Halton Medical Centre

Halton, Aylesbury, Buckinghamshire, HP22 5PG

Defence Medical Services inspection report

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information given to us by the practice and patient feedback about the service.

Overall rating for this service	**Good**	
Are services safe?	**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 of Halton Medical Centre on 26 March 2024.

As a result of the inspection the practice is rated as good overall in accordance with the Care Quality Commission's (CQC) inspection framework.

Are services safe? – requires improvement

Are services effective? – good

Are services caring – good

Are services responsive to people's needs? – outstanding

Are services well-led? – good

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 CQC will complete at the invitation of the DMSR in its role as the military healthcare regulator for the DMS.

At this inspection we found:

- The practice demonstrated a person-centred inclusive approach to accommodate the needs of individuals and units. Patients were included in decisions about their treatment and care.
- The practice used various means to seek patient feedback about the service and then acted on feedback to improve the patient experience. Feedback about the service was positive. It showed patients were treated with compassion, dignity and respect.
- Effective safeguarding arrangements were in place station-wide and the practice had good lines of communication with the unit, welfare team and local safeguarding team. At practice level, searches, alerts and coding for vulnerable patients were not consistent.
- The practice was well-led and the leadership team had the vision, capability and commitment to provide a patient-focused service. At the time of the inspection, staffing

levels were adequate. The leadership considered succession planning to ensure sufficient capacity and capability.

- The electronic organisational-wide system (referred to as ASER) was used to record significant events, incidents and near misses. Not all locum staff had access to the system. We identified some incidents that had not been reported through ASER.
- Whilst patients received their medicines in a safe way, medicines management systems required strengthening.
- Quality improvement was embedded in practice, including various approaches to monitor outputs and outcomes used to drive improvements in patient care.
- Some of the healthcare governance processes needed further development, particularly in relation to risk assessments and safety checks.

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

- To support the rehabilitation of injured recruits, each recruit maintained a food diary for 5 days. A theme of non-nutritious and unhealthy foods was noted. As a result, a nutrition brief was delivered by the Primary Care Rehabilitation Facility (PCRF) to recruits undergoing rehabilitation. This audit was carried out in November 2023 and a re-audit of the food diary was planned to be repeated in 6 months. This initiative was submitted as a quality improvement project.
- A weekly multi-disciplinary meeting was held to discuss the needs of recruits. Recruits were active participants at this meeting and attended alongside flight staff if they wished. The recruits completed an electronic feedback questionnaire after the meeting about whether they felt involved in their ongoing care and if there was anything that could be changed to improve their experience. Feedback from recruits was positive. This initiative demonstrated a person-centred inclusive approach.

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

- Revisit the arrangements for the building upgrade planned to take place this summer to ascertain it fully captures all the risks identified. This is to ensure the infrastructure is safe for patients, staff and others who use the building.
- Review the DPHC policy requirement for emergency life support taking into account whether clinical staff working in families practices should have training in Paediatric Immediate Life Support.

The Chief Inspector recommends to the practice:

- Ensure regular searches are undertaken to identify patients who are vulnerable, including care leavers. Alerts and clinical coding should be routinely and consistently added to the clinical records of vulnerable patients.

- Consider implementing a process to identify firearm licence and shotgun certificate holders, including for newly registered patients, so a digital firearms marker can be added to the patient's electronic health care record.
- Systems to support the safe management of medicines should be strengthened to include:
    - Maintaining a record of when control solutions for blood glucose monitors have been opened.
    - Completing a risk assessment for emergency medicines used that are not on the core DPHC list in line with policy.
    - Ensure Hazchem 2 and Hazchem signs are displayed in all the required areas.
    - Telephone requests for repeat medicines should be reviewed to ensure it is appropriate in line with policy and documented in the patients' records.
    - Update the records for patients no longer using or ordering repeat medicines.
    - Undertake a high-risk medicines audit.
    - Ensure the delegated authority for controlled drugs is correct in line with policy.
    - Ensure the new versions of the Bmed12 registers are put in place and loan certificates for medicines are renewed in accordance with policy.
    - Ensure the destruction of controlled drugs is in accordance with policy.
- Risk assessments for the Primary PCRF, including for out-of-hours use of the PCRF gym, should be reviewed to ensure each risk assessment is sufficiently detailed.
- Ensure portable appliances in the PCRF gym are tested as required to ensure their safety.
- Ensure all locum and temporary staff have access to the ASER system to record significant events and incidents. Provide refresher training for staff to ensure they are aware of the types of incidents that should be reported.
- The use of the Musculoskeletal Health Questionnaire should be reviewed to ensure it is consistently used as required.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Healthcare

Our inspection team

The inspection team was led by a CQC inspector supported by a team of specialist advisors including a primary care doctor, nurse, pharmacist, physiotherapist and practice manager. As part of their induction, a new specialist advisor shadowed the inspection. A CQC pharmacist specialist and national advisor for Defence Primary Healthcare also shadowed on the inspection.

Background to Halton Medical Centre

Halton Medical Centre provides a primary care service to a patient population of 1,400 including 438 service personnel, 530 Phase 1 recruits and the remaining patients are entitled civilians. Medical centre facilities include a Primary Care Rehabilitation Facility (PCRF) and dispensary; both located within the building.

The operational focus for the medical centre is to support recruit training to ensure Aviators Training Academy (referred to as AvTA) Phase 1 students are fully fit to pass their training and commence a specific trade training. Phase 1 students undergo a 10-week course and there are intakes of 80-120 students every 2 weeks.

The medical centre is open from 07:30 - 17:00 hours. A duty doctor is available until 18:30 hours. Patients have access to NHS 111 access out-of-hours.

The PCRF was open Monday to Friday 08:30 - 12:00 hours for recruits only. Monday to Thursday 12:00 - 17:00 hours and Friday 12:00 - 17:00 hours was for other military patients.

The medical centre does not provide airfield medical cover. The airfield is covered by the NHS.

The staff team

Doctors	Senior Medical Officer Deputy Principal Medical Officer Civilian medical practitioner x 3 (1 full time; 2 part time) Locum GP x 1 General Duties Medical Officer
Nurses	Principal Nursing Officer Military nurses x 2 Band 6 practice nurse Band 5 practice nurse x 2 (1 part time vacant post) Locum nurses x 2
Practice management	Warrant Officer Practice manager Deputy practice manager

Administrators	Seven – 4 x full time; 3 x part time
Pharmacy technician	One
PCRF	OC physiotherapist Four physiotherapists (3 full time; 1 part time) Locum physiotherapists x 2 Exercise rehabilitation instructor
Medics	Nine
Other	General Duties Medical Officer visits the practice every 6 weeks

Are services safe?

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

Safety systems and processes

The Senior Medical Officer (SMO) and the Civilian Medical Practitioner (CMP) were the safeguarding leads for the practice. All staff were in-date for safeguarding training at a level appropriate to their role. Reviewed in 2023, the safeguarding policy referenced adults and children and included contact details for the local safeguarding teams. The policy review included the addition of action to take if a child failed to attend for an appointment. We highlighted during the inspection that the policy would benefit from including the clinical codes to use on DMICP (electronic patient record system) when managing individual safeguarding issues. A safeguarding decision/action guidance flowchart was displayed in clinical rooms.

