Dishforth Medical Centre

Dishforth, North Yorkshire, YO7 3EZ

Defence Medical Services inspection report

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

Overall rating for this service	**Good**	
Are services safe?	**Requires improvement**	
Are services effective	**Good**	
Are services 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 of Dishforth Medical Centre on 10 December 2024.

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

Are services safe? – requires improvement

Are services effective? – good

Are services caring – good

Are services responsive to people's needs? – 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 the CQC's observations and recommendations.

This inspection is one of a programme of inspections the 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.
- Patient feedback about the service was positive. It demonstrated patients were treated with compassion, dignity and respect.
- Overall review of clinical records and processes to monitor care showed patients received effective clinical care. However, there were gaps with the monitoring of long term conditions.
- 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 who were vulnerable or had a caring responsibility.

- Although staff described an inclusive and supportive leadership style, team morale had declined over the last year mainly due to a shortage of staff. The Senior Medical Officer was pro-actively addressing this.
- Many of the governance systems underpinning the safe running of the practice were not up-to-date, including risk assessments, the Health Assessment Framework (HAF), standard operating procedures (SOP) and duty of candour.
- Medicines and medical products were well managed.
- Infection prevention and control audits were undertaken. Clinical waste was managed well.
- The building was not suitable as a healthcare environment. Even though the premises was clean, there was no formal process in place for monitoring the health, safety and environmental cleaning contract.
- The management of samples needed to be strengthened.

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

The Primary Care Rehabilitation Facility (PCRF) identified an ongoing trend of increased referrals post leave periods. Data was collected to determine if an increase in training load was the cause. Initial data collection from September to November 2020 indicated 42% of all patients referred showed evidence of a spike in training load. Of the training injuries, 60% had increased their training load. The 10 year average for referrals over the same timeframe was 72. From these findings, a change strategy was developed, including education of service personnel, Chain of Command and working alongside the physical training instructors. The referral for the same timeframe following this educational intervention reduced significantly to 39. The PCRF service evaluation for 2024 highlighted that the spike in loading as a potential cause of injury reduced from 39% to 23% over 3 years. This work was presented at the quality improvement forum and there was now wider work happening across Defence Primary Healthcare on this subject.

The Chief Inspector recommends to DPHC:

- Ensure current staffing levels are sustained to maintain governance requirements and to safeguard the health, wellbeing and morale of staff. Review the skill mix for doctors to ensure continuity of medical provision is maintained.
- Ensure improvements are made to the infrastructure and other facilities used by the practice to meet the standards of the Health and Social Care Act 2008: ‘Code of Practice about the prevention and control of infections and related guidance’, and to address the known access restrictions in accordance the Equality Act 2010.

The Chief Inspector recommends to the practice:

- Review and strengthen the processes for managing long term conditions (LTC) to ensure all patients are reviewed appropriately, and to identify patients with a potential

LTC. Ensure clinical staff are familiar with the processes and use the relevant DMICP templates and clinical coding to capture reviews for patients.

- To ensure the quality of care and patient safety, all governance systems should be reviewed and updated, including the Health Assessment Framework, risk management, SOPs and the duty of candour log.
- Ensure arrangements are put in place to monitor the safety of the premises, including a process to monitor the contract for environmental cleaning.
- For continuity and oversight, ensure secondary roles allocated to Regimental Aid Post or other military staff based in the building are supported by a DPHC member staff either acting as lead or deputy lead for the role.
- Review the process for sample management so it is streamlined to minimise the risk of errors. Ensure the pathway for the management of pathology results is clearly understood and followed by all clinicians.

Dr Chris Dzikiti

Interim Chief Inspector of Healthcare

Our inspection team

The inspection team was led by a CQC inspector and involved a team of specialist advisors including a primary care doctor, nurse, pharmacist, physiotherapist and practice manager. A newly recruited specialist advisor shadowed the inspection as part of their induction.

Background to Dishforth Medical Centre

Dishforth Medical Centre supports an approximate service personnel population of 1,500 for 3 units, either based at Imphal Barracks or within the surrounding area. Families are not registered at the practice.

Routine primary care and occupational health is provided by the practice along with a Primary Care Rehabilitation Facility (PCRF) for physiotherapy and rehabilitation. The practice has a dispensary.

The practice forms part of the ‘White Rose Network’ (referred to as ‘The Network’ throughout the report) along with Leconfield, Imphal Barracks and Leeming medical centres.

The practice is open from 08:00 to 16:30 hours Monday, Tuesday, Wednesday and Thursday and from 08:00 to 15:00 hours on Friday. The practice is closed each day for lunch from 12:30 to13:30 hours. Shoulder cover is provided by Leeming Medical Centre until 18:30 hours weekdays. From 18:30 hours midweek, weekends and public holidays patients are directed to NHS 111.

The staff team

Senior Medical Officer	One - civilian
Regimental Aid Posts [1]	**Regimental Medical Officers** 21 Engineer Regiment x 1 4th Regiment Royal Artillery x 1 **General Duties Medical Officers** x 3 **Combat Medical Technician (medics)** [2] 6 Regiment Royal Logistics Corps x 3 4th Regiment Royal Artillery x 4; Medical Sergeant post vacant 21 Engineer Regiment x 3
Practice nurses	Band 6 Band 5 Healthcare assistant – post vacant
PCRF	Band 7 physiotherapist Band 6 physiotherapist Exercise rehabilitation instructor
Pharmacy	Pharmacy technician - civilian
Practice management and administration	Practice manager - civilian Administrators – 2 posts full time; 3 posts part time

[1] A team of clinical staff attached to a unit/regiment. When not deployed, the team are based within the medical centre to support force health protection and to maintain their clinical currency.

[2] A medic is a unique role in the forces. Their role is similar to that of a health care assistant in NHS GP practices but with a broader scope of practice.

Are services safe?

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

Safety systems and processes

The Senior Medical Officer (SMO) and the Band 7 lead physiotherapist were the safeguarding leads for the practice. All staff were in-date for safeguarding training at a level appropriate to their role. Last reviewed in April 2024, a safeguarding standard operating procedure (SOP) was in place for children and adults which included links to external agencies. The regional nurse advisor organised a quarterly regional safeguarding presentation which was delivered in various ways to maximise staff attendance. In addition, the SMO indicated training was available from the local authority on current topics.

Although the practice had a vulnerable patients SOP, a vulnerable patients SOP for The Network had been developed at the end of November 2024. Clinical coding and alerts were applied to the DMICP (electronic patient record system) record for patients identified as vulnerable, care leavers and those under the age of 18. A DMICP search was established to check monthly for vulnerable patients and under 18s. There were 9 patients under 18 at the time of the inspection.

Vulnerable patients were discussed at the monthly clinical meetings. We were given an example of how the practice, welfare team and the Chain of Command had worked effectively together to support a vulnerable person during COVID-19.

The SMO described how the practice had developed links with the 2 local GP practices at which the families of the service personnel registered. This working relationship meant any safeguarding issues with family members were identified early.

The chaperone policy was reviewed in May 2024. It indicated that friends and family could act as chaperones. This was contrary to the DPHC SOP (G-19) which stated, “a chaperone is an independent person that is appropriately trained”. In addition, the SOP outlined that a relative or friend of the patient is not an impartial observer and so would not usually be a suitable as a chaperone. We were provided with a copy of the revised chaperone policy promptly after the inspection to confirm it had been revised to reflect the DPHC SOP. The availability of a chaperone was prominently displayed throughout the practice. Our review of patient records showed the offer/use of a chaperones was coded on DMICP, along with a record of the name of the chaperone and service number for military staff.

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 staff were suitable to work with vulnerable adults and young people. DBS checks were renewed in accordance with DPHC policy. A process was in place to monitor the professional registration and vaccination status of staff. All relevant staff had indemnity insurance.

The Band 6 nurse was the lead for infection prevention and control (IPC) and had completed the link practitioner training to undertake this role. All staff were up-to-date with mandated IPC training.

