Brize Norton and Bicester Combined Practice

Brize Norton Practice Carterton Oxfordshire OX18 3LX
Bicester Practice, St Georges Barracks, Arncott, Bicester OX25 1PP

Defence Medical Services inspection

This report describes our judgement of the quality of care at RAF Brize Norton and Bicester Combined 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?	Outstanding	☆
Are services well-led?	Good	

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Summary

About this inspection

We carried out this announced comprehensive inspection on 23 April 2024.
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? – outstanding
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:

Feedback showed patients were treated with compassion and respect, had prompt access to the service and were involved in decisions about their treatment and care. The practices pro-actively responded to patient feedback and made improvements to the service as a result.

Extensive safeguards were in place, including close working with the welfare team, to support vulnerable patients

The practices were well-led and the leadership team demonstrated they had the vision, capability and commitment to provide a patient-focused, caring and responsive service. The leadership approach was collaborative and inclusive.

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

The arrangements for managing medicines minimised risks to patient safety. However, the monitoring of patients on repeat medicines needed strengthening.

Healthcare governance processes were well-developed and routinely used to monitor service performance.

Clinical audit was comprehensive and used regularly used to monitor if healthcare was provided in accordance with standards.

Staff consistently sought ways to develop and improve. Quality improvement activity was embedded in practice and was used to drive improvements in patient care. Quality improvement projects had been shared widely and some had been adopted by other Defence practices.

The Primary Care Rehabilitation Facility were forward thinking in their approach to providing individualised, holistic patient care. However, they did not provide patients the option to self-refer into the service.

Notable Practice

Due to the number of patients requiring hospital appointments, a specific group mailbox address was made just for hospital appointments. Patients were given these details to email in when they had queries: this was monitored daily. Patients were also given a patient service letter which explained the process and timelines for referrals, what happens with the appointment letters, telephone numbers for the hospitals, a link to NHS waiting times for the area and Patient Advice Liaison Service (PALS). This allowed patients to be better informed and could gain rapid easy access when they had questions or required guidance.

The PCRF took a holistic view of patients, including the impact of injury on mood and sleep and the benefits of healthy lifestyle. They had developed a patient-facing SharePoint page which contained extensive signposting to resources for mental health, sleep and nutrition in an easy to access format. It was well designed, thorough, covered a range of areas, and made resources easy to access and enabled patients to navigate through their own care pathway.

The PCRF had developed a health optimisation day. This was developed from the DoFit course, which they did not feel they had the capacity to deliver in its original form. They developed a programme and booklet to cover a range of lifestyle factors. This had received positive patient feedback and the team were developing the structure based on this. The booklet was well designed and used specialist knowledge.

A station line manager support group was introduced to provide a way for Chain of Command to access advice around optimal support for and management of patients who were working light duties only or were downgraded or on sick leave. The practice manager and Warrant Officer hosted line manager support groups in different departments on the station including an in-depth presentation. This had helped the medical team to familiarise themselves with the services required for each unit and to better understand how the medical centre could support that unit and their personnel.

Paediatric Immediate Life support (PILS) is not currently classed as mandated or a requirement within Defence Primary Healthcare policy. Nevertheless, the team at Brize Norton recognised that with children registered at their service, staff needed to have the appropriate training to potentially deliver life support to children. Training was therefore

delivered in house by the paramedic and this included care of paediatric patients. Following this the practice has requested Paediatric Immediate Life Support training for 12 members of staff.

The Chief Inspector recommends to Brize Norton and Bicester Combined Medical Practice

Consider the use of Direct Access to Physiotherapy (DAP) in the Primary Care Rehabilitation Facility (PCRF)

Ensure a cleaning contract is secured and staff monitor standards against this.

The Senior Medical Officer (SMO) should have delegated authority from the Commanding Officer of the unit to ensure the safe management of controlled drugs.

Control testing of the blood glucose monitor should be recorded.

Ensure all patients on repeat medicines are reviewed.

Ensure the system in place for the safe disposal of clinical waste includes ownership of consignment notes for a complete audit trail of disposal.

Continue to address the back log in the summarisation of patients' medical notes.

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

The Defence Medical Services (DMS) support information pages to the DMS Care Leavers Hub should be made available to all patients who are registering at a practice. This should be considered an organisational directive to add to the eRegistration form.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

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

Our inspection team

The inspection team was led by a CQC inspector. The team included specialist advisors including a primary care doctor, a pharmacist, a practice manager, a physiotherapist and a nurse. A second CQC inspector visited Bicester.

Background to Brize Norton and Bicester Combined Practice

Brize Norton Practice is located near Oxford. The practice is combined with Bicester, which is located approximately 24 miles away. The practices offer care to service

personnel and also a number of families, including children as per local eligibility criteria. At the time of inspection, the patient list was approximately 6,000 (including 350 dependents). This is not inclusive of reservists or transient population.

In addition to routine GP services, the practice offers a range of services, including physiotherapy services, minor surgery, travel advice, Weight management and smoking cessation clinics. Family planning and sexual health advice is available. Midwifery clinics are held fortnightly.

Both practices are open 08:00 to 18:30 Monday, Tuesday, Wednesday, Thursday and Friday. Wednesday 12:00 to 18:30 services are reduced to allow meetings and training to be conducted.

