nurses said they felt they had the sufficient skills and were competent within their individual scopes of practice to deliver paediatric care. At the time of the inspection 2 nurses had completed paediatric basic life support (BLS) training. There was no record of any training moulages undertaken including any with a paediatric focus, this was accepted as an area for development.

Current Defence Primary Healthcare (DPHC) policy was not clear on the requirement beyond adult BLS. The SNO on taking up post had implemented advice that staff should complete online paediatric BLS training, this has now been revised and was a direction for all staff to complete. Completion of face to face confirmation of skills would be completed as a matter of urgency. Equipment was available in the resuscitation room that was specifically for paediatric care and alongside this there was the ‘paediatric six pathway and Sepsis Trust information on the wall to support the team.

Within the PCRF, physiotherapy staffing levels were sufficient to meet demand, however, exercise rehabilitation instructor (ERI) staffing levels limited the ability of the PCRF to deliver optimal rehabilitation to some patients. The PCRF had applied for funding for 2 locum ERIs, only 1 was approved and 1 was rejected. Pragmatic approaches had allowed operations to continue at present but with the Officer in Command (OC) post being vacant, this was likely to impact on the output and support of care, especially of trainees. Plans had been put in place to mitigate full operations. Leadership within the PCRF had been passed to the band 7 physiotherapists, with military ERIs sharing roles and responsibilities of the senior ERI (as this post was vacant) to support delivery. This was to ensure a sustainable and resilient model of management to support deployments both at the time and in the future.

Staff working in both practices had completed adult basic life support, anaphylaxis and automated external defibrillator (AED) training. Equipment was in place to support the

delivery of paediatric resuscitation. Information about sepsis was displayed in various areas of both practices. All staff had received training in climatic illness but not sepsis.

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

Wet Bulb Globe Temperature checks to indicate the likelihood of heat stress were undertaken. At Windsor a red flag system was used when temperatures exceeded normal limits.

Unplanned admissions to hospital were managed well, including effective communication and monitoring between the practice 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.

Ambient temperature monitoring was being completed in accordance with the DPHC SOP for temperature monitoring. Oxygen was held and was accessible with appropriate signage in place. There was an AED kept in each medical practice and in each PCRF.

Waiting patients could be observed at both practices at all times by staff.

Information to deliver safe care and treatment.

There were several processes in place for the summarising of patients notes depending on the patient group. Families' notes were monitored and hastened until they were received and summarised. At the time of the inspection, only 2 sets of families' notes were awaiting summary. Permanent staff notes were summarised at e-registration initially by the administrators then by the nursing team. Regular searches of the clinical system were undertaken to ensure summarising was kept up-to-date. However, some new recruits coming through were found to not have had their notes summarised by the external recruitment team, this had been raised as a concern and was recorded on the risk register. This presented a potential risk with the practice being unaware when receiving patients with a condition that may require treatment.

There was a doctor and physiotherapist designated solely for the recruits as a single point of contact for them. There were good links in place with the Department of Community Mental Health (DCMH), alongside this there was local work being undertaken with the Chain of Command with regard to management and education around self-harm and suicidal ideation. DCMH contact information was built into the standing orders so they could be called direct out of hours. Case discussions with the DCMH consultant were undertaken, if required, prior to a full referral.

Clinicians used peer review to measure and ensure quality of care delivery across the staff team at both practices. Clinicians within the PCRF across both sites undertook a yearly notes audit in line with DPHC guidance. Peer review was also embedded into everyday working along with joint working and frequent discussions together as a team. There was a formal process in place for the ERI to receive formalised peer review, clinical supervision

and mentoring on musculoskeletal assessment skills. The PCRF team at Windsor were well supported by Pirbright with fortnightly visits from band the 7 physiotherapist and lots of access to peer review. The Windsor team were included in all meetings either remotely or face to face and shared all policies and documentation.

There was a process in place for the peer review and audit of nursing records. Clinical supervision and protected time for continual professional development was in place, peer reviews were conducted and professional development plans were part of mid and end of year discussion for all nursing staff.

Medics saw patients as part of 'sick parade' and were supported by the nurses and the duty doctor. However, there was no formal process in place for the support and supervision of medics notes and consultations.

