Lichfield Combined Medical Practice, Whittington and Birmingham Medical Practice

Whittington Barracks, Lichfield, WS14 9PY

Birmingham Medical Facility, Old Queen Elizabeth Hospital, North Level 2, Birmingham, B15 2TH

Defence Medical Services inspection report

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

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

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Summary

About this inspection

We carried out an announced comprehensive inspection of Lichfield Combined Medical Practice on 4 and 5 February 2025.

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

Are services safe? – requires improvement

Are services effective? – requires improvement

Are services caring – good

Are services responsive to people's needs? – good

Are services well-led? – requires improvement

CQC does not have the same statutory powers with regard to improvement action for 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 observations and recommendations within this report.

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 were generally positive. It demonstrated patients were treated with compassion, dignity and respect. A number of comments received highlighted challenges with continuity of care.
- Overall review of clinical records and processes to monitor care showed patients received effective clinical care.
- Effective safeguarding arrangements were in place. However, we highlighted that not all patients under 18 years had an alert on their record.

- 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, there had not been the capacity to extend this to the Birmingham Medical Facility (BMF). Team morale had declined over the last year mainly due to a shortage of staff.
- Governance systems underpinned the safe running of the practice including risk assessments, Health Assessment Framework (HAF), standard operating procedures (SOPs), duty of candour and equipment care.
- Actions, observations and recommendations from various audits, inspections and monitoring processes were recorded but these were more supportive of mandatory processes than tools to drive quality improvement.
- Medicines and medical products were well managed. We highlighted the security and access arrangements as an area to be addressed.
- Infection prevention and control audits were undertaken and had highlighted that the infrastructure of the premises at BMF did not support effective cleaning and infection prevention.
- Clinical waste was managed well and monitored effectively through regular audit.

The Chief Inspector recommends to DPHC:

- 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.
- Ensure staffing levels are sufficient to fulfil governance requirements and to safeguard the health, wellbeing and morale of staff. Consider how support can be provided based on the opal status declared.

The Chief Inspector recommends to the practice:

- Ensure all staff trained to level 3 have also completed levels 1 and 2 safeguarding training.
- Add alerts to the records of all patients under the age of 18.
- Prioritise services provided and escalate issues when workforce levels do not support the full delivery of services.
- Introduce monitoring of patients on repeat medicines to ensure they are regularly reviewed.
- Ensure information leaflets/booklets are available for patients on high risk medicines.
- Improve security and safety arrangements for the emergency trolley.
- Prioritise the completion of mandatory training for staff.

- Implement a catch up programme for notes summarising that addresses both the quality of the work and the outstanding quantity requiring completion.
- Ensure there is effective oversight in place for all clinical staff, of note, in the Primary Care Rehabilitation Facility (PCRF) and for the medics when assessing same day appointment requests.
- Prioritise completion of the work being done to improve the processes around sample handling and monitoring.
- Review the procedures around security in the dispensary at Lichfield Medical Centre.
- Ensure new patients on a high risk medicine are identified at the registration stage.
- Carry out regular audits on antibiotic prescribing to ensure current guidelines are being adhered to or justification recorded when not.
- Strengthen the integration of the PCRF in particular around lone working arrangements.
- Role specific inductions should extend to the PCRF and include departmental specific training.

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, exercise rehabilitation instructor and practice manager. Three newly recruited specialist advisors shadowed the inspection as part of their induction. In addition, a CQC colleague attended as an observer.

Background to Lichfield Combined Medical Practice

Lichfield Medical Centre (referred to as LMC throughout the report) combined with Birmingham Medical Facility (referred to as BMF throughout the report) and became known as Lichfield Combined Medical Practice (LCMP). Full operational capability was granted in October 2024. The facilities at Lichfield are within Whittington Barracks, at Birmingham, they are within the Queen Elizabeth Hospital. The BMF site opened its doors on the closure of Belle View Medical Centre and is housed in an old NHS trust building. The Contract with the Trust is reported as hard to navigate and restricts meeting Defence Primary Healthcare standards.