The Primary Care Rehabilitation Facility (PCRF) had recently (2023) undergone significant building works and were continuing with process of optimising infrastructure. The PCRF is located close to Brize Norton and is open Monday to Thursday 08:00 to 17:00 and on Friday 08:00 to 16:30.

Outside of these times patients can attend the local NHS primary care practice and access NHS 111 from 18:30.

The staff team

	Brize Location	Bicester Location
Senior Medical Officer (SMO)	1	0
Deputy Senior Medical Officer (DSMO)	1	0
Unit Medical Officer (UMO)	5	0
General Duties Medical Officer	0	0
GP Registrar	3	0
Locum doctor	1	0
Civilian medical practitioner	5	1
Management	5	1
Nurses	6	1
Locum Nurse	1	0
Pharmacy technician	1	0
Exercise rehabilitation instructors (ERI)	4	1
Locum ERI	1	0
Physiotherapists	4	0

Locum Physio	1	1
Administrators	10	1
Medics	29	0
HCA	1	0

Are services safe?

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

Safety systems and processes

The practices worked to the Defence Primary Care Healthcare (DPHC) Tri-Service safeguarding policies. All staff within the practices had received up-to-date safeguarding training at a level appropriate to their role. The practice's standard operating procedures (SOPs) for both adult and child safeguarding had been reviewed and included contact details for local safeguarding teams.

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

Safeguarding concerns were discussed at monthly meetings. Vulnerable person registers, including patients under the age of 18, were maintained and a search of DMICP (electronic patient record system) was undertaken monthly. However, we noted that the register was not an accurate reflection of the current patients of concern as patients were still on the register that should have been removed.

Welfare meetings were held and representatives invited from the medical team, the padre, a representative from the SSAFA ((Armed Forces charity) Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System team and the welfare team. The Commanding Officer of the station also attended on an ad hoc basis. The Deputy Senior Medical Officer attended the monthly meeting at Bicester and doctors attended the local Safeguarding Board update meetings. The practice wrote letters to the local schools and NHS GP practices giving them the contact details at RAF Brize Norton and Bicester in particular those individuals responsible for safeguarding.

Practice meetings were held monthly and representatives from SSAFA and the health visitor also attended. Meeting minutes were available via Teams making information accessible to all.

All doctors had information given to them with regard to safeguarding arrangements and this was included in their induction pack, they also had a doctor's handbook that included information in it. There was a safeguarding board in the corridor and it included flow charts of how to refer to safeguarding for both children and adults, information was also displayed in every clinical room.

The practice was a domestic abuse safe haven and had posters and information showing patients how to seek help anonymously. We met with a member of the welfare team who described the relationship with the practice as supportive and very responsive to patient's needs.

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 there were 2 links that

took them to the government website explaining their entitlements, and also a civilian website that detailed support for them. They were also sent a letter that included information about local support networks and asking if they wanted any further support. Whilst there was good information for external support, the Defence Medical Services (DMS) support information pages to the DMS Care Leavers Hub was absent, this should be made available to all patients who are registering.

Staff were registered as patients in practice. RAF Benson was located relatively nearby and a number of discussions had been had about staff registering there. However, RAF Benson could not increase their patient population at present. There was an agreement in place that staff should see civilian doctors as their first point of contact then the Unit Medical Officer (UMO), this was detailed in the staff induction pack.

Notices advising patients of the chaperone service were displayed in each room and in the reception area. There was a list of trained chaperones and chaperone training was held regularly. All training was recorded so staff could review it at any time. 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. However, the practice could demonstrate that relevant safety checks had taken place for the staff, at the point of recruitment, including a DBS check to ensure staff were suitable to work with vulnerable adults and young people.

There was a dedicated lead for infection prevention and control (IPC) and they were qualified for the role. There were also dedicated leads in both the PCRF and at Bicester. The IPC audit was conducted from August to August and was spread over the year, with any shortfalls being discussed at practice meetings and managed on a management action plan. Recent points picked up on the audit were completed within the month.

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. There was a designated room allocated for any patient identified as having a contagious disease. Personal protective equipment was available in the corridors as well as clinical areas. Hand gel was available throughout for staff and patients in all areas.

Environmental cleaning was provided by an external contractor twice daily. We visited both practices and the PCRF and all were clean and tidy throughout. However, there was no current cleaning contract in place as this was under review. Currently the staff were unable to monitor against the contractual requirements, instead one of the nurses monitored day-to-day standards as best they could. 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. We noted consignment notes were held by the station and the practice had to request the details, for example how many bags had been collected. The practice had requested copies from the contract manager. An annual waste audit was completed for all

areas, the last had been carried at Brize Norton in June 2023, Bicester in January 2024 and the PCRF in January 2024.

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 all staff were aware of. Written consent was gained and scanned onto DMICP. Continual professional development was carried out between the clinicians who practiced acupuncture to maintain their skills.

Gym equipment in the PCRF treatment area was maintained, serviced and monitored. Checks on equipment were completed daily.

Evidence was seen of effective processes for the management and action of Medicines and Healthcare products Regulatory Agency (MHRA) and National Patient Safety Alerts. Evidence was seen of an in-date electronic MHRA Alert register and that the practice had a system in place to ensure that they are receiving, disseminating and actioning all alerts and information relevant to the practice. Evidence was seen that there was a section in the practice meeting for alerts to be discussed.

Valproate (medicine to treat epilepsy and bipolar disorder) searches were regularly undertaken.