The practice was represented at the bi-monthly station meetings to discuss individuals at risk. The Flight Commander for recruits, Welfare and Support for Personnel (referred to as WaSP) team, SSAFA (Armed Forces charity) and Padre attended the meetings. In addition, the CMP had links with the local safeguarding team and attended their meetings. Contact details for the WaSP team were displayed for patients and staff.

Flow charts were displayed in clinical rooms outlining the action to take if there were concerns about a child or adult's welfare. It included links to the Buckinghamshire safeguarding for reporting a concern. The practice held a DMICP list of vulnerable patients which was reviewed monthly. This list was updated as the practice become aware of a patient who met the criteria for inclusion either through handover or a consultation. Although a vulnerable patient search was set up on DMICP and last run in March 2023, there was no evidence to indicate this search was run on a regular basis. This was a risk as there may be vulnerable patients within the patient population the practice was unaware of. Similarly, without searches to cross reference, there was a risk vulnerable patients could move to another medical centre without the practice or the receiving practice being aware of their vulnerability.

We undertook our own searches for patients under the age of 18 (82), vulnerable adults (16) and vulnerable children (21). Of the 41 sets of clinical records we reviewed, 17 did not include an alert to identify the patient was vulnerable. Although the use of coding was more consistent for children, the irregular use of alerts supported our observation that searches were not routinely undertaken. We cross referenced random DMICP numbers from our vulnerable children's search with the DMICP list held by the practice and found several patients on the search that were not included in the practice list.

From our conversation with the Welfare Officer, the number of under 18s known to the WaSP team differed to that held by the practice. WaSP were supporting a small number of care leavers, yet our search of DMICP identified no care leavers. Data about care leavers was not collating as part of the initial first registration. Despite these system oversights, we concluded from our discussion with the Welfare Officer that vulnerable patients were well managed within the station.

Evidence was not provided by the practice to demonstrate how data to support the issuing of a firearm licence/shotgun certificate was collected. GP practices are requested to code when patients are issued with firearm licences or shotgun certificates so that the police can be informed if the patient develops any conditions that could influence their fitness to hold a licence.

The clinical records we reviewed for children demonstrated multi-disciplinary team (MDT) discussions were held in many cases. The example the practice provided of a safeguarding concern indicated the child was effectively managed through the MDT and included a referral to Child and Adolescent Mental Health Services (referred to as CAMHS) and to 'Youth Concern', a local support service for 13-25 year olds. WaSP interviewed all under 18s every 2 weeks to ensure they were safe and to offer additional support. The station was inspected by Ofsted (regulator of services for children and young people) in January 2023 and practice staff were interviewed as part of the inspection. The station received a good report.

A chaperone policy was in place and included the clinical codes to use for the offer/use of a chaperone. Staff who had the role of chaperone had received chaperone training. The availability of a chaperone was included in the patient information leaflet and was displayed throughout the premises.

Although the full range of recruitment records for permanent and locum staff was held centrally, the practice manager demonstrated that relevant safety checks had taken place at the point of recruitment, including a Disclosure and Barring Service (DBS) check to ensure staff were suitable to work with vulnerable adults and young people. DBS checks were renewed in accordance with Defence Primary Healthcare (DPHC) policy. The vaccination status for staff members was monitored by the Principle Nursing Officer. The professional registration status of staff was monitored by the practice manager.

A practice nurse was the lead for infection prevention and control (IPC) and was booked to attend the IPC Link Practitioner training in April 2024. The IPC deputy lead post was unfilled at the time of the inspection. All staff were in date for IPC training. Two audits were undertaken each month. Hand hygiene and personal protective equipment audits were completed in February 2024. An action plan had been developed following the audits. IPC was a standing agenda item at healthcare governance meetings.

The Band 7 physiotherapist provided acupuncture. A combined consent form and patient information leaflet was completed and scanned to the patient's DMICP record, confirmed through a clinical records audit. Acupuncture needles were stored in a cabinet in the Primary Care Rehabilitation Facility (PCRF) store area. We discussed with staff that the acupuncture risk assessment would benefit from further development to include the risk of leaving needles in place following treatment.

Delivered by an external contractor, an environmental cleaning contract and schedule was in place. The premises was deep cleaned in August 2023 when recruits were on leave. The IPC lead carried out a monthly spot check and made contact with the contract manager if any concerns were identified.

The deputy practice manager was the lead for oversight of clinical waste. The clinical waste policy was reviewed in November 2023. Consignment notes were in place and up-to-date. Secure storage for clinical waste was located outside of the building. The last annual clinical waste audit (July 2023) showed the practice was fully compliant. The

deputy practice manager attended the station-led monthly waste management meeting. Sharps boxes were labelled, dated and used appropriately.

Risks to patients

Staffing levels were sufficient to ensure provision of person-centred clinical care. This was evidenced through feedback from patients, who indicated there was timely access to appointments and the ability of the practice to offer flexible appointments. Clinical vacancies were covered by locum staff.

Both the daily checks and weekly content checks of the emergency medical trolley in the treatment room were recorded. Similarly, the trolleys held in the nursing department were checked daily and expiry dates of emergency equipment checked monthly. Although CardioChek blood glucose monitors were used, there was no record to indicate when the control solutions had been opened. Control solutions for CardioChek machines are suitable to use for 10 months after first opening.

The emergency medicines held were in accordance with the DPHC emergency medicines standard operating procedure (SOP). A record was maintained of the emergency medicines monthly checks. We checked the emergency medicines and equipment and all were in-date including medical gases, which were at sufficient capacity. Three emergency medicines in use were not on the core DPHC list. A risk assessment for each of these had not been completed and ratified by the Regional Clinical Director in line with the DPHC SOP (04-07-001 annex C). The medics fire exit did not have Hazchem 2 and Hazchem 5.1 (signs indicating the storage of dangerous substances).

The staff team was up-to-date with Basic Life Support training, anaphylaxis and the use of an automated external defibrillator (AED). The SMO and deputy SMO were trained in Intermediate Life Support. Although not mandated by DPHC, staff indicated they would benefit from Paediatric Immediate Life Support training as children were registered at the practice. An AED was located in the PCRF gym. The names of the first aiders for the practice were displayed.

Both clinical and non-clinical staff we spoke with were aware of the signs and symptoms of the deteriorating patient/sepsis. The in-service training (IST) record showed sepsis training was facilitated by one of the practice nurses for all clinical staff in March 2024. In addition, minutes indicated the updated sepsis guidance was discussed at one of the doctor's meetings. Often the first point of contact for patients, reception staff confirmed they had received training in sepsis and said they would refer to the duty doctor with any concerns about a patient.

The IST record indicated one of the doctors facilitated measles awareness training for all staff in February 2024. Scenario-based training or moulages was sporadic with the last session taking place in May 2023. Staff advised that further moulage training was planned and the IST programme showed it was scheduled for May 2024 (anaphylaxis) and September 2024 (chest pain).