Staff confirmed that access to patient records was only occasionally a concern and did not pose a significant risk to continuity of patient care. In the event of a DPHC-wide outage, the practice would refer to the Business Resilience Plan seeing emergency patients only and routine clinics maybe cancelled. Appointments were printed out at the end of each day for the following day and hard copy forms were held for use in this scenario and documentation would be scanned onto DMICP when available.

There was a process in place for the management of referrals but this was not failsafe. Referrals were sent to the referrals clerk by email, by direct task or by hand. A group task box was available but not used. Cover was provided by Windsor but correspondence we were shown clearly demonstrated that the staff providing cover did not fully understand the process. The practice had yet to move to the new mandated DPHC referrals tracker even though the deadline for transfer was late June 2024. The tracker that was being used did not include appointment dates so we were unable be assured that all 2 week wait (urgent) referrals had an appointment although we were told appointments were kept in hard copy. This meant that staff covering absences from Windsor did not have access to all the data they needed to manage the referrals effectively.

An effective process was in place for the management of specimens and this was supported by an SOP. There was a combined SharePoint specimen register for recording samples from both sites which was reviewed daily by the duty nurse at Pirbright. At Windsor, a DMICP register was also maintained as not all medics had access to the SharePoint register.

Results were returned via the PathLinks (electronic link between the pathology laboratory and healthcare professionals) inbox. These were then reviewed daily by a clinician to confirm receipt and action any urgent results. They were then allocated back to the requesting doctor or the duty doctor for any further action.

Safe and appropriate use of medicines

The was a dedicated lead for medicines management. 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.

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 clear processes in place for the access to CDs out of hours. A review of the most recent destruction certificate confirmed that accountable and controlled drugs were being destroyed in accordance with policy

The medical emergency trolley and medicines were checked weekly by one nurse and one health care assistant. It was recorded on a spreadsheet with the serial tag. We noted the names were entered but as it was electronic there were no signatures, meaning serial tags could be deleted and reinserted without being known. Tags were in place with a list of expiry dates held.

We checked all the emergency medicines and kit and these were in-date. We saw that the Entonox cylinder (used for pain relief) was linked up to an administration tube on the trolley but it was empty. There was a replacement next to it but it was lacking serial numbers so medics were unsure of its legitimacy to use. There was also no Entonox in the resuscitation room. The group practice manager was made aware and took swift action to rectify this. The group practice manager kept a log of cylinder and gas expiry dates.

The pharmacy technician was registered to access the Medicines and Healthcare products Regulatory Agency (referred to as MHRA) and the Central Alerting System (CAS) website for alerts. These were actioned by the most appropriate person and information was shared and discussed throughout the medical centre at practice meetings

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 and the ambient temperature in these rooms was monitored.

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. A spreadsheet had been developed that was maintained by the dispensary that informed all staff of what vaccination PGDs they were in-date for. Neither practice used Patient Specific Directions.

There were clear and thorough processes in place for the requesting and issuing of repeat medication. Through discussion and review of DMICP records, it was evident that there was a clear audit trail for the request of repeat medication.

The dispensary has a coded door and lockable door handle to control access. Access into a secondary room was lockable from within dispensary by key. The extra room had flimsy locks from the corridor (fridges were stored here and were individually locked). The locks on those doors had been reported. 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.

Valproate (medicine to treat epilepsy and bipolar disorder) searches were regularly undertaken. We noted that the search was set for military personnel only. As a families practice a search for all patients should be established.

A process was established for the management and monitoring of patients prescribed high risk medicines (HRM). We saw that this was a collaborative approach between the prescribing clinicians and the pharmacy technicians. There was a register of HRMs in place 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.

We looked at medicines at Windsor. Emergency medicines were easily accessible to staff in a secure area of the practice 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.

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, all stock had been removed at the time of inspection due to a planned power outage.

Track record on safety

Measures to ensure the safety of facilities and equipment were in place. The camp conducted inspections and held the details on a spreadsheet. Health and safety audits were completed and sent back to the health and safety team. Electrical safety checks were up-to-date. Water safety checks were regularly carried out. A legionella risk assessment had been completed in February 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.