Risks to patients

There was a good balance of well-trained civilian and military staff which afforded continuity of care. Within the PCRF there was 1 vacant physiotherapy post, a temporary healthcare worker request was in place but there had been no applicants to date. Within the nursing team there were 2 vacancies and 2 new nurses had been recruited and were currently going through the recruitment process. Within the pharmacy there was a vacancy for a pharmacy technician, this was being covered by a Junior Non-Commissioned Officer (JNCO) as they were unable to get locum cover.

Senior leaders monitored how many routine clinics were available and could be flexible if needed. Clinicians were proactive and prospectively booked medicals and added additional clinics each month as needed to ensure patients could get the medicals they needed whilst balancing with routine care.

Wet Bulb Globe Temperature checks to indicate the likelihood of heat stress were undertaken.

Only doctors that had completed Aviation Medicine training (MAME) provided cover to the airfield out of hours. The doctors were trained for battlefield advanced trauma life support (BATLS), military pre-hospital emergency care (mPHEC) training and advanced life support (ALS). All medics were Immediate and Emergency Care Provider (IECP) & Battlefield Advanced Trauma Life Support (BATLS) trained. The practice had considered the needs of the population and as a result all clinical staff had received paediatric life support training delivered by the paramedic

Staff working in both practices had completed basic life support, anaphylaxis and automated external defibrillator (AED) training. Information about sepsis was displayed in various areas of both practices. All staff had received training in climatic illness and sepsis. Reception staff had ‘action cards’ which detailed how to respond to an emergency if an extremely unwell patient presented to the front desk. All staff were aware of the major incident plan and were required to sign annually to state they have read the document and updates were disseminated during meetings.

Emergency scenarios were undertaken by all staff in the practices on a regular basis with the last 2 being in March and April 2024. The most recent scenarios included the care and management of a patient having a severe allergic reaction and an unwell and unresponsive child. Emergency training to familiarise staff with equipment and kit check training took place. These were all documented in the training register, alongside who delivered the training, and who attended. To date, the PCRF staff had not been involved in this but there was a plan to include them in the future.

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 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. There was an AED on the emergency trolley that could be used for paediatrics, but the pads were for children 10kg and over, nothing for smaller children. The paramedic responsible for ordering stated that the order request for paediatric pads had been declined by Team Leidos. They were seeking alternative ways to get them ordered.

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 practice and the PCRF and staff knew of its location.

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

Information to deliver safe care and treatment.

A SOP was in place for the management of the summarisation of patients’ records. However, the practice was aware that this was not being managed effectively nor in a timely way. On the day of the inspection, we found there were approximately 1,800 military notes requiring summarising, this was on the practice development plan, and a plan was in place to address this, with an aim that the backlog would be resolved within 5 months. All new patients’ notes were being summarised straight away.

Clinicians used peer review to measure and ensure quality of care delivery across most of the staff team at the practices. Clinicians within the PCRF undertook a yearly notes audit

in line with DPHC guidance. A notes audit was completed for all new staff and locums within 2 weeks of starting, this was recorded on the PCRF audit tracker (replicated on the practice workbook but also separately for visibility). A summary with action points had been produced and a reaudit was on the plan.

There was a formal process in place for the exercise rehabilitation instructors (ERI) to receive formalised peer review, clinical supervision and mentoring on musculoskeletal assessment skills.

There was a formal process in place for the peer review of nursing records. Monthly clinical supervision and protected time for continual professional development was in place, peer reviews were conducted quarterly and professional development plans were part of mid and end of year discussion for all nursing staff. Staff from nearby facilities were also invited to attend the clinical supervision, from Abingdon, Shrivenham and Benson. Staff spoken with felt that they had meaningful discussions with line management to complete their appraisals.

Medics were overseen primarily by the paramedic, they managed their training and competencies, and conducted record audits of DMICP consultations. The Sergeant reviewed all medics consultations daily and an overall audit was conducted quarterly.

The practice and PCRF had moved to using Microsoft Teams to communicate and found this useful to record and disseminate information to all. This system allowed retrospective information to be available for new staff as they could see previous posts, not just those after their start date.

Staff confirmed that access to patient records was only occasionally a concern and did not pose a significant risk to continuity of patient care. Staff said the main issue was with printers ‘dropping off system’ which occurred intermittently most days. 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.

The management of referrals was failsafe. There were 2 civilian administrators and 1 military staff member responsible for referral management across both sites, referrals included internal and external referrals for hospital appointments (urgent and non-urgent, radiology, the Department of Community Mental Health and the PCRF. Staff were able to describe the process in detail. Details were uploaded onto the portfolio spreadsheet tracker, which was colour coded to show when the referral was made and the date of when to review progress, this was checked weekly. Once the letter/ appointment was received it is sent to the patient via email. Email addresses were confirmed on new patient registration. Due to the amount of telephone calls the department previously received with patients chasing hospital appointments, a specific group mailbox address was made just for hospital appointments. Patients were given these details to email in when they had queries, this was monitored daily. Patients were also given a patient service letter which explained the process and timelines for referrals, what happens with the appointment letters, telephone numbers for the hospitals, a link to NHS waiting times for the area and Patient Advice Liaison Service (PALS).

