Brawdy Medical Centre

Cawdor Barracks, Brawdy, Haverfordwest, Pembrokeshire, SA62 6NN

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	Requires improvement	
Are services safe?	Requires improvement	
Are services effective	Requires improvement	
Are service caring?	Good	
Are services responsive to people's needs?	Good	
Are services well-led?	Requires improvement	

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Summary

About this inspection

We carried out this announced comprehensive inspection of Brawdy Medical Centre on 10 September 2024.

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

Are services safe? – requires improvement

Are services effective? – requires improvement

Are services caring – good

Are services responsive to people's needs? – good

Are services well-led? – requires improvement

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 approach to accommodate the needs of individuals and units. Patients were included in decisions about their treatment and care.
- Our review of records and processes to monitor care showed patients received effective and timely clinical care.
- Patient feedback about the service was positive. It demonstrated patients were treated with compassion, dignity and respect.
- Effective safeguarding arrangements were in place. Patients vulnerable due to their mental health were well managed and supported.
- Flexible access and services were offered to patients with a caring responsibility.

- Staff spoke highly of the culture within the team and described an inclusive and supportive leadership management style.
- Many of the governance systems underpinning the safe running of the practice were not up-to-date, such as risk assessments, ASER (organisational-wide system for reporting significant events) and equipment checks.
- Actions, observations and recommendations from various audits, inspections and monitoring processes were not recorded so it was unclear when and how they had been or were being addressed.
- Evidence of appropriate recruitment, induction and completion of mandated training was not in place for all staff.
- Although there was clearly an ethos of in-service training and workforce development, not all of this training was recorded, notably scenario-based training.
- Medicines and medical products were well managed.
- Mandated audits were completed. However, there was scope to develop clinical audit based on population need.
- The practice was clean and appropriate measures were in place to minimise the risk of infection. Infection prevention and control audits were undertaken. Clinical waste was managed well.

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

- In the absence of a Regimental Medical Officer (RMO) (usually the clinical work of medics is supervised by an RMO), the Senior Medical Officer (SMO) provided a high level of ongoing clinical supervision. Following the daily triage clinic, the medics presented each case to the SMO who encouraged critically appraisal of the course of action taken. The patient records were reviewed by the SMO as part of this process. The medics valued the well-structured clinical supervision, support and training/development they were exposed to at the practice.
- The SMO used the ‘Staying Safe from Suicidal Thoughts’ formal risk stratification evidence-based process to develop a ‘safety plan’ for individual patients. This was then used as a monitoring tool and also to advise the Chain of Command about a patient’s risk and to inform the Vulnerable Risk Management system. If appropriate, patients with complex/concerning mental health needs were discussed at the ‘ghost clinic’. If relevant, the safety plan was used to aid referral to the Department of Community Mental Health. The SMO used ‘Getselfhelp.co.uk’ to support learning and professional practice, and to signpost patients to cognitive behaviour therapy resources, including worksheets, information booklets and videos.
- With a waiting list of up to 18 months for referrals to ophthalmology, the administrator made contact with a local optician service to see if they could offer support. A triage process was agreed and patients accepted were contacted directly by the optician and offered an appointment. Although an evaluation of this arrangement had not yet taken place, verbal feedback from patients was positive as they received treatment quicker than waiting for an NHS ophthalmology appointment.

- The practice's health promotion information was shared with the unit in a portable document format (PDF). It was electronically displayed around the camp so ensured up-to-date information was accessible to a wider audience. It also meant the health promotion information refreshed monthly by the practice was consistent with the information displayed around the camp.

The Chief Inspector recommends to Defence Primary Healthcare (DPHC):

Review leadership presence at the practice to ensure current arrangements are adequate at all times to ensure sufficient staff presence, fulfil governance requirements and to safeguard the health and wellbeing of staff.

The Chief Inspector recommends to the practice:

- A full review of governance systems and processes should be undertaken to ensure they are up-to-date and routinely used to monitor the safety and quality of the service. In particular the review should take account of the following:
    - To support with the identification of themes, all incidents and events that meet the ASER reporting criteria should be managed in line with DPHC policy.
    - Review the risk register so it is streamlined and configured in accordance with DPHC policy.
    - Risk assessments for the practice should be reviewed to confirm they are relevant and current, including risk assessments for substances hazardous to health and for the Primary Care Rehabilitation Facility (PCRF).
    - Ensure equipment checks are routinely undertaken and monitored in accordance with DPHC policy.
    - Actions, observations and recommendations from various audits, inspections and monitoring processes should be recorded so it is clear when and how they have been (or are being) addressed. In accordance with recent direction, all outstanding actions should be included in the Health Assessment Framework (HAF) management action plan (MAP) to support efficient and central oversight.
    - The HAF and MAP should be regularly reviewed to ensure they are up-to-date.
    - Review the induction programmes for permanent and locum staff to ensure they are relevant, current and include a role-specific induction. Introduce a process to confirm staff have completed their induction.
    - Ensure the practice receives confirmation of the pre-employment checks for locum staff.
    - A process should be established to prompt completion of and to monitor staff mandated training, including training for key lead roles. Document all scenario-based training, so there is an up-to-date record of the training staff have received.
    - Review the approach to the monitoring of antibiotic prescribing to ensure it is sufficiently objective.

- Arrange for the physiotherapist to have access to the Defence Rehabilitation SharePoint and the full range of best practice guidance. The Musculoskeletal Health Questionnaire is a mandated patient-reported outcome measure and should be routinely used in accordance with the DPHC standard operating procedure.
- Ensure training in learning disability and autism is provided in accordance with the DSMR regulatory instruction issued in April 2024.
- Prioritise the practice manager for a healthcare governance course.

Dr Chris Dzikiti

Interim 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 physiotherapist and practice manager. The primary care doctor, and pharmacist carried out the inspection remotely. A member of the internal Healthcare Governance and Assurance team shadowed the inspection.

Background to Brawdy Medical Centre

Rurally located and a short distance from the village of Brawdy, the medical centre provides a routine primary care, occupational health and rehabilitation service to a military service population of approximately 472 who are subject to operational deployment at short notice.

A primary care rehabilitation facility (PCRF) is located within the medical centre and provides a physiotherapy and rehabilitation service. As there is no dispensary at the practice, prescriptions are dispensed from a local pharmacy.

The medical centre is open from 08:00 to 17:00 hours Monday to Thursday. Medical cover is provided on Friday available through the General Practice Remote Support (referred to as GPRS) South Wales Group Network. From 18:30 hours midweek, weekends and public holidays patients can access NHS 111.