There were a range of both clinical and non-clinical risk assessments in place including lone working and a separate set specific to the PCRF. There were some minor amendments required to the already extensive Control of Substance Hazardous to Health (COSHH) risk assessments and this was also rectified immediately.

Both practices hand PCRFs had a mixture of fixed alarms. There was an alarm system checklist on the healthcare governance workbook which documented monthly testing.

Lone working within the gym or the PCRF was rare as the medical centre opening hours exceeding those of the PCRF. However, if it did occur, then managers were alerted at the start and end of the session.

Lessons learned and improvements made

All staff worked to the DPHC policy for reporting and managing significant events (SE), incidents and near-misses, which were recorded on the electronic organisational wide system (referred to as ASER). They were discussed at the healthcare governance meeting every 6-8 weeks but sooner if more urgent. An ASER register was maintained.

The staff database showed that not all staff (65% completed) had completed ASER training to access the system. All staff we spoke with knew how to raise an SE or incident. We were provided with an example of a patient who had recently moved into the area and there was a delay in obtaining their records. The patient saw lots of doctors in the first few months and no one particular doctor took ownership of this person’s care. This was

discussed at a doctors' meeting and a doctor was allocated to the patient to provide consistency and more joined up care. The PCRF also gave us several examples of SEs raised and they showed appropriate and positive actions taken as a result.

Are services effective?

We rated the practice as good for providing effective services.

Effective needs assessment, care, and treatment

Clinicians had opportunities to attend regional forums, such as regional governance meetings and nurse development forums. National Institute for Health and Care Excellence (NICE) and other guidance was a standing agenda item at the practice meetings and at the weekly doctors' meetings. Defence Primary Healthcare (DPHC) standard operating procedures (SOPs) were shared with all staff via emails as updates happened. Any new updates were discussed in the clinicians' meetings and then shared with the wider team as needed. A recent example of new guidance was with concussion management, this led to an audit being completed by one of the doctors and a physiotherapist. The audit found there were inconsistencies with recording correct codes and using the correct templates. As a result some work had been completed by the Regimental Medical Officer at Windsor who had put together a template using a scoring system that would cover everything. This had been finalised and was going to be pushed out to other Phase 1 establishments for them to adopt.

The Primary Care Rehabilitation Facility (PCRF) staff attended monthly meetings to share and discuss evidence-based guidance, including NICE & Scottish Intercollegiate Guidelines Network. They also had a monthly continuing professional development (CPD) session with delivery from all staff members and a wide range of topics. The PCRF staff also attended the multi-disciplinary team (MDT) clinical meeting, and they had representation at practice meetings.

A case load management tool was developed by the PCRF team as a method of tracking the active caseload for the whole PCRF, which enabled the Officer in Command (OC) to have oversight of the total caseload at any time, for example how many ankle injuries or shoulder injuries were on the caseload. This then linked into the Patient Reported Outcome Measures providing a rich database which could be used to monitor the effectiveness of the PCRF through clinical audit.

Staff were also kept informed of clinical and medicines updates through the DPHC newsletter circulated each month

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.

The PCRF at Pirbright did not have all the equipment and space it needed to deliver a safe and effective service. The PCRF was managing with the space it had but there a number of improvements in the infrastructure of the rehabilitation gym that could provide more capacity: The PCRF had an application with the unit for building improvements including:

- A change of sink within the rehabilitation gym clinic room to meet Infection Prevention and Control (IPC) compliance.

- The removal of a dividing wall between the clinic room and adjoining room in order that there was sufficient room for physical testing within the clinic room.
- A change of flooring within the area next to the rehabilitation gym in order to be IPC compliant.

The improvements would allow a much greater scope for functional assessments within the clinical space of the rehabilitation gym.

Both PCRFs ensured that it took a holistic view of patients. As part of the new patient questionnaire, there were prompts to ask about sleep, mood, diet and stress. Patients were referred to the dietician, or medical staff when needed.