An effective process was in place for the management of specimens and this was supported by an SOP. Samples taken were recorded on an online spreadsheet and results were returned via the PathLinks (electronic link between the pathology laboratory and healthcare professionals) inbox. These were then reviewed 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 Unit Medical Officer 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. We noted that the SMO did not have delegated authority from the commanding officer of the unit and subsequently there was no delegation in place to the pharmacy technician. However, all internal and external quarterly checks were being completed in line with policy. Immediately following the inspection the medical centre took actions and this has now been resolved.

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 not being destroyed in accordance with policy, the destruction should be witnessed by the account holder (the SMO) and an individual external to the practice appointed by the commanding officer of the unit.

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. We noted the blood glucose monitor was not available in the treatment room on the day and there was no evidence of any weekly checks completed.

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 now discussed. However, previous minutes of meeting did not show that drug recalls and alerts had been discussed.

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; we noted that the ambient temperature in these rooms was not monitored. This was acknowledged and the team said this would be put in place.

The blood glucose monitor was not in the treatment room and there was no record of control testing of the blood glucose monitor.

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

Practice nurses used Patient Group Directions (PGDs) for immunisations and primary care treatments. Nurses were authorised to use the PGDs using the correct policy and documentation, they were aware of the policy and of the importance of consulting the PGD when immunising or supplying medicines through the PGDs. Audits were competed monthly. 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. Upon review of DMICP records, we found 1,588 patients were eligible for repeat medication but only 1,260 had been reviewed, we found 328 had not been coded as being reviewed.

There was a process and clear audit trail for the management of information about changes to patient's medicines received from other services.

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. There were no patients prescribed this medicine at the time of the inspection.

The high-risk medicines (HRMs) register supported the management of patients prescribed HRMs. An audit had been completed in August 2023 and showed 23 patients were on HRMs and 21 had received the required monitoring. The audit showed monitoring was correct for all except for 2 patients who had not attended despite being recalled. One of these patients had recently had a dose change of a medicine but had not had their follow up blood test. Appropriate HRMs and shared care agreement alerts were raised on patient's DMICP records.

We looked at medicines at Bicester. 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.

Dispensed items were stored securely whilst awaiting collection. These items were dispended from Brize Norton of a nearby community pharmacy. A check of items being stored showed that all were within a few weeks of having been dispensed.

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. The station conducted inspections and held the details on a spreadsheet, health and safety audits were completed and sent back to the station 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 January 2024.

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 active and retired risk and issues registers. The 4T's have been applied to the risks and all had been given a review date. The active risk register included risks transferred to Regional Headquarters and all the main risks identified by the management team. There was a range of clinical and non-clinical risk assessments in place including lone working. All the known Control of Substance Hazardous to Health (COSHH) items in use at the practice had an appropriate risk assessment in place.

The practice and PCRF had a mixture of fixed alarms. There was an alarm system checklist on the healthcare governance workbook which documented monthly testing.

Lessons learned and improvements made

All staff across both practices had access to the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events and incidents. They were discussed at the 2 weekly ASER meeting and all findings were saved on Teams for all staff to read. An ASER register was maintained.

A trend analysis of all ASERs was undertaken between March 2023 and March 2024 to identify recurrent significant event trends and ensure actions implemented had mitigated further occurrences. There were in total 55 ASERs received through this period. Results showed the practice had a high reporting rate for incidents and staff seem confident to report ASER's. It was found that 54% of all ASERs within the year were due to administration and IT errors and issues. The referrals department was identified as a high-risk department for errors having significant impact on patients. As a result of this a restructure of departments was undertaken. This saw staff spending longer within departments and saw a considerable reduction in ASERs from this department. Following this the results were shared to all staff for learning and discussion. The practice improved its mentoring programme amongst the medics and was going to be continued to include all clinicians.

The PCRF team had a good understanding of the ASER system and all had logins. We saw an example whereby the ERI had put in an ASER relating to an injury on a treadmill.

The outcome of this was positive with some health promotion advice posters being put up in the PCRF.

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. NICE and other guidance was a standing agenda item at the monthly clinical meetings. These were reviewed every month by the nursing team and were shared out to individuals to discuss. Most recently, audits were completed on stroke and transient ischemic attacks. The team used the quality outcome framework (QOF) as the standard to measure against and the audits showed clinicians were delivering care for these patients against best practice. Heads of Department meetings were also held monthly where NICE and Scottish Intercollegiate Guidelines Network (SIGN) updates were discussed. Records of these meetings were seen.

The Primary care Rehabilitation facility (PCRF) staff attended monthly meetings to share and discuss evidence-based guidance, including NICE & SIGN. 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.

Clinical supervision informed changes and provided opportunities for discussion in updated evidence-based guidelines. Nurses were able to show the last clinical supervision documents that detailed the discussions that took place, as well as reflection on how this might change their practice.

Staff were also kept informed of clinical and medicines updates through the Defence Primary Healthcare (DPHC) newsletter circulated each month. Vulnerable patients and patients with complex needs were discussed at the MDT meeting, which the local health visitor was invited to attend. Entries in patients' records confirmed these discussions took place and were recorded

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.

Audits undertaken by the PCRF were integrated with the practice audit programme within the healthcare governance workbook. The practice lead undertook the infection prevention and control (IPC) and waste management audits. There were no recent clinical audits completed by the PCRF, they had competed patient satisfaction surveys and notes audits. They were aware they needed to improve this and had a plan in place.