Clinical staff completed heat illness training as part of their induction. Heat injury was scheduled to take place in April 2024 as part of the IST programme. Staff provided examples of actual emergencies involving 3 patients presenting with heat illness, 2 of which were transferred to hospital via 999. Following a review of heat injury casualties and

to ensure a more streamlined response, the practice prepared a box with all the equipment in one place, including all of the required blood bottles.

Information to deliver safe care and treatment

The practice experienced issues with accessing connectivity and access to DMICP similar to other Defence-wide medical centres. A significant event raised in February 2024 highlighting that operational capability of the practice had been seriously compromised. For example, it took 25 minutes for reception staff to log on to DMICP at the start of the day. There was a delay of 3 hours to connect printers. It took 30 minutes for surgery 8 to connect. Attachments either did not load or took several minutes to do so.

We were informed of a station-wide power outage during a vaccination clinic. The clinic was stopped and rearranged. The outage was station wide so emergency generators were available for the vaccination fridge. Data loggers were checked and sent to Regional Headquarters. A significant event was not raised for this incident. During planned outages the week prior to this inspection, clinics were re-arranged and staff worked from home if appropriate. The duty team always remained in building.

To minimise the risk associated with connectivity issues, the business resilience plan outlined the action to take. Clinic lists were printed at the end of each day in the event of a DMICP outage the following morning. Hard copy consultation forms were available for use during an outage and records scanned onto the system at a later point. The station was notified of any outages and staff used the community Facebook page to inform patients if necessary. As a last resort, clinical activity could be re-located to High Wycombe Medical Centre.

Effective processes were in place for the summarisation of patients' records. A clinical code applied to DMICP records confirmed summarisation had been completed. At the time of the inspection, 96% of service personnel records and 99% of civilian records had been summarised.

Although we did not see the records, we were advised that a review of doctors' record keeping was currently taking place. We were satisfied that the record keeping audit tool used was appropriate and comprehensive. Peer review was discussed at the nurses' meeting. Each nurse had peer review dates identified. The nurses supervised the work of medics during the morning triage clinic. At end of the emergency clinic (referred to as sick parade) a debrief was held with the medics. In addition, feedback was given to medics when they supported vaccination clinics and with the taking of blood.

PCRF staff received an annual peer review. Record keeping for PCRF staff was audited annually with the most recent completed in June and July 2023. Feedback and an action plan, if appropriate, was provided by the peer reviewer. The Band 7 was the clinical supervisor for the OC physiotherapist and Band 6 physiotherapists. Exercise rehabilitation instructors (ERI) used the new 'Individual Development Programme' and received supervision from the Regional Trade Specialist Advisor (referred to as RTSA).

The nursing team oversaw the process for the management of samples. A specimen register was maintained and a synonym (short cut to standardise clinical activity) was used, including the DMICP specimen template. Both the duty nurse and duty doctor checked Path Links (system used to manage samples) daily for results, following which

the specimen register and patient's record were updated accordingly. Results were also reviewed by the doctor who requested the specimen. The doctor was informed if results were not received within 2 weeks. Patients were either contacted by the doctor with their results or received the results through a gov.notify text.

An effective system was in place for managing both internal and external referrals including urgent 2-week-wait (2WW) referrals. The doctor tasked the administrative team who processed the referral and added it to the referrals spreadsheet. For 2WW referrals the appointment could be booked straight away via the NHS e-Referral Service. The referral register was reviewed at least once a week and updated. The hospital notified the practice if the patient did not attend their scheduled appointment.

Safe and appropriate use of medicines

One of the doctors was the lead for medicines management and the pharmacy technician was the deputy lead. Terms of reference were in place to reflect these lead roles.

The dispensary was secured when the pharmacy technician was not present. A local working practice protocol for out-of-hours access to the dispensary was in place and measures were established to ensure security of the dispensary keys. We highlighted to the pharmacy technician that the keys for the cabinet containing controlled drugs (potentially addictive and harmful medicines subject to regulation) needs to be secured in a sealed bag and access recorded.

All receipt and supply of prescriptions (Fmed 296) was correctly recorded and accounted for. The Fmed 296s were held securely in the dispensary and monitored by the pharmacy technician.

There were no non-medical prescribers in the practice. Patient Group Directions (PGD), which authorise practice nurses to administer medicines in line with legislation had been signed off by the doctor. Nurses had completed the required training. Appropriate protocol templates and clinical coding were used. Nurses had access to the current PGD page. A PGD audit was completed in November 2023. Patient Specific Directions were not used at the time of the inspection.

In the main, repeat prescriptions were requested by the patient via eConsult or email. Telephone requests were also accepted even though this was not in accordance with policy. Telephone requests were usually only accepted in exceptional circumstances and documented in the patient's clinical record. The dispensary was in the process of reintroducing a repeat prescription drop off box.

We undertook a search which showed there were 298 patients on repeat medications; 177 had been reviewed and 121 patients had not been reviewed. Our review of a random selection of 5 patients from the 'not reviewed' group indicated that many of these patients were on legacy repeat medication, which required an administrative review to remove or renew the medications on the repeat medication list. This oversight did not adversely affect the care of the patients. Appropriate clinical coding was applied to DMICP when medicines had been reviewed.

High risk medicines were managed by the medicines management lead. We checked 5 patient records; 3 had shared care agreements which were in date and the monitoring in line with the shared care guidelines. A high risk medicines audit had not been undertaken.

Patients prescribed 'red' medicines were supplied by secondary care providers or their contractors. 'Red' drugs were correctly recorded on DMICP in accordance with policy (JSP 950 leaflet 9-3-4). We noted that a shared care agreement was refused in July 2023 yet the practice continued to prescribe the medicine for the patient. The SMO confirmed they would obtain a new updated shared care agreement from the secondary care provider.

Patients were informed of side effects to medicines through the patient information leaflet provided. In addition, the pharmacy technician counselled each patient.

The vaccines were appropriately stored in the fridge, in date and all temperatures recorded were within the correct range. Ambient and fridge thermometers were all in date for calibration. All probes were correctly immersed in liquid bottles. Pharmaceutical refrigerators were clean and less than two thirds full.

To improve the rotation of vaccines and prevent expired vaccines being given in error and prevent wastage of vaccines, red elastic bands were put on vaccine boxes that were due to expire in the next month so they were used first. This initiative was identified as a quality improvement project in October 2023.

The pharmacy technician was responsible for ordering and accounting of the cold chain pharmaceuticals. Nurses and medics were responsible in the absence of the pharmacy technician. No vaccines were moved between medical centres.

Two prescriptions were awaiting collection for longer than 7 days. One patient had been contacted and this was recorded on their clinical record. The other patient was receiving a 2 months' supply each month so would have sufficient stocks.

Medicines held at the dispensary were stored securely. Controlled drugs (CD) were kept in an appropriate cabinet. CDs and accountable drugs were checked monthly and quarterly in accordance with policy. The SMO did not have the delegated authority from the Commanding Officer of the station and consequently the pharmacy technician also lacked the delegation from the SMO. This was not in line with policy.

The practice was using old version of the Bmed12 prescription registers. These registers did not accommodate for the details of patients, relatives or representatives collecting Schedule 2 controlled drugs to be recorded. New versions of the registers were introduced in 2020. Furthermore, the loan certificates for medicines were renewed every 3 months, which was not in accordance with DPHC policy. The SOP requires these to be renewed at weekly intervals.