Measures were in place to minimise the outbreak and spread of communicable diseases. IPC posters were displayed detailing personal protective equipment and waste streams. Hand sanitiser was available at doors leading directly to the practice and appropriate equipment was available for bodily fluids spills and health care related waste. The practice followed DPHC SOPs in relation to isolation requirements, including the use of toilets, immediate action drill for sharps and splash injuries. We were given an example of an infectious disease outbreak that had occurred within the training wing at Dishforth. IPC procedures were immediately implemented and it was reported to DPHC Public Health and to the Chain of Command.

IPC audit to check compliance with the IPC SOPs was completed on a regular basis and action plans produced following an audit cycle. The audit was repeated every 3 months. The infrastructure was old and previously used as an accommodation block. It was not suitable as a clinical environment for many reasons, including non-compliance with IPC standards. The SMO advised that a new building had been considered in 2018 but this had not progressed.

The known IPC risks related to the infrastructure were identified on the risk register. We were advised that a statement of need had been raised for the taps to be replaced in clinical rooms. Cracks in clinical flooring had been reported and had been poorly patched up. It was indicated on the register that a risk assessment was due to be undertaken by the facilities manager. It was unclear if this had taken place.

As there was no gym in the Primary Care Rehabilitation Facility (PCRF) an allocated area within the unit gym was used by PCRF staff. The gym was not compliant with IPC standards and was not a DPHC asset so had been added to the risk register. IPC non-compliance was discussed at the unit's healthcare governance meetings.

It was not clear how the environmental cleaning contract was monitored to ensure the service was delivered in accordance with the contract. The cleaning standard was not displayed to indicate the level of cleaning expected for each room/area. Cleaning records were available, including for the PCRF gym.

The practice carried out some level of monitoring environmental cleaning through the IPC audits. For example, a previous audit identified the cleaner's cupboard was unclean, cluttered and mops were stored incorrectly. This was discussed directly with the cleaners and standards improved. This example indicated the need to instigate contract monitoring arrangements. Deep cleaning took place annually during the host units' standdown period. Cleaning resources were available for staff including spill kits and decontamination equipment.

Supported by an SOP, acupuncture was provided by the PCRF. IPC measures were taken with this procedure to minimise the risk of infection.

The nursing team oversaw clinical waste. A clinical waste log and consignment notes were in place and up-to-date. The most recent pre-acceptance audit, quarterly return and

summary report were all in place. Sharps boxes were labelled, dated and disposed of appropriately. Clinical waste was stored securely outside of the building, including pharmaceutical waste.

Risks to patients

The practice had experienced a turbulent year in terms of recruitment and retention of staff. The practice manager post had been vacant for 12 months with the position recently filled in September 2024. The SMO undertook the role of practice manager whilst the post was unfilled. The 2 practice nurse posts had been vacant until mid-2024; 1 post for 6 months and the other for 10 months. The health care assistant (HCA) post had been vacant for 5 months. This had been added to the risk register and recruitment to the post had commenced. The exercise rehabilitation instructor (ERI) was due to leave the service early 2025.

Although both the Regimental Medical Officers (RMO) were non-deployable, they could be recalled by the regiment for other duties. Staff reported that the medics were often unavailable due to unit commitments. The General Duties Medical Officers were supernumerary and were frequently recalled by the unit at short notice as well as requiring supervision by their respective clinical supervisors within the practice.

At the time of the inspection, staffing levels were adequate to meet patient population need. However, the mix of military and civilian doctors was not well balanced as the SMO was the only civilian. Relying on RMOs and the wider Regimental Aid Post (RAP) clinical team is a risk and an unreliable sustainable staffing solution. The RAP's primary commitment is to the unit and RAP staff can be recalled by the unit at any stage, including at short notice. At the time of the inspection, the HCA role was being undertaken by the medics. Leeming Medical Centre provided cover for the practice during periods when the practice was closed (standdown).

Practice meetings were used to identify and forecast upcoming gaps in the workforce. Staff reported they valued being part of The Network as there was the option to lean into other practices for support, particularly if short of staff. Where possible, staff leave was coordinated around the block leave periods for the units.

A full check of the medical emergency kit and emergency medicines was undertaken monthly or if the trolley had been opened/used. These checks were recorded. We were advised that daily checks of the trolley were due to be implemented. All medicines and emergency equipment was present and in-date. An emergency medicines risk assessment was completed in November 2024 for items not held on the trolley. Medical gas cylinders were stored alongside the emergency trolley and appropriate signage was in place. A regiment-owned automated external defibrillator (AED) was available in the unit gym.

The staff team was up-to-date with basic life support training, anaphylaxis and the use of an AED. Scenario-based training was periodically facilitated. A recent session involved treating a patient who had collapsed in the medical centre. Learning from this was mainly the recognition of access restrictions within the building.

Clinical staff had completed thermal injury training. We were advised there was not a requirement for spinal injury training above the basic medics' training. Both clinical and non-clinical staff had completed training so were familiar with the signs and symptoms of sepsis. Sepsis information was in displayed in the practice, including a handbook for recognising the deteriorating patient.

Information to deliver safe care and treatment

Staff reported that there had been a reduction in the number of DMICP outages in the last year with the exception of a major outage effecting all medical centres in November 2024. Although it had not significantly impacted patient care, the practice did not have a contact list of patients affected at the time of the outage. This had been identified as a learning point and it was planned to review the impact of this large scale DMICP outage at the next practice meeting.

Records of all new patients joining the practice were scrutinised for any outstanding alerts or issues. Monthly DMICP searches were undertaken to identify non-summarised or out-of-date records (up to 5 years). Staff acknowledged there was a backlog with summarisation. An audit completed in March 2024 identified 67% of records were out-of-date for summarisation. This was due to inconsistent staffing levels throughout the year, particularly in the nursing team. This issue was also identified at the internal assurance review (IAR) in September 2024.

The SMO reported that summarisation was a constant requirement due to the 30% turnover of patients every year. A plan was in place to reduce the backlog and records requiring summarisation had reduced from 500 (33%) to 400 (26%) due to the recent efforts of the practice nurses. The nurses had dedicated time to address the backlog, including during the Christmas holiday period. Furthermore, a nurse within The Network was assisting with summarisation whilst they were working from home.

The IAR made a recommendation about ensuring peer review/consultation audits for all clinical staff. Since then, the doctors had completed an audit of each other's records. One of the RMOs reviewed the notes for the SMO to ensure objectivity. The nurses had audited each other's record keeping. The RMOs monitored the record keeping for medics, as part of the supervision of medics to ensure they maintained currency. Records showed that the PCRF team regularly undertook consultation audits with the most recent carried out shortly before this inspection. Our review of the record audits demonstrated a clear and accurate record of healthcare delivery in accordance with professional standards.

The IAR identified the pathology process was not failsafe. Staff confirmed this was mainly due to errors generated from the local laboratory. The nurse had arranged a meeting with the hospital laboratory manager. Regional Headquarters were also involved and had raised a 'quality alert' to NHS pathology laboratory management. This matter was ongoing and not just limited to Dishforth Medical Centre as it has been recognised nationally as a concern in some regions. A headquarters working group, including the regional patient safety lead, was monitoring this as DPHC does not have an interface with the NHS system for pathology. While there were work arounds, no solution had been found.

To mitigate the risk, the status of samples was being constantly monitored. Tests were followed up if any delays occurred and significant events had been raised where appropriate. Copies of paper forms were retained to ensure that all tests requested had been returned. A results audit had been completed and an action plan developed. We discussed the benefits of a monthly audit to identify the numbers of patients needing to be recalled for repeat testing due to lost or non-processed samples as this would support the quality alert.

Seven SOPs were in place for the management of samples and results. We highlighted that condensing these into 1 SOP would be more streamlined and strengthen the failsafe process. Nurses reported it was time consuming rectifying or addressing the work of doctors, such as doctors not fully completing pathology forms. The extra burden on nurses could lead to tests being missed, therefore compromising patient safety.