The PCRF took a holistic view of patients, including mood, sleep and lifestyle. They had developed a patient-facing SharePoint page which contained extensive signposting to

resources for mental health, sleep and nutrition in an easy to access format. It was well designed, thorough, covered a range of areas, and made resources easy to access.

The PCRF had developed a health optimisation day. This was developed from the DoFit course, which they did not feel they had the capacity to deliver in its original form, they developed a programme and booklet to cover a range of lifestyle factors. They had received positive patient feedback and were developing the structure based on this. The booklet was well designed and used specialist knowledge.

The Department of Defence Rehabilitation guidelines were linked on the PCRF SharePoint page and staff were aware of them. Members of the PCRF were involved in the working groups that developed the guidelines.

The PCRF has had a recent extension and refurbishment, which gave them enough individual clinic rooms. The gym was a reasonable size and was well-equipped for delivering rehabilitation sessions, including group sessions.

Monitoring care and treatment

There were individual named leads and deputies in place for all for all chronic conditions. Dedicated clinics were in place such as an asthma clinic for children. Other long-term conditions (LTCs) were managed routinely with response to recalls and patients were booked in appropriately. It was recognised that some patients were unable to attend their reviews due to unsociable work hours, so for these patients, alerts were put on their records to allow them to be captured opportunistically wherever possible. One of the nurses managed the searches, sent text messages inviting for recalls and medication reviews and ensured that the patients were booked in with the appropriate clinician for their specialty. This included arranging for bloods to be taken a week before if required. A register was in place and was accompanied by a standard operating procedure (SOP). The register was monitored monthly. Any changes in NICE or SIGN guidance was documented in the register if parameters changed.

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 22 adult patients on the diabetic register. For 15 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 132 patients on the hypertension register and all had had their blood pressure taken in the past 12 months. Of these, 82 patients had a blood pressure reading of 150/90 or less.

There were 69 patients with a diagnosis of asthma. Of these, only 67% had received a review in the past 12 months. The nursing team recognised this was an area for improvement, this was due to lack of qualified staff securing funding for training. This was currently being rectified and they had a nurse booked for training in May. Following the course of a 2-cycle asthma audit an increase in compliance was seen and positive control

of patient's symptoms. Asthma review consultations were of a high standard and included the full range of recommended screening questions, with a clear plan in place as needed.

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. The clinical searches showed there were 1,246 eligible patients, 81.9% of these had received a health check.

Step 1 and step 2 of the mental health intervention programme was undertaken at the practice. Patients with mental health needs were discussed at the multi-disciplinary team (MDT) meetings. In addition, patients could be referred to the welfare team, SSAFA, the RAF Benevolent Fund, Oxfordshire Mind, the Hub of Hope, and the Padre for additional support. The practice had devised a mental health and wellbeing booklet that it gave to patients, it was a resource designed to empower patients, with practical strategies to promote good mental health and well-being. We reviewed a small number of patients records which showed appropriate evidence-based management including assessment, diagnosis and intervention.

There was active management of children's immunisation status. Currently, 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. The practice had systems in place that gave assurance that the children registered had been recalled or had an appointment booked at the appropriate time. A childhood immunisation audit was in place, it stated the rationale and criteria required to benchmark against and utilise the NICE quality statements in assessing the data available. It included collaboration with external agencies such as the CHIS, this information returned to CHIS, safeguarded the loss of information risked when families were deploying overseas.

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. There was a dedicated audiometric clinic daily, but with only one machine this meant limited appointments of 9 a day. There was priority made for those at high risk occupationally like those at very high readiness to deploy or air crew. Arrangements had been made to recall another machine in order to have at least one other audio booth which would double the effort to catch up outstanding hearing tests.

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. All referrals made were discussed with the Band 7 or Officer in Command (OC) to ensure they were being sent to the most appropriate place. The PCRF had a monthly MDT meeting with the MIAC clinicians to discuss potential referrals. All referrals were added to a list held on DMICP, when the RRU issued an appointment, the letter was sent back to the PCRF as a new referral and the administrative team then informed the patient of the appointment and removed them from the referrals list.

There was a full and comprehensive audit calendar in place. There were monthly audit meetings and the minutes were shared on Teams. They were also added to the healthcare governance workbook along with an action plan and next review date. An example of recent audit was-

Chronic fatigue:

This audit was initiated following 2 complaints from patients with long covid who had not recovered well. An audit was completed in March 2024 and a plan was made to implement changes and improve management of these patients. This was a good example of proactively implementing change through audit to improve patient care.

The nursing team used audit to inform clinical tracking of guidelines when managing LTCs, as well as acute presentations. The last asthma audit for adults and children demonstrated positive responses to only 1 out of 4 QOF targets, this had resulted in an action plan to address and improve the other 3 targets for positive control and management of asthma. During the school holidays there was a clinic added specifically to address these shortfalls for adults and children. We saw the current asthma management was compliant for those who have been reviewed. Peer review was used to determine the effectiveness of documenting and treating appropriately. A training platform 'Red Whale' was used by the nursing team to maintain clinical currency, as well as NICE and SIGN notifications, and publications for changes in guidelines. The Oxford Vaccine Group (NHS) provided annual updates and training.

Other audits undertaken by the nursing team included smoking, flu, childhood immunisations, cytology, diabetes, including a gestational and pre diabetic audit, gout, IPC, annual Patient Group Directive (PGDs) and consent audits. They conducted a 6 monthly nurse satisfaction audit that was sent to patients to determine if there was anything they would like to see provided an if they were happy with the service.