The staff team

Doctors	One Senior Medical Officer
Nurses	One military nurse One civilian nurse
Practice management and administration	Practice manager One practice administrator
PCRF	Locum physiotherapist
Combat Medical Technicians (medics)*	Two (unit assets)

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

Are services safe?

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

Safety systems and processes

A safeguarding lead and deputy were identified for the practice. The staff database for the practice was held centrally on the regional Defence Primary Healthcare (DPHC) Wales and West Regional headquarters (RHQ) website. The database showed all staff were in-date for safeguarding training at a level relevant to their role. Reviewed in May 2024, the safeguarding policy for adults and children included contact details for the local safeguarding teams. In addition, staff had access to the organisational ‘Safeguarding Children, Young People and Vulnerable Adults’ standard operating procedure (SOP), which included links, email addresses and contact details for the welfare team based on the camp, and local and regional external safeguarding agencies. Staff had the safeguarding app on their mobile phones. Safeguarding information was displayed in the clinical rooms and patient waiting room.

Patients identified as vulnerable had a recognised clinical code and alert applied to their DMICP record (electronic patient record system). The code was used to run monthly DMICP searches in order to monitor the number of vulnerable patients and to update the practice clinical register.

A vulnerable patient register was held in the restricted clinical area of SharePoint and only clinical staff and the practice manager had access; patients were identified on the register by their DMICP number only. All vulnerable patients were reviewed by the clinical team each month at the ‘ghost clinic’ and their clinical record updated at the time of the meeting. The SMO attended the Commanders Monthly Care Review (referred to as CMCR) meeting at which the care of vulnerable patients was discussed. There were no registered patients under the age of 18 at the time of the inspection.

We were given an example of how a vulnerable patient was successfully supported involving liaison with and transfer to civilian services.

For enhanced support, patients had access to the welfare team who were based in a separate facility in Haverfordwest approximately a 20 minute drive away. This arrangement was in place to reduce the stigma of access. In addition, the welfare team had space in the medical centre to see patients who did not wish to travel.

The availability of a chaperone was outlined in the practice information leaflet and displayed in the patient waiting area along with a list of staff who were trained chaperones. The role of a chaperone was discussed as part of in-service training facilitated by RHQ in August 2024. The mandatory consent/chaperone audit was completed in May 2024.

Although the full range of recruitment records for permanent 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 permanent staff were suitable to work with vulnerable adults and young people. DBS checks were renewed in accordance with DPHC policy. The vaccination status for staff members was checked on induction.

The practice did not have evidence of the full pre-employment checks for the locum employed since August 2023. The staff database was blank for the locum's DBS check, Official Secrets Act sign off and vaccinations.

The lead and deputy lead for infection prevention and control (IPC) were held by the practice nurses. The staff training database indicated that no staff in the practice had completed the IPC link practitioner training, an organisational mandatory training requirement for the IPC lead. The staff training database showed not all staff were in-date for the DPHC mandated annual IPC training. However, the Senior Medical Officer (SMO) had facilitated IPC in-service training for all clinical staff in May 2024.

Measures were taken to minimise the spread of infectious diseases, including regular hand washing assessed as part of IPC audit (February 2024). If a patient telephoning for an appointment was suspected as having an infectious disease, they were triaged by telephone. A separate entrance and 'hot area' were used to assess the patient. Sufficient personal protective equipment was available for staff to use.

A range of IPC audits had been undertaken throughout 2024. The findings and actions were discussed at the practice meetings. However, there was no system to capture the actions identified to ensure that they were being monitored and completed. In accordance with RHQ guidance, actions should be transferred to the Healthcare Assurance Framework (referred to as HAF) management action plan.

The practice manager oversaw the environmental cleaning contract. The cleaning log indicated monthly checks of cleaning were undertaken by the practice nurse in conjunction with a representative from the contracted cleaning team. According to the 'deep clean and curtain rota' register, the last deep clean was undertaken in June 2024.

A lead and deputy were identified to oversee clinical waste. Reviewed in May 2024, a local clinical waste SOP was in place. The medic who acted as deputy checked the rooms and clinical waste bins each week to ensure clinical waste was processed for collection on a Thursday. The records we reviewed showed a waste log was maintained and consignment notes were up-to-date. The last pre-acceptance healthcare waste audit was undertaken in August 2024. Secure storage for clinical waste was located outside of the building. Sharps boxes were labelled, dated, used and disposed of appropriately.

Risks to patients

Staffing levels was captured on the risk register as it was a key risk for the practice. Although fully staffed at the time of inspection, there was limited staffing resilience particularly if a member of staff left or was absent from the practice.

The current locum physiotherapist was due to start on a full time permanent contract in October 2024. Although not scaled for an exercise rehabilitation instructor (ERI), the SMO indicated that the addition of an ERI would be advantageous due to the high rate of service personnel downgraded with musculoskeletal injury.

Staff we spoke with suggested clinical staffing levels at the time of the inspection were sufficient to meet the needs of the patient population. All staff were DPHC employed aside from the 2 medics who were assets of the 14 Signal Regiment. The medics' primary role was to provide medic duties and to cover exercises for the regiment. When not required in

their primary role, they worked at the practice. The medics maintained a rota of their activity with the regiment, including a forecast of events and their annual leave, which enabled the practice manager to monitor their availability for the practice workforce. Whilst the medics contributed to the operation of the practice, it is noteworthy that their input at the practice was not guaranteed given their primary commitment to the regiment and that they could be recalled by the regiment at any stage.

The position for a 0.5 whole time equivalent administrator had been removed from the practice and the administration officer said this had impacted their workload, including access to cover when they were absent from the service. Due to personal circumstances, the practice manager worked remotely and spent 1 week a month at the practice. The practice manager was due to be based full-time at the practice when their circumstances changed. There was no timeframe for when this would happen. We highlighted that this arrangement meant the practice manager was limited in what they could achieve remotely and their absence placed additional strain on the team.

One of the practice nurses was military but the post was a non-deployable role so they were not expected to deploy. The practice manager and administrator managed their annual leave to ensure administrative cover. This was the same arrangement for the nurses and the 2 medics. If the SMO was away from the practice, GPRS was available or one of the doctors in the South Wales network provided temporarily cover. The option of employing a locum doctor was limited due to the short period of employment and remoteness of the location.

Each week the South Wales region (Brawdy, Brecon, St. Athan, Chepstow and Hereford medical centres) held a network meeting. This was attended by all practice managers, the regional area manager and was optional for doctors and nurses. Requests for staff support was raised during this meeting to cover any workforce shortfalls. The practice manager advised that the area manager was investigating options for the other medical centres to support with administrative tasks whilst the practice manager was working remotely.

The nurses were responsible for checking the emergency kit including the emergency medicines. Our review of the monitoring records, kit, gases and medicines showed checks were up-to-date. Prochlorperazine (medicine to treat motion sickness) was on order and all clinicians had been made aware. In accordance with DPHC policy, a risk assessment was held for emergency medicines not held at the practice. We noted that adult airways (size 3 and 4) had expired and the checklist indicated they were retained at risk until the practice received a replacement.

The emergency kit and medicines were stored in a side room when the building was closed. The risk register stated the air conditioning (AC) unit in this room was inefficient with temperatures reaching just below 25°C. This occurred at weekends when the AC appeared not to operate. The AC was checked and was working correctly. The emergency trolley was since moved to the medicines room at the weekends where there the temperature control was appropriate.

The staff team was up-to-date with basic life support training, anaphylaxis and the use of an automated external defibrillator. One of the nurses was trained in advanced life support. Recognising the deteriorating patient/sepsis training was delivered to the team in July 2024. Not all non-clinical staff attended the training. As the training session was recorded, we were advised that staff who missed it would be given access to the recording. Sepsis red flag posters were displayed in the clinical rooms. Staff had completed heat injury

training and non-freeze cold injury training was scheduled to take place in October 2024. Staff told us that scenario-based training or moulages were held on a regular basis, usually as part of the Wednesday afternoon team training. They provided a variety of examples of the topics covered. However, these were not always captured on the training register to illustrate the training topic, who attended and any lessons learnt.

Information to deliver safe care and treatment

Captured on the risk register, staff advised that loss of IT connectivity was increasingly more of a problem. When unplanned outages occurred, the practice deferred to the business continuity plan (BCP). In preparation for loss of connectivity, the clinic list was printed for the next day and clinical staff made paper notes which were added to DMICP when the system was back online. Although there were no recent incidences of prolonged outages, the BCP provided guidance to ensure continuity of care by facilitating remote clinics and leaning into the GPRS network for the South Wales region. The administrator worked on a stand-alone system so encountered fewer IT issues.

When new patients registered at the practice their records were summarised by the nurses. The 5-yearly summarisation of patient records showed 18% were outstanding. This had been acknowledged by the practice and added to the risk register. A plan was in place to address the backlog.

Arrangements were in place for the auditing of clinical record keeping. Records for nurses were audited by the nurses at Brecon Medical Centre. Although the position was vacant at the time of the inspection, the SMO's records were usually audited by the regional SMO. The physiotherapist was a long-term locum. Even though there was no process for the auditing of their record keeping, the Band 7 physiotherapist at St Athan Primary Care Rehabilitation Facility (PCRF) carried out a one-off audit in preparation for the inspection. The physiotherapist at Brawdy Medical Centre had not received a copy of this audit at the time of the inspection. We did note that a link to this audit was available on the audit schedule for the practice.

The medics described well-structured and comprehensive support following the daily triage of patients with minor illnesses. In the absence of a Regimental Medical Officer (usually the facilitator of supervision for the clinical work of medics), the SMO was providing ongoing support. Following the triage clinic, the medics presented each case to the SMO who encouraged them to critically appraise the course of action they took and consider whether alternative approaches could have been taken. The patient records were reviewed by the SMO as part of this process. Medics said the nurses were also available for support. The medics were aware of their clinical limitations and referred to the SMO or nurses if they believed they were triaging a patient outside of their scope of practice.

An SOP was in place for the management of samples and the nurses oversaw the process. A specimen register was maintained and used to monitor the status of each sample. Military transport was used to take the samples to the laboratory. The SMO reviewed all results. Patients were contacted by telephone to inform them of their results.

An effective process was in place for managing referrals including urgent 2-week-wait referrals and internal referrals. The practice had recently transitioned to the new DPHC centralised process for referral management. This provided a variety of functions to

support the monitoring of referrals, including an alert to prompt follow-up on the referral. The administrator oversaw and monitored the progress of referrals. Following receipt of a task from the SMO, the administrator added the referral to the system. In the absence of a system, such as the English NHS e-referral Service (known as e-RS), additional processes were in place to ensure the referral had been received and was being processed.

The physiotherapist managed their own referrals, such as those to the Regional Rehabilitation Unit (RRU). Referrals were tracked through a weekly virtual meeting with the RRU. Arrangements were not defined as to who would oversee PCRF referrals at the practice should the physiotherapist have a planned or unplanned absence from the service. We considered this a risk as the physiotherapist was a sole worker in the PCRF. After the inspection, PCRF referrals were added to the central referral management system so the administrator had oversight of these referrals.

Safe and appropriate use of medicines

One of the nurses was the lead for medicines management and the SMO was the deputy lead. Terms of reference were in place for these lead roles. As there was no dispensary attached to the practice, prescriptions were dispensed from a ‘local agreement pharmacy’. Prescriptions were written, signed, scanned and emailed to the pharmacy. The original prescription was then posted to the pharmacy. No dispensed medicines were held at the practice for patient collection.

Stock management and ordering were completed by nursing staff. Stock was appropriately checked in accordance with organisational policy. Items ordered were approved by the regional pharmacist. On receipt of new stock, the batch number and expiry dates were added to the paper invoice which was then filed. The medicines were entered into DMICP, including the batch number and expiry dates. We noted that plug sockets for the fridge did not have ‘Do not switch off’ notices displayed and highlighted this at the time of the inspection. The DPHC ‘Healthy Vaccines’ poster was displayed. Although vaccines were not usually moved from the practice, a reusable cold chain box was available should vaccines require transporting to another practice within the network.

A bound book held in the dispensary was used to record the receipt and supply of the FMed296 prescription forms which were held in a secure cupboard. Two staff signed the prescription forms in and out of the book and they were then stored in a locked drawer/cupboard in consulting rooms. Although the total was checked, a running total of FMed296 forms was not recorded. The lead said they would start recording the running total. The prescriptions for controlled drugs (medicines with a potential for misuse) were checked each month.

Copies of Patient Group Directions (PGD), which authorise nurses to administer medicines, were signed by the SMO and held electronically along with training certificates for both nurses. PGD audits had been completed and uploaded to the RHQ healthcare governance system. PGD medicines were issued directly to patient at the practice and the DMICP PGD protocol was used. Patient Specific Directions were not used.

The practice held a minimal stock of controlled drugs (CD). CDs were not delivered to the practice and no patient-dispensed CDs were stored. An SOP was in place for access to the CD cabinet and keys. The keys to the CD cupboard were held in a coded locked box in

reception, which was also in a locked room. Although the keys were signed in and out on loose sheets, best practice is to use a bound book and we highlighted this at the time of the inspection. A list of staff with access to the keys was in place. The SMO was responsible for the duplicate keys and held these securely.

When stock CDs were ordered and received they were entered in the CD book and locked in the cupboard; witnessed by both the nurse and SMO. They were added to DMICP and receipts were filed.

Prescriptions for CDs and accountable drugs were recorded in a hard bound book. Monthly and quarterly checks were completed appropriately. The external checks were undertaken with a Warrant Officer or more senior ranked person. Destruction certificates were in place and appropriately signed, witnessed and stored. A CD audit was completed in March 2024.

The GPRS network provided cover when the practice was closed. The shared remote cover was unable to obtain CDs from faxed or emailed prescriptions. We discussed this with the regional pharmacist as it particularly impacted Brawdy Medical Centre given there was just one doctor and the practice was closed on Fridays. From the evidence provided, we concluded there was no clear way to improve the cover for Brawdy Medical Centre. The regional pharmacist agreed that this issue would be captured on the West Wales Medicines RHQ risk register. From a patient perspective, the Brecon Medical Centre was the closest (2 hour drive) so the patient could travel to collect the CD prescription. If the need was urgent then the patient could attend A&E, a 20 minute drive away.

Patients prescribed high risk medicines (HRM) and those subject to a shared care agreement (SCA) were reviewed in the regularly held ‘ghost clinic’. The nurses carried out the DMICP searches prior to the clinic. Both the SMO and nurse reviewed the patients, which involved a check that appropriate tests had been completed and the SCA was being adhered to. The SMO updated the patient’s DMICP record and the nurse updated the clinical practice register. The ‘ghost clinic’ was being effectively used to regularly monitor the health status of patients prescribed these medicines. Although not captured on the audit log, the regional pharmacist completed a HRM audit for the practice in July 2024.

Patients were given the information leaflet for the medicine they were prescribed and were advised of any adverse effects. Specific information for HRMs was issued by the dispensing pharmacy. Anti-malarial warning cards were held at the practice for PGDs.

For repeat medicines, the patient submitted an eConsult. The SMO reviewed the request and issued the repeat medicine or requested a face-to-face consultation with the patient. The SMO reviewed secondary care prescriptions and made any necessary changes to the patient’s DMICP record.

There were defined processes in place for the ordering and receiving of vaccines. All vaccines were in-date and the vaccines were being correctly rotated in the pharmaceutical fridge. There was sufficient space around the vaccine packages for air to circulate. No food or specimens were held in the pharmacy fridges. The temperature of the fridges was monitored twice a day by the nurses when the practice was open. This was achieved using an external thermometer with a probe in a small eye dropper bottle of water.

The nurses conducted Valproate (medicine to treat epilepsy and bipolar disorder) searches each month for both male and female patients prescribed this medicine. We confirmed there were no patients prescribed valproate at the time of the inspection.

The SMO adhered to the Welsh government prescribing guidelines. They also referred National Institute for Health and Care Excellence (referred to as NICE), 'NB Medical Education' and 'GPnotebook'. Although the recommended (should) antibiotic prescribing audit was scheduled for quarter 1 (January – March 2024), this had not been completed. The SMO said the audit was planned and they had sought clarity from the Regional Quality Assurance lead as to whether a standardised search was in place for this audit. Being the only doctor in the practice, we discussed whether the SMO undertaking the audit was sufficiently objective.

The medicines lead advised us that they were well supported by the regional pharmacist with any medicine management related issues. The regional pharmacist visited the practice in August 2024.

Track record on safety

The practice manager was the lead for health, safety and fire prevention. They had completed the Institute of Occupational Safety and Health course in July 2024. Meeting minutes confirmed health and safety was a standing agenda item at the practice meetings.

A Safety, Health, Environment and Fire (referred to as SHEF) inspection was carried out by the health and safety department in April 2024. Although the actions from the SHEF inspection had been completed, they were not captured on a management action plan (MAP) or similar.

A fire risk assessment was conducted in October 2021 and lasted for 5 years. The assessment identified the evacuation procedure and drills were insufficient and the storage of medical gas cylinders was not suitable. These recommendations had not been captured on a MAP to ensure appropriate follow up. The observation regarding the evacuation procedure/drills remained outstanding at the time of the inspection.

The risk register indicated the '4 T's process' (transfer, tolerate, treat, terminate) were considered when managing risks. Both retired risk and transferred risk registers were maintained. Our appraisal of the registers indicated a review would be beneficial as some risks could either be combined, retired or transferred. The status of transferred risks would be clearer if captured on the main risk register rather than on a stand-alone register. A joint fault reporting log was in place for both the medical and dental centres. The log showed that all work service requests for 2024 had been completed. The risks and issues registers were reviewed quarterly. Outcomes of the meetings were documented in the healthcare governance workbook and in the issues log/risk register.

The range of clinical and non-clinical risk assessments for the medical centre were up-to-date for a review. The links to the PCRF risk assessments were not accessible on the healthcare governance workbook. All PCRF risk assessments were out-of-date for a review and some were no longer relevant to the service provided.

Data sheets were available for substances hazardous to health (referred to as COSHH products). It was unclear when some COSHH risk assessments had been reviewed as the master register stated 'needs updating' alongside a number of products.

The legionella risk assessment for the building was completed in June 2024. The last assessment was conducted June 2024 and was valid for 2 years. Water safety checks

were undertaken by the contractor and water outlets were last tested in June 2024. An electrical check was last conducted on the in February 2023 and was valid for 5 years. Evidence of a gas check was not available at the time of the inspection.

The practice manager was the equipment lead and one of the medics was the deputy lead. Clinical equipment was serviced annually by the medical and dental servicing section (a military capability referred to as MDSS). All clinical equipment was in-date for servicing and testing. An equipment inspection (referred to as a LEA) was undertaken in March 2024. The 3 non-conformances identified had been added to the management action plan for completion. Pre-user equipment checks (referred to as 373s) were printed at the start of each month and placed in each clinical room. A check of these showed that staff were regularly checking the equipment in the medical centre clinical rooms. Although 373 forms were available in the PCRF, they had not been completed as the locum physiotherapist had not been made aware of the need to undertake this task.

Wet globe bulb testing to indicate the potential for heat stress was not required as no PCRF-led outdoor physical activity took place and the gym was temperature controlled.

An integrated alarm system was in place in all clinical areas for staff to summon assistance in the event of an emergency. We tested an alarm during the inspection and staff promptly responded. Checks of the alarm were carried out with the most recent taking place in August 2024. Although we were advised lone working rarely happened, a risk assessment was in place should staff need to work alone in the building.

Lessons learned and improvements made

Significant events, incidents and near misses were reported and managed through the organisational-wide ASER system. All staff had access to the system. RHQ facilitated ASER training in March 2024 and 4 of the practice staff attended.

The ASER register showed 3 incidents were reported in 2024, all of which were closed on the system. We queried this low number and practice staff acknowledged that not all incidents had been reported through ASER. We were assured by the SMO that significant events/incidents related to clinical care or harm (including potential harm) to a patient was always reported.

The recognised underreporting was mainly in relation to infrastructure issues and system issues, such as IT outages and DMICP failure. Staff indicated that raising ASERs was time consuming and disheartening when numerous ASERs submitted had resulted in no change (at organisational level). As with the case of DMICP, we highlighted that routinely submitting ASERs supports with the identification of themes so the DPHC gain an understanding of the extent of issues.

ASERs were a standing agenda item at the monthly governance meeting. Prior to the meeting, the ASER register was reviewed in preparation. The outcome/lessons identified were captured on the register. Aware of limited ASER submissions, the staff team recently started discussing potential ASERs in more detail at the governance meeting. Following the discussion, it was agreed if the issue met the criteria for submission. Our review of meeting minutes confirmed that an ASER relating to IT was discussed and 2 others were raised following a recent meeting.

Staff were also encouraged to submit anonymised ASERs if they believed it was inappropriate to discuss the matter in a multi-disciplinary meeting.

Arrangements were in place for the management and actioning of alerts from the Medicines and Healthcare products Regulatory Agency and National Patient Safety Alerts received from RHQ via the Central Alerting system. We were unclear about how frequently alerts were checked. After the inspection, the area manager provided evidence to confirm the practice was monitoring alerts in accordance with regional guidance. The practice nurse checked for alerts each week and the monitoring of alerts was recorded on the Headquarters SharePoint. Alerts were shared with relevant staff via email from the SMO and were also discussed at the healthcare governance meetings. We were given an example of an alert recently discussed.

Are services effective?

We rated the practice as requires improvement 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, Specialist Pharmacy Services, clinical pathways, current legislation 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. A NICE tracker was maintained and new or updated guidance was discussed at the governance meetings. The Senior Medical Officer (SMO) maintained an electronic repository of evidence-based medicine.

Patients with complex or concerning needs were discussed at the ‘ghost clinics’. The SMO also had the option to discuss the treatment and care of patients with the SMO at Brecon Medical Centre.

We noted from our review of consultations for patients referred to the Primary Care Rehabilitation Facility (PCRF) that an assessment of lifestyle factors, such as mood, sleep and diet were not routinely recorded in the patient records. The locum physiotherapist was not familiar with the Defence Rehabilitation SharePoint or the full range of best practice guidance. Furthermore, they had not been shown where to find the guidelines.

The Musculoskeletal Health Questionnaire (MSK-HQ), the standardised outcome measure for patients to report their symptoms and quality of life, was not being used. Instead, the physiotherapist used the Functional Activity Assessment (FAA). Both the FAA and MSK-HQ are mandated patient-reported outcome measures in accordance with the DPHC standard operating procedure. The locum physiotherapist was not aware of this as they had not received a rehabilitation induction.

With limited patient-reported outcome measures to determine the quality of treatment and care, we referred to patient records and the DPHC patient satisfaction survey specific to the PCRF. Patient records indicated thorough and effective care was provided and all feedback regarding the patient experience was exceptionally positive.

The practice had secured the ‘Game Ready System’ (compression with cold therapy) and held ‘Game Ready clinics’. Although the impact of this clinic had not yet been formally measured, the increased availability of the treatment (all clinicians could use the system) aided recovery from acute injuries without the patient needing to wait for a physiotherapy appointment.

The PCRF was well equipped for the size of the facility and the equipment was well laid out. A business case had been submitted for equipment to maximise rehabilitation. For example, a cable machine had been requested to support end-stage shoulder rehabilitation to a higher level even though current modifications ensured patients received adequate care in this area.

Step 1 of the DPHC mental health pathway was delivered at the practice. The SMO used the ‘Staying Safe from Suicidal Thoughts’ formal risk stratification evidence-based process

to develop a 'safety plan' for individual patients. This was then used as a monitoring tool and also to advice the Chain of Command about a patient's risk and to inform the Vulnerable Risk Management system. Patients with complex/concerning mental health needs could be discussed at the 'ghost clinic'. Where appropriate, the safety plan was used to aid referral to the DCMH for patients requiring intervention beyond step 1 of the pathway. Our review of clinical records showed patients with a mental health need were very well managed and appropriate clinical coding was consistently used.

The SMO also used 'Getselfhelp.co.uk' to support learning and professional practice, and to signpost patients to cognitive behaviour therapy resources, including worksheets, information booklets and videos.

Monitoring care and treatment

The nurses oversaw the process for managing patients with a long term condition (LTC). Monthly searches were undertaken and DMICP showed patients due a review were recalled appropriately. The 'ghost clinics' were used for the nurses and SMO to discuss patients at which the LTC register and the patient's DMICP record were updated and a clear plan identified for each patient. Monthly chronic disease meetings were held, which the SMO and nurses attended.

At the time of the inspection, there were no patients with a diagnosis of diabetes. Over 40 health checks were provided and included a blood test (referred to as HbA1C) to check for pre-diabetes. Seven patients were coded as having pre-diabetes and they remained on the register for an annual review.

Twelve patients were identified as having hypertension (high blood pressure) and all had a record confirming their blood pressure was checked in the past 12 months.

Twenty seven patients had a diagnosis of asthma and 24 had an asthma review in the preceding 12 months. The asthma template within the chronic disease DMICP menu was consistently used. All patients were reviewed at the chronic disease meeting.

We reviewed a random sample of records for patients with an LTC and those with pre-diabetes. We identified no concerns as records showed appropriate recalls; monitoring and follow-up was up-to-date. Clinical coding was consistently accurate for all records we reviewed.

Audiometry assessments were in date for 84% of the patient population. A review of patient records indicated appropriate Hearing Conservation Programme recalls were in place and patients were being managed in line with DPHC policy.

Separate leads were identified for administrative and clinical audit. Quality improvement activity, including audit, predominantly comprised organisational mandated audits, data searches and routine checks. We looked at the 'audit and assurance check schedule' for the last 12 months. Links to confirm each audit had been completed were missing in many instances so we were uncertain as to whether they had been undertaken or the schedule had not been updated. For example, we reviewed the consent and cervical cytology audits. Both were of good quality but the latter audit was not included as a link on the audit schedule.

Clinical audit based on the needs of the patient population was limited. We were advised that the locum physiotherapist would start to undertake clinical audits when they were employed full time. The SMO confirmed they a rolling programme was in place for undertaking high risk medicines prescribing, antibiotic prescribing and consultation audits.

Effective staffing

The induction programme for locum and permanent staff was out-of-date. The practice manager had identified this and had added it to the management action plan for follow up. There was no evidence provided (hard copy or electronic) to confirm that each member of staff had completed the workplace induction programme. The lengthy induction document held by the practice was for all staff, including locums. It mainly focussed on generic elements of induction (some of which was not relevant to all staff) and not role specific elements. The physiotherapist received a practice-based induction. However, they had no rehabilitation-specific induction as there was no physiotherapist was in post when they started working there as a locum. Furthermore, there was no written rehabilitation-specific information available for the physiotherapist to reference. Following the inspection and prior to taking up the permanent position, the physiotherapist arranged to spend a day at PCRF Larkhill to gain a more detailed knowledge of Defence rehabilitation.

The practice manager was responsible for monitoring the staff training database and the area manager also conducted a weekly review of practice’s progress. Our review of the database highlighted numerous mandatory courses had not been completed by all staff and there was no clear system to address the shortfalls. However, we were unsure if staff had completed the training and the training database had not been updated. The practice manager was in the process of contacting Regional Headquarters to ascertain whether the database was accurate, and once confirmed, the plan was to prompt staff to complete the mandatory training if applicable. Providing staff with protected time to complete the training was being considered.

A comprehensive in-service training (IST) calendar was in place with training facilitated once a month. Records showed training sessions were provided this year on a variety of topics, such as peri-menopause, recognising sepsis, role of the chaperone and chronic pain management. Staff told us IST supported them with their continuing professional development (CPD) and revalidation. The physiotherapist reported attending regional rehabilitation IST training days and some weekly online training, though some of the online training was not physiotherapy related. In addition, staff were encouraged to complete CPD courses to improve practice outputs/outcomes and further enhance their skills. Clinicians were suitably skilled and clinically experienced to respond the needs of the patient population.

Clinical supervision was in place for most clinical staff, both in-service and within the region. For example, the nurses participated in the regional network for nurses and had access to group or individual supervision from the Senior Nursing Officer and nurses at Brecon Medical Centre. The SMO has access to support from other doctors through the GPRS Network. The medics were closely supervised by the SMO through the daily triage debriefs. They told us they were receiving good quality clinical experience and education at the practice.

Coordinating care and treatment

The practice had effective relationships with the regiment and welfare team, enhanced by regular attendance at the monthly Commanders Monthly Care Review meeting and quarterly Unit Health Committee meeting. The nurses had direct access to the laboratories to discuss any issues or queries regarding samples. Through shared care agreements, they also had well developed relationships with the retinopathy screening service, diabetic nurse and gastroenterology nurse.

The physiotherapist and SMO met each week to discuss patients and facilitated joint appointments with patients following surgery. These appointments were booked prior to the surgery to ensure patients were seen in a timely fashion. In addition, the physiotherapist held a weekly meeting with the Regional Rehabilitation Unit to discuss patients and referrals.

Patient records were structured in a format so the patient’s plan of care supported continuity in the event another doctor in the GPRS network needed to follow up in the absence of the SMO.

For patients moving to another Defence medical centre, a handover was provided to the receiving SMO, including a summary of care. Patients leaving the military were offered pre-discharge and discharge medicals. A summary of the patient’s clinical record was provided and patients were signposted to a range of civilian services. A ‘support for service leavers’ leaflet was available in the waiting area.

Helping patients to live healthier lives

One of the nurses was the lead for health promotion. A health promotion calendar and log were in place. A dedicated health promotion room was attached to the waiting area and included a range of displays and health promotion leaflets. At the time of the inspection, there was a display about heat illness and another about high blood pressure. Quick response or QR codes for both clinicians and patients were available to access health information. For example, a QR code was displayed for patients to access the NHS body mass index calculator. A camp-wide health promotion event was held in 2023.

The practice’s health promotion information was shared with the unit in a portable document format (PDF). It was electronically displayed around the camp so ensured up-to-date information was accessible to a wider audience. It also meant the health promotion refreshed monthly by the practice was consistent with the information displayed around the camp. With one central update each month, this integrated approach to health promotion had the potential to be adopted across DPHC.

Although the SMO saw patients with sexual health needs, patients were mainly signposted to the local integrated contraception and sexual health unit (referred to as iCaSH) or to ‘Frisky Wales’ sexual health for advice, contraception and testing/screening. Condoms and chlamydia testing kits were available in the waiting room.

Processes were in place to ensure patients eligible for national screening were recalled. DMICP searches were undertaken each month. At the time of the inspection, no there were no patients eligible for bowel, breast and aortic aneurysm screening

The number of women that had a cervical smear in the last 3-5 years was 30, which represented 81% of the eligible female population. The NHS target was 80%.

A system was in place to recall service personnel due vaccinations. The 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
- 91% of patients were in-date for vaccination against tetanus
- 98% of patients were in-date for vaccination against hepatitis B
- 96% of patients were in-date for vaccination against hepatitis A
- 97% of patients were in-date for vaccination against measles, mumps and rubella
- 89% of patients were in-date for vaccination against meningitis

Consent to care and treatment

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. In addition, they understood the Mental Capacity Act (2005) and how it would apply to the patient population group. Consent and mental capacity training was scheduled for the staff team in November 2024.

Our review of patient records showed that implied and formal consent was sought depending on the procedure. A consent and chaperone assurance check was carried out for the nurses in the first quarter of 2024.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

As part of the inspection, we received a large number of patient feedback cards who shared their views of the service. We also looked at the feedback submitted via the Defence Primary Healthcare (DPHC) patient experience survey. Collectively, feedback highlighted that staff were kind, empathic and patient focussed. Comments from patients suggested they were respected and listened to and were not rushed during consultations.

Staff provided various of examples of when the practice had 'gone the extra mile' to ensure timely and appropriate care, particularly for patients with mental health needs.

Involvement in decisions about care and treatment

Feedback consistently highlighted that patients were involved with planning their care; confirmed by our review of patient records and the use of informed consent.

A translation service was available but had not been used. Some staff were not aware of how to access this service and the practice manager said they would raise awareness with the team of the DPHC policy for the translation and interpreter service.

A practice nurse and the practice manager were the champions for carers. The carers policy was reviewed in May 2024. Information regarding carers was displayed in the waiting area and within in the practice leaflet. Carers were identified through the patient registration process, through the welfare team or opportunistically. A monthly DMICP search was undertaken for carers and the correct coding and alerts were applied to their clinical record. Carers were offered an annual flu vaccine, an annual health check and flexible appointments. Information was displayed describing what constitutes a carer and additional services available. Seven carers were identified at the time of the inspection.

Privacy and dignity

The reception area and waiting area were separate so CCTV was used to monitor the waiting room. If patients wished to discuss a sensitive issue or appeared distressed at reception, they were offered a private room to discuss their needs.

Patient consultations took place in clinic rooms with the door closed. Privacy curtains were available in all clinical rooms for intimate examinations.

The physiotherapist used an individual clinic room but reported there had been an occasion when an individual was using an adjoining room and the physiotherapist was able to hear the conversation. This was not reported as an ASER but changes were made to offset the diaries for use of the rooms to minimise risk of overhearing consultations.

Given the low number of clinical staff, accommodating a patient's option to see a clinician of a specific gender could not be met. The practice could offer the patient a chaperone or the patient could travel to one of the other practices within the South Wales network.

Are services responsive to people's needs?

We rated the practice as good for providing responsive services.

Responding to and meeting people's needs

The responsiveness and flexibility of practice staff to accommodate patient needs was a theme emerging from patient feedback. This included clinicians seeing patients during their lunchbreaks if needed. Patients deemed to be vulnerable were offered longer appointments. eConsult and telephone consultations had improved accessibility for patients. If the regiment needed to deploy at short notice the practice adapted its clinic times to meet the need.

With a waiting list of up to 18 months for referrals to ophthalmology, the administrator made contact with a local optician service to see if they could offer support. A process was agreed whereby patients referred to ophthalmology were triaged to determine if their needs could be met by the optician. Patients accepted were contacted directly by the optician and offered an appointment. Although an evaluation of this arrangement had not yet taken place, verbal feedback from patients was positive as they received treatment in a timelier way. We discussed the potential for this initiative to be raised as quality improvement project once a formal evaluation was completed.

In line with the Equality Act 2010, an access audit for the building had been completed. However, it had not been updated since the refurbishment in September 2023. The practice manager repeated the audit shortly after the inspection and it reflected the adjustments made as part of the refurbishment. To support the needs of people with a disability, an accessible parking space, automatic opening front door, accessible toilet and hearing loop was available. A statement of need had been submitted to install all doors with automatic opening. Clinicians were familiar with the new Defence Primary Healthcare (DPHC) transgender standard operating procedure.

Issued by the Defence Medical Services Regulator in April 2024, we asked about the Regulatory Instruction, 'Training for staff in learning disability and autism' and how it was being implemented. Staff were unaware of this instruction at the time of the inspection and said they would ensure it was followed up and the training sourced.

There was evidence that the practice responded to feedback from patients. For example, patients requested a water dispenser in the waiting room and the practice submitted a request to both the Quarter Master and DPHC.

Timely access to care and treatment

Feedback indicated patients were satisfied with the flexible access to appointments.

An urgent appointment with a doctor, nurse or medic could be accommodated on the same day. A routine appointment with the doctor could be facilitated within a week and with a nurse on the same day. In addition, eConsult was available and this process was mainly used for repeat prescriptions. Four appointments were available each week for

specialist medicals. These could also be facilitated remotely from Chepstow Medical Centre.

Patients with an urgent need could see the physiotherapist the next day and there was a wait of 1 week for a routine appointment. The Direct Access to Physiotherapy referral pathway (referred to as DAP) was available for patients. Although an audit of DAP had not been undertaken, the physiotherapist advised us that referrals were appropriate and waiting times indicated the demand was within capacity. The physiotherapy service was meeting its key performance indicators.

Due to the availability of just one doctor, home visits were not provided.

The patient information leaflet, and patient information board provided details about opening times and access to medical care out-of-hours (OOH). A duty medic was on call and offered advice and could refer the patient to the on call doctor, local hospital or suggest a routine appointment during clinic hours.

A board in reception outlined who was providing OOH and which practice was providing GPRS for the South Wales group network.

Listening and learning from concerns and complaints

Both the practice manager and Senior Medical Officer oversaw complaints, which were managed in accordance with the DPHC complaints policy. Both verbal and written complaints were recorded on a complaints log. Three complaints had been received since June 2022 and all had been actioned and closed.

Complaints was a standard agenda item at the practice meetings. Refresher training in complaints was scheduled for the staff team in September 2024.

The patient survey for June/July 2024 indicated 21% of patients did not know how to submit feedback or make a complaint. The practice manager advised that during this period the practice was awaiting the contractor to site new patient noticeboards. Therefore, no information was available in the waiting areas during the time the patient survey was undertaken. At the time of the inspection, patients were made aware of the complaints process through the practice information leaflet and information displayed in the waiting area.

Are services well-led?

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

Vision and strategy

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

> "Provide and commission safe and effective healthcare which meets the needs of the patient and chain of command in order to contribute to Fighting Power."

The mission statement for the practice was defined as:

> "The aim of the MTF [medical centre], Cawdor Bks [Barracks] is to provide a high standard of primary care to our entitled patients by working together as a cohesive multi-disciplinary team in an effective and efficient manner."

The challenges associated with clinical delivery at Brawdy Medical Centre have been longstanding. The main challenge being the rural and isolated location, which has impacted staff recruitment in general. Given the small size of the practice, there was limited resilience to cover staff absence. This was a similar picture for other small practices in the region.

To maximise resilience and led by a regional Senior Medical Officer (SMO), the GPRS South Wales group network was established in December 2020. Objectives of the GPRS included strengthening service resilience during times of staff shortage, sharing best practice and the use of collaboration to promote collective development. This initiative had been recognised as a regional quality improvement project (QIP). A weekly South Group telephone call was held to share information, policy updates, discuss GPRS and confirm shoulder cover. In addition, each medical centre provided practice updates for the area manager and SMOs. Although the regional SMO position was vacant at the time of the inspection, the GPRS continued to operate effectively.

To address environmental sustainability, the practice aimed to reduce the use of paper by communicating via email and the use of links and QR codes. Recycle bins were available.

Leadership, capacity and capability

The SMO was the designated clinical lead and the military practice nurse was the nominated deputy. Since taking up post in January 2024, the practice manager was working remotely except for 1 week a month when they were based at the practice. This was intended to be a temporary arrangement but due to unforeseen circumstances had continued longer than anticipated. From a leadership perspective and to support staff numbers, this was not ideal as some day-to-day practice management duties were being picked up by the administrator, which added to their already busy workload. As the practice manager had not worked in practice management for some time, they expressed an interest in attending a healthcare governance course for practice managers.

Practice staff described a good relationship with Regional Headquarters (RHQ) and the area manager visited the practice each month.

Culture

From patient feedback, interviews with staff and a review of clinical records, we were assured patients were central to the ethos of the practice. Even with limited resilience in staffing levels, the practice team were diligent with ensuring the needs of patients were met.

Staff spoke positively about the inclusive culture and strong collaborative teamwork. They felt respected, valued and empowered. In particular, the medics spoke highly of the clinical support they received and the experience and training opportunities they were receiving at the practice. All staff were included in ‘white space’ and social activities, including the contracted cleaning staff.

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. Staff said they would feel comfortable raising any concerns and were aware of the whistleblowing policy. They 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. The practice maintained a duty of candour log. The staff team completed duty of candour training in June 2024.

Governance arrangements

In line with the practice’s mission statement, we identified from the evidence reviewed and patient feedback that clinical care provision was effective and well managed.

A healthcare governance/audit board was available in the conference room to encourage team discussion. However, we identified shortfalls with underpinning practice-wide governance structures, of which the practice was aware. These included recruitment, staff training, equipment care, access to and use of the ASER system and underdeveloped improvement plans to monitor the progress of actions resulting from audits and other practice monitoring processes.

We were not provided with evidence of a practice business plan or practice development plan (PDP) to continually drive improvement. Utilising a PDP would enable the practice to demonstrate awareness of areas that require improving or further development. In addition, a PDP supports forward planning and timeframes for actions.

The healthcare governance workbook included a wide-range of governance information that was accessible to all staff, such as practice administrative and clinical protocols to

support staff in their roles. We noted that 3 protocols were out-of-date for a review. The practice manager was aware of this and had prioritised them for a review.

There was a clear staffing structure in place and staff are familiar with their roles and responsibilities, including delegated lead roles in specific topic areas. Terms of reference (ToR) were in place to support job roles, including staff who had lead roles for specific areas. Resilience was provided by appointed leads having named deputies. Not all staff had yet signed the annual review of their ToRs. We discussed with the practice manager the benefit of reviewing these to establish if any were missing and whether additional duties could be incorporated into each individual's ToR.

A 5-week rotation of a range of multi-disciplinary meetings/forums was established to ensure effective communication, information sharing and training for the staff team. These included a practice, healthcare governance and risk/audit meetings.

The last internal assurance review took place in April 2023 and the practice received a rating of limited assurance.

Managing risks, issues and performance

Risks identified for the service were logged on the risk register and kept under scrutiny through review at meetings. There was scope to improve how the risk register was structured and we discussed this with the practice manager during the inspection. We identified shortfalls with the review of risk assessments (RA). For example, all RAs for the Primary Care Rehabilitation Facility were out-of-date and RAs for substances hazardous to health were overdue for an annual review.

The Business Continuity Plan (BCP) was reviewed in January 2024 and had been standardised with other practices to cover all potential incidents that could affect the practice. The BCP had been exercised in real time when, for example, there had been DMICP outages. The practice did not hold the camp-wide major incident plan (MIP). The practice manager said they would confirm with the unit whether the medical centre was included in the overall MIP.

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. Staff appraisals were up-to-date.

Appropriate and accurate information

The DPHC electronic health assurance framework (referred to as HAF) was used to monitor performance. The HAF is an internal quality assurance governance tool to assure standards of health care delivery within Defence healthcare. Our review of the practice HAF indicated limited engagement across all key lines of enquiry (KLOE) and the self-assessment had not been updated since January 2023. Several links within the supporting evidence of the HAF were not accessible and no actions were in place for KLOEs graded as limited assurance. Although the staff found the HAF to be time consuming and

burdensome, the practice manager had identified a need for it to be reviewed to ensure active engagement with this required process.

We were advised that RHQ had encouraged all outstanding actions as a result of audit, inspections and outstanding tasks to be recorded within the HAF and monitored via the management action plan (MAP). The MAP was reviewed by the staff team at the 'Risk, Issues, Quarterly Audit and HAF Review meeting'. It had been updated in the lead up to this inspection, which demonstrated the practice had commenced recording actions from inspections, such as those from the equipment care audit.

Processes were in place to ensure compliance with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. Caldicott checks were undertaken each month with the latest completed in August 2024.

Engagement with patients, the public, staff and external partners

Options were available to prompt patients to provide feedback on the service. Complaints, suggestions and compliment forms were available for patients to complete. In addition, a book was available in the waiting area for patients to record feedback. A notice board in the patient waiting room provided patients with a response to their feedback.

Staff were encouraged to provide feedback at the scheduled monthly meetings and via the open-door policy. There was an outstanding action on the MAP to develop and distribute a staff survey.

The practice worked closely with the Chain of Command and welfare support services to ensure a collective approach to ensuring the health needs of the regiment and with supporting vulnerable patients. A practice nurse and a medic attended the unit health committee meetings.

Continuous improvement and innovation

Staff continually sought ways to improve the service. For example, the introduction of 'Game Ready System' clinic. In addition, the physiotherapist had reorganised the gym to improve the use of space.

There was 1 QIP documented on the QIP register. Notable practice we identified had the potential to be acknowledged as a QIP, such as the arrangement with the local ophthalmologist and the assessment/management of patients with a mental health need. Raising QIPs (or purple ASERs) and uploading them to the DPHC Healthcare Governance webpage showcases positive performance at the practice and also enables the sharing of good practice with other DPHC facilities. The practice acknowledged that this area needed further development. In addition, we identified that there was scope for the practice to broaden the approach to quality improvement by undertaking clinical audit based on population need.