Monitoring care and treatment

One of the doctors was the lead for all for all chronic diseases. There was chronic disease register with all long-term conditions (LTCs) recorded, although we did find some inconsistencies across both sites as one location was using a comprehensive spreadsheet the other was not. There was a document folder on SharePoint with each disease entered onto a tracker. One of the nurses managed the searches, sent text messages inviting for recalls and medication reviews. Nurses used the 'gov.notify' texting service for recalls using standardised text messages and also included individual tailored detail; for example, what the appointment was for e.g. blood tests or urine checks. This process was repeated up to 3 times in an attempt to get the patient to make an appointment. They also used a 'non responder' message which prompted them, and included a link, to read information from NICE empowering them to make choices about their care even if they were non-responders. This was recorded in their notes.

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 13 adult patients on the diabetic register. For 11 patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For 19 patients with diabetes, the last blood pressure reading was 150/90 or less which is an indicator of good blood pressure control.

There were 53 patients on the hypertension register and 35 had had their blood pressure taken in the past 12 months. Of these, 44 patients had a blood pressure reading of 150/90 or less.

There were 37 patients with a diagnosis of asthma. Of these, 22 had received a review in the past 12 months. We saw patients had been recalled but had not responded, nurses were proactive in pursuing this.

Patients with mental health needs were managed and supported in line with standard practice. Step 1 of the mental health intervention programme was provided mainly in relation to anxiety and depression. This included use of the appropriate assessment tools. Medical staff described a good relationship with the Department of Community Mental Health (DCMH). Our review of records for patients with a mental health need showed they were appropriately supported and managed.

There was an area on SharePoint specially for doctors that included a host of updated information on different subject matters, for example, dermatology information tailored to the population, young people's mental health, minor surgery including wound care, emergency trolleys, the list was extensive.

There was active management of children's immunisation status. Currently, clinicians' stations rely on Child Health Immunisation Service (CHIS) to send them a list of children who are due or outstanding various childhood immunisation, via email. There were 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 medics. Audiology statistics showed 78% 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 wait times for the patients, currently at 7 weeks. There were regular direct communications with the RRU at Aldershot and this allowed staff to expediate patients if needed. The PCRF had regular multi-disciplinary meetings with the MIAC clinicians to discuss potential referrals.

Quality improvement activity (QIA) was evident throughout both practices. QIA comprised both clinical audit, DPHC mandated audits and data searches. Despite the challenge of inconsistent staffing levels, QIA was continuous. We identified some innovative practice, in particular the new template for concussion management and the practice was also housing Sickle Cell research via Army Recruiting and Training Command. Audits followed a clear structure, standards and referenced evidence-based medicine guidance. Appropriate action was taken if analysis identified shortfalls. The outcome of clinical audits was discussed with the staff team if appropriate.

Some example audits were:

Injury surveillance audit: This audit identified a change in injury timelines, in that more injuries began occurring later down the training pathway (approx. 8-weeks into training) and this corresponded with change in the training pathway, to place a greater emphasis on strength and conditioning build up during the initial 8-weeks before a transition into loaded marching / tabbing / running. The audit identified that the transition into higher impact tabbing / loaded marching / running was a point of high injury risk. This was fed back to the training staff and work on optimising the training pathway was ongoing.

Magnetic resonance Imaging (MRI) outcomes audit: an audit was carried out for those patients referred for a knee MRI, investigating the accuracy of initial clinical impression compared to the MRI report. The audit highlighted a relatively low accuracy between initial impression and MRI diagnosis. As a result further training was put into place resulting in increased accuracy.

The PCRF team ensured that the occupational requirements of the patient were considered when assessing and providing care pathways. Trainees being the biggest population at risk had an elongated and highly appropriate pathway for considering the needs of the service user and returning them to fully operational capacity. There was a very good relationship with the training team which enabled them to make recommendations for achievable timelines to be completed.

Effective staffing

There was an extensive and bespoke induction programme, with a separate induction for locum staff. For doctors there was 2 weeks set aside for them to visit different departments, they also had this time to be able to shadow other clinicians to learn the day to day routines. There was an induction register on SharePoint. Both DPHC induction and workplace induction were recorded on the staff database. The group practice manager monitored induction to completion and induction checklists were retained.