A cytology audit was completed annually. There was good management of recall and getting patients screened in a population group that was fast moving. Domestic violence questioning was asked at cytology appointments, but not the HARK (humiliation, afraid, rape, kick) questions. This had been highlighted as best practice and was being introduced by the nursing team.

Effective staffing

The practice had an extensive and bespoke induction programme, with a separate induction for locum staff. There was an induction register on SharePoint. Both DPHC induction and workplace induction were recorded on the staff database. All staff were given the opportunity to meet monthly with their line manager to discuss their career, development or anything they chose.

Mandatory training was a part of the induction pack which listed the training requirements and the links on where to find the training. There was a training log on the healthcare governance workbook which captured internal and external trainings. Protected time was allocated for mandatory training as well as CPD, there was also clinical time allocated that was available to be utilised as needed. Reminders were sent by the training lead to hasten staff to keep mandated training in date. Certificates were maintained by individual staff.

Role-specific training was available for relevant staff. For example, nurses had completed spirometry training, doctors were qualified for aviation medicine.

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 practice 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, Oxford NHS, Men's Health Partnership Team, multi-agency safeguarding hub (MASHH), Child Health Community Teams, Schools, ODES Diabetes Team, Nathnac, (travel advice) SSAFA, padres, welfare and station executives.

There were good lines of communication established with the individual squadrons having their own named doctor assigned to them. Aviation medicine dial in calls were held every month.

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.

The doctors conducted regular handovers to other practices (including NHS) appropriately, this usually took the form of direct discussion with an appropriate clinician. For patients leaving the military, pre-release and final medicals were offered and information given.

Helping patients to live healthier lives

Health promotion was run from the NHS promotion calendar with information posters displayed. The health promotion displays at both practices 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 both practices and the wider station. Medics were frequently employed in developing resources but also the NHS Calendar of events and Public Health England resources were used as well for national campaigns. Recent boards included travel health, sepsis, prostate awareness screening for men of Afro Caribbean ethnicity over 45 years of age, and all men over 50. Wellness days were held in the gym that mirrored any campaigns the facilities were promoting. Biannual Health and Wellbeing days were held to target as many populations and issues as possible and were supported by the station to encourage attendance.

One of the nurses was the lead for sexual health. Sexual health advice and contraception were provided, including implants and intrauterine devices. New partner screening and under 25-year-old screening was advertised as being available across the wider station outside the practice. Condoms were available in the toilets, and waiting rooms, and local NHS sexual health screening clinics were advertised in patient waiting areas as well as toilets.

All eligible female patients are on the national cervical screening database and 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:

- 91% of patients were in-date for vaccination against diphtheria.
- 91% of patients were in-date for vaccination against polio.
- 95% of patients were in-date for vaccination against hepatitis B.
- 96% of patients were in-date for vaccination against hepatitis A.
- 91% of patients were in-date for vaccination against tetanus.
- 99% of patients were in-date for vaccination against MMR.
- 94% 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 93%.
- 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 93%.
- The percentage of children aged 2 who had received immunisation for measles, mumps and rubella (one dose of MMR) was 97%.
- 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

One of the doctors delivered training in the Mental Capacity Act (2005) and how it would apply to the patient population. Clinicians understood the requirements of legislation and guidance when considering consent and decision making. A review of patient notes evidenced that verbal consent was recorded and coded appropriately on DMICP. 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 and this was regularly audited.

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 the practices. A total of 41 patients responded (25 from Bicester and 16 from Brize) and feedback was entirely positive.

The last patient survey, undertaken by the combined practice between September and October 2023, showed 96% (of applicable patients) said they were treated with care and concern. We spoke with 2 patients on the day and they were happy the care they had received.

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 1 member of the welfare service, who said staff at the practice were always available when needed and were kind and compassionate.

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.

Patients identified with a caring responsibility were captured on a DMICP register. It included what had been discussed at the monthly practice/clinical meeting and any actions identified. There was a practice leaflet which included information for carers. Alerts were made on individual patient's notes to ensure that longer appointments were given if needed. There were 42 carers registered. Searches were conducted to ensure that the flu vaccine was offered appropriately. There was a carers poster on display in the waiting area. All newly identified carers received a letter from the practice with all the information they should need. Carers were offered longer appointments, early/late appointments, and depression screening annually.

Cytology leaflets were in a range of different languages, there were translation services advertised at reception and on the eRegistration form, and a translation service was available also, this included a summarising and translation of written documents for patients that might have been posted abroad outside of the typical Defence Primary Healthcare (DPHC) facility.

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. The chaperone list stated what staff, were male or female so patients can choose where able. 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 (PCRF) was in separate clinical rooms, the rehabilitation gym was open plan so conversations could be overheard. This had been mitigated by having music playing. Staff also have the option to use a private office for confidential conversations. Staff also worked in other rooms if not seeing patients to allow staff to have more privacy when carrying out patient assessments.

At Bicester the PCRF occupied rooms within the same building to the main practice. Clinical rooms provided privacy for patients.

The reception area at Bicester was well laid out with the waiting area in a separate room meaning that conversations between patients and reception would unlikely be overheard. If patients wished to discuss sensitive issues or appeared distressed at reception, they were offered a private room to discuss their needs. This was supported by clear signage on the reception desk and in the waiting area. There was a television in the waiting area that provided background noise to promote privacy. The reception had a sliding glass window which could be closed to promote confidentiality during telephone calls.