The pathway to ensure results were checked by an appropriate clinician was not clearly understood by all staff. We heard that the General Duties Medical Officers (GDMO) were allocated time to check all the pathology reports and, in the absence of a GDMO, the nurses checked the results. The doctor who requested the test was then sent the results. Other doctors we spoke with said they only checked the results they requested.

Patients were asked how they wished to be informed of an abnormal pathology result; either email, via text or a telephone call. Normal results were not routinely shared with patients unless the patient requested so. Test results requiring follow up were usually managed by a telephone call or a face-to-face appointment.

An effective system was in place for managing both internal and external referrals including urgent and 2-week-wait (2WW) referrals. Overseen by the administrative team, the practice was using 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 and the ability to transfer details of the referral if the patient moved to another practice.

Most external secondary care referrals were made via the NHS e-Referral Service and some referrals were sent by email, such as those to radiology. The status of referrals was reviewed twice a week and the system updated accordingly. A review date was set for 4 weeks after the patient's appointment date and referrals requiring follow-up were highlighted in red. The system showed that urgent and 2WW referrals were given priority and patients were seen within expected timeframes. Outcome letters received from secondary care were dated, stamped and passed to the doctor for review. They were then scanned to the patient's DMICP record. Patients who failed to attend their secondary care appointment were followed up and the matter passed to the Chain of Command if necessary.

Patients were referred to the Defence Medical Rehabilitation Centre at Stanford Hall for diving chest X-rays as these were not provided by the NHS. Clinically required radiology was provided by the hospital in Northallerton. As a 'wet signature' was required on the request forms, the administrative team oversaw the process to ensure the form was signed, scanned and emailed to the hospital.

The physiotherapists monitored their own referrals. A caseload tracker was in place with tabs to indicate patients who had been referred. It was reviewed monthly at the caseload management meeting.

Safe and appropriate use of medicines

The SMO was the lead for medicines management and the pharmacy technician (PT) was the deputy lead. The SMO's terms of reference indicated the PT had delegated responsibility for dispensing in line with DPHC's medicines management policy. One of the nurses oversaw medical supplies.

Military prescriptions (Fmed 573 and Fmed 296) were managed and stored securely. An Fmed 296 register was established and we confirmed the stock logged on the register matched the stock held in the dispensary. The supply criteria was being met except for the supply of Fmed 296s, which was recorded as signed out to a prescriber's room via reception. For safety reasons and to ensure an audit trail, we discussed with the PT that they consider the prescriber signing out on the Fmed 296s rather than going via reception.

The dispensary SOP contained information on how to access the dispensary keys including when the PT was absent. We discussed with the PT that it would be supportive if staff with access to the dispensary signed off that they had read and understood the dispensary SOPs, such as the SOP for temperature monitoring.

Controlled and accountable drugs (medicines with a potential for misuse) were stored in the controlled drugs (CD) cabinet. The CD keys were kept in a safe and records showed the combination was changed every 6 months. A spare key was kept in a signed sealed envelope in the CD safe. All prescribers and nurses had signed to confirm they had read the CD SOP and a register was maintained each time a clinician accessed the dispensary and CD cabinet.

Monthly and quarterly CD checks were carried out in line with policy. NHS primary care prescriptions (FP10) were checked as part of monthly and quarterly CD checks. We checked the records for the transaction of 3 items in the registers and they matched the DMICP record. A CD notice of delegation was available and had been signed by the Commanding Officer, SMO and PT. The destruction certificates we reviewed were in accordance with policy and had been signed by the duty officer and SMO. A CD audit for 2023/24 had been completed and no issues were identified.

The PT was the lead for the cold chain and a practice nurse deputised. The 2 new pharmaceutical fridges were in accordance with policy. The PT ordered vaccines in response to requests from the nurses. A minimum stock of vaccines was held due to on-going deployments. Vaccines were recorded on DMICP and our check of the fridges showed all were in-date. Stock was rotated appropriately with longer expiry dates to the rear of fridge. Based on our review of 6 months of records, fridge temperatures were correctly monitored and were in range. Thermometers were in-date. The batch numbers and expiry dates on DMICP matched the stock present for cold chain medicines and those held in the ambient cabinet. Approved insulated boxes to maintain medicines at a stable temperature were held for use in the event of a power failure.

Patient Group Directions (PGD) to administer medicines in line with legislation were used by the nurses. Although we did not see training certificates, the nurses reported that their PGD training was current. PGDs had been signed off by the SMO within the last 2 years and the nurses advised that no delegation under PGDs occurred. We reviewed a range of DMICP consultations undertaken by the Band 6 nurse and all followed the DMICP PGD protocol. A PGD audit was completed for 2023/24 and no issues were identified. Patient Specific Directions (PSD) were used by clinicians, including medics. Our review of patient records showed the consultation was recorded by the doctor and the medicine administered on the PSD.

Repeat prescriptions could be requested via forms available on the pharmacy noticeboard and the repeat prescription mailbox. No telephone requests were accepted. There was a 48-hour timeframe to turnover prescriptions but often they were completed sooner. When the PT was absent from the service, the administrative team checked the repeat prescription mailbox and tasked prescribers for follow-up. If there were no concerns after the authorised number of repeat prescriptions had passed, and the review was still in-date then the PT tasked the doctor to review the patient and provide a prescription. If the medicine review was out-of-date then the PT advised the patient to make an appointment for a review.

A process was in place to monitor high risk medicines (HRM), including regular searches to identify when blood tests were due and to identify if newly registered patients were prescribed an HRM. The PT had a range of information cards for HRMs if required by the prescriber. Our review of a selection of patient records showed HRMs were well managed in line with DPHC requirements for monitoring. There was 1 patient prescribed a medicine that required a shared care agreement (SCA) and the SCA was accurate and up-to-date. HRMs were effectively monitored to regularly review the health status of patients prescribed these medicines. They were monitored through consultations, alerts and the monthly clinical meeting at which every patient prescribed a HRM was discussed.

The PT attended the practice clinical meetings, as part of the monthly review of patients prescribed an HRM. Directed by the SMO, the PT was involved in the routine system searches to identify patients requiring a medicines review and this had contributed to the resulting outcome of 100% compliance for reviews. The PT reviewed patients who had not been contacted for or requested a medicine review and forwarded this information to the prescribers to action.

Expiry reports were in place for the last 3 months for different stock areas, including cold chain, the dispensary, PGD stock and the doctors' stock.

All prescriptions were signed before dispensing. We observed the PT effectively counselling patients about their medicine, including responding to any patient questions. Prescriptions were dispensed with the patient information leaflet. In addition, the SMO said they provided patients with advice on side effects and referred patients to the electronic medicines compendium website for further information.

Patients who failed to collect their medicine, such as antibiotics within 3 days, were contacted by the PT, the issue highlighted to the SMO and a record made on DMICP using the 'not collected' clinical code.

Staff followed the practice SOP for the scanning of correspondence for the prescribing of medicines from secondary care. Scanned letters were tasked to a doctor for review. In addition, the DPHC 'Total Triage' SOP provided the facility for patients to book an appointment with a clinician/prescriber. The aim of Total Triage was to remove pressure from reception staff by experienced clinical staff swiftly identifying which care pathway the patient should take.

Communication was generally received for patients who were prescribed medicine out-of-hours, including those who attended A&E or a walk-in-clinic. It was also the responsibility of the patient to inform the practice if they had been prescribed medicine by another service.

Routine DMICP searches for patients prescribed Valproate (medicine to treat epilepsy and bipolar disorder) were undertaken with the most recent conducted in December 2024. The PT was aware of the considerations and action required for patients prescribed this medicine.

The latest antibiotic audit was completed in September 2024 by one of the GDMOs. It looked at 21 antimicrobial prescriptions. Only 51% adhered to the current guidance (or had a documented reason why this was not adhered to). This indicated 49% of prescriptions had not followed the guidance and it was identified that all had been prescribed by a locum doctor who was no longer working at the practice. Although the audit was due to be repeated in 12 months, we discussed whether it would be valuable to undertake a further audit in 6 months.