Mandatory training was recorded on the healthcare governance workbook which captured internal and external trainings. Protected time was allocated for mandatory training as well as continued professional development (CPD), there was also clinical time allocated that was available to be utilised as needed. It was not clear how many of the staff team were in-date for mandatory training. There were gaps in the training log with some staff having none of the updated mandatory courses recorded as completed. For example; IPC, safeguarding, paediatric basic life support and ASER training. It was unclear as to whether staff had not completed training or simply had not recorded it.

The doctors all completed regular appraisal and revalidation. The nurses had completed their revalidation. All clinicians were aware of the CPD requirements and used clinical meetings, mandatory training, and practice meetings to support with meeting this requirement

Role-specific training was available for relevant staff. For example, nurses had completed spirometry training, travel vaccinations, yellow fever, ear irrigation immunisations and vaccines. One of the doctors was qualified in aviation medicine and one was sexual health trained.

Coordinating care and treatment

The practice staff met with welfare teams and line managers to discuss vulnerable patients. The group practice manager was on the local NHS practice managers forum and previously the Senior Medical Officer (SMO) had linked with the Integrated Care Board to ensure continued good communication and understanding.

Doctors were proactive in discussion with their peers from other areas when recruits were set to leave phase 1. All recruits were unable to leave with a medical problem unless this had been appropriately handed over to the receiving medical centre. For patients leaving the military, pre-release and final medicals were offered and information given. The doctors conducted regular handovers to other practices (including NHS) appropriately, this usually took the form of direct discussion with an appropriate clinician.

Staff told us that they had forged some good links with other stakeholders, including the local NHS Midwifery and Health Visiting service, local NHS services, multi-agency safeguarding hub (MASHH), Child Health Community Teams, Schools, SSAFA (the armed forces charity), padres, welfare and station executives. There were good lines of communication established with the individual units having their own named doctor assigned to them.

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

Helping patients to live healthier lives

One of the doctors was the lead for sexual health. Sexual health advice and contraception were provided, including implants and intrauterine devices. Health and lifestyle information was available throughout the patient areas of the buildings. The health promotion board at Pirbright had been updated in line with national initiatives, we noted this had not been completed at Windsor.

PCRF staff used the rehabilitation pathways that incorporated a number of wider health related topics. They also attended unit health fairs with the medical practices.

All eligible female patients are on the national cervical screening database and were recalled by the nurse. The latest data confirmed an 88% 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:

- 93% of patients were in-date for vaccination against diphtheria.
- 93% of patients were in-date for vaccination against polio.
- 92% of patients were in-date for vaccination against hepatitis B.
- 88% of patients were in-date for vaccination against hepatitis A.
- 93% of patients were in-date for vaccination against tetanus.
- 97% of patients were in-date for vaccination against MMR.
- 90% of patients were in-date for vaccination against meningitis.

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 100%.

The percentage of children aged 2 who had received their booster immunisation for Pneumococcal infection (i.e., received Pneumococcal booster) (PCV booster) was 100%.

The percentage of children aged 2 who had received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e., received Hib/MenC booster) was 100%.

The percentage of children aged 2 who had received immunisation for measles, mumps and rubella (one dose of MMR) was 100%.

The percentage of children aged 5 who had received immunisation for measles, mumps and rubella (two doses of MMR) was 100%

Consent to care and treatment

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. Implied consent was mainly used, we saw the nursing records did not consistently record this when obtained from patients. Written consent was taken for invasive procedures and implied consent for non-invasive examinations.

Informed written consent was taken for acupuncture and then then scanned to the patient's DMICP record. Written consent was taken for minor surgery. We confirmed consent was accurately recorded though our review of DMICP records.

Clinicians understood the Mental Capacity Act (2005) and how it would apply to the patient population group. They had received training recently in mental capacity. Clinicians were aware of both Gillick competence (young people under 16 with capacity to decide) and Fraser guidelines (advice/treatment focussed on a young person's sexual health).

Are services caring?

We rated the practice as good providing caring services.