LCMP supports an approximate service personnel population of 1,340 which does fluctuate but is approximately a 50/50 split between the 2 sites. Families are not registered at the practice and are signposted to local NHS practices. Whittington Barracks houses the Defence Medical Academy and is the headquarters for Defence Primary Healthcare (DPHC HQ). It is also dedicated training centre for defence personnel. BMF houses the Royal Centre of Defence Medicine.

Routine primary care and occupational health is provided by the practice along with a Primary Care Rehabilitation Facility (PCRF) for physiotherapy and rehabilitation. There is a dispensary at Whittington Barracks. At BMF, pharmacy arrangements are outsourced.

The practice is open from 08:00 to 17:00 hours each weekday. The practice is closed each day for lunch from 12:30 to13:30 hours but remains open for emergency access and urgent walk-in patients. The duty phone is responded to during the lunch hour. Shoulder cover is provided by Cosford 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

Doctors	
Senior Medical Officer (SMO)	1 (temporary cover in place with new SMO started on 4 February 2025)
Civilian Medical Practitioners (CMPs)	3 (2.6 full time equivalent)
Regimental Aid Posts [1]	1 Regimental Medical Officer (50:50 job share with DPHC HQ) 9 medics (3 medics with a medical condition restricting deployment)
Practice nurses	Band 7 (post currently vacant due to long-term absence) Band 6 3 (2.6 full time equivalent) Band 5 1 RAF non-commissioned officer student post
PCRF	Band 7 physiotherapist Band 6 physiotherapist (post vacant until April 2025) Exercise rehabilitation instructor
Pharmacy	Pharmacy technician (post vacant since February 2024)
Practice management and administration	Practice manager Business manager (post temporarily vacant due to maternity leave) Deputy practice manager (gapped since September 2024) Administrators – 5 posts full time (2 posts vacant)

[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 acting Senior Medical Officer (SMO) and 1 of the civilian medical practitioners were the safeguarding leads for the practice. Staff were in-date for safeguarding training at a level appropriate to their role with the exceptions being members of staff who were on long-term absence. However, those trained to level 3 had not completed levels 1 and 2. NHS training sessions were made available to military staff Safeguarding policies were in place for children and adults were available on the healthcare governance (HcG) workbook and displayed in the patient waiting area.

Vulnerable patients were identified through the patient registration process, summarisation of patient records and through identification from the welfare team. A clinical code and alert were applied to individual DMICP (electronic patient record system) records to ensure the small number of patients recognised as vulnerable were readily identified. Regular DMICP searches including for care leavers were undertaken to identify vulnerable patients for review at a dedicated ‘vulnerable patient’ meeting attended by doctors and nurses. We discussed that it would be best practice to maintain a list of vulnerable patients separate to DMICP.

The acting SMO attended the Commander’s Monthly Case Review meetings and the practice manager attended the quarterly Unit Health and Wellbeing Committee meetings at which the needs of vulnerable patients were reviewed. There were 15 patients under the age of 18 registered at the practice, 7 did not have an alert on their record.

We were given examples of how the practice had worked effectively together to support a vulnerable person. These demonstrated a joined up approach with the welfare team and Chain of Command.

The chaperone policy was reviewed in June 2024 and formed part of the induction. A standard operating procedure (SOP) was available on the HcG workbook. The availability of a chaperone was prominently displayed in the patient information leaflet and on posters in the waiting area and in clinical rooms. In addition, there was a list of trained chaperones on the HcG workbook (included the date when training had been completed). Our review of patient records showed the offer/use of a chaperones was coded on DMICP and the practice used synonyms as short cuts to standardise the record keeping. Chaperone training was completed by all staff with refresher training planned for March 2025. However, it was normal procedure to use a nurse when a chaperone was required.