Track record on safety

The SMO was the risk owner for the practice and the practice manager was the risk manager. One of the medics was the lead for health and safety (referred to as SHEF) and the practice manager was the lead for equipment. The medical centre shared the building with the 6 Regiment Royal Logistic Corps (RLC) and a corporal from the RLC was the building custodian and fire representative. Whilst acknowledging a period of vacant DPHC posts and a reliance on RAP staff, we highlighted that it would be more appropriate for continuity and oversight by the practice if a DPHC staff held a deputy lead role alongside military staff with lead roles.

The risk management policy for the practice was updated by the SMO in December 2024. In accordance with DPHC requirements, a range of risk assessments were in place and these were last reviewed in April 2023 so were overdue a review. They took into account the DPHC '4 T's process' (transfer, tolerate, treat, terminate) to illustrate at what level each risk was being managed. For ease of reference, we highlighted that including the '4 T's' for each risk identified on the risk register would be useful. The SMO agreed that this would be actioned.

The SMO and practice manager oversaw the risk register. We identified risks that were not included on the risk register, such as medics holding lead roles, the vacant HCA post and taps not compliant with IPC standards. The practice manager provided evidence to confirm that the risk register was updated following the inspection.

The SHEF lead was new to the role and was unable to confirm whether health and safety checks of the building were undertaken. Equally, practice staff we asked were unable to confirm how the infrastructure was monitored. This oversight likely related to a DPHC member of staff not having a lead or deputy role to prompt oversight of SHEF.

The detailed risk assessments for the PCRF been written by the physiotherapist but not signed off. Usually the SMO is responsible for sign-off but they had not completed the higher level risk assessment training. Equally, the physiotherapist had not completed the course. Although the physiotherapist was holding the risk, this had not been formally confirmed by Regional Headquarters.

The SMO had completed the risk assessments for substances hazardous to health (referred to as COSHH) and safety data sheets were held for each COSHH product. Risk assessments were reviewed annually or if there was a change to the products used. Cleaning staff were responsible for monitoring the COSHH products they used.

Processes were in place for the regular monitoring of utilities. The gas safety certificate was issued in July 2024 and the electrical inspection certificate in October 2021. The legionella risk assessment was carried out in November 2023. Taps that were infrequently used were flushed weekly.

The 5-yearly fire risk assessment for the premises was completed in May 2022. Weekly and monthly checks of the fire alarm system and firefighting equipment were up-to-date from September 2024. Prior to this date there were large gaps in the checking of fire equipment, including the weekly fire alarm checks. These gaps had not been identified by the practice, which possibly related to practice staff not having a lead role for fire so therefore not having oversight of the building fire arrangements. A fire evacuation drill was held annually with the most recent taking place in September 2024.

The practice manager was the lead for equipment. The actions identified from the 2023 annual equipment inspection (referred to as a LEA) for the medical centre had been completed. An LEA was undertaken in November 2024 and the practice had not received the report at the time of the inspection. Electrical portable appliances were tested (referred to as PAT testing) to ensure equipment was safe. A training log was in place to show staff were competent in the use of all clinical equipment.

The ERI managed equipment for the PCRF and records confirmed the ERI inspected the equipment each month. The physical training instructors assisted the ERI with the maintenance of the gym equipment. We found that overall the process for monitoring PCRF equipment maintenance was not robust. Although a generic certificate of servicing was available, it did not provide detail as to which specific items of equipment had been serviced. This information was requested and provided as evidence promptly after the inspection. Our review indicated that some items had been missed for servicing. The PCRF tagged this equipment as ‘out-of-use’ and a further service was arranged for January 2025.

In-date SOPs were available for use of the gym and heat illness. Wet globe bulb testing (WGBT) was undertaken in the gym to indicate the potential for heat stress. WGBT readings were recorded by gym staff and displayed. There was air conditioning in each room of the PCRF.

An alarm system was in place for staff to summon assistance in the event of an emergency. We activated a few of these off throughout the day to establish if they could be heard in all areas and staff responded promptly. We were advised staff rarely worked in the building on their own.

The lone working risk assessment (May 2024) did not reflect current arrangements so the practice manager promptly updated this following the inspection. Personal alarms were used by the PCRF team when using the unit gym. In addition, CCTV in the gym was linked to the guardroom and there was always a duty physical training instructor available.

Lessons learned and improvements made

The practice worked to the DPHC policy for reporting and managing significant events, incidents and near-misses, which were recorded on ASER (organisational-wide system for reporting significant events). All staff had completed ASER training to access the system. One of the practice nurses was the lead for ASER and the practice manager deputised.

An ASER register was established. We discussed 2 that were still active and the practice manager confirmed after the inspection that these had both since been closed. For completeness and ease of reference, we highlighted that it would be beneficial if the outcome/lessons learnt for each ASER was recorded on the register. ASER was a standing agenda item at the practice meetings. Meeting minutes from October 2024 showed ASERs were discussed and changes made if appropriate.

All staff interviewed provided examples of ASERs discussed at the practice meeting. We identified an ASER theme related to duty of candour, a set of specific legal requirements that services must follow when things go wrong with care and treatment. Staff had recognised this and taken action. These included a tasks rota and protected time for the administrative team to minimise multi-tasking and distractions while whilst managing patient documentation.

The pharmacy technician was the lead for managing notices and alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) received through the Central Alerting System (CAS). They checked the CAS/MHRA website each morning and updated the CAS alert register accordingly, including action taken. For any medicine or device alerts received, the pharmacy technician checked to determine whether the product was stocked and forwarded the pertinent CAS alert to prescribers. Links for all CAS alerts received each month were included in the practice meeting minutes. In the absence of the pharmacy technician, both nurses had access to the CAS alert system so that they could action an alert and forward it to prescribers.

Are services effective?

We rated the practice as good for providing effective services.

Effective needs assessment, care and treatment

The practice meetings held each month included updates for staff on developments in clinical care including National Institute for Health and Care Excellence (NICE) guidance, the Scottish Intercollegiate Guidelines Network clinical pathways, current legislation, standards and other best practice guidance (BPG). The agenda was set by the Senior Medical Officer (SMO) who also reviewed the update topics for discussion. Staff were kept informed of clinical and medicines updates through the Defence Primary Healthcare (DPHC) newsletter circulated each month. We discussed with the SMO treatment that had deviated from internal or national guidance staff and were assured there was an acceptable clinical rationale for this.

Minutes from the October 2024 practice meeting showed guidelines/updates were discussed, including the noise-induced hearing loss surveillance standard operating procedure (SOP) and the audio referral SOP. NICE updates were discussed at the Primary Care Rehabilitation Facility (PCRF) meetings and BCP at the sub region clinical meetings. In addition, updates were discussed at The Network meetings.

Patients with complex needs were identified initially through scrutiny of their clinical records when first registering at the practice. Their needs were managed within the practice through multi-disciplinary team engagement with other units and departments, such as the PCRF, Department of Community Mental Health (DCMH), welfare units and Chain of command. DMICP clinical coding was used to identify patients with complex needs, based mainly on clinical diagnosis or a vulnerability status.

Although Regimental Medical Officers (RMO) focussed on force health protection and deployability status, all RMOs were content to see patients from any units but ensured that the unit lead was aware of any significant or complex issues. The General Duties Medical Officers (GDMO) reported there were opportunities to discuss with the SMO patients with complex needs if needed and they had dedicated time to discuss patients directly with their supervisor.

Our review of PCRF patient records confirmed a holistic approach was undertaken including an assessment of lifestyle, such as diet, sleep, smoking habits and a fitness test. The physiotherapists used the Musculoskeletal Health Questionnaire (MSK-HQ) and Functional Activity Assessment (FAA). Both the MSK-HQ and FAA are standardised outcome measure for patients to report their symptoms and quality of life. The MSK-HQ was used at the initial appointment and on discharge of the patient. The use of the MSK-HQ was clinically coded via the DMICP template. Data was collated annually for FAA and MSK-HQ.