The controlled drugs keys were held securely but were not sealed with several staff having access to the keys. If these are not sealed then it is difficult to ascertain if the keys and controlled drugs have been accessed. There was no dispensary key; access was via a digital key. The entry to the dispensary was manually logged in a register. However, there was no way of knowing if anyone had accessed the dispensary unless they had completed the entry log.

Destruction of controlled drugs was not in line with the DPHC policy as the account holder (usually the SMO) did not witness the destruction with an independent party. All destructions were correctly recorded in the Bmed12 register and receipts were correctly completed. Orders for controlled drugs were made on the ordering system ECAT.

A valproate (medicine to treat epilepsy and bipolar disorder) search was set up on DMICP but there was no indication that searches were run on a regular basis. We undertook a search and no patients were prescribed valproate at the time of the inspection. The pharmacy technician was aware of the importance of oral contraception and whole pack dispensing.

A CD audit was completed in May 2023. An antibiotic prescribing audit for sore throats was undertaken in June 2023. It showed 75% of patients prescribed immediate antibiotics met National Institute for Health and Care Excellence criteria.

Track record on safety

The Warrant Officer was the lead for risk management. Taking account of the '4 T's process' (transfer, tolerate, treat, terminate), the risk register was comprehensive, regularly reviewed and included detail of action the practice was taking to address each risk. Four risks had been transferred to Regional Headquarters. These were staffing, pelvic stress injury and 2 risks related to the ageing infrastructure. We considered that further risks on the register should be transferred and the others transferred to the issues log. The Warrant Officer said the register would be reviewed. Minutes demonstrated that practice risks were discussed at the healthcare governance meetings.

A range of regularly reviewed clinical and non-clinical risk assessments were in place for the medical centre. The PCRF were using an older version of risk assessment forms. The health and safety review for the station advised that the risks could remain on the older version of forms and be transferred to the new form when next reviewed. Identified hazards in some risk assessments for the PCRF were inconsistent. For example, the office/administration risk assessment, which included the use of electrical equipment identified, only one hazard; trips and falls. Other hazards were not included such as risk of electrical shock.

The PCRF had a comprehensive risk assessment in place for hydrotherapy, including a contract for hiring the pool. We were informed this had been sent to the contract management team at RAF Halton for review. The named user in the contract was not appropriate in terms of seniority. We discussed with PCRF staff that this needs to be taken into account as part of the contract review.

We noted the control measure section was incomplete for individual products hazardous to health (referred to as COSHH). Practice staff highlighted that they followed the action outlined in the COSHH data sheets if a member of staff was exposed to a harmful substance.

Health and safety inspections were carried out in March and September each year. We reviewed the August 2023 report. It covered the work environment, emergencies, asbestos, electricity, risk assessments, lighting, display screen equipment, contractors/visitors, personal protective equipment, COSHH and fire. No actions were identified.

Evidence was provided to demonstrate electrical safety and portable electrical appliances checks were up-to-date for the medical centre and PCRF. However, electrical testing was out-of-date for a radio, radiator and kettle in the PCRF gym. Managed by the permanent ERI, physical training equipment in the PCRF and PCRF gym was in-date. The treadmill

needed a new replacement belt so was out of use until it was fixed. The cold/heat therapy machine and ultrasound/combination therapy machine were serviced by an external contractor.

The legionella risk assessment from 2016 graded a number of water outlets as a high risk. An email from the contractor to the practice confirmed a further legionella risk assessment was undertaken in October 2023. The report was only recently issued to the contractor who were in the process of costing the remedial actions required. The duty medics flushed all taps each week.

An equipment inspection (referred to as a LEA) was undertaken in February 2024. Three non-conformance and 4 observations were identified. The practice received the report in March 2024 and a plan was in place to discuss the actions.

The ERI used a wet-globe bulb temperature (WGBT) to monitor the temperature in the PCRF gym. Staff had access to the WGBT tables displayed in the gym. In addition, staff had access to a document displaying 'Rating of Perceived Exertion' and activity profiles for estimating work rate that included maximum work rate limit charts. Patient information about exercising in the heat was displayed in the PCRF gym entrance. Comprehensive risk assessments were in place for heat illness and cold injury.

The station fire department carried out a formal fire risk assessment of the premises in May 2023, which was valid for 5 years. The fire department checked the fire alarm weekly. Fire extinguishers were serviced in March 2024. The practice carried out monthly checks of firefighting equipment and the escape route from the building. At induction, new staff were expected to sign to say they had read the fire orders. Fire evacuation drills were held annually. In addition, the fire department carried out random fire drills with the most recent taking place in November 2023. We were advised that the fire department responded if the alarm was activated. The names of the fire wardens for the practice were displayed.

Throughout the inspection we observed issues and risks with the infrastructure. Examples include corroded pipes, safety marking tape on some stair steps and uneven and/or damaged flooring. There were holes, cracks and flaking paint in some areas. We observed mould in the room where sharps boxes were stored and were advised this had been caused through a leaking roof that had since been fixed. Numerous trip hazards were evident throughout the building. We were told that some clinical areas were due to be upgraded during summer leave this year. However, we considered that many other areas needed attention to ensure the infrastructure was safe.

Lone working occasionally happened in the PCRF and gym and risk assessments were in place to support this. Staff were encouraged to carry a mobile phone and personal alarm.

An integrated emergency alarm system was in place and a record maintained to demonstrate the alarm in each room was tested weekly. We activated a range of alarms during the inspection and staff responded immediately. Within the PCRF, the alarm in the treatment cubicle area did not work and staff were unaware of this. We reported this to the OC physiotherapist at the time of the inspection. The risk assessment for out-of-hours use of the PCRF gym would benefit from further development to emphasise that users should not perform maximal intensity training or exercise testing involving maximal effort.

Lessons learned and improvements made

The practice worked to the DPHC policy for reporting and managing significant events, incidents and near-misses, which were recorded on the ASER system. The staff database showed all staff had completed ASER training to access the system.

An ASER tracker was maintained, including actions required/taken and completion date. All staff we spoke with knew how to report an SE or incident. Healthcare governance minutes confirmed SEs were routinely discussed including lessons learned.

Not all permanent staff we spoke with had a link to the ASER system but this was rectified during the inspection. Locum staff in the PCRF did not have ASER log in.

An ASER submitted by the PCRF in January 2024 to report faulty patient rocker boots was closed by the leadership team as it was deemed not to meet the criteria for an ASER. Alternative action was taken so the issue was escalated. We discussed re-submitting this given the patient safety implications and because we were aware of other PCRFs in the region who had reported similar issues with this equipment. Processing the matter as an ASER supports with identifying themes and informs future procurement decisions. We also noted that a significant event had not been raised when there was station-wide power outage during a vaccination clinic.

Staff provided examples of improvements made following a review of a significant event. Some of these were dispensing errors and a member of the management team now conducts a second check to minimise a recurrence. A further example involved a person under 18 given an adult vaccine instead of child vaccine. Since then, the practice require both military and civilian patients to submit an eConsult prior to attending for a vaccination and the child immunisation clinics are undertaken with 2 nurses present.