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 Defence Primary Healthcare (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 7 nurse was the lead for infection prevention and control (IPC) and during period of leave was covered by the Band 6 nurses at each site. The IPC link practitioner training had been completed by the leads and 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 handwashing instruction. Hand sanitiser was available at doors leading directly to the practice and appropriate equipment was available for bodily fluids spills and healthcare related waste. The practice followed DPHC SOPs in relation to isolation requirements, a room was allocated to be used in the event of an outbreak and an 'outbreak policy' was written but due a review. Any patient suspected of having an infectious disease prior to entering the building was triaged by telephone and if required to attend in person, was chaperoned through a different entrance and given a face mask to wear.

The IPC SOP was reviewed annually and guidance was also contained in a sub-set of policies and SOPs that included curtain changing, decontamination, sharps/body fluid exposure and national standards of healthcare cleanliness. IPC audits were submitted through the DPHC online portal in accordance with the required frequency. An action plan was in place from the last annual IPC audit, December 2024 at Lichfield Medical Centre (LMC) and January 2025 at Birmingham Medical Facility (BMF). At LMC, 3 actions were outstanding and were due to be discussed at the next practice meeting. These included a weekly clean of the water cooler and the requirement to have holders for gloves/aprons where samples were tested. At BMF, the facilities were dated and the infrastructure issues created IPC problems. The BMF patient toilet was not fit for purpose with inadequate ventilation and space, peeling paint and an unpainted door which prevented effective cleaning being possible. The disabled toilet was located on the ground floor with no effective system to sound the alarm or call for help. These issues had been raised in January 2023 and escalated to DPHC Headquarters in November 2023. A visit had been planned for October 2024 but this had been cancelled and there had been no progress. We noted that there were no dates on the curtains at BMF to notify when last changed.

An environmental cleaning schedule was in place and despite the infrastructure issues, BMF had access to the Birmingham Hospitals Trust and found it straightforward to request a 'terminal clean' (the cleaning of a room after use to control the spread of infections). The cleaning schedule included bi-annual deep cleans as a minimum which took place during the host units' standdown periods. Environmental audits were completed annually at both sites. At LMF, areas were checked and a signoff sheet completed weekly. Cleaning resources were available for staff including spill kits and decontamination equipment.

There was no PCRF (primary care rehabilitation facility) staff member allocated so the IPC leads included the PCRF in their audit programme. The room used at BMF was not inspected as no services were being provided at the time of inspection (due to staff shortages) but had been internally audited in January 2024. The PCRF at LMF was audited annually with the most recent carried out in March 2024. There was a log of cleaning issues and action had been taken. The HCG workbook included detail of when and to who issues were escalated but the record could have included more detail of actions taken post escalation to evidence that the issue had been resolved.

At LMC, the dental centre practice manager oversaw the contract for clinical waste for the whole building. A clinical waste log (maintained by the nurses) and consignment notes (retained by the practice manager) were in place and up-to-date at both sites. 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 including pharmaceutical waste was stored securely outside of the building. The last audits for PCRF waste were carried out in September 2024 for LMC and in October 2024 for BMF.

Risks to patients

The practice had significant problems with attendance, recruitment and retention of staff. Although the team demonstrated a committed and flexible approach to completing tasks, concerns of staff burnout were raised to us from both internal and external sources. A number of staff described the demands on them to be similar to what is expected when on operations and not sustainable for a fixed base medical centre. We heard reports of staff working regularly outside their contracted hours to complete essential tasks. The less than optimal skills mix and opening hours compounded the problem with staff shortages. Due to staff absence, there were only 2 clinicians were trained to deliver occupational medicine and there were 36 joint medical employment standards (JMES) due to be reviewed in the next month (JMES is a medical examination to determine fitness to perform tasks and delays can be impactful on an individual's career progression). The opening hours at BMF made it necessary to have a doctor in the building until 16:00 but the hours worked did not cover this.