The physiotherapist and exercise rehabilitation instructor (ERI) carried out joint patient reviews every 4 – 6 weeks as required. In addition monthly caseload meetings took place

to discuss complex patients, including those under the care of the PCRF for a protracted period of time.

All patients accessed their rehabilitation exercise programme through Rehab Guru (software for rehabilitation exercise therapy). There were plans to utilise skills sub-regionally to develop and share Rehab Guru templates between practices. PCRF staff had access to the new defence rehabilitation website.

Step 1 of the DPHC mental health pathway was delivered at the practice. Patients were referred to the DCMH if they had symptoms of psychosis, post-traumatic stress disorder, there was evidence of direct self-harm or a referral was clinically indicated. The practice had access to out-of-hours contact details for the DCMH. The SMO encouraged all clinical staff to use the mental health templates especially regarding self-harm. Our review of clinical records showed patients with a mental health need were well managed and appropriate clinical coding was used.

Mental health information resources were displayed and accessible via quick response/QR codes. These included information related to stress, sleep, low mood and suicide.

Monitoring care and treatment

The nursing team conducted regular DMICP searches to identify patients with a long term condition (LTC) who required a review of their condition. Patients were recalled at appropriate intervals, including follow-up prompts for those who did not respond. Patients were initially seen by a nurse for checks, such as blood pressure, weight, blood or urine tests. They were then referred to a doctor for a medication and annual review of their condition.

There were low numbers of patients identified as having an LTC. The information provided by the practice identified 35 patients with high blood pressure, 7 with diabetes and 22 with asthma. The DMICP searches we carried out did not correlate with these figures and identified other issues. For example, our standardised search showed 8 (36%) patients diagnosed with asthma had not been reviewed in the last 12 months.

Foot checks for some patients with diabetes had not been coded or documented. The practice had also identified this oversight. While the new Band 6 nurse was gaining experience with managing LTCs, a nurse specialist from another practice held a clinic at the practice each month to undertake reviews for diabetic and asthmatic patients. The SMO reported that the foot testing tool had gone missing which is why foot checks had not been completed. This reason had not been recorded in the patients' notes.

While the records we reviewed demonstrated positive control for patients with known high blood pressure, patients with an isolated elevated blood pressure had not been followed up. The SMO explained that patients presenting at the total triage clinic always had their blood pressure checked and this could be raised for various reasons. Usually these patients would be recalled but had not been while the practice had no nurses. Patients were encouraged to have their blood pressure checked (usually at a local pharmacy) and report the result to the practice.

The doctors we spoke with were aware of the DPHC SOP for managing chronic disease as well as the templates available for common LTCs. Some of the doctors reported they did not always remember to use the templates but said this was improving. Not all doctors we spoke with were aware of the medication review template. We noted clinical coding was not always appropriately applied, which could skew the results of the practice searches.

The SMO acknowledged that work was required to ensure patients with LTCs were managed and monitored to the highest level. The gaps in follow-up were due to prolonged vacancies in the nursing team. The 2 nurses were only appointed mid-2024 and both had recently qualified as nurses.

After the inspection, the SMO reviewed the clinical records for the patients with an LTC we had concerns about. They confirmed all patients with diabetes now had the correct clinical code applied and would be recalled by the 17 January 2025 for a review, including those who had missed the foot check. In addition, a plan was in place to recall all patients from our search identified with raised blood pressure. The SMO confirmed that the Band 6 nurse had already started working to address the gaps in reviews for patients with asthma.

The SMO's improvement plan included training medics about the action to take for isolated raised blood pressure readings. Clinicians were to be reminded at the clinical meetings about the consistent use of templates. In addition, a nurse undertaking a 'return to work' programme had recently started a placement at the practice. They were undertaking a primary health care degree that focussed on LTC management. It was the intention that they would support the Band 6 nurse with improving the processes for managing LTCs.

Audiometry assessments were in-date for 97% of the patient population. Our review of patient records demonstrated Joint Medical Employment Standards (referred to as JMES) were appropriately managed.

The Band 6 nurse was the lead for audit and the Band 7 physiotherapist was the deputy lead. Quality improvement activity, including clinical audit was used to evaluate the quality of care and improve patient outcomes. An integrated audit programme was established for the medical centre and PCRF. A register was in place for the audits completed each year with the date of the next cycle highlighted. The majority of the audits were those directed by DPHC with some additional clinical audits. Audits were uploaded to the DPHC governance SharePoint page, where they were identified as a 'must', 'should' or 'could' audit.

A wide-range of quality assessment and improvement work was undertaken by the practice and PCRF team. A minor surgery audit was completed annually and the last one was completed in December 2023. The 2024 audit was in near completion; the SMO was awaiting data from one of the other practices in The Network. The H3 (hearing) audit we reviewed was undertaken to check that service personnel had received an appropriate medical grading. As a result, the practice identified the practice had no H4 personnel who were not medically non-deployable.

The PCRF annual end-of-year statistics report incorporated a caseload review, referral rates, key performance indicators and the top 6 referral injury types. These were then used

to develop injury prevention strategies. Clinical audits completed included acupuncture, patient feedback and MSK-HQ. These were reaudited annually.

An audit to review the issuing of acute ankle management information by clinicians and medics to treat acute injuries showed 14% of patients had received this information. The follow-up actions included the re-education and making the sheets more accessible on DMICP. Although a re-audit was planned, it was challenge given the turnover of Regimental Aid Post staff.

Audit was a standing agenda item at practice meetings. The practice meeting minutes from October 2024 showed breast screening, asthma, high blood pressure, summarising and patient group direction audits were discussed. Links to the audits were included in the minutes.

The quality of the audits we reviewed were appropriate. Now that staffing levels had increased, the practice could consider more clinical audits particularly looking at chronic disease. These type of audits would likely highlight the issues we identified with the identification and monitoring of patients with an LTC, including patients with potentially undiagnosed conditions.

Effective staffing

An induction pack was in place for new staff and included a checklist for role specific elements. The SMO advised that they checked the induction was completed for new staff. The locum induction pack was bespoke depending on the role.

The SMO used the GP induction pack for locum doctors. It was tailored to each individual based on whether they had experience of defence primary healthcare. The practice mainly used locums who were familiar with the service. Given the concern with a previous locum not following antimicrobial prescribing guidance, the SMO planned to ensure this was raised as part of the induction should the individual work at the practice again.

The practice manager monitored mandatory training and we confirmed the majority of civilian and military staff were up-to-date with training. A process was in place to alert staff when their mandatory training was due to be completed. Staff had protected time for training, administration, recalls, continuing professional development and peer review, including working from home days to complete the training. In-service training was mainly facilitated on Wednesday afternoons.

Staff had access to training specific to their lead and secondary roles for example, the Band 6 nurse was in the process of undergoing cytology training. They had completed the initial course and were having supervision with a mentor for conducting cytology clinics and examinations. As they were new to the Band 6 role, the nurse required support to develop further into the role, including the scheduling of competencies to be met over the next 12 months. The SMO was trained to complete aviation and diving medicals and they also provided minor surgery. One of the RMOs was qualified to complete diving medicals. The Band 7 physiotherapist had completed an injection therapy course and delivered

treatment through patient specific directions following a discussion with the SMO. An SOP was in place to support the delivery of this treatment.

Supervision arrangements were in place, enhanced by the practice being part of The Network. For example, the nurses engaged with other practice nurses for peer review and clinical supervision. GDMOs had dedicated supervised time with their supervisor each week, although it did not always take place if clinics were busy. The GDMOs said they could ask for advice as and when it was required.

The medics were supported by the nurses with conducting vaccination clinics. They had received vaccination training and maintained clinical competency through supervision with the nurses. The medics also facilitated the total triage clinics. The action plan from the internal assurance review in September 2024 confirmed the SMO had assessed the medics' competency to run these clinics. This was supported by a competency sign-off form. The PCRF team maintained a register of clinical supervision, peer review and case discussions.