A patient safety alerts SOP was in place and reviewed in March 2023. Medicines and Healthcare products Regulatory Agency (referred to as MHRA) alerts were emailed to clinical staff by the pharmacy technician. Alerts was a standing agenda item at the healthcare governance meetings, confirmed by meeting minutes from February and March 2024. Although not minuted, MHRA alerts were also discussed at the weekly Heads of Department meetings.

Are services effective?

We rated the practice as good for providing effective services.

Effective needs assessment, care and treatment

Processes were in place for clinical staff to keep up-to-date with developments in clinical care including National Institute for Health and Care Excellence (NICE) guidance, the Scottish Intercollegiate Guidelines Network, clinical pathways, current legislation, standards and other practice guidance. Staff were kept informed of clinical and medicines updates through the Defence Primary Healthcare (DPHC) newsletter circulated to staff each month. Clinical updates were discussed at practice and clinical meetings. Meeting minutes showed that a NICE updates regarding sepsis and monkey pox were discussed in December 2023.

Patients who were vulnerable and those with cancer care needs were discussed formally at the Tuesday afternoon meetings. An informal discussion regarding complex or concerning patients was held at the daily morning meeting. In addition, clinical meetings were held each month and staff could suggest topics they wished to discuss

The Primary Care Rehabilitation Facility (PCRF) team used a variety of Patient Reported Outcome Measures (PROMs), such as Orebro, FAA, VISA, Tampa Scale of Kinesiophobia and STarTBack. It is noteworthy that STarTBack is a screening tool used to match patients to treatment packages appropriate to their needs rather than a tool to measure patient outcomes. We highlighted that outcome measures indicated in best practice guidelines should also be considered, such as those for anterior cruciate ligament reconstruction. Feedback on PROMs was gained from the patient satisfaction questionnaire.

The Musculoskeletal Health Questionnaire (MSK-HQ), the standardised outcome measure for patients to report their symptoms and quality of life, was used on initial assessment and on discharge. We found it’s use was inconsistent. Out of 5 sets of audited DMICP records, only 1 record had evidence of its use. Rehabilitation Dashboard data showed MSK-HQ score completion by initial and discharge appointments from 1 October 2022 to 28 September 2023 showed MSK-HQ scores were recorded for only 1% of new patients and 9% of discharges.

The PCRF included a good sized clinical area with a well-equipped separate gym area.

Monitoring care and treatment

A lead doctor and deputy lead nurse was identified for each chronic disease and other clinical conditions. A standard operating procedure (SOP) was in place for each chronic condition, supported by a quick reference guide. The nurses carried out the DMICP searches and recalled patients for bloods and other tests. Both Population Management (referred to as POPMAN) and DMICP were used for searches and cross referenced. The chronic disease register was updated bi-monthly following the search for each chronic disease. The nurses updated the lead doctor when searches were undertaken and/or as

required. Registers for each condition were held on DMICP in Practice Documents and could be picked by any member of clinical staff. The searches we undertook confirmed active recall of patients was taking place. We reviewed a random sample of patient records and both recall and monitoring were sufficiently documented.

The 10 patients identified on the diabetic register had been followed up. For patients at risk of developing diabetes, an annual HbA1c blood glucose test for patients was undertaken for those with a with a previously recorded HbA1c of more than 42. An annual HbA1c blood test was taken for patients who have had gestational diabetes. Forty patients were identified as having hypertension (high blood pressure) and 30 had a record confirming their blood pressure was checked in the past 12 months. Thirty two patients had a diagnosis of asthma and 77% had an asthma review in the preceding 12 months. Asthma templates were directed, but the practice identified these were not always used. This omission had led to a mismatch in data capture by POPMAN. Patients' records were scrutinised bi-monthly to monitor template use and diary corrections were made accordingly. Clinical staff were consistently advised to always use the templates provided.

In accordance with tri-service policy, patients with sickle cell trait (SCT) were identified through a 'Family Origin Questionnaire'. Those identified as SCT positive were added to register on DMICP and alert placed on their clinical record. They were offered an appointment with a doctor to discuss the implications of a SCT status.

We were advised that the practice was the pilot site for SCT checking and had produced the SOP that is now used in other facilities. We noted it did not make reference to gaining informed consent from the patient prior to release of medical information to the Chain of Command (CoC). We discussed with the doctors the need to improve documentation in this area. Consent is important as the patient was asked to wear a wrist band that essentially communicates they have a blood disorder to all who see it. Both the SMO and DSMO stated the patients gave verbal consent but did acknowledge the omission of reference to consent in the SOP. We looked at 2 sets of notes; an alert was in place and the Joint Medical Employment Standards (referred to as JMES) was appropriate.

Audiometry assessments were in date for 87% of the patient population.

The management pathways for patients with a mental health need varied for recruits, regular service personnel and civilians. There were good links with WaSP team and Padre. The NHS 'Talking Therapies, for anxiety and depression programme' (formerly known as Improving Access to Psychological Therapies - IAPT) or Child and Adolescent mental Health services (referred to as CAHMS) was used for civilians. Patients could self-direct to online Step 1. The Deputy Senior Medical Officer (DSMO) used resources, such as 'Headspace' and Living Life to the Full'. The standard DMICP template was used for referral to the Department of Community Mental Health (DCMH). The clinical records we reviewed showed patients with a mental health need were well managed and supported.

A lead and deputy were identified as the leads for audit. Quality improvement activity included clinical audit, DPHC mandated audits and data searches. An audit calendar was in place for 2023/2024 and included the frequency of a repeat audit. An audit register confirmed when each audit had taken place and outlined the key findings. We looked at a range of audits including hypertension, diabetes, epilepsy, stress fracture and lower back pain (LBP). Most were repeat audits. The audits were well written and measured against clear standards. We did highlight that the LBP audit would benefit from a repeat earlier

than the stated 12 months due to low scores of some criteria. We considered the expected standard set at 100% was unrealistic.

Effective staffing

A training manager was in place to ensure induction packages were prepared, followed and completed. All new staff completed the DPHC standardised induction. Role specific induction packs were in place and an induction pack was in place for doctors. A member of staff who recently joined the practice described the induction as supportive.

The training manager monitored the mandated training and followed up with individuals whose training was due to expire. Staff were given protected time to complete this required training. There was good compliance with mandated training with mitigating circumstances for staff who were out-of-date. A register of in-service training (referred to as trade training) was maintained, including a programme of planned training for 2024.

PCRF staff attended quarterly regional in-service training events held at the Regional Rehabilitation Unit in Halton; the most recent was held in February 2024. The nursing team was represented at the DPHC regional nurses' forum.

Clinicians had training specific to the needs of the patient population. For example, the SMO and DSMO had completed the Diploma in Aviation Medicine. The OC physiotherapist had completed the Military Aviation Medical Examiner (referred to as MAME) course so they could screen fitness for flying without referring the patient to the doctor. Medics had received vaccination training.

The practice had numerous staff on placement including medics in Phase 2 training and nurses spending time at the practice to determine whether primary healthcare was a career pathway they wished to pursue. Placements were structured so trainees were able to fully participate in clinical elements of the practice. Staff had had the opportunity to attend clinical placements in Cyprus and Germany and some staff had applied for clinical placements in Stoke Mandeville Hospital next year.