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 outstanding for providing responsive services.

Responding to and meeting people's needs

The practice had a flexible approach to the management of appointments to meet patients' needs. Protected appointments were in place for the administration of e-consults, 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. The staff at Bicester told us of a recent response to a rapid deployment test when a dedicated vaccination clinic had been hastily arranged to ensure all patients were fit to deploy. This had been achieved by the end of the following working day.

The practice was a LGBTQ+ accredited practice and had created their own local standard operating procedure to manage transitioning patients in line with the General Medical Council guidelines. A policy was in place to guide staff in exploring the care pathway for patients transitioning gender and PRIDE training had been conducted to raise awareness and to promote equality and inclusion. There were gender neutral toilets available in both locations.

Paediatric Life Support for paediatrics (PILS) is not currently classed as mandated or a requirement within DPHC policy. So training was delivered in house by the paramedic and included care of paediatric patients. Following this the practice has requested Paediatric Life Support training for 12 members of staff.

The practice newsletter for patients was introduced and this was displayed around the practice and station and on social media.

Due to the amount of telephone calls the department previously received with patients chasing hospital appointments, they have a specific group mailbox just for hospital appointments which patients are given and this was monitored daily.

The practice had received a 'Good' award from the LGBT Foundation for Pride and Practice assurance, which worked to improve the experiences of LGBTQ+ population accessing primary healthcare. A station line manager support group was introduced, this was started due to the Chain of Command continually asking for advice or sending the patients back to the practice for updates to paperwork, because they were unsure what could/couldn't be done when a patient was on light duties, downgraded or off sick. The practice manager and Warrant Officer hosted line manager support groups in different departments on the station including an in-depth presentation. This had helped to get to know the services required for each unit and how best the practice could support that unit and their personnel.

Basic Life Support for paediatrics (BLS) is not currently classed as mandated or a requirement within DPHC policy. So training was delivered in house by the paramedic and

included care of paediatric patients. Following this the practice has requested Paediatric Life Support training for 12 members of staff.

The practices were Royal College General Practitioners Veterans Accredited practices.

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.

Timely access to care and treatment

Details of how patients could access the doctor when the practice was closed were available through the station helpline and was outlined in the practice information leaflet. Shoulder cover was provided by the duty doctor until 18:30 hours, then patients were directed to the NHS 111 service.

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. Book on the week appointments were available for out-of-area patients who might be needing to schedule something for a short time as they were passing through due to their duties, so these were protected for those short notice in advance appointments.

There were various named appointment slots also, for specific types of appointment, for example asthma reviews, diabetic foot checks, cytology, or any other appointment that might need longer due to clinical demand so that the reception staff can book patients most effectively with the best clinician. Named nurses clinics assisted in this so reception knew what type of appointment could be booked with the appropriately skilled and experienced nurse for specialist requests.

Direct Access Physiotherapy (DAP), a DPHC requirement to support patient choice, was not available to patients, instead all referrals had to go through a doctor first. Defence Primary Healthcare (DPHC) had given direction (2018) that DAP was to be rolled out to PCRFs in all regions. This had been previously discussed as it was felt the department would be overloaded and that the doctor waiting time was shorter than the PCRF waiting time, they didn’t feel it would be beneficial to patients.

Urgent physiotherapy appointments were available within 1-2 days, a routine new patient physiotherapy appointment and follow up appointment was available within 14 days, a follow up appointment was available within 10 days. Waiting times for a new patient appointment to see the Exercise Rehabilitation Instructor was 14 days and a follow up appointment was available within 5 days. There was no wait for rehabilitation classes.

Home visits were offered by the practices. A home visit standard operating procedure was in place. A log of home visits was maintained. The criteria for home visits was outlined in the patient information leaflet.

Listening and learning from concerns and complaints

The 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, 6 written complaints had been recorded within the past 12 months. A trend analysis was completed in March 2024.

Information was available to help patients understand the complaints system, including in the patient information leaflet and in the waiting room. The latest patient survey results from January 2024 showed 96% of applicable patients said they felt listened to.

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’.

RAF Brize Norton and Bicester Combined Practice had their own mission statement which was:

> ‘To facilitate operational readiness and high-quality healthcare that inspires confidence, through collaborative, innovative and effective patient-centred care.’

Care was delivered to patients through an integrated multi-disciplinary approach. There was clear engagement and support from the practice 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. The PCRF had a detailed development plan looking at what they wanted to achieve as a department and how they were going to achieve it. This was a clear plan with focus on staff, infrastructure, training, patient delivery.

The practices 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 practice 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. The staff teams at both practices worked hard to deliver the best possible care to patients. All staff we spoke with described a committed and able leadership team.

All the staff we interviewed spoke highly about how both practices were 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.

Staff particularly said the service was well structured, and communication was good. Senior leaders had implemented an anonymous 360-degree feedback survey to support with developing individual staff and the practices overall.

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

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.

We interviewed a cross section of staff, and all told us that it was a happy place to work and that they could rely on their work team to discuss and mitigate any concerns they faced. They spoke about colleagues who were supportive, compassionate, and caring.