Coordinating care and treatment

The practice team had effective lines of communication with the units. An RMO attended the monthly Commanders Monthly Case Review (CMCR) meeting for the unit they were attached to and the SMO attended the Royal Logistics Corps CMCR. Each member of the PCRF team was allocated a CMCR to attend. This meant each unit had a single point of contact with both the practice and PCRF. At these meetings vulnerable patients were discussed along with an update on occupational health, injury and downgrade statistics.

We spoke with the Welfare Officer for 1 of the regiments who described how the practice worked well with the welfare team to ensure vulnerable service personnel were effectively supported. The SMO and Band 7 physiotherapist were the main points of contact for the welfare units.

The practice had a good working relationship with the 2 nearest NHS GP practices at which most families of service personnel were registered. In addition, the practice had good links with internal defence services including the DCMH, Regional Occupational Health Team and Regional Rehabilitation Unit.

DPHC guidance was followed for patients leaving the military including, pre-release and final medicals. During the pre-release phase, patients received a summary of their healthcare record and given information about registering with NHS primary care. The welfare team provided service leavers with a range of information about additional services, such as Op COURAGE, a free NHS service in England that provides mental health support for veterans and their families. Furthermore, patients were advised about the Armed Forces Covenant, which is a guarantee that those who have served in the armed forces are treated with fairness and respect.

Helping patients to live healthier lives

Both the nurses oversaw the health promotion programme. The NHS calendar for health promotion was followed and also included any local issues. A range of patient leaflets available to patients following consultations, such as vaccination information, sexual health contact for screening, diabetes management, and lifestyle checks. Health promotion displays at the time of the inspection included World Aids Day, contraception, whooping cough and pregnancy. The effect of health promotion activity was not regularly audited for impact/outcome. This will be considered once a health care assistant is appointed as they will take the lead for health promotion. The practice and PCRF staff supported with the unit-led health fairs.

The PCRF could refer patients to either a physical training instructor (PTI) or the nursing team for weight management if needed. The PCRF team were involved in injury prevention initiatives with all the units. A display in the PCRF included information and pictures about how to undertake strength and condition exercises safely.

The PCRF identified an ongoing trend of increased referrals post leave periods. Data was collected from patients to determine if an increase in training load could be a causative factor. Initial data collection from September to November 2020 indicated 42% of all patients referred showed evidence of a spike in training load. Of the training injuries, 60% had increased their training load. The 10 year average for referrals over the same timeframe was 72. From these findings, a change strategy was developed, including education of service personnel, commanders and working alongside the PTIs. The referral for the same timeframe following this educational intervention reduced significantly to 39.

The PCRF had consistently monitored referral rates and the loading profile of patients. The service evaluation for 2024 highlighted that the spike in loading as a potential cause of injury reduced from 39% to 23% over 3 years. This work was presented at the quality improvement forum and there is now wider work happening across DPHC on this subject.

Sexual health advice and some treatments for some sexually transmitted infections was provided by the practice. Patients could also be referred or sign posted to local sexual health clinics in Ripon and Thirsk, which provided face-to-face appointments. Long-acting reversible contraception (referred to as LARC) were provided within The Network or through local sexual health clinics. An arrangement was in place for pregnant service personnel to register with a local NHS practice for midwifery care.

One of the RMOs was leading on introducing ‘nature prescriptions’ (a form of social prescribing). This initiative was in conjunction with the North York Moors Trust whereby doctors can ‘prescribe’ outdoor activities in the Yorkshire Dales to promote physical and mental health. The initiative was due to be formally rolled out in February 2025.

An SOP was in place for the management of patients eligible for the national screening programme. There were very low numbers of patients eligible for bowel and breast screening and no patients met the criteria for abdominal aortic aneurysm screening. The Band 6 nurse was the lead for the monitoring of cervical cytology. Whilst they were undertaking the cytology training, a nurse within The Network was running the monthly searches and conducting the cervical screening clinics. Texts were sent to patients along

with an email and letter explaining to the patient why they were eligible for screening. Ninety-six percent of eligible patients were in-date for cervical screening. The NHS target was 80%.

The medics oversaw the vaccination monitoring and recall for the units they were attached to. Service personnel were encouraged to use the 'MyHealth' app to manage and track the status of their audiology and vaccinations. At the time of the inspection, the vaccination statistics for eligible service personnel was:

- 100% of patients were in-date for vaccination against diphtheria.
- 100% of patients were in-date for vaccination against polio.
- 97% of patients were in-date for vaccination against hepatitis B.
- 98% of patients were in-date for vaccination against hepatitis A.
- 100% of patients were in-date for vaccination against tetanus.
- 99% of patients were in-date for vaccination against measles, mumps and rubella.

Consent to care and treatment

Implied and verbal consent was mostly taken depending on the intervention. Verbal consent secured for management of referrals, vaccinations and blood tests was recorded in the patients' records. Written consent for acupuncture and minor surgery was taken and the consent form scanned to patient's record. In addition, consent was sought to release 'medical-in-confidence', usually in relation to the sharing of information with the unit Chain of Command.

A consent audit was completed in September 2024 and a high level of compliance was noted. Some action points were raised where documentation could be improved upon and a further audit was scheduled in 3 months. Synonyms within the local working policy supported with compliance.

Clinicians understood the Mental Capacity Act (2005) and how it could apply to the patient population. Staff reported that the SMO had delivered in-service training on mental capacity. In addition, mental capacity was covered within The Network clinical supervision for nurses. We were given an example when a capacity assessment was considered for a patient who sustained a head injury.

The practice policy was up-to-date and included reference to mental capacity, the Gillick and Fraser guidelines (consent guidance for children) and vulnerable adults.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

As part of the inspection, we received feedback about the service from 48 patients. We reviewed the 15 responses received from the practice's most recent patient survey. Included also was the Primary Care Rehabilitation Facility analysis of the feedback from 63 patients (August – September 2024). Feedback suggested staff were kind, understanding and compassionate.

The practice responded positively to patient feedback. For example, the camera in the waiting room was adjusted when a patient raised that it was too intrusive.

Staff provided various of examples of when the practice had 'gone the extra mile' to support patients. For example, the Senior Medical Officer (SMO) contacted the secondary care clinician for a patient who had been waiting over 12 months for surgery and within 6 weeks the surgery had been completed. The patient recovered well and returned to full duties.

Continuity was facilitated where possible, such as for rehabilitation. Patients saw the same physiotherapist throughout the care pathway, including joint reviews with the exercise rehabilitation instructor.

Involvement in decisions about care and treatment

Feedback indicated patients were involved with planning their care and this was confirmed by our review of patient records. Patients reported that they were given sufficient time to ask questions and their condition including any prescribed medicine explained in a way that they understood.

A translation service was available for patients who did not have English as a first language. We were advised that it was mainly used to translate clinical records. We noted the translation service was not advertised in patient areas. Promptly after the inspection, the practice manager confirmed posters were now displayed about the service in both the downstairs and upstairs waiting areas.

Patients with a caring responsibility were identified through the new patient registration process or through the Commander's Monthly Case Review meetings. Monthly searches were carried out and the 6 carers identified had a clinical code and alert applied to their record. Information for carers was displayed for patients to access. They were offered enhanced services, such as the flu vaccination and an annual heath check. Carers were discussed in the clinical meeting and Vulnerable Risk Management meeting. Information about support services was displayed in the waiting area and outlined in the practice's patient information leaflet.

Although the practice had a local standard operating procedure (SOP) for carers, the SMO had taken the lead with developing an integrated SOP for The Network. This was to ensure consistency and streamline services across The Network.

Privacy and dignity

Patient consultations/assessments took place in clinical rooms with the door closed. Regularly changed disposable privacy curtains were available in all clinical rooms for intimate examinations. Measures were in place at reception for patients to talk to the receptionist discreetly.

If a patient had a preference to see a nurse or doctor of a specific gender and this could not be accommodated then they could be offered a gender of choice chaperone. Alternatively, patients could attend another practice within The 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

Patient feedback indicated that patients were satisfied with the responsiveness of the service. Total triage was run by the medics and was solely for on-the-day appointment requests. It only considered requests for urgent appointments and not for eConsults. There was a very low number of requests for on-the-day appointments; 15 to 25 each week.