Coordinating care and treatment

The practice had effective relationships with the station, including the Flight Commander for recruits, the WaSP team, SSAFA and the Padre. The practice was represented at the station personnel support committee meetings, which provided the opportunity to discuss patients at risk and patients who were downgraded. The PCRF was represented at the multi-disciplinary team meetings if injured patients were being discussed. The nurses had links with local NHS services, including district nurses and health visitors. The practice had effective relationships with internal services including the DCMH, Regional Occupational Health Team and Regional Rehabilitation Unit.

A 'Leaving the Military' SOP was in place. For patients leaving, pre-release and final medicals were offered. They were also provided with a comprehensive veterans pack and other information. Patients were also made aware of the Veterans Health Service and, if appropriate, the Veterans Mental Health Transition, Intervention and Liaison Service

(TILS). Although there was no formal process for civilians leaving, patients with a complex or long term condition were handed over to the new GP if appropriate.

Helping patients to live healthier lives

One of the nurses was the lead for health promotion. A health promotion calendar was established with a specific topic identified each month. A wide range of health promotion/lifestyle information leaflets was available in the waiting area for patients. Leaflets included information about diabetes, alcohol use, prostate awareness and childhood immunisations. Information about women's health, sepsis and sexual health was displayed. Practice staff, including the PCRF, participated in the station-led health and wellbeing days. At one of days, the aim of the PCRF was to raise awareness of women's health rehabilitation, including the role of physical training instructors with pre and post-natal support and information.

The OC physiotherapist had published an article in the station magazine in relation to getting fit for winter to prevent injuries while skiing. The PCRF could also refer patients to attend the Defence Occupational Fitness (referred to as DoFIT) course to learn about nutrition sleep and lifestyle factors. In addition, the PCRF delivered education sessions to injured recruits on lifestyle factors, nutrition, and sleep.

The PCRF were involved in the RAF injury training steering group, which looked at training design to help prevent injuries and instigating any changes in policy for injury prevention. For example, females marching at the front to help prevent pelvic stress injury by gait over extension. In addition, the station's working group has investigated how to improve sleep and diet and the possibility of introducing vitamin D supplementation.

To support the rehabilitation of injured recruits, each recruit maintained a food diary for 5 days. A theme of non-nutritious and unhealthy foods was noted. As a result, a nutrition brief was delivered by the PCRF to recruits undergoing rehabilitation. This audit was carried out in November 2023 and a re-audit of the food diary was planned to be repeated in 6 months. This initiative was submitted as a quality improvement project.

One of the doctors was the lead for sexual health and had undertaken the appropriate training (referred to as STIF). Sexual health advice and contraception were provided, including implants and intrauterine devices. Patients were also sign posted to a local sexual health clinic in Aylesbury.

A lead doctor and deputy lead nurse was identified for each of the screening programmes. Bowel, breast, cervical and abdominal aortic aneurysm screening (AAA) was led by the NHS. Patients received letters directly from the NHS. The nurses tracked the patients to confirm they had been offered screening; monthly for cytology, 3 monthly for bowel and breast and 6 monthly for AAA.

The number of women that had a cervical smear in the last 3-5 years was 221, which represented 91% of the eligible female population. The NHS target was 80%.

The status of childhood vaccinations was:

- The percentage of children aged 1 who had completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (i.e., 3 doses of DTaP/IPV/Hib/Hepatitis B) was 100%

- The percentage of children aged 2 who had received their booster immunisation for Pneumococcal infection 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%

For service personnel, the vaccination statistics were:

- 93% of patients were in-date for vaccination against diphtheria
- 93% of patients were in-date for vaccination against polio
- 93% of patients were in-date for vaccination against tetanus
- 97% of patients were in-date for vaccination against hepatitis B
- 98% of patients were in-date for vaccination against hepatitis A
- 87% of patients were in-date for vaccination against measles, mumps and rubella
- 98% of patients were in-date for vaccination against meningitis

A lead nurse was identified for childhood vaccinations and another nurse oversaw the vaccinations for service personnel. DMICP searches were conducted each month and patients recalled.

Consent to care and treatment

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. Although clinicians understood the Mental Capacity Act (2005) and how it would apply to the patient population group, mental capacity training had not been delivered in the last 12 months. We were advised this would be added to the in-service training programme.

A consent policy was in place for the PCRF but we were unable to confirm if one was in place for the practice. Implied and formal consent was mostly used. A generic consent audit had not been undertaken within the last 12 months. We were advised this would be added to the audit schedule.

Informed written consent was taken for acupuncture and then then scanned to the patient's DMICP record. Written consent was taken for minor surgery. The SMO provided minor surgery and had carried out an audit within the last 12 months at the medical centre they were previously based at. We confirmed consent was accurately recorded though our review of DMICP records.

Clinicians were aware of the 'Gillick competence' (process to assess whether a child has capacity to consent to medical treatment) and the 'Fraser guidelines' (process to decide if a child can consent to contraceptive or sexual health advice/ treatment). We were provided with appropriate examples of when these processes had been used to assess a child's capacity to consent.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

As part of the inspection, we received feedback about the service from 46 patients. Feedback indicated staff were friendly and went 'above and beyond' to accommodate patients' needs. Patients said they were listened to and were treated with kindness and respect.

Support services available to service personnel and families included a community centre, the SSAFA team and the WaSP team. A station family day was held each year.

Both patients and staff provided various of examples of when the practice had 'gone the extra mile' to ensure timely and appropriate care, including responding to a medical emergency on the station in 2023 with a successful outcome for the person who was acutely ill.

Involvement in decisions about care and treatment

Feedback indicated patients were involved with planning their care, confirmed by our review of patient records. Supported by a standard operating procedure, a translation service was available for patients who did not have English as a first language. Staff said they had not needed to use this service.

If appropriate, patients had the option to see the same clinician. Specifically, the primary Care Rehabilitation Facility (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.

One of the nurses was the lead for lead for patients with a caring responsibility. Carers were identified through the patient registration process, through the welfare team or opportunistically. Although our DMICP search identified 17 carers, the carers register listed 19 carers. We reviewed a selection of records for carers and alerts were in place for the majority. Carer information was displayed, including how to access the local carers support service. Information was also outlined in the patient information leaflet including the definition of a carer role and included website links. Carers were offered an annual health check.

Privacy and dignity

Patient consultations took place in clinic rooms with the door closed. Privacy curtains were available in all clinical rooms for intimate examinations. The PCRF consisted of a number of curtained cubicles with plinths to treat patients and there was access to a separate

treatment room if more privacy was needed. Radios were used in the cubicle area to help mitigate potential privacy and confidentiality issues.

A separate room could be used at reception if patients required privacy, and private breast feeding and baby changing facilities were available.

The staff team had completed Defence Information Management Passport training which incorporated the Caldicott principles. These principles were displayed at the practice.

At the time of the inspection, there was a good mix of male and female clinicians so patients had the option to see a doctor of a specific gender. We were given an example of when a patient's wish for a doctor of a specific gender had been accommodated.

Are services responsive to people's needs?

We rated the practice as outstanding for providing responsive services.