Although amber opal status (OPAL definitions in DPHC policy meant that certain tasks were to be prioritised due to significant capacity concerns) had been declared, the full range of services with the exception of sports medicals continued to be provided. Administrative errors such as confidentiality breaches were considered to be due to workload. Posts were vacant across all departments with the most significant impact being the lack of resource to complete administrative and monitoring activity, for example, clinical audit. Although administrative tasks were being completed, this impacted medics who were used to fill gapped posts within the administration team. This reduced opportunities for them to develop and utilise their clinical skills. Although medics were employed to cover administrative roles, they were having to be used to cover gapped administrative posts. Treatment being delivered was safe but the requirements for temporary healthcare workers led to a lack of continuity for patients and more pressure on the workload for substantive staff. Staff sickness was a standing agenda item om the heads of department meeting agenda to ensure concerns and needs were discussed. Return to work interviews were held as part of trend analysis on sickness absence. Staffing levels were also reviewed at Monday morning meetings and clinics redistributed or cancelled to address any priorities.

Clinical hours had been restricted to mornings in the main at both practices (BMF had only offered morning nursing clinics for the last 2 years to maintain a safe service. Due to losing a key member of staff and the upcoming CQC inspection, the acting band 7 nurse had been granted 5 hours overtime per week for the last 3 months. Annual leave was deconflicted and school holidays taken into consideration. However, nurses stated that day

to day work was happening but they had been unable to develop any initiatives for proactive care.

A full check of the medical emergency kit and emergency medicines was undertaken monthly and a record of checks kept on SharePoint. Processes governing when the trolley had been opened/used at LMC required strengthening. Checks of the tags should be recorded on a check list (referred to as Fmed 373s) to provide a record and the trolley was unlocked contrary to the security requirements for some of the medicines contained. The trolley had recently been relocated and gas signage together with ambient room temperature monitoring were required. All medicines and emergency equipment was present and in-date. Emergency medicines were kept in the dispensary as it was a temperature controlled location. It was stated that the emergency medicines SOP had been reviewed recently by the acting SMO although the last signed off review was completed in February 2024. Medical gas cylinders were stored alongside the emergency trolley and appropriate signage was in place. An automated external defibrillator (AED) was available in the PCRF building but there was no signage in situ. At BMF, staff had access to the hospital's emergency trolley system and nurse checks were carried out daily.

The staff team was up-to-date with basic life support training, anaphylaxis and the use of an AED. The locally held staff database was updated after training by individuals and there was an SOP for resuscitation that included an assessment of the local population at risk. Resuscitation leads had terms of reference in place.

At LMC, the equipment on top of the resuscitation trolley was checked daily. The medicines held in the grab bag and in the resuscitation trolley were listed and the pharmacy technician had responsibility to ensure they remained in-date. The temperature of the room where the trolley was stored was recorded daily and the drugs grab bag was changed completely at the end of the summer period when the room temperature was likely to have regularly exceeded 25 degrees Celsius. The resuscitation trolley was checked monthly by nursing staff to ensure all equipment inside the trolley was in-date and relevant with the recommendations of The Resuscitation Council. The log of equipment was held on an excel document on Sharepoint so that rapid identification of any item due replacement could be done well in advance to ensure receipt before expiry. A quick guide folder that detailed the latest guidelines was held with the resuscitation trolley.

Scenario-based or 'moulage' training had not been facilitated in the last 12 months and this was attributed to impact of staffing gaps. At BMF, the close proximity to the accident and emergency department was identified as a caveat to their minimal training.

Clinical staff had completed thermal injury online training. The rooms used for rehabilitation were air-conditioned to mitigate the risk of heat/cold injuries. We were advised there was no 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 displayed in the practice, training was programmed in for June 2025.

Information to deliver safe care and treatment

Staff reported minor concerns with DMICP outages, there had been approximately 5 outages in the last 12 months which had resulted in cancelled clinics. During both planned and unplanned outages, the practice initiated the business continuity plan. Clinic lists were routinely printed for the following day so patients could be contacted in the event of an outage. Hard copy consultation formed part of the 'break out packs' available for use during these incidents and records were scanned onto the system at a later point. The PCRF rearranged new patients when experiencing a power outage and follow up consultation notes were recorded on paper and then scanned onto the system.