The PCRF really made use of individual strengths for example the Band 6 physiotherapist was looking at statistics collection, the Flight Sergeant had developed the SharePoint pages and implemented their psychology learning into staff surveys and patient resources. The management team were supportive of innovative ideas and looking at the wider picture, with aims to add to the injury prevention space and be proactive rather than reactive.

The staff were clearly valued and efforts were made to ensure a high level of clinical care but also staff satisfaction through an in-depth staff survey, which was developed by a physiotherapist who had an interest in clinical ‘burnout’. This was an in-depth look at mental health and wellbeing and was on the audit plan to be repeated later this year.

Staff wellbeing was given a high priority across both practices. A register was kept for those out of work on deployment or off sick, the Chain of Command kept in regular contact and offered support alongside the welfare team. The practice offered flexible working for staff members where possible. On Fridays, all teams met together and had an extended tea break, all staff brought in baked goods to compare skills in the cake making department to share with all staff. There was an entertainment committee whose job it was to provide team events for those months with a fifth week so there can be whole practice afternoons out as a team.

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.

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. This included heads of department, HCG, clinical, audit and quality improvement projects (QIP) and a practice meeting.

A comprehensive range of practice Standard Operating Procedures (SOPs) was in place and all in date for a review. An HCG workbook was used to bring together a range of governance activities, including the risk register, audit, health and safety and in-service training. The workbook was clear and comprehensive and was reviewed monthly. The practice manager and deputy practice manager monitored the management practice plan for the practice and send out reminders for staff to update and action. Actions were recorded on the workbook for quick and discussed at practice meetings. The practice had worked hard to maintain the healthcare governance workbook, it was extensive, well referenced and integral to the effective running of the service.

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

The leadership team adopted a whole team approach to governance activities. Lead or secondary roles were shared across the team for most staff groups. Terms of reference were current for staff, including those with lead roles. There was a clear staff reporting structure in place and staff were aware of their roles and responsibilities. Staff produced an HCG tree that was displayed in the waiting room, so all staff could see the full picture and understand governance and what it meant.

Managing risks, issues and performance

There was a current and retired risk register on the HCG workbook along with current and retired issues. The register articulated the main risks identified by the practice team. The registers were regularly reviewed. There were a range of risk assessments in place including both clinical and non-clinical risks. These were reviewed and discussed at the HCG monthly meeting, the top 3 risks were discussed in the practice meeting

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 2023. It clearly detailed the action to be taken in the event of loss of any services. The practices

also had a role in the Station Major Incident Plan which was reviewed annually during a tabletop exercise and crash exercise.

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. All staff attended the quarterly practice meetings and audit meetings, which informed the compliance with the HAF command requirements. Minutes were disseminated from these meetings and available on SharePoint to view. Each department had an area to discuss their assurance arrangements within the department. All areas were reviewed on a rolling basis and as required if there are changes directed from headquarters. 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 practice acted on feedback received, including the DPHC online survey. Text messages were sent out weekly for patients that had been seen to complete the patient satisfaction survey, this had improved responses.

The practices used a Teams channel for communication, this had reduced emails and could reach all staff.

There was a ‘you said we did’ board in the patient waiting area, that details comments made by patients, and what the facilities response to these comments has been when there have been changes to established practice. One example was that it was difficult to see the physiotherapist outside of typical hours, there was discussion following this to determine if there was scope to have early and late appointments to accommodate and what the impact of this would have on the rest of the working week. The nursing team also has had similar comments/requests for timings of appointments outside of the usual times and these have been accommodated both long and short term.

A station line manager support group was introduced, this was started due to the Chain of Command continually ringing the practice or sending the patients back to the practice for updates to paperwork, because they were unsure what could/couldn’t be done when a patient was on light duties, downgraded or off sick. The practice manager and Warrant Officer hosted line manager support groups in different departments on the station

including an in-depth presentation. This had helped to get to know the services required for each unit and how best the practice could support that unit and their personnel.

There was a patient feedback box in the waiting area for compliments and suggestions. A Microsoft forms link was also available on the patient-facing SharePoint pages, and a patient satisfaction survey was conducted in June 2023 to assess the impact while the PCRF was dispersed between the gym and practice while refurbishment work took place.

The PCRF led fitness test was introduced because of patient feedback. Patients were concerned about attempting a fitness test on return from injury and the potential impact of the result on their career/grading. Also, a leg press machine was loaned to the station gym after patient comments that they struggled to complete all their exercises due to equipment availability.

Options were available for staff to provide both formal and informal about the service. These included regular 1-2-1 sessions with their line manager and the staff satisfaction survey.

To increase the communication between the practice and patients a monthly newsletter has been introduced. This was shared via several channels including social media to all patients and the wider station.

Continuous improvement and innovation

There was much evidence of continuous improvement across the combined practices. They were currently running a QIP competition to win a shopping voucher, encouraging everyone to come up with new ideas within the practices, they currently had 9 ideas from Junior Non-Commissioned Officers.

The PCRF had developed a patient-facing SharePoint page which contained extensive signposting to resources for mental health, sleep and nutrition in an easy to access format. It was well designed, thorough, covered a range of areas, and made resources easy to access.

The PCRF had developed a health optimisation day. This was developed from the DoFit course, which they did not feel they had the capacity to deliver in its original form, they developed a programme and booklet to cover a range of lifestyle factors. They had received positive patient feedback and were developing the structure based on this. The booklet was well designed and used specialist knowledge.