Responding to and meeting people's needs

A theme emerging from the patient feedback was the responsiveness of the practice team to accommodate their needs. In addition to positive feedback about clinicians, it is noteworthy that patients acknowledged the responsiveness of reception staff, whom they said made every effort to secure them an appointment even at short notice.

The practice had a dynamic and highly flexible approach to the management of appointments to meet patients' needs. This flexibility was enhanced as the duty doctor was available until 18:30 hours. Protected appointments were in place for the administration of e-consults, children and 'book on the day' appointments. Each doctor had a daily free slot that a nurse or physiotherapist could utilise if required. A dedicated 'last appointment of the day' was available for school age children. 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 WaSP team were often the first line of contact for vulnerable patients. They sometimes accompanied patients to their appointments, and also had direct contact with the doctors. The reception team was made aware if there was they WaSP team was involved with a patient so allocated a double appointment. If there were no appointments available, reception liaised with the management team who ensured an appointment was made available.

Through discussions with staff and our review of patient records, we identified numerous examples of how the practice responded to the specific needs of individuals and units. Examples include:

- The timings of clinics were regularly monitored and changed as needed. For example, the recruit vaccination clinics were changed to accommodate training timetables, which in turn meant other clinic times needed to be adjusted. Proposed changes were discussed with the Chain of Command and information circulated to all patients.
- A weekly multi-disciplinary meeting was held to discuss recruits. Recruits were active participants in this meeting and attended the meetings alongside flight staff if required. The recruits were asked for feedback about whether they felt involved in their ongoing care and if there was anything they could be done to improve their experience.
- The development of a tailored weight management plan to fit with a patient's level of motivation.
- The use of psychological and social models (love languages, drama triangle and empowerment dynamic) to support a patient's mental wellbeing.
- In response to the diagnosis of a case of a highly contagious condition, key staff were promptly informed and immediately co-ordinated the care of the individual and others within the unit. All prescriptions were provided by the duty doctor with the support of the pharmacy technician and the outsourcing local pharmacy. The flight staff and Primary

Care Rehabilitation Facility (PCRF) team were briefed and the facility cleaned. The unit received briefs from the environmental health practitioner and one of the doctors about transmission, how to prevent spread, how to apply topical medicine and the importance of washing clothes and bedding. In addition, information leaflets were distributed about the condition. The clinical team closely monitored the situation outside of clinic hours to ensure topical medicine was applied correctly.

- The needs of a young person involved securing timely advice from a paediatric consultant. The practice liaised with the school nurse and provided supportive letters to the school. Ongoing regular 30-minute appointments were provided for the patient. To maintain trust and respect the patient's wishes, the patient was not referred to external services. At the same time, the doctor monitored the patient to ensure they were safe and there were no safeguarding issues emerging. With the level of support provided by the practice, the doctor noted that the patient's confidence increased and family relationships improved.
- A patient who had surgery privately acquired a post operative infection so attended to medical centre, who went beyond the patient's expectations of being seen so promptly.
- Through feedback, patients asked for access to a swimming pool. The station provided funding to allow monthly access to a swimming pool at Stoke Mandeville. Patients also had access to weekly hydrotherapy at a local swimming pool. PCRF staff treated up to 5 patients in the pool with a lifeguard present. We were shown a copy of the hydrotherapy pool operating procedures which contained all necessary safety and emergency procedures.

The practice had been involved from the early planning stages with the integration of transgender recruits. A training session designed to ensure staff used correct and appropriate terminology had been held. This then led to the practice ensuring the availability of a gender neutral toilet. Details were displayed about who to contact within the RAF LGBT Freedom Network.

In line with the Equality Act 2010, an access audit for the medical centre was completed in May 2023. An accessible parking space and accessible toilet was available. There were 4 steps from reception to access the waiting room and some of the clinical rooms on the first floor. This was not suitable for pram or disability access. Given the limitations of the building, the practice had made reasonable adjustments. For example, once a patient checked in with reception then they could leave the building and use another door to access the first floor. In addition, a chair was available for anyone who required to be seated at reception. The practice had a portable induction hearing loop with clear signage at reception to indicate the availability of this device. We noted that the practice received a patient suggestion for neurodiverse signposting for civilian patients. We were unable to confirm if this had been actioned.

Halton Dental Centre had to relocate to High Wycombe Dental Centre for a few weeks and they had a staff member that used a wheelchair. The temporary workplace was not suitable for a wheelchair, so Halton Medical Centre hosted the individual. A personal emergency evacuation plan (referred to as PEEP) was put in place to ensure a safe evacuation should the need arise.

Timely access to care and treatment

Feedback indicated patients were satisfied with access to a doctor, nurse and medic. To ensure the streamlining of appointments and access to clinics, the reception team had access to a reference guide for appointments and clinics that included the duration of each appointment.

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.

Recruits had access to an urgent appointment with a physiotherapist within 1 day and it was 2 days for other patients. Routine and follow up appointments could be accommodated within 2 to 5 days. There was a wait of 2 to 5 days for an appointment with an exercise rehabilitation instructor. A Pilates class was provided for up to 5 patients with weekly availability. The PCRF was meeting its key performance indicators.

Patients could refer directly to physiotherapy through the eConsult online form. This Direct Access to Physiotherapy referral pathway had not been audited due to the low number of patients using this pathway. We highlighted that an audit of this pathway would be of benefit to ensure policy guidelines were being followed.

There was a 5 day wait for medicals and a 5 week wait for patients referred to the Multi-Disciplinary Injury assessment clinic. A weekly multi-disciplinary team meeting was held with the Regional Rehabilitation Unit for all PCRFs in the region; any delays or urgent referrals were discussed at this forum.

Home visits were offered by the practice. A home visit standard operating procedure was in place and was last reviewed in August 2023. A log of home visits was maintained, which showed 4 home visits in 2022 (mainly Covid-19 related). The criteria for home visits was outlined in the patient information leaflet.

The patient information leaflet, answerphone message and patient information board outside of the medical centre provided details about opening times and access to medical care out-of-hours.

Listening and learning from concerns and complaints

The practice manager was the lead for complaints. Complaints were managed in accordance with the Defence Primary Healthcare complaints policy and the practice policy. Both verbal and written complaints were recorded on the complaints log. The complaint log showed 5 complaints were received between January 2022 and February 2024. We discussed the complaint received this year and were satisfied it was effectively managed in accordance with policy.

Complaints were discussed in the monthly practice meetings. In addition, the weekly 'round up' email sent to the team included any updates on complaints.

Patients were made aware of the complaints process through the practice information leaflet and information displayed in the waiting room.

Are services well-led?

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

Vision and strategy

The practice worked to the Defence Primary Healthcare mission statement outlined as:

> "…. to provide safe, effective healthcare to meet the needs of our patients and the chain of command in order to support force generation and sustain the physical and moral components of fighting power."

The mission statement specific to Halton Medical Centre was defined as:

> "To provide a confidential and integrated service that is responsive to the health and welfare of trainees, permanent staff, and their families."

An additional mission statement for the Primary Care Rehabilitation Facility (PCRF) was also in place.