The summarisation of patient notes was carried out by the nurses but we found that the searches were not current and therefore the data was not accurate. The data produced by the practice was showing that 100% of notes were summarised but a clinical search ran as part of the inspection showed that there were 281 patients whose notes required summarising. A DMICP search we ran revealed that 678 had not been summarised in the last 3 years (DPHC policy states they should have been summarised in the last 5 years but there was no established search for this on DMICP as yet). Records of all newly registered patients joining the practice were scrutinised for any outstanding alerts or issues and there was a local working practice policy for Phase 2 trainees to identify their clinical needs (vaccines, audiometry) ahead of the initial new patient consultation.

When reviewing the records we came across a few sets of notes for patients with chronic disease where the summary pages were very untidy. We found an example of summarising according to the Read coding applied previously. This was not good practice as it would not identify any errors nor exclusion in coding.

Some arrangements were in place for the auditing of consultation records. The nurse team had carried out peer reviews of one another's notes in the last month. Consultation auditing was also carried out within the nursing team. This had repeated quarterly and the last result achieved 85% compliance. Improvement had been facilitated by the extensive use of synonyms. Using the DPHC audit tool, doctors regularly audited the records of their colleagues by random allocation and this included an audit of the SMO's consultation notes. The clinical record audits we reviewed were of a good standard.

There was no system to ensure a registered healthcare professional reviewed clinical records maintained by the medics. In the PCRF, low staffing levels and single handed posts had resulted in no recent assurance activity over clinical practice and note keeping. However, good communication links were established with the Regional Rehabilitation Unit and the exercise rehabilitation instructor (ERI) received annual reviews and an in-house assessment. Multidisciplinary meetings that included the physiotherapist and ERI were held.

There was no clinical oversight from a healthcare professional for the medics. Although a more senior medic planned quarterly audits, these had not been done in the last quarter. This was attributed to a lack of time. Much of the clinical work carried out by the medics was preliminary (blood pressure, blood tests) but they were triaging calls from patients. Although trained to carry out this role (related rather than specific training), without clinical

oversight, clinical development and identification of issues would not likely happen unless caught opportunistically.

Although there was a system in place for the management of samples (included SOPs for both pathology link results and specimen handling), the nursing team were reviewing the process to make improvements. A specimen register was maintained and there were separate registers for LMC and BMF. Tests were followed up if any delays occurred and each result was audited through daily checks. Two recent results remained unfiled on Path Links (NHS clinical pathology service) so the system was not as robust as it could be. There was awareness that the inbox did have lots of results that could not be archived because of linked tasks (outstanding actions). This had been discussed at a doctors' meeting in September 2024 but the plan was yet to be fully actioned. Patient samples were sometimes left in the sluice, this had led to problems with patient confidentiality and sample being identifiable.

Patients were asked how they wished to be informed of an abnormal pathology result; either by email, via GOV.UK.Notify or a telephone call. Normal results were not routinely shared with patients unless the patient requested so. Test results requiring follow up were 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 referrals manager, 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 continuously and the system updated accordingly. 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 where wait times for secondary care were longer than expected, safety netting was in place with the patient advised to return if symptoms worsened.

Any additional or second opinion requests for imaging would generate a new referral and this would be tracked in the same way. Imaging not reported on within 4 weeks of the appointment was picked up from the referral tracker spreadsheet and requests made to the hospital for copies of reports to be sent directly to the referrals clerk via post. Images that enhanced a referral to secondary care such as ones taken by the patient and included with a GP referral followed strict guidelines which the patients were advised of before sending. They were saved to the patient record and sent securely via the electronic referral system.

The physiotherapists monitored their own referrals using an electronic system. External referrals to Regional Rehabilitation Unit and Minor Injuries Assessment Centre were managed by the department via DMICP tasks and acceptance on to a caseload

register. On appointment of the part-time administration support officer, it was planned to implement a robust referral tracker as a second line of assurance to these.

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.

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.

Access to the dispensary was controlled by a key code. There was an SOP that stated 'limited access' but did not state who. Staff reported that access was permitted for the PT, SMO and medics but the practice nurse was also aware of the code.