The specific needs of patients were identified when scheduling appointments through the use of DMICP alerts, such as those for vulnerable patients and carers. This meant these patients were promptly identified and prioritised for an appointment. Extended appointment times could also be facilitated. Appointments were scheduled to accommodate patients' working hours and those travelling a distance.

A 'who should I see at the medical centre' leaflet was available, which detailed the types of clinics available and the clinician the patient needed to book an appointment with. We noted that some links to access further information on the practice patient information leaflet did not work. We discussed this with the Senior Medical Officer (SMO) who said they would review it.

We were given examples of when the practice had pro-actively responded to patient feedback. For example, more time was now included to explain to the patient their injury. Furthermore, additional and simplified patient information was introduced about how to make a complaint.

One of the medics was the diversity, equality and inclusion (DE&I) lead for the practice. In line with the Equality Act 2010, an access audit for the building had been completed in May 2024. There was ramp access to the front door and a regularly serviced stair lift to the upper floor. Although located in a storage room, an accessible toilet was available. However, there were many areas of non-compliance as the infrastructure was not designed for a healthcare facility. For example, the accessible parking bay was not sufficiently wide and some doors were too narrow to accommodate wheelchairs. Furthermore, there were accessibility issues with the unit gym. These issues were added to the risk register promptly after the inspection.

Clinicians had experience of providing support for patients in the early stages of gender transition and they followed the Ministry of Defence policy in relation to the management of transgender service personnel. Regular reviews were provided for those transitioning, including signposting to other services. Although not currently a clinical need, we noted there was no formal process to identify females transitioning to male for inclusion in the health screening programme. We discussed this with the SMO during the inspection.

One of the administrators was leading on the mandated 'Oliver McGowan training' (for learning disability and autism) introduced in April 2024. They had completed the training

shortly before the inspection and were considering the options to cascade the learning to the wider team. We discussed the value of network-wide training in conjunction with other who had completed the training. The lead had a plan to ensure relevant alerts were placed on the records of patients with neurodiversity/autism.

Timely access to care and treatment

From patient feedback we confirmed patients were satisfied with timely access to a clinician. One of the medics described how an assessment was carried out as part of the morning total triage clinic. If they were concerned and unable to manage the patient's issue then they referred to a doctor as there was always appointments available with a doctor on the same day.

Routine appointments with a doctor could be facilitated within a day. Same day urgent appointments were available with a nurse and within 1 day for a routine appointment. An urgent physiotherapy appointment was available within 24 hours, routine appointment within 8 days and it was 2 weeks for a follow-up appointment.

The Direct Access Physiotherapy pathway was available for patients to use and the physiotherapists could accommodate the demand. There were minimal wait times for referral to Regional Rehabilitation Unit (RRU) as the PCRF could refer to various RRUs. The waiting time for the Multidisciplinary Injury Assessment Clinic was 3 weeks.

Being part of The Network meant there was access to clinical services not provided at the practice, such as family planning and dermatology. The SMO provided minor surgery and other services in the Network had access to this.

Requests for home visits were rare and based on urgent clinical need. If a home visit was required then the practice followed the generic Defence Primary Healthcare policy (DPHC), which outlined safety arrangements for the clinician.

Listening and learning from concerns and complaints

The SMO was the lead for complaints and the practice manager deputised. Complaints were managed in accordance with the DPHC complaints policy and the practice standard operating procedure.

Both verbal and written complaints were logged and monitored. Complaints about clinical care were referred to the SMO. If the complaint was about the SMO then a lead for clinical complaints within the Network reviewed it. The B7 physiotherapist investigated complaints about the Primary Care Rehabilitation Facility.

The SMO outlined a recent clinical complaint, which was appropriately managed and to the satisfaction of the complainant. However, the complaints log lacked summary detail of how it was managed, including the outcome. Minutes showed that complaints and compliments were a standing agenda item at practice meetings. The SMO conducted a

complaints audit in 2023 and was due to be repeated this year to assess the service from a patient's perspective.

Patients were made aware of the complaints process through the practice information leaflet and information displayed in the waiting area. Patients had the option to submit a concern anonymously through the patient feedback cards.

Are services well-led?

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

Vision and strategy

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

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

The practice was part of the White Rose Network consisting of 4 other practices; Leeming, Imphal Barracks and Leconfield medical centres. This arrangement was supportive as access to services had improved by providing resilience and equity of access to patient focussed services. For example, the sharing of health promotion resources and access to a specific diabetes support meeting for the Fijian population. As staffing levels were identified as a main risk, the practice could lean into The Network for support during periods of staff shortages.

A project team report was produced each month for The Network. Meeting minutes showed it covered issues such as the memorandum of understanding for this collaborative initiative, total triage, skills matrix across all practices and the development of a Network-wide SharePoint. A lead SMO was identified as the liaison for The Network on a rotating 6-monthly basis and the Senior Medical Officer (SMO) for Dishforth Medical Centre was undertaking this role until January 2025. Work was ongoing to develop standard operating procedures (SOP) for The Network so that work was not repeated and there was the opportunity to utilise best practice from all practices. We recognised that developing The Network was a time consuming process for the SMO who already was undertaking numerous other roles.

The Regional Clinical Director (RCD) visited regularly and was due to visit the practice to discuss the DPHC's vision and future planning. Patient and commander feedback was considered as part of the service development.

A Primary Care Rehabilitation Facility (PCRF) development plan for 2024/25 was in place. Its focus was on capacity, efficiency collaboration and injury prevention, including flexibility of regional resources and better management of sub-acute injury by doctors and medics. This was measured by key performance indicators, which the PCRF was meeting.

To address environmental sustainability, recycling was encouraged and the use of QR codes and electronic information rather than printed information. Recycle bins were available and a notice was displayed reminding staff to switch off electronic items at the end of the day. Batteries and print cartridges were sent to the Quarter Master for recycling. The practice aimed to reduce pharmaceutical waste by not overstocking and sharing

excess medication within The Network. A long-term goal of the pharmacy technician was to carry out an inhaler audit with the aim to introduce ‘greener products’.

Leadership, capacity and capability

The leadership team comprised the SMO and Band 7 physiotherapist, both of whom had worked at the practice for many years. After a gap of 12 months, a new practice manager was appointed in September 2024. With limited experience of healthcare and DPHC, they required a longer period of mentoring beyond the initial induction period, including completion of the practice manager’s course. The Band 6 nurse joined the practice in the summer. Recently qualified and new to primary healthcare, they were being supported and mentored by a senior nurse within The Network. The SMO had applied for funding for 360 degree training for the leadership team but this had been refused.

In the absence of a practice manager and nurses during the year, the SMO had undertaken multiple roles over and above their routine clinical role, including practice administration and nursing duties. This was reflected in the number of lead roles the SMO had taken on. Even though some of these roles had since been re-allocated, the SMO retained oversight until new staff were familiar with systems and processes. The former practice manager had taken up post as the regional training lead and had been leaning in to support the practice while the practice manager role was vacant.

The dependence on Regimental Aid Post (RAP) Medical Officers and medics to support clinical provision and to cover DPHC staffing gaps was a risk given that the RAP team’s primary role is to the unit, and they could be recalled by the unit/regiment at any point.

Despite this staffing context over the last 12 months, we recognised that the SMO had worked tirelessly to maintain the service while continuing to provide a clinical service for patients and to the Chain of Command. Workforce resilience was a key risk for the practice and was captured on the risk register.

Staff described how the practice was well supported by Regional Headquarters (RHQ). For example, the regional nurse advisor was providing support to the nurses. The practice manager was supported monthly by RHQ and the area manager visited every 6 weeks. The regional assurance lead visited regularly and carried out a range of governance and assurance checks.

Culture

From patient feedback, interviews with practice staff, a discussion with the Welfare Officer and review of patient records, we confirmed the practice provided holistic and person-centred care. Staff understood the specific needs of the patient population and coordinated the service to meet those needs. This patient focus continued despite a long period with limited staffing levels.

Mixed views were expressed about morale within the team with some groups of staff suggesting morale had been impacted by a shortage of staff over the last year, including clinical staff and the absence of a practice manager until September 2024. We heard the additional responsibilities re-allocated to staff had resulted in discord and stress for some, including an increase in staff sickness. The medics had taken on additional duties, which at times created a dilemma between the orders from their command units and the needs of the practice.

Some staff groups indicated that morale was impacted by communication processes that were not always effective. They said they were to last to hear about changes or updates at times.

Recognising there was an issue, the SMO carried out a 'staff stress survey'. It identified, "…a significant level of stress and sub-optimal team dynamics…". Although funding for external team building/mediation was sought through DPHC, Defence Business Services and the Employee Assistance Programme, it had been declined. Given the associated increase in staff sickness and refusal for funding, the SMO completed a risk assessment in November 2024 with the risk identified as 'transferred'.

The army mediation team were considering what support they could provide to the practice and the Band 7 physiotherapist had a team building day planned early in 2025. In addition, the practice manager had introduced an activity for staff to highlight positive work undertaken by colleagues. At the end of the month, the nominated staff received a box of chocolates. Annual 'thank you' awards had been issued to civilian staff in recognition of their hard work.

Staff reported that morale was improving now that staffing levels had increased. Acknowledging the SMO had the added responsibility of managing the practice for an extended period, they said the SMO checked in on them regularly and was always available to provide support.

Staff we spoke with knew how to access the policy on whistleblowing and said they would have no hesitation using the policy if they had concerns. The whistle blowing policy and information about 'freedom to speak up' were advertised in staff areas for awareness. The SMO planned to review the policy and re-promote it to the staff team.

Processes were established to ensure compliance with the requirements of the duty of candour (DoC), including giving those affected reasonable support, information and a verbal and written apology. An example provided by the PCRF demonstrated that the DoC principles had been adhered to. A DoC register was maintained and we noted that it included patient identifiable information. The practice manager rectified this promptly after the inspection by switching to using DMICP numbers only. A number of DoC issues had been raised as ASERs and appropriate action had been taken for each. Some of the ASERs we looked at were clearly a DoC but had not been captured on the DoC register.

Governance arrangements

The Band 6 nurse was the lead for healthcare governance (HCG) and the Band 7 physiotherapist deputised. We identified gaps in governance systems many of which constituted minor system adjustments, which the practice addressed promptly after the inspection. Other governance processes required a more detailed attention including, environmental cleaning, risk management, oversight of SHEF and the processes to manage long term conditions. A wide-range of practice SOPs were in place but some were out-of-date for a review.

A clear reporting structure was established and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. Terms of reference (TOR) for staff were up-to-date. We noted 1 TOR was unsigned and this was addressed promptly after the inspection. We were concerned that new and inexperienced staff were taking on too much too soon, such as the nurses supervising the medics.

Formal and informal communication channels were established, including regular structured meetings. Practice, clinical, PCRF, administrator and heads of department meetings were held each month. The practice meetings (incorporating governance) minutes demonstrated the DPHC standardised approach was followed. Medics held meetings when needed. The nurses held daily informal meetings and the administrative team had a team ‘huddle’ each Monday. The practice manager planned to hold monthly meetings with the Medical Sergeants once all the posts were filled.

A programme of quality improvement activity was established to monitor the outcomes and outputs of clinical and administrative practice. Audits were presented and discussed with staff at the practice meetings.

Managing risks, issues and performance

Not all known risks were captured on the risk register. This was addressed promptly after the inspection and the updated risk register was provided as evidence. The key risks for the service were the infrastructure, workforce resilience and staff morale. Staff identified governance management and time for training/additional duties as further potential risks. There had been discussion around protected time and the leadership was supportive of this. Minutes demonstrated that the risk register was reviewed at practice meetings. As staffing levels was a key risk, any forecasted gaps in the workforce were discussed and either a locum sourced or support requested through The Network. Risk assessments were in place but these were overdue a review. Significant events and incidents were discussed at practice meetings, including any improvements identified.

A business continuity plan (BCP) was in place. It was activated in November 2024 when there was a DMICP outage. Supported by RHQ, the Band 6 nurse took the lead with effectively activating the BCP. Each camp had a major incident plan. There had been no recent requirement to action these.

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

An internal assurance review was undertaken in September 2024 and the rating was 'limited assurance'. A large number of improvement points were identified and a detailed action plan developed. Many of the actions had been completed, including those related to medicines management and infection prevention and control (IPC). The aim was for all actions to be completed by the end of March 2025. The action plan was reviewed at practice meetings.

The practice used the HCG workbook to manage and monitor governance activity. The Band 6 nurse updated the workbook so the evidence was consistently up-to-date.

Due to staffing constraints and aware that the Health Assessment Framework (HAF) needed attention, the regional assurance lead reviewed the HAF with the SMO in August 2024. We identified that the HAF was not used to its full effect as the internal governance system to monitor performance. Although management action plans (MAP) were in place, the MAP associated with the HAF was not effectively used. For example, IPC actions points were recorded on a separate MAP. We highlighted that the purpose of the HAF MAP is to ensure all improvement actions are contained in one place for effective oversight and monitoring. We were advised that a plan was in place to focus on developing the HAF now that staffing levels had increased.

Arrangements at the practice were in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. The Caldicott Principles, guidelines for the management of patient identifiable information, were followed. The SMO was the lead for Caldicott and was handing this task over to the practice manager. The practice manager carried out Caldicott checks each month to ensure records were not being accessed inappropriately. Any concerns identified were promptly addressed. The staff team had completed Defence Information Management Passport training which incorporated the Caldicott principles.

Engagement with patients, the public, staff and external partners

Options were available to prompt patients to provide feedback on the service. Patients could complete the DPHC survey, leave feedback on an electronic tablet and complete the 'Care to comment' forms. A notice board provided patients with action the practice had taken in response to feedback.

In addition to the 'stress survey', staff were encouraged to provide feedback at the practice meetings, through one-to-one supervision and via the open-door policy.

The practice worked closely with commanders, welfare support services and other defence services to ensure a collective approach with meeting the needs of the service personnel population.

A questionnaire was sent to the middle grade commanders for all the units. Key areas for consideration included employment advice, gradings, force preparation and overall care. Analyses of the feedback led to changes, such as continuing telephone appointments post Covid-19 for grading reviews (unless face-to-face appointments were deemed necessary). As expected, each RMO focussed on their own unit but it was not clear who was responsible for looking at the whole patient population, from a force protection perspective. Overall, the findings indicated a satisfaction with the service provided by the practice with the highest scores achieved for force preparation and overall care. Some of the changes requested were not currently feasible, such as online booking of appointments.

Continuous improvement and innovation

The practice team was committed to continually improving the service and this was evident through quality improvement activity. Despite depleted staffing levels over the last 12 months, the practice continually considered and introduced ways to improve the service.

One of the RMOs was leading on ‘nature prescribing’ (a type of social prescribing); a project by the Yorkshire Dales National Parks team. The team had developed a calendar of local and accessible activities to support with improving mental and physical health and wellbeing. The Personnel Recovery Unit (North) were facilitating a ‘nature prescribing’ conference in February 2025. The agenda included health and wellbeing teams from the Yorkshire Dales Authority and the North York Moors providing an overview of the project. The practice planned to go live with this initiative following the conference.

The overall quality improvement project (QIP) register for the practice contained no recent QIPs with the last recorded in 2020. However, QIP meeting minutes for the PCRF documented the following initiatives.

2023 - resource sharing in the sub region had decreased waiting times.

2024 - strength and conditioning delivered by the exercise rehabilitation instructor prior to service personnel returning to the unit improved patient’s confidence in readiness for mainstream physical training.

2024 - training was delivered to doctors based on a clinical red flag audit. As a result documentation of red flag screening had improved from 6% to 28%. A re-audit was planned.