Kindness, respect, and compassion

In advance of the inspection, patient feedback cards were sent to both sites, feedback was from patients that had been seen by the Primary Care Rehabilitation Facility (PCRF), the dispensary and the medical and administrative staff. A total of 36 patients from Pirbright and 16 from Windsor responded and feedback was positive, reflecting a general theme of kind and caring staff.

The last patient survey, undertaken by the combined practice between September and October 2023, showed 100% (of 29 applicable patients) said they were treated with kindness and compassion. We spoke with 3 patients on the day and they were happy the care they had received. We were given numerous examples where staff went over and above to care for their patients. One example was when a patient arrived at Pirbright and had a panic attack, staff immediately brought the patient into the nurse treatment room prior to their appointment to reassure them and allow them more time. They talked to the patient to help calm them and try to understand what led to the panic attack, they did not just focus on the patient's physical injury. Following this they arranged a doctor's appointment and arranged with the Chain of Command for the patient to go home on some compassionate leave.

Patients could access the welfare team and various support networks for assistance and guidance. Information regarding these services was available in the waiting areas and the clinical staff were fully aware of these services to signpost patients if required. We spoke with a member of the welfare service, who said staff at the practice were responsive and caring and always put the patients' needs first.

Collaborative working between departments was strong with good communication leading to safe and caring outcomes for patients. An example of this was the medical centre along with the welfare team and the training teams managing a patient with adjustment difficulties and supporting them throughout them leaving the military. This included arranging for someone to meet them at train station when they went home and calling and following up with their parent the next day. One of the doctors then arranged for them to be registering them with their local NHS practice.

Involvement in decisions about care and treatment

The clinicians and staff at the practice 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.

Supported by a standard operating procedure, a translation service was available for patients who did not have English as a first language. Within the camp there was a Gurkha

population, one of the doctors spoke Hindi and one of the locum doctors had worked in Nepal so was able to communicate with the Gurkhas community well.

Carers were identified through the patient registration process or through the welfare team or opportunistically. At time of inspection 30 carers were identified and this data was captured using the e-registration system. There were posters throughout the buildings informing individuals if they are a carer to identify themselves (if they wish) to the practice. There was information for carers included in the practice leaflet.

Privacy and dignity

Patient feedback showed that patients were confident that the practice would keep information about them confidential. All stated that they felt that their dignity and privacy were upheld by staff. Consultations took place in clinic rooms with the door closed. Patients were offered a private room if they wanted to discuss something in private or appeared distressed.

Patients could request specific sex clinicians or a second opinion. Patients were offered alternative appointments if there was not an appropriate clinician on any given day. The PCRF offered patients follow-up appointments with the same clinician so ensure continuity of care. If patients needed to be seen by a different clinician for the same issue, a handover was provided for the new clinician if needed.

The physiotherapist assessment and treatment areas at Pirbright Primary Care Rehabilitation Facility (PCRF) was in curtained areas, radios were played to minimise conversations being overheard. Staff also worked in other rooms if not seeing patients to allow staff to have more privacy when carrying out patient assessments.

The PCRF at Winsor had 2 clinical rooms, 1 was in use by the exercise rehabilitation instructor and 1 by the physiotherapist. The cubicles in the physiotherapy room were also separated by curtains which could cause some issues with patient confidentiality. Again this was mitigated by having the radio on and the ability to take a patient to another room if there was a sensitive conversation happening. Close to the PCRF department there were some contractors who had been historically sited within a corridor of the medical centre. A door was moved to a different corridor to try to prevent the noise from their office being heard within this area, but this had not helped.

The reception area at Pirbright was large and well laid out with the waiting area was at a distance from the reception in a separate room meaning that conversations between patients and reception would unlikely be overheard. At Windsor the waiting room was in view of the reception and conversations could also 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. There was a television in the waiting area in each practice that provided background noise to promote privacy.

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 combined practice had adopted the ethos of 'right place, right time, right clinician' to meet needs of patients located in either Pirbright or Windsor. There were good secondary care partnerships in place including good relationships with Frimley Park NHS Trust who also provided a walk in X-ray service.

Staff were constantly ready to respond to the occupational needs of patients. Phase 1 recruit's needs were discussed with the Chain of Command and the occupational health medical requirements such as vaccinations, initial medical assessments, and prerelease to phase 2 medicals were scheduled into a training program. Urgent appointments were always available for recruits to attend.

There was a flexible approach to the management of appointments to meet patients' needs this included e-consults, children and routine appointments. Longer appointments could be accommodated for patients with complex needs.

It was recognised that the structure the Gold Platoon (recruits who needed more than brief or short term rehabilitation) pathway required improvement, this was based on patient feedback. Issues were raised with motivation for those patients in early stages of rehabilitation. As a result of this, a new structure had been introduced with rehabilitation groups containing a mix of early, mid and late stage patients, with greater involvement of each section commander. Each group integrated with each other at different stages of the rehabilitation pathway. Positive feedback had been received from patients since this was introduced.

An Equality Access Audit as defined in the Equality Act 2010 was completed at both sites within the past year. Any points identified were discussed and put onto the issues register.

A dedicated member of staff was the lead for diversity and inclusion, there was good communication with the unit leads. There was a notice board with information and contact details for patients in both waiting rooms. A policy was in place to guide staff in exploring the care pathway for patients transitioning gender. All staff had received training in learning disability and autism.

There was a dedicated room available at Pirbright for those women who wanted to breastfeed. It was a quiet and comfortable room for them to use and relax in. Baby changing facilities and nappies were also available and a small, low toilet for children to use.

Timely access to care and treatment

Details of how patients could access a doctor when the practices were closed were available through the camp helplines and was outlined in the practice information leaflets

and in the unit orders. Both practices were open until 18:30 hours daily with the duty doctor and a nurse covering. Both practices were also open on Saturdays and Sundays for recruits that needed to be seen by a 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.

Direct Access Physiotherapy (DAP), a Defence Primary Healthcare (DPHC) requirement to support patient choice, was available to patients at both sites. Urgent physiotherapy appointments and follow up appointments were available at Pirbright on the same day, and at Windsor within 1 day. Routine new patient physiotherapy appointments were available with 1 day. Waiting times for a new patient appointment and a follow up to see the exercise rehabilitation instructor were within 1 day. There was no wait for rehabilitation classes.

Listening and learning from concerns and complaints

The group practice manager was the lead who handled all complaints in the practice. The practice had implemented a process to manage complaints in accordance with the DPHC complaints policy and procedure, 2 written complaints had been recorded within the past 12 months.

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

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 practice 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'.*

Care was delivered to patients through an integrated multi-disciplinary approach. There was clear engagement and support from the practices to support the Primary Care Rehabilitation Facility (PCRF) priorities. Teams across both sites were proactive in health promotion support, lifestyle advice and access to mental health provision. This was a clear plan with focus on staff, infrastructure, training, patient delivery.

Leadership, capacity, and capability

The staff spoke of a good working relationship with the regional team and the senior management team had regular dialogue with the Regional Clinical Director and Regional Headquarters. The staff teams across both practices worked hard to deliver the best possible care to patients.

There was planned devolution of roles when the Senior Medical Officer (SMO) post became vacant and the Officer in Command from the PCRF stepped into the management role having had a comprehensive handover. The staff team were extremely complimentary about the OC leadership of the team as a whole. The nursing team rotated roles amongst themselves to provide leadership when the Senior Nursing Officer post was vacant, this also gave them development opportunities. Staff within the PCRF also effectively covered the vacant OC post.

The group medical practice was an approved training practice and had a good training ethos that considered the population it provided care for. There was protected time for practice meetings and training although not all staff had completed or recorded their training adequately. Staff we spoke with had a positive attitude towards learning.

To address environmental sustainability, recycling was encouraged, appliances were switched off when not in use and the heating turned off at weekends. They also trying to reduce paper wastage where possible. Remote dial in for meetings was encouraged to reduce travel. There was a change in operational approach, and if staff did not need to be in the office they could work from home, a flexible working policy supported this.

One of the nurses personally delivered blister strips to a recycling centre as there was no system within the military. Prescribers reviewed inhaler use and the effect on the carbon footprint and as a result made an inhouse formulary based on clinical recommendations, cost and environmental impact of inhalers.

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 practice. 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. The team enjoyed social events together that promoted team cohesion.

We interviewed a cross section of staff, and all told us that it was a happy place to work and that they could rely on their work team to discuss and mitigate any concerns they faced. A staff climate survey was undertaken and some parts suggested morale was low, this generated an opportunity for staff to drive and voice changes. Following this, there were now team coffee mornings in place and staff awards. The PCRF were also fully engaged with the climate survey from which some issues were identified. As a result, the Army leadership team provided 3 afternoon sessions for staff which empowered the team to improve and develop.

Staff said they would feel comfortable raising any concerns and were familiar with the whistleblowing policy. An anonymous whistleblowing portal with quick reference (QR) codes had introduced and was displayed throughout both practices.

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

Communication across both practices was strong and an appropriate meeting structure and healthcare governance (HCG) approach was in place. Due to significant posts vacant in the senior management team, a few people including the group practice manager were covering many different secondary roles. However, there was a plan to share the workload more appropriately with the imminent arrival of new staff. Training needs had already been identified in some cases, and applications submitted such as the Infection Prevention and Control link practitioner and the Joint Practice Manager course.

There was an HCG workbook in place for monitoring governance activity. There were separate spreadsheets for each area of activity and, due to the development of a healthcare governance SharePoint landing page that guided individuals to each section. The group practice manager had a meeting arranged within the month with the regional IT lead to further enhance and streamline the Sharepoint site.

There was a range of standard operating procedures (SOPs) in place for all key processes and these were kept under review. There was an SOP tracker in place which identified the document owner and the required review date for monitoring purposes.

A thorough rotation of a range of meetings was in place to ensure effective communication and information sharing across the staff team. Other meetings included heads of department, HCG, clinical, PCRF, administrative and the practice meeting. The group practice manager attended the NHS practice manager meeting every other month which improved links with the local practices where service families were also registered. Meetings were held every other month with key personnel within the host units.

An understanding of the performance of the practice was maintained. The system took account of medicals, vaccinations, cytology, and non-attendance.

Managing risks, issues and performance

There was an active risk register with a separate register of transferred risks, there was also an issues log. All the known key risks and issues were recorded on the registers. Although initially the 4Ts process' (transfer, tolerate, treat, terminate), were not clearly applied to risks and a review date was not evident; this was rectified during the inspection. There were a range of both clinical and non-clinical risk assessments in place including lone working and a separate set specific to the PCRF.

A management action plan had been developed using the internal assurance visit as a baseline, this was easily accessible and was kept up to date and review was ongoing.

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 continuity plan was in place and this had been reviewed in September 2024. 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 including nursing representation were predominantly the main authors of the HAF, responsible for the documentation of what is happening within the department Staff spoken to on the day of inspection understood the role they played in managing the governance and assurance of the framework.

There were arrangements at the practice in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

Various options were available to prompt patients to provide feedback on the service and the practices acted on feedback received, including the DPHC online survey. There had been 29 responses in the past 6 months. To improve communication there was an iPad newly available in the waiting room for trainees to complete an anonymous survey as they did not routinely have access to their phones to scan QR codes. There was no patient participation group in place but this was being considered for the future. A suggestion box and forms were also available in the waiting room with responses displayed in the conference room for staff to review.

Continuous improvement and innovation

The new management team were working to improve understanding of quality improvement projects (QIPs) and relevant audit. There was an active QIP register in place with input from across the team including the PCRF. The group combined practice operated a whole team approach to improvement through open team discussions and meetings. Of note:

The nurses had developed a spreadsheet that was maintained by the dispensary, that informed all staff of what vaccination Patient Group Directions they were in-date for.

As a result of new guidance regarding concussion management, an audit was completed by one of the doctors and a physiotherapist. The audit found there were inconsistencies with recording correct codes and using the correct templates. As a result some work had been completed by the Regimental Medical Officer at Windsor who had put together a template using a scoring system that would cover everything. This had been finalised and was going to be pushed out to other phase 1 establishments for them to adopt.

The development of a case load management tool by the PCRF team as a method of tracking the active caseload for the whole PCRF to monitor effectiveness.