Controlled and accountable drugs (medicines with a potential for misuse) were stored in the controlled drugs (CD) cabinet. A register was maintained each time a clinician accessed the dispensary and CD cabinet. However, the SOP required updating to confirm who had permitted access including when outside of working hours.

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 4 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 (CO) and acting SMO. The destruction certificates we reviewed were in accordance with policy and had been signed by a suitable external officer and acting SMO (or delegated doctor if absent). A CD audit for 2024 had been completed and no issues were identified. We highlighted that justification should be added to the audit when findings were not fully compliant.

The vaccine fridges were compliant with policy. However, we found that the data logger in the dispensary fridge was not on and required a replacement battery. This had been escalated to the regional pharmacist as it required authorisation. 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 rear of fridge. Based on our review 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 when transferring vaccines between clinics. These would be conditioned in advance of notified power outages. In addition, there was an emergency fridge at the LMC where stock could be transferred to when required. BMF had a backup generator in place due to it being an NHS trust building. During the Christmas shutdown period, vaccinations were transferred to a supporting department within the trust who took safe custody for temperature management during close periods.

Patient Group Directions (PGDs) to administer medicines in line with legislation were used by the nurses. An audit from August 2024 evidenced that their PGD training was current. In addition, an individual and unit audit had been carried out in January 2024 and no issues were identified. PGDs had been signed off by the SMO within the last 2 years and the nurses advised that no delegation under PGDs occurred. Patient Specific Directions were not currently used by clinicians although staff were aware of the requirements and required support from DPHC on defining the scope of the new role of a nurse assistant once in post.

Repeat prescriptions could be requested via email, placing a repeat prescription request slip in a box outside the dispensary, in person or via eConsult. Telephone requests were not accepted and this was explained in the patient information leaflet. There was a 72-hour timeframe to fulfil prescription requests but often they were completed sooner. 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 sign the printed prescription. If the medicine review was out-of-date then the PT telephoned the patient to make an appointment for a review. There was no data available on the number of patients receiving repeat medicines and how many had a medicines review in the last 12 months.

A process was in place to monitor high risk medicines (HRM), including regular searches to identify when blood tests were due. There was good communication between the PT and practice nurses who conducted monthly checks to review and recall patients for monitoring. This process was managed using a spreadsheet. Our review of a selection of patient records showed that although notes could have been set out more concisely, HRMs were managed in line with DPHC requirements for monitoring. However, the DPHC standard searches were not being used and this left a potential gap in identifying new patients on HRMs. HRMs were effectively monitored to regularly review the health status of patients prescribed these medicines. They were monitored through consultations, alerts and though audit. We highlighted that the audit could be more effectively used for quality improvement by a formal analysis of the data to make suggestions for improvement.

The PT attended the practice clinical meetings and was involved in the routine system searches to identify patients requiring a medicines review. The PT reviewed patients who had not been contacted for or requested a medicine review and forwarded this information to the prescribers to action.

All prescriptions were signed before dispensing. We observed the PT effectively counselling patients about their medicine, including responding to any patient questions. Prescriptions of steroids were dispensed with patient information cards but there were no information cards for direct oral anticoagulants (an HRM with a high risk of bleeding) nor methotrexate booklets (an HRM normally initially prescribed in secondary care).

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, there was an SOP that required 10% of scans to be checked.

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.

Monthly DMICP searches for patients prescribed Valproate (medicine to treat epilepsy and bipolar disorder) were undertaken. There were no patients on Valproate but the PT was aware of the considerations and action required for patients prescribed this medicine.

There was no evidence of any recent antibiotic audits to monitor that antimicrobial prescriptions adhered to the current guidance.

Track record on safety

The SMO was the risk owner for the practice and the practice manager was the risk manager. The practice manager and deputy were the leads for health and safety (referred to as SHEF) and for the maintenance of medical equipment. The practice manager and business manager shared the lead for infrastructure (building custodians) and these roles incorporated responsibilities for fire safety.