It was evident the practice was meeting its mission statement as we found the service was highly responsive to the needs of individual patients and the occupational needs of units. Integration was promoted with the practice, evident through the close working relationship between medical centre staff and the PCRF team. Furthermore, the practice worked closely with the Chain of Command and welfare support services within the station to ensure the needs of vulnerable patients were closely monitored.

The patient population was taken into account with strategic planning. A whole team approach was adopted with planning, particular the process and planning of recruit medicals to ensure a smooth process for 120 recruit medicals conducted every 2 weeks. The practice communicated closely with units to ensure other activities did not take place on the same day as medicals, such as physical training.

The practice worked closely with High Wycombe Medical Centre and the High Wycombe team relocated to Halton Medical Centre for approximately 6 months when its Senior Medical Officer (SMO) was deployed. The practice also provided physiotherapy support for 2 months in the absence of physiotherapy staff at High Wycombe. A strategic plan was in place to create a formal network between the 2 practices. The practice also supported Abingdon and Benson medical centres with the administration of yellow fever clinics.

The Warrant Officer was the environmental representative for the station. To address environmental sustainability, the practice aimed to reduce the use of paper by communicating via email and the use of links rather than producing paper booklets. Signs were displayed encouraging staff to switch off lights if they were not needed. The medical centre was equipped with recycle bins and had the facility to recycle batteries.

Leadership, capacity and capability

Staff we spoke with advised that there was sufficient management/leadership capacity to meet the needs of the practice and patient population. They described an inclusive leadership approach, including the visibility and support from the management team.

The leadership team described good and effective support from Regional Headquarters (RHQ), including support with policy and human resource queries.

In terms of succession planning, there was resilience in experience within the practice between the SMO, deputy SMO (DSMO), Warrant Officer and practice manager. The DSMO had been given incremental additional responsibility with the SMO focussing more on health care governance (HCG). In addition, the practice recently changed the format of the practice meeting with junior staff chairing the meeting to gain experience and confidence in a senior management role. The status of staffing was regularly communicated with RHQ. Furthermore, the team had good links with career managers to ensure not more than one member of staff deployed at the same time.

Culture

It was clear from patient feedback and interviews with staff that the needs of patients were central to the ethos of the practice. Staff understood the specific needs of the patient population and tailored the service to meet those needs.

Staff told us they were supported, respected and valued by the leadership team. They said that everyone in the team had an equal voice, regardless of rank or grade. Both formal and informal opportunities were in place so staff could contribute their views and ideas about how to develop the practice. The leadership team promoted an open-door policy and encouraged staff to share their views at meetings.

To promote and sustain positive team morale, regular social and team building events were held, which included both military and civilian staff. Examples were a visit to the Halton Heritage Site, walks in Wendover Woods and a visit to HMS Queen Elizabeth in Portsmouth. A trip to Parliament was planned and low ropes sessions for both morning and afternoon to enable the whole team to attend. Staff have also had the opportunity to take part in adventure training days, such as water skiing and canoeing expeditions.

A number of staff had been awarded the station Commander's Coins for recognition of their hard work both in and outside of the practice. Staff had also received 'Thank You Awards' in the form of gift vouchers from RHQ.

Staff said they would feel comfortable raising any concerns and were familiar with the whistleblowing policy. We were given an example of when the leadership team listened and promptly acted when a member of staff raised a concern about the outcome of a clinical intervention. The response involved consulting with an expert, the provision of peer review and a regional hub being developed. Patients affected were also consulted and they had no concerns. Contact with patients was recorded on the duty of candour log. In addition, an audit was undertaken. Staff were familiar with the Freedom to Speak Up (FTSU) policy and were aware of how to access FTSU representatives.

Processes were established to ensure compliance with the requirements of the duty of candour, including giving those affected reasonable support, information and a verbal and written apology. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.

Governance arrangements

There was a clear staff reporting structure in place. Staff were aware of their roles and responsibilities. Staff with lead roles had protected time to carry out their additional duties. Terms of reference (ToR) were established for those with secondary roles. The ToRs we looked at would benefit from a review to ensure they are up-to-date and appropriately signed.

Whilst we found patients were receiving safe and effective care, we identified some governance systems that needed to be strengthened. These systems mainly relate to medicines management, DMICP searches and generic governance systems.

A 5-week rotation of a range of meetings was in place to ensure effective communication and information sharing across the staff team, including a daily briefing which staff valued as it provided an opportunity to air worries and discuss any concerning patients. Other meetings included heads of department, HCG, clinical, audit and quality improvement projects (QIP) and a practice meeting. Information was consolidated in the practice meetings, which the SMO, Warrant Officer and practice manager filtered. Station-led meetings/forums included the Injury Steering Group Meeting, station Health and Wellbeing and the Station Personnel Support Committee. The health visitor and SSAFA were both invited to the alternate monthly Vulnerable Patient meetings. A PCRF meeting was held each month.

The practice used a management portfolio tool that captured all protocols, standard operating procedures (SOP) and minutes of meetings in one place. A comprehensive range of practice SOPs 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. 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 last internal assurance review took place in November 2022 and the practice received a rating of good.

Managing risks, issues and performance

An effective process to identify, understand, monitor and address current and future risks including risks to patient safety was in place. Risks to the service were well recognised, logged on the risk register and kept under scrutiny through review at meetings. The practice manager reviewed the risk register each month and risk was an agenda item at the monthly meetings.

The business resilience plan in place and reviewed in 2021. Reviewed May 2023, an epidemic and pandemic preparedness plan was in place.

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

The leadership team was familiar with the policy and processes for managing staff performance, including underperformance and the options to support the process in a positive way.

Appropriate and accurate information

The DPHC electronic health assurance framework (referred to as HAF) was used in to monitor performance. The HAF is an internal quality assurance governance tool to assure standards of health care delivery within defence healthcare. All staff were involved with updating the HAF, which was a standing agenda item at HCG meetings.

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. The quick response or QR code was displayed at reception. HCG meeting minutes from February 2024 showed 19 patients provided feedback between December 2023 and February 2024; all feedback was positive

A suggestion box with colour coded forms was available in the waiting area for patients to submit feedback. Some recent forms submitted complimented staff, in particular reception staff. This was shared with the team at a practice meeting and recorded on the DPHC compliments page.

Recruits directly involved in the MDT recruit meeting provided feedback electronically. Fifteen responses were recently received and all 15 confirmed they were included in the discussion about their care, 27% were satisfied with others present and 87% stated they would not change anything about the process. This initiative was submitted to DPHC as a QIP.

A patient engagement group was held. Despite extensive advertising, only one patient attended and they were asked to attend by their line manager. The practice has instead concentrated on other ways of obtaining feedback.

Options were available for staff to provide both formal and informal about the service. These included the colour coded forms similar to those used for patient feedback. There was an SMO suggestion box in the staff room and staff could provide feedback at practice meetings.

Continuous improvement and innovation

A quality improvement programme was in place. The audit register clearly demonstrated that the practice actively engaged with audit activity. Quality improvement activity, including individual audits, were discussed at the clinical and/or practice meetings, confirmed by a review of meeting minutes. Quality improvement projects (QIP) carried out by the practice were held on the DPHC Healthcare Governance webpage and 15 QIPs were logged.