Abbey Wood Medical Centre

Abbey Wood, Filton, Bristol, BS34 8JH

Defence Medical Services inspection

This report describes our judgement of the quality of care at Abbey Wood Medical Centre. It is based on a combination of what we found through information provided about the service, patient feedback and through interviews with staff and others connected with the service.

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

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Summary

About this inspection

We carried out an announced comprehensive inspection at Abbey Wood Medical Practice on 20 June 2023. We rated the service as requires improvement overall with a rating of requires improvement for the safe and well-led key questions and inadequate for effective. The caring and responsive key questions were rated as good. A copy of the previous report can be found at:

https://www.cqc.org.uk/dms

We carried out this announced focused follow up inspection on 26 September 2024. The report covers our findings in relation to the recommendations made and any additional improvements made since our last inspection.

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? – good

Are services effective? – good

Are services caring – good

Are services responsive to people's needs? – good

Are services well-led? – good

CQC does not have the same statutory powers with regard to improvement action for the Defence Medical Services (DMS) under the Health and Social Care Act 2008, which also means that the DMS 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 the DMS. DMSR is committed to improving patient and staff safety and will ensure implementation of CQC's observations and recommendations.

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

At this inspection we found:

- Patient feedback about the service was positive. It showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.

- The practice had good lines of communication with the unit, welfare team and the Department of Community Mental Health to ensure the wellbeing of service personnel.
- Safeguarding arrangements had been strengthened and staff knowledge tested. Policies detailed the codes to be used and in conjunction with the welfare team, vulnerable patients were reviewed regularly to ensure that their needs were being met.
- The arrangements for managing medicines, including the management of medicines given under patient group directives (PGDs) had been improved and staff had received relevant training. The appropriate authorisation for PGDs was documented and information had been made easily accessible.
- An ongoing catch up programme was in place to review patients on repeat medication and prioritisation had been given to those on multiple medicines. It was evident that the programme had addressed and reduced the historic backlog of reviews overdue.
- Processes around high-risk medicines had been strengthened and provided a coordinated approach and effective monitoring of patients.
- There had been a focus on mandated training for staff which was now up-to-date. Future requirements followed a planned schedule.
- The programme of internal audit had been expanded to include clinical audit based on patient population need/or based on national guidance. It was evident that this was driving improvement but could be further expanded to incorporate the work carried out by the nursing team.
- The processes in place to manage patients with long-term conditions (LTCs) were now effective and patients were recalled in line with Defence Primary Healthcare (DPHC) policy. The accuracy of LTC registers where coding issues had been identified was assured through audit.
- All staff could access the system to report an incident and were fully supported to do so. The systems and management of significant events were good. Although trained, some staff were not confident enough to make their own entries and would benefit from refresher training.
- The management of referrals was good with a robust process in place for monitoring.
- Patients found it easy to make an appointment and urgent appointments were available the same day across all departments including the Primary Care Rehabilitation Facility (PCRF).
- Governance systems had been developed since the last inspection and the benefit of additional non-patient facing doctor time had facilitated significant improvement. Information captured to monitor service performance had been scrutinised to ensure accuracy and relevance to the demographic.
- The medical centre benefitted from an inclusive leadership style, such that staff felt valued and able to contribute to improved ways of working. An inclusive whole-team approach was supported by all staff who worked collaboratively to provide a consistent and sustainable patient-centred service.
- Terms of reference were now in place to provide clarity for staff on their roles and responsibilities. These extended to all assigned secondary/lead roles.

- Staff were aware of the requirements of the duty of candour, (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). Examples we reviewed showed the practice complied with these requirements.
- The risk register was in accordance with DPHC policy and captured all risks for the practice. Risk resolution was now supported through escalation to region where local solutions could not be found.

We found the following areas of notable practice:

- The practice had contacted the Community Blood Transfusion service and a donor recruitment event was hosted and used as a health promotion opportunity. Another future event had been arranged. A 'woman's health day had been well attended and supported by keynote speakers. A new initiative that had recently been introduced was a 'healthier with nature group' booklet. As service personnel often feel isolated at Abbey Wood (no mess or social side), the booklet was used to sign post walking routes and information on the surrounding area.

The Chief Inspector recommends to DPHC

- Review the infrastructure of Abbey Wood Medical Centre and take actions to ensure it meets with good practice infection control requirements. This should include a sluice, the replacement of carpet in the consulting room and upgrading the sink to ensure compliance.

The Chief Inspector recommends to the practice:

- Further assess the lone working arrangements and monitoring of environmental conditions in the PCRF to ensure that risks are considered and minimised through mitigation.
- Strengthen the administration around specimen handling and tracking to make the system failsafe.
- Continue to improve the completion rates of and follow up to audiometric testing on eligible patients.
- Consider the need to include thermal injury, sexual health and emergency scenario training as part of the internal programme for staff.
- Continue to extend the clinical audit programme to incorporate quality improvement for the nursing team.
- Review the induction arrangements for the PCRF.

Dr Chris Dzikiti

Interim Chief Inspector of Healthcare

Our inspection team

The inspection team was led by a CQC inspector. The team included specialist advisors including a primary care doctor, a nurse, a physiotherapist, pharmacy technician and a practice manager. In addition, a new physiotherapist specialist advisor shadowed this inspection.

Background to Abbey Wood Medical Centre

Abbey Wood Medical Treatment Facility is a tri-service medical centre based in Bristol. It provides primary care to a practice population of approximately 1,300. Military personnel work alongside civil servants within an office-based environment, providing equipment and support for current and future operations. They are a contracted civilian practice, with the practice team all working for Hanham Health, a local GP practice. The demographic is different from most military medical centres with 63% of the patient population aged over 40 years. The patients are dispersed with a high prevalence of home working and downgraded personnel representing 25% of the patient population.

There is no dispensary at the practice, instead a local contract is in place for prescriptions to be dispensed by a pharmacy near to Abbey Wood.

The practice is open from 08:00 to 12:00 hours and 13:00 to 16:30 hours Monday to Friday. From 16:30 until 18:30 hours patients can contact Hanham Health which has a surgery located a few miles away. Outside of practice hours patients contact the NHS 111 service.

The staff team

Senior Medical Officer (SMO)	1
Civilian Medical Practitioners	4 (all part-time)
Operations Manager	1
Nurses	1 senior nurse 1 practice nurse
Senior Medical Administrator Medical Administrator	2 1
Healthcare assistant/receptionist Receptionist	1 1
Physiotherapists	2

Are services safe?

We rated the medical centre as good for providing safe services.

At the last inspection, we rated the practice as requires improvement for providing safe services. This was because of gaps found in the processes around the monitoring of vulnerable patients, safeguarding, high-risk medicines, risk register and health and safety. At this inspection, the practice was able to provide clear evidence to show that they had addressed these issues.

Safety systems and processes

The Senior Medical Officer (SMO) was the lead for safeguarding and terms of reference were in place to reflect this. All staff had received up-to-date safeguarding training at a level appropriate to their role. The medical centre had child and young adult safeguarding policies in place that included contacts for local safeguarding teams. These policies were regularly reviewed and updated with the last review carried out in May 2024. The policy now covered internal processes and was available for staff to access on SharePoint.

A vulnerable adults register was in place and was updated monthly by the administration team. In support of this, the practice also had a vulnerable patient policy. This policy detailed how to manage vulnerable patients and included obtaining written consent from the patient for inclusion on the register. New patient questionnaires were reviewed to identify vulnerable patients. Patients on the register were regularly reviewed by a doctor and had an alert on the system in line with Defence Primary Healthcare (DPHC) policy. Read coding had been updated for all vulnerable adults in accordance with DPHC policy. Not all staff were familiar with the safeguarding and DPHC standardised codes that should be applied but these were circulated after the inspection.

There was a dedicated safeguarding meeting held annually and staff reported that any safeguarding concerns would feature in the clinical and healthcare governance meetings held with more regularity. Primary care rehabilitation facility (PCRF) staff advised us that the SMO would feedback from welfare meetings if any concerns had been raised for any patients undergoing rehabilitation treatment. Safeguarding was also a standing agenda item at the monthly doctors' meeting. The practice maintained close links with Unit welfare. Patients on unfit live arms limitation were considered monthly with both the welfare and administrative team to ensure the review was up-to-date. Patients who did not respond to a recall were referred back into the welfare team. Department of Community Mental health patients were recorded on a separate register to ensure that they were being reviewed regularly whilst awaiting their appointment.

Safeguarding concerns were discussed at the monthly unit welfare meetings. The SMO attended along with SSAFA (the armed forces charity), the welfare team, padre, unit welfare officers and community support officer. Senior leaders for Abbey Wood attended twice a year. The practice also met weekly with the welfare team. As part of the inspection we spoke with a member from the welfare team who confirmed the practice had always responsive in helping with any patient who needed to be seen urgently.

We saw a safeguarding audit had been completed in May 2024. This looked at the confidence of the team with regard to safeguarding procedures. All staff agreed that safeguarding was everyone's concern and all knew who the lead was and felt confident in identifying safeguarding concerns. The team had not reported any safeguarding concerns in recent years and there were no children registered at the practice. To maintain knowledge, safeguarding had been added to the practice meeting agenda to keep staff updated with educational information and to maintain staff confidence in the identification and reporting of any concern.

Chaperone training was now in-date and recorded on the training log. There was a mixture of clinical and non-clinical staff who had received face-to face training through the training department at Hanham Practice as well as a more recent refresher training. A notice advised what staff would provide cover for the day. A list of chaperones was maintained on the healthcare governance workbook and the chaperone policy was displayed throughout practice. Use of a chaperone was always offered for intimate examinations. We highlighted that the list of chaperones was all female but there were male doctors who should be included.

Staff who acted as chaperones had received a Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. All staff were employed by the NHS and contracted to DPHC. Professional indemnity was held on the staff database and monitored by the practice manager.

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. Professional registration renewals were managed by the practice manager. On the day, the PCRF staff were added the list to ensure checks were made at regular intervals.

There was a dedicated lead and deputy in place for infection prevention and control (IPC), both had completed the IPC link training and other IPC training at Hanham Health Practice. The 'must do, could do' audit list from DPHC was not being used but annual IPC audits were undertaken. Actions required were consolidated into an action plan that charted progress until completion. It was clear that the lead was aware of IPC best practice guidelines. For example, general purpose bins were not foot operated and had no lid. Replacement bins had been requested. Outstanding issues that continued from when we last visited included carpet in the consulting room, no sluice and a non-compliant sink. These issues were known to the DPHC infrastructure team and were yet to be resolved. Although these did not conform to best practice guidelines for IPC, they were not presenting any immediate risk to patients or staff. No invasive procedures were carried out in the consulting rooms that were carpeted. There had been no significant events related to IPC recorded in the last 12 months. To support effective hand hygiene, a light box and disclosure solution was used at a staff meeting in December 2023. We highlighted that good practice is to have cleaning logs for the spirometer and ear irrigator; these were introduced after the inspection. We highlighted that the products used to clean the ear irrigator were classed as hazardous and should be stored in a separate locked area. This was actioned after the inspection.

Environmental cleaning was provided by an external contractor. A written cleaning schedule was in place and this was signed off to confirm that cleaning tasks had been completed in line with the agreed frequency. Cleaning standards were monitored by the practice manager and at the time of inspection, the practice was clean and free of clutter. A schedule was in place for deep cleaning to be carried out every 6 months.

Healthcare waste was appropriately managed and disposed of. Clinical waste was monitored daily and, when required, yellow bags containing waste were secured, labelled and locked in containers awaiting collection. Clinical waste was collected weekly and an annual waste audit carried out in August 2024 evidenced full compliance.

Risks to patients

Abbey Wood Medical Centre was providing 10 clinical sessions with a doctor for patients each week. Since the last inspection, the contract had been amended to include 2 protected sessions for the SMO. There was a good skill mix within the clinical team. For example, there was a doctor who undertook daily triage and a member of the administrative staff was trained as a healthcare assistant. The administration team had a broad range of transferable skills which facilitated daily tasks being distributed to all staff. The operations manager readily supported covering reception when required. All staff worked very closely with each other and could easily step into their role should there be unplanned or planned absences.

As staff were contracted to DPHC to provide a service, there was continuity of staff to ensure the safe running of the practice from Hanham Practice.

We reviewed the medicines on the emergency trolley and found they were appropriate and in-date. Defibrillators were located in the medical centre. Oxygen was stored safely and was readily accessible with appropriate signage in place.

Records showed all staff had completed basic life support training as an online course, this was to be supplemented with a face to face training session planned for October 2024. Staff had completed sepsis training in August 2024. The response to a medical emergency had not been tested through emergency scenario training. Although not mandatory, it is good practice to provide staff with the confidence in the rare event that they would be required to deal with a real life emergency. However, on the day of the inspection there was a medical emergency situation which was well managed.

Staff had access to emergency medicines and equipment in the practice. Daily checks on the emergency kit were carried out and the crash trolley opened periodically and items listed on a check sheet. Although there was no face-to-face training using the equipment, nursing staff had all signed the ‘equipment competency form.’ Medical gases were kept on the trolley as part of the emergency equipment.

There were leaflets in the waiting room about sepsis and all staff had received training. However, although planned and documented on an action plan, clinical staff had not received training in heat/cold illness. Following the inspection, the Senior nurse confirmed that this training had been arranged. Administrative staff were able to describe what they would do if a patient became ill whilst in the medical centre and there was guide for staff to refer to. Waiting patients could be observed at all times by staff working on the front desk.

PCRF staff were aware of the wet globe bulb test but it was not actively used on site due to the gymnasium being managed by civilians. No load carrying physical training was completed and in summer, doors were opened to control heat and allow patients to move outside as needed. As a result, no true measure of temperature was taken. Risk assessments were completed by the practice manager for the PCRF. Further detail should be added to reflect the dis-location of the PCRF, particularly in its lone working risk. This was also true for patient access and risk of medical emergency where limited support was immediately available from colleagues. Personal alarms were used but it was not guaranteed that these would be audible to colleagues in the building. This was being addressed through a fixed alarm being fitted and the interim workaround was for the PCRF to call the guardroom who would then call for an ambulance.

Information to deliver safe care and treatment.

New patients due to arrive at Abbey Wood were emailed a new patient questionnaire. When completed, this was submitted to the nursing team for scrutiny and summarising. At the last inspection, we found a discrepancy in the date for notes awaiting summarisation when compared to a search carried out on the day. When notes are not summarised, there is a risk that active conditions are not captured or coded correctly and systems to monitor patients may not be effective. In May 2024, the search had been revised to include notes not summarised in the last 5 years. On 1 July 2024, the practice identified that there were 698 sets of notes awaiting summarisation or overdue. On the day of inspection, we found that this had been reduced to 278 and the catch up programme continued with staff granted protected time to clear the backlog. We reviewed samples of notes that had been summarised and saw that the work was being done in a meticulous way correcting errors that had not been resolved at previous medical centres where patients had been registered.

A process was in place for the management of specimens. Samples sent for analysis were recorded on a spreadsheet and the request sent to the laboratory using a paper copy. Any result returned that was out of range was referred to the doctor. We reviewed examples from the spreadsheet that tracked all requests. Findings provided assurance that the system worked but there was scope to improve the recording and reporting to minimise the risk of a sample being lost. Although ASERs had been raised with the laboratories, we found an example where a result had been emailed from the laboratory instead of returned through PathLinks (an electronic system used to manage sample requests and results). This should have been raised as an issue with the laboratory as the email was sent to an individual who was not at work on the day. We found that missing results had been actioned but not always recorded on the tracking sheet so appeared outstanding.

Peer review of doctors and nurse DMICP (electronic patient record system) consultation records had previously been undertaken in September 2020 and included a notes audit. There was no evidence of an audit on the clinical notes made by the nurses. However, this had now been mandated and was included on the 2024 audit programme. The doctors met together for a weekly meeting at Hanham Heath Practice. In addition, some remote meetings and doctors' meetings were held throughout the year at Abbey Wood. The Senior nurse could access the lead nurse at Hanham Health Practice for support and clinical supervision and found this arrangement effective.

PCRF staff had recently carried out a clinical note taking audit and this was now programmed to be repeated annually. The physiotherapists had reviewed their own notes, we discussed that best practice would be to complete each other's and going forward with only 1 physiotherapist due to be on site, we discussed utilising other local PCRFs to aid with notes audits and peer reviews.

The management of referrals was clear, comprehensive and effective. The majority of external referrals were made via the NHS electronic referral system (eRS). A referrals tracker was maintained and 2 week wait urgent referrals were highlighted to make them easily visible. The referrals register was held in a limited access folder on SharePoint and was password protected. The register included both internal and external (secondary care) referrals.

Tabletop instructions were available to all staff, for example, on how to manage referrals, raising work services and raising business cases.

Staff confirmed that access to patient records was only occasionally a concern but did not pose a significant risk to continuity of patient care. In the event of a DPHC-wide outage, the medical centre would revert to seeing emergency patients only. Appointments were printed out at the end of each day for the following day and hard copy forms were held for use in this scenario and documentation would be scanned onto DMICP.

Safe and appropriate use of medicines

Systems were in place to ensure doctors signed repeat prescriptions before the medicines were dispensed and handed out to patients. There was an outsourced contracted pharmacy which reportedly provided a good service for patients and worked closely with staff. Patient information with pharmacy details was clearly displayed and there was an effective policy in place. A record was maintained of all prescriptions issued that made it easier to reconcile with the lists provided by the community pharmacy. We were not made aware of any delays in patients receiving medication.

We reviewed the notes of patients on repeat medicines and through a search, found 66% had a recent review recorded. The practice had focussed on reviewing patients on 4 or more repeat medicines; 82% had been reviewed in the last 12 months. A catch up programme was in place and highlighted that the number of reviews overdue was decreasing. We highlighted that the DPHC template was not being used but found that reviews had been Read coded appropriately.

There had previously been inconsistency in the system and procedures for the review of high-risk medicines (HRMs). We found previously that there was inconsistency in coding, alerting, recording of drugs as hospital only, and missing Shared Care agreements (SCAs). Medicines that required critical monitoring requirements were not always being completed in line with guidance. At this inspection, we found that the required improvements had been made. The HRM register had been updated and was reviewed regularly by the SMO. The local Trust was used as an excellent source of information and had good SCA protocols that detailed what monitoring was required for each individual patient. The shared searched were not being run in accordance with DPHC policy. However, we reviewed a range of patients on HRMs using a bespoke search that had

been designed by the SMO. We found this to be robust in picking up any patient on an HRM. Regular correspondence with the medicines optimisation team took place and patient recalls were in line with monitoring protocols.

There was an ‘’amber drugs register kept in the practice, (amber drugs are specialist drugs initiated by secondary care prescribers, but with the potential to transfer prescribing to primary care with written SCAs and according to the agreed process for the transfer of care). This was maintained by the senior administrator and covered whether there was a SCA in place, what monitoring was needed, how often and the date of last review/bloods.

There was only one controlled drug (CD) held at the practice (diazepam). Controls were in place to meet legal requirements but we highlighted that the format did not follow the standard operating procedure which made checking and accounting easier to follow. Although there had not been any recent CD destruction, staff were aware of the processes and paperwork and would seek advice from the regional pharmacist.

Blank prescription forms and pads were securely stored and there were systems to monitor their use. Records showed that staff recorded fridge and room temperatures; this made sure medicines were stored at the appropriate temperature. Staff were aware of the procedure to follow in the event of a fridge failure.

Patient group directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. At the last inspection we found that these had not always been appropriately reviewed and signed off by the SMO, and there was no evidence to show that all nurses had completed their training. Following the last inspection, the medical centre confirmed to us that training certificates were in place and all staff had previously received training and this was in-date. At this inspection we found that the actions taken had continued to be effective. Certificates were in place and templates used on DMICP. There was easy access to policy so nurses could view at the point of giving a vaccine. Individual PGD audits were completed, the most recent in September 2024. Patient specific directions were being used as a one-off to use up some vaccines that had a heat excursion following a fridge failure (therefore classed as ‘off licence’ cannot be issued under a PGD).

Track record on safety

There was a designated health and safety lead within the medical centre. Electrical, gas and water safety checks were regularly carried out including a full legionella risk assessment by an outside agency. These checks were coordinated through the safety, health, environment and fire (SHEF) team who had responsibility for the site. Certificates had now been made available to the medical centre and were in-date. A major fire risk assessment of the building was undertaken annually, the last one in October 2023. This was supplemented by annual visits from the Regional Warrant Officer and support from the onsite SHEF team. Firefighting equipment tests were current. Staff were up-to-date with fire safety training and were aware of the evacuation plan. There was clear signage to inform of the floor plan and emergency exit routes. Risk assessments had been undertaken for substances hazardous to health (referred to as COSHH).

We looked at the practice's arrangements for the provision of a safe service. A risk register was maintained but took account of the 'four T's' (transfer, tolerate, treat, terminate) to clearly indicate where and how risks were being managed. Risk was discussed as part of the healthcare governance meetings. There were 3 risk assessments in place for the medical centre - infection, prevention and control, infrastructure and lone working. These were discussed regularly with the local and DPHC infrastructure team. The practice had mitigated these risks as far as they could so had transferred each risk onto the regional risk register.

There were handheld mobile alarms in all rooms. There was a record in place to record that alarm checks had been completed. There were also alarms installed in clinical rooms but these were not audible, instead lights flashed outside of the room when an alarm was made. A request had been submitted for the installation of an alarm system. A special plug was used to send an alert message out should there be a sustained power outage.

A maintenance contract for equipment was displayed in the PCRF, all equipment was in-date for servicing. This included additional equipment located in the main gymnasium.

Lessons learned and improvements made

All staff had access to the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events and incidents. The medical centre carried out a thorough analysis of the significant events that had been reported. Staff understood their roles in discussing, analysing, and learning from incidents and events. We reviewed safety records, incident reports and national patient safety alerts. We saw that there were regular practice meetings where these were discussed. We saw that learning from the reported significant events was shared to make sure action was taken to improve safety in the practice. When there were unintended or unexpected safety incidents, we were told patients received reasonable support, truthful information, and an apology and were told about any actions to improve processes to prevent the same thing happening again.

From interviews with staff and evidence provided, it was clear there was a culture of reporting incidents. Both clinical and non-clinical staff (including PCRF staff) gave examples of incidents reported through the ASER system including the improvements made as a result of the outcome of investigations. For example, improving patient confidentiality in the waiting room. Quarterly trend analysis of significant events took place with the last conducted in May 2024. No trends had been identified from the 4 events recorded and lessons learnt had been acted on appropriately.

The practice had a system in place to distribute alerts from the Medicines and Healthcare products Regulatory Agency. Discussion took place at clinical meetings and was recorded in the minutes. We highlighted that registering to receive alerts into a group mailbox would remove the dependency on the 3 staff members registered to receive alerts.

Are services effective?

We rated the medical centre as good for providing effective services.

At the last inspection, we rated the practice as inadequate for providing effective services. This was because there was no structured process to review clinical guidelines, gaps in staff training, the patient recall process needed improving and bringing into lone with Defence Primary Healthcare (DPHC) policy and the audit programme being in need of development.

Effective needs assessment, care, and treatment

Clinicians had access through various channels to relevant and current evidence-based guidance and standards, including National Institute for Health and Care Excellence and the Scottish Intercollegiate Guidelines Network guidance. We had previously highlighted that due to time constraints and clinician availability, there was no regular or structured processes within Abbey Wood to review updates or discuss these with clinical colleagues to ensure evidence based best practice was updated in line with amendments and DPHC policy. This had been addressed with the introduction of a reinvigorated doctors' meeting schedule. Changes to organisational standard operating procedures and medicines updates were standing agenda items at healthcare governance meetings. Discussion included the local Integrated Care Board medicines optimisation updates and updates in clinical guidelines.

Primary care rehabilitation facility (PCRF) staff used functional activity assessments and the musculoskeletal health questionnaire to measure performance related to patient outcomes. The PCRF team were aware of best practice guidelines although there was no formal audit to evidence these were followed. Rehab Guru (an application used to provide a home exercise programme) was utilised and evidenced in the patient notes. The Department of Defence Rehabilitation website was no longer active but staff were aware of DDR pages on SharePoint and could access as required.

The PCRF area was a narrow space for all of the equipment but was sufficient for the normal working practice of having one patient in at any given time. Equipment available was appropriate for the treatment provided and had often been sourced through external funding. The main gym was in close proximity and provided the PCRF team with access to a wider rehabilitation space and more equipment.

The DPHC team produced a newsletter that was circulated to clinicians providing further information and a summary of relevant updates on clinical guidelines.

Monitoring care and treatment

The nursing team monitored patients with long-term conditions (LTC). The population manager facility (referred to as 'POPMAN') was used to identify patients with an LTC and audit was used to review the accuracy of these clinical searches. A spreadsheet had been created following last CQC visit which served as a cross check to the system data. A

review of this evidenced an effective system which matched with patients on DMCIP and the nurse felt there was sufficient time to manage the number of patients with an LTC. Where chronic disease reviews had been undertaken, they were of good quality and the appropriate templates had been used.

We searched the clinical system and it identified all patients coded as diagnosed with asthma had been reviewed in the last 12 months. The asthma control test score was only documented in half of the patients and the issue of the 'Asthma Management Plan' to the patient was reportedly done but had not been documented. We carried out a review of medication issued to patients and this indicated reasonable control.

There were 19 patients coded as diagnosed with diabetes. We found that 83% had a blood pressure reading of 150/90 or less (the target is 93%) and those with a blood pressure reading of 140/90 was 79% (target is 78%). A total of 71% had a last recorded cholesterol of less than 5 which is an indicator of good control.

Eighty-three patients were coded as having high blood pressure. Of these patients, 83% had a blood pressure reading of 150/90 or less (compared to the target of 80%)

Patients diagnosed with atrial fibrillation had been reviewed and each had had been assessed for the risk of stroke (CHA2DS2-VASc score). Those indicated as being at risk were on anti-coagulation therapy (blood thinning medicines).

There were 6 patients coded as having coronary heart disease. All of these patients had a blood pressure reading of 150/90 or less and all were taking aspirin or equivalent.

Patients presenting with a mild to moderate anxiety or low mood were assessed in accordance with the pathway and treated initially at the practice (step 1) or referred to the Department of Community Mental Health team if their clinical need was assessed as greater than what step 1 could provide. There were 10 patients coded as diagnosed with depression, 9 of these had received a review between 10-56 days following diagnosis. We saw that the patient who had not been reviewed within 56 days had been recalled on several occasions and had attended just outside of the 56 day target. There was a small number of patients diagnosed with a significant mental health issue, these had all been reviewed appropriately. The practice had identified coding issues so had undertaken a depression review audit in July 2024 to provide assurance evidence of newly diagnosed patients with depression undergoing a review within the target parameters. The audit identified coding errors external to the practice and issues with the template used. These had artificially increased the numbers on the register.

Audiology statistics showed 55% of patients had received an audiometric assessment within the last 2 years. The medical centre had previously told us that getting up-to-date with the audiometry testing had always been a challenge, and the backlog had increased during COVID-19 when assessments had been put on hold in line with DPHC direction. However the catch up programme was having a positive impact, 40% was the figure 12 months ago.

Since the last inspection there was evidence of clinical audit being added to the practice audit plan. An audit had been carried out for antibiotic prescribing in August 2024 to review choice of antibiotic, dose and duration were in in with the local formulary guidance. The

results confirmed that there was good practice around antimicrobial stewardship. We saw the most recent clinical audits included undiagnosed hypertension and follow up for newly diagnosed patients with depression. These were both first cycle audits to establish a benchmark for future repeated cycles. A register was in place of quality improvement activity. However, the audit cycle for the nurses was not clear on lessons identified and processes implemented having been reviewed. Although the DPHC mandated audits (cytology, safeguarding and infection prevention and control) were being completed, the audit plan for the nurses was limited and did not appear to be driving improvement.

PCRF auditing was happening although there was no structured programme. Note audits had been self-conducted and the results had not been discussed formally. However, we saw positive examples of actions taken as a result of the note audits. A recent example was an audit that looked at the body mass index (BMI) of patients and referral into the PCRF with 23% of the practice population having a BMI of over 30 (an indication of obesity). This project had yet to be completed at the time of inspection but was a good example of how audit was being viewed as tool to monitor and improve clinical output.

Effective staffing

At the last inspection it was highlighted that there was insufficient time allocated for doctors to complete clinical leadership work and essential administrative tasks. This had been addressed with protected time now built in for the SMO. This additional time consisted of 2 sessions per week for administration in addition to 1 afternoon for meetings and training.

The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. There were some desk top instructions in place for new doctors to refer to. There was no specific induction for the PCRF but staff told us that information was passed on informally.

The staff database showed that completion rates for mandatory training were high. The only training showing as not completed (operation inclusion training) had been planned for October 2024. Administrative staff had previously reported that they often undertook training at home as there was not enough time to complete all that was required and there had been no practice training plan to forecast and prepare for upcoming training needs. Staff spoke positively on how the situation had improved and time had been protected for mandated training. The practice manager maintained a central record of training that had been completed and emailed individual reminders when courses that required a refresher were close to expiring.

Clinicians had the appropriate skills for their role and were working within their scope of practice, for example 1 of the doctors was a Military Aviation Medical Examiner and 3 were trained to undertake diving medicals. Clinical staff kept up-to-date with their own continual professional development and revalidation. Performance appraisals were conducted by line managers for all staff. All doctors were in date for appraisal and all doctors and nurses had completed timely revalidation.

Staff were encouraged to manage their own personal development and were helped and encouraged to do so. For example, the senior administrator had trained to be a health care assistant and was trained in phlebotomy.

Coordinating care and treatment

The medical centre staff met with welfare teams and line managers to discuss vulnerable patients. Staff told us that they had forged some good links with other stakeholders, including the local NHS, social services, and voluntary organisations.

The PCRF reported no issues with wait times for referrals into the Regional Rehabilitation Unit (RRU) and Multidisciplinary Injury Assessment Clinic. There was no specific tracker for these referrals. However, patients were provided with a referral letter and advised to contact the practice in 2 weeks if they had not been contacted. Multidisciplinary team meetings were held and PCRF staff attended ad-hoc dependant on patients to be discussed. PCRF staff also reported on the flexible approach in the practice that often allowed for discussions to take place at the time when treating the patient. Regular discussions took place with the RRU.

For patients leaving the military, pre-release and final medicals were offered. During the pre-release phase the patient received an examination and a medication review. A summary print-out was provided for the patient and electronic notes were sent to the NHS practice. If the patient was deemed vulnerable, the medical centre staff worked with them and the welfare department to help them register and access the NHS services they needed. Hanham Health was a Veterans Friendly practice and the SMO was the veterans link person and had good knowledge of resources and patient's entitlements. There was a useful leaflet 'Leaving the Armed Forces, Support for your future Health and Wellbeing available to patients.

Helping patients to live healthier lives

The nurses shared the lead for health promotion. We saw information leaflets were available in the treatment rooms. There were notice boards located in reception; some example topics covered mental health fitness and blood pressure. There were opportunities offered to patients' partners to join them in the consultation for health care advise, for example nutritional advice for a pre-diabetic patient. Networking with Hanham Health Practice was seen to have been beneficial. The practice had contacted the Community Blood Transfusion service (no mobile unit anymore) and a donor recruitment event was hosted and used as a health promotion opportunity. Another future event had been arranged. A 'woman's health day had been well attended and supported by keynote speakers. It was planned for these events to be repeated. A new initiative that had recently been introduced was a 'healthier with nature group' booklet. As service personnel often feel isolated at Abbey Wood (no mess or social side), the booklet was used to sign post walking routes and information on the surrounding area.

The nurses had no specific sexual health training but were able to provide general sexual health support and advice. As the service was contracted, sexual health followed a

different pathway to most military medical practices. Patients were signposted to local sexual health services for procedures not undertaken at the medical centre.

All eligible female patients were on the national cervical screening database and had been recalled by the nurse. The latest data confirmed a 99% uptake, the NHS target was 80%. The practice had recently noticed 2 newly registered patients who were overdue a recall. These were raised as significant events and fed back to the previous medical centres at which the patients were registered. Regular searches were undertaken to identify patients who required screening for bowel, breast, and abdominal aortic aneurysm in line with national programmes.

An effective process was in place to recall patients for their vaccinations. The patient population included many patients who were not deployable so had developed their own set of key performance indicators through liaison with the Joint Personnel Administration team which had been agreed with the Regional Operations Manager. Vaccination statistics were identified as follows:

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

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

99% of patients were in-date for vaccination against hepatitis B.

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

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

99% of patients were in-date for vaccination against MMR.

88% of patients were in-date for vaccination against meningitis (only being administered where there is a specific need due to a shortage of stock)

Staff had a good understanding of the Mental Capacity Act (2005) and how it would apply to the patient population, all staff had received training in the Mental Capacity Act.

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. Clinicians advised us that implied consent was accepted for basic procedures such as the taking of blood pressure. Written consent was taken for more intimate examinations.

A consent form was completed in advance of the PCRF team delivering acupuncture, a photo of the form was taken and then sent to the administrative team to scan onto the clinical operating system.

Are services caring?

We rated the medical centre as good providing caring services.

Kindness, respect, and compassion

In advance of the inspection, patient feedback cards were sent to the medical centre. A total of 27 patients responded and feedback was positive about the care provided and the helpfulness of staff.

Patients could access the welfare team and various support networks for assistance and guidance. Information regarding these services was available in the waiting areas and the clinical staff were fully aware of these services to signpost patients if required. We spoke with the Unit Welfare Officer who reported that a member of the practice team (normally the Senior Medical Officer) attended the monthly Unit Health Committee meetings and maintained regular communication with the welfare service in between times which included attendance at any case conferences held. The medical centre team had a 24/7 phone line into the welfare team and reported any concern whether clinical or not.

Involvement in decisions about care and treatment

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

Patients identified with a caring responsibility were captured on a DMICP register. There was a practice leaflet which included information for carers and information on the notice board. Hanham Health Practice facilitated a carers forum and patients of Abbey Wood were able to use this too if they chose to.

The practice staff were a friendly and open team who treated everyone with the same level of respect. Patients identified as needing extra support to access the medical centre, for example, any patient with a phobia, had an alert on their notes to highlight to staff that they had special support requirements. There was information about the lesbian, gay, bisexual and transgender community outside the waiting room for patients to refer to.

Staff explained that they occasionally saw patients who spoke English as a second language. They could access a translation service if they needed it.

Privacy and dignity

Consultations took place in clinical rooms with the door closed. Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.

Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed, they could offer them a private room to discuss their needs. There was a radio playing to provide a sound barrier, phone calls regarding patients were only made in the closed office. All staff had completed the Defence Information Management Passport training which incorporated the Caldicott principles.

The primary care rehabilitation facility had a room with a room with a closed door and a mirrored window to offer patient privacy.

The mix of male and female staff allowed the medical centre to facilitate patients who wished to see a clinician of a specific gender.

Are services responsive to people's needs?

We rated the medical centre as good for providing responsive services.

Responding to and meeting people's needs

Appointment slots were organised to meet the needs of specific population groups. For example, the staff team reviewed the way that clinics were set up, meeting together to discuss how improvements could be made to make the process more efficient. This included a daily clinic co-ordinator who checked that all paperwork was correct and in place prior to the appointment. Forms were sent by email to the patient, in advance if appropriate, for the patient to complete before their appointment to save them waiting.

Patients were able to receive travel vaccines when required and the practice was a yellow fever centre. Eye care and spectacles vouchers were available to service personnel from the practice.

The practice manager was the lead for diversity and inclusion. There was good communication with the Chain of Command and nominated leads within the medical centre. An Equality Access Audit as defined in the Equality Act 2010 had been completed within the past year and the building found to be suitable. There was a notice board with information and contact details for patients in reception. The practice was aware of the requirement for staff training in learning disability and autism. The online courses had been added to the training timetable.

Dependant on the patient's clinical need, the option of a telephone or face-to-face appointment or eConsult could be offered. Telephone requests were added to a doctor's routine clinic as appropriate. Home visits were rare but could be accommodated if required. The practice had developed a wallet sized card that detailed websites where further resources could be accessed to support health and wellbeing. This was available in the patient waiting room.

Patients were able to make a direct appointment with a physiotherapist without having to be referred by a doctor.

Timely access to care and treatment

Details of how patients could access the doctor when the medical centre was closed were available through the station helpline, put out on unit orders and on the answer phone message. A brief was given by Senior Medical Officer to the team at Hanham Health Practice prior to prolonged periods of leave to remind them of protocols. If a patient were seen at Hanham Heath, they would try and get them seen by a clinician who worked at Abbey Wood. The team at Hanham Heath could refer to Department of Community Mental Health (DCMH) and had all the packs of all paperwork required. DCMH would accept email referrals from Hanham Heath if needed due to no DMICP access.

Details of the NHS 111 out of hours service was outlined in the practice information leaflet. Shoulder cover was provided by Hanham Heath until 18:30 hours, then patients were directed to the NHS 111 service.

Urgent doctor and nurse appointments were available on the day. Routine doctor appointments were available within 3 days. Routine appointments to see a nurse were available within 2 days.

Routine and follow up appointments with a physiotherapist were available within 2 days and urgent cases could be seen the same day. Continuity of care through the rehabilitation pathway was achieved by routinely booking patients in with the same clinician. Any handover was provided verbally as well as documented as a summary on DMICP.

Listening and learning from concerns and complaints

The operations manager was the lead who handled all complaints in the practice. The practice had implemented a process to manage complaints in accordance with the Defence Primary Healthcare complaints policy and procedure, 2 complaints had been recorded within the past 12 months and we saw this had been handled in accordance with policy and documented at each stage.

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

Are services well-led?

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

At the last inspection, we rated the practice as requires improvement for providing safe services. This was because of issues with capacity to carry out non-patient facing clinical tasks such as clinical meetings and shortfalls across the governance structure. Since the last inspection, the contract had been reviewed and 2 additional sessions had been added to allow non-patient facing clinical and governance tasks to be completed.

Vision and strategy

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

The overall medical centre mission statement was;

‘The aim of Hanham Health as a General Medical Practice (Community) is to provide the best possible health care for our patients while promoting better physical and mental health by offering a planned programme of health promotion and preventative care based on local and national guidelines.’

The medical centre also had their vision statement-

- To provide the best possible health care for our patients.
- To promote better physical and mental health by offering a planned programme of health promotion and preventative care based on local and national guidelines.
- To provide a comprehensive range of services both within the practice and by referral to other agencies.
- To ensure that the services are easily accessible, efficient and responsive to the needs of patients.
- To provide a professional, pleasant, safe, supportive and efficient working environment for everyone in the practice. To include all members of the team in planning and decision making by encouraging teamwork and good communication.
- To maximise the profitability of the organisation to ensure the best possible service to patients and fair remuneration to all members of the practice team.

Abbey Wood had taken steps to address environmental sustainability. For example, waste bins were available to segregate waste. There was an active quality improvement project to reduce the use of paper and printing.

Leadership, capacity, and capability

The practice had a supportive leadership strategy and vision that all staff championed. Staff reported feeling supported within their roles and listened to when suggesting change or raising concerns.

The staff team felt well supported by the regional team with the Senior Medical Officer (SMO) meeting monthly with them. They reported having good relationships and links with the Regional Clinical Director, the operations manager and the healthcare governance manager who were described as approachable and contactable. The practice manager had regular meetings with the area manager.

We saw that leaders recognised the challenges they faced in delivering a high-quality service to all patients at Abbey Wood. There was a clear leadership structure and staff felt supported by management, the SMO had addressed the issue previously highlighted with not having enough dedicated time to pursue the additional duties required. Clinical meetings had been reintroduced and there was now an established routine that included monthly doctor's, healthcare governance and practice meetings. Multidisciplinary team meetings were also held with the Primary Care Rehabilitation Facility (PCRF) team.

Culture

Staff continually looked at ways to improve the service for patients. All staff described an approachable and supportive leadership team that was committed to ensuring cohesion, equality, and inclusion. It was clear from discussions with staff that their contributions to the development of the service were valued. All staff attended the practice meetings where they could put forward suggestions or raise concerns.

We heard from staff that the culture was inclusive with an open-door policy with everyone having an equal voice, regardless of rank or grade. All were familiar with the whistleblowing policy and said they would feel comfortable raising any concerns. We interviewed a cross section of staff, and all told us that it was a happy place to work and that they could rely on their work team to discuss and mitigate any concerns they faced. They spoke about colleagues who were supportive, compassionate, and caring.

Staff wellbeing was given a high priority at the medical centre and several initiatives had been put into pace to support this. For example, a lunchtime walk and gym groups were organised on a frequent basis for the whole team. In addition, 'well-done Wednesdays' were used to recognise both individual and team achievements.

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. We were provided with examples of when duty of candour had been applied.

Governance arrangements

We found that the gaps and shortfalls across the governance structure had been addressed. A regular programme of practice meetings had been established, roles and responsibilities had been defined and an audit programme initiated included the Defence Primary Healthcare (DPHC) mandated programme and in-house clinical audits. The healthcare governance workbook (HcG Wb) was the overarching system used to bring together a range of governance activities, including the risk register, staff database and

standard operating procedures. Complaints and the quality improvement activity (QIA) were held on the DPHC SharePoint page in lists as mandated by DPHC Headquarters.

A QIA programme had been established for 2024/25. This included further clinical audits in key areas that had not yet competed including antibiotic prescribing and a notes audit.

Staff told us the practice leaders were approachable and took the time to listen to all members of staff. All staff were involved in discussions about how to run and develop the medical centre. Staff told us there were regular meetings and there was an open culture within the medical centre where they had the opportunity to raise any issues and talk openly. All staff were now invited to the healthcare governance meetings and that there was a set agenda for each meeting that included risks and issues, significant events, audit, team health and wellbeing, business resilience and mandatory training.

There was a clear staffing structure in place and staff had their own job descriptions (NHS). Individual and specialist terms of reference were now in place to support job roles, including staff who had lead roles for specific areas. Copies required signing by staff members, the practice confirmed that this had been done soon after the inspection.

A meeting schedule was established, and this included 3 monthly healthcare governance, safeguarding, practice and Unit Health Committee meetings. Quarterly meetings were held with DPHC Headquarters. Discussion at each meeting was recorded and made available to those unable to attend.

Managing risks, issues and performance

There was a current and retired risk register on the HcG Wb along with current and retired issues. The register articulated the main risks identified by the practice team such as the need to replace carpets in clinical rooms, infection prevention and infection control non-compliance (basins), and the infrastructure. These had now been transferred to the regional risk register and with workarounds in place, were not presenting any immediate risk to staff or patients.

Staff who were not performing would be supported initially to identify any underlying cause and implement support structures. If performance did not improve then formal performance management processes, would be followed. This was provided by an external human resources company.

The business continuity plan (BCP) had been reviewed and was exercised to ensure that staff knew what to do in an emergency. The BCP covered all the main risks to the service. And a ‘when activated report’ to document any learning.

Appropriate and accurate information

The HAF commonly used in DPHC services to monitor performance is an internal quality assurance governance assurance tool to assure standards of health care delivery within defence healthcare. All feedback following reports from audits or inspection were

highlighted in the ‘HAF management action plan’ to capture oversights and target areas for quality improvements and mapping actions were reviewed for each domain. Following on from feedback on the day, the leadership team had already addressed several issues which had been documented with action/timelines in place.

Engagement with patients, the public, staff and external partners

There were a few options in place to encourage patients to provide feedback on the service and contribute to the development of the service. These included a patient experience survey via a QR (quick response) code on all emails and a patient experience survey that was undertaken throughout the year. Recent results were positive about all aspects of care delivered by the medical centre. For example, 91% of patients said they were generally satisfied with their healthcare and 97% said they were able to access healthcare easily.

A ‘feedback tree’ was displayed in reception. Examples of changes made in response to patient feedback included the introduction of a confirmation email to confirm that prescription requests had been received, the introduction of confidentiality cards at reception to provide patients with the option to write what they would like to discuss or book an appointment and the introduction of a clinic co-ordinator to review the next day’s appointments to ensure the correct amount of time has been allocated. In the PCRF and following patient feedback, showers were installed in the changing rooms.

Continuous improvement and innovation

The staff team actively had the motto “How Can We Do Better.” Staff worked closely which each other and ensured all administrative staff had the skills to cover other staff absences. A tasking list was held within the main administrative office which was distributed amongst the team each day which ensured all responsibilities were covered. At 11:45 each day, all staff come together and checked that jobs had been completed and if not, staff worked together to get these completed. Clearly the staff cared about the medical centre and the patients, some of the staff had worked there for many years and were adaptable to changes/improvements to working practices.

We saw a safeguarding audit had been completed in May 2023 this looked at the confidence of the team with safeguarding procedures. A repeat cycle had been carried out in May 2024 and showed increased confidence in the safeguarding process across all staff at the practice. All the staff agreed that safeguarding was everyone’s concern and all knew who the lead was and felt confident in identifying safeguarding concerns but were less confident in the Abbey Wood processes for reporting of adult of child concerns. As result this has been added to the practice meeting agenda to keep updated staff to safeguarding issues and some educational information included to inform continued discussion.