The practice manager managed the risk registers at both sites. In accordance with DPHC requirements, a range of risk assessments was in place and these were reviewed monthly at the HcG meetings. They took into account the DPHC ‘4 T’s process’ (transfer, tolerate, treat, terminate) to illustrate at what level each risk was being managed.

The practice manager had completed the risk assessments for substances hazardous to health (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 May 2024 (LMC) and June 2024 (BMF) and the electrical inspection certificate in July 2024 (LMC) and February 2024 (BMF). The legionella risk assessment was carried out in May 2024 at LMC but there was no copy of the most recent one from BMF. The last documented test at BMF was in 2021 and staff had been chasing the last report and evidence of repeated testing since early 2024. There was evidence that remedial action had been taken as a result of legionella testing. For example, a sink had been removed and water temperature issues in a nurse’s room had been rectified. Staff reported that obtaining information from the Trust was challenging.

The 5-yearly fire risk assessment for the premises was completed in March 2024 at LMC. At BMF, the NHS Trust had advised that they held an in-date certificate but the practice had been unable to obtain a copy. Weekly and monthly checks of the fire alarm system and firefighting equipment were up-to-date. A fire evacuation drill was held annually with the most recent taking place in December 2024 at LMC. BMF did have an annual assessment due to the location being inside an NHS building. Both sites tested the fire alarm weekly (carried out by the contracting team). The building custodians completed online audit for unit monitoring purposes through an online audit tool on Share

Point. There were appointed fire leads at both sites and weekly checks of fire equipment and the fire panels. Regimental Sargeant Majors signed both sites off under unit CO's fire warden responsibilities.

The practice manager was the lead for equipment. The actions identified from the 2024 annual equipment inspection (referred to as a LEA) for the medical centre had been completed. 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 and recorded the checks on the HcG workbook. We found that overall the process for monitoring PCRF equipment maintenance was robust with Medical and Dental Service Sections visits caried out annually to carry out servicing and calibration.

In-date SOPs were available for use of the gym and how to treat 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 at LMC.

An alarm system was in place for staff to summon assistance in the event of an emergency. We tested the response to the panic alarm in the PCRF during our visit and there was no response. Staff reported that normally there would be a phone call response from the guard room. This was reliant on PCRF staff answering the phone call and there was no evidence of a physical follow up when the call was not answered. Staff were not clear on how to respond if a medical emergency were to occur. A risk assessment had been completed but it lacked detail on the emergency points of contact.

Personal alarm boxes were available at LMC to be signed out from reception on a daily basis for those who occupied single office space. When the distress button was activated from an alarm box, it notified the guardroom and included a loud noise from the box itself. For all other staff members, each desk space had a pull cord (rape alarm) that made a loud noise to alert others when activated. A business case had been submitted to upgrade the alarm system at LMC.

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 and had access to the system. One of the practice nurses was the lead for ASER and the business manager deputised.

An ASER register was established and 30 had been raised in the preceding 12 months. We discussed 2 in detail and found they had been managed effectively and included a record of resultant actions. ASER was a standing agenda item at the practice meetings and those of a clinical nature were discussed at clinical meetings. Meeting minutes from October 2024 showed ASERs were discussed and changes made if appropriate.

The trend analysis carried out in-house was not embedded as an effective process as the time period we reviewed (October to December 2024) lacked detail on effective action taken and did not include some of the ASERs that we were shown. However, we were told that trend analysis was carried out by the Regional HcG Lead.

The practice manager was the designated lead for alerts management and delegated day to day responsibility to a senior/lead medic (junior non-commissioned officer or JNCO) and to the PT who managed notices and alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). The lead medic checked the Central Alerting System (CAS) and MHRA website each morning and updated the CAS alert register accordingly, including a record of 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 out to prescribers. A link for all CAS alerts received that month was included in the HcG workbook although these did not work when we tried to follow them. In the absence of the PT and JNCO, the practice manager had access and was registered to receive notifications. This structure applied to both sites.

Are services effective?

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

Effective needs assessment, care and treatment

The clinical 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). Staff were kept informed of clinical and medicines updates through the Defence Primary Healthcare (DPHC) newsletter circulated each month. Links to policies were included in the minutes and on the healthcare governance (HcG) workbook.

Minutes from the doctors' meeting showed guidelines/updates were discussed, staff reported that the business manager and referrals clerk provided a support to ensure guidelines were being followed. Clinical pathways were discussed at doctors' meetings. The Primary Care Rehabilitation Facility (PCRF) used audit to monitor adherence with BPG. For example, annual audits were carried out on the treatment of back pain.

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.

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.

In addition to the weekly departmental meeting, PCRF staff attended clinical meetings and could discuss complex patients with the wider team, 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). 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. Our review of clinical records

showed patients with a mental health need were well managed and appropriate clinical coding was used.

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 prompt for those who did not respond. Patients were initially seen by a medic or nurse for preliminary checks, such as blood pressure, weight, blood or urine tests. One of the nurses was an independent prescriber so was able to prescribe and had extensive experience manging LTCs in the NHS. Doctors were involved with medication reviews and maintained an oversight of LTCs as part of the clinical meetings. A meeting was planned for a full review with of LTCs with the new Senior Medical Officer (SMO). In addition, the practice development plan included an aim to better coordinate blood tests with patient reviews.

There were higher than average numbers of patients identified as having an LTC due to the patient demographic. The information provided by the practice identified 71 patients with high blood pressure, 69 had a blood pressure recorded in the last 12 months, 56 patients had a blood pressure reading of 150/90 or less which indicated positive blood pressure control. Of the 9 patients on the diabetes register, 6 had a last measured total cholesterol of 5mmol/l or less which is an indicator of positive cholesterol control, and 8 had a last blood pressure reading of 150/90 or less. There were 21 patients on the asthma register, 17 had been given an asthma review in the last 12 months. The remaining 4 were actively being followed up and had been invited for a review.

The use of LTC templates was consistent and failsafe searches were used to maintain comprehensive registers of all patients with an LTC. The Band 7 nurse was involved in the LTC working group and used the DPHC standard operating procedure (SOP) to guide practice. A review of the notes highlighted good practice with treatment and care provided to patients. We noted that the summary page for some patients was not clearly laid out, for example, non-problems filed as problems. This resulted in significant history not always being visible on the front page creating a risk that they could be missed. More detailed summarising would rectify this issue and although some of these issues were received into the practice when registering new patients, we found evidence that issues had not always been corrected when summarised at the practice.

A register was held of any patients who had been identified as pre-diabetic, all patients on this register had been assigned a Read code (C11y5) and diary entry to allow for a monthly search to identify patients who due their annual review. The annual review consisted of a glucose screening test, blood test, history and lifestyle advice (including Qrisk3 calculation) which was in line with the DPHC SOP for chronic disease and LTC management. In the past year, searches had been completed to identify patients who may not have been coded effectively and therefore may have been at risk of not being recalled for an annual blood test. A search was completed at least every six months to capture new patients.

Through a review of clinical records and discussions with the doctors, we were assured that the care of patients with a mental illness and/or depressive symptoms was being effectively and safely managed, often in conjunction with the Department of Community Mental Health (DCMH). Waiting times for an initial assessment were 2-3 weeks. The practice followed the DPHC guidance and provided step 1 interventions and immediate referral for appropriate diagnoses. We noted that there were some useful counselling services available locally that could bridge the gap into DPHC. Mental health information resources were displayed and accessible in patient waiting areas. A depression audit had been carried out which looked at timeliness of follow up after diagnosis. This audit highlighted a good compliance with standards.

Patients were invited opportunistically for NHS health checks to offer health promotion and identify patients who may be at risk of developing diabetes. A clinical search highlighted that 219 of 423 eligible patients had completed an overs 40s health check.

Audiometry assessments were in-date for 73% of the patient population. Our review of patient records demonstrated Joint Medical Employment Standards (referred to as JMES) were appropriately managed although there was a backlog of patients to be seen.

The Band 6 nurse was the lead for audit and the business manager was the deputy lead. Quality improvement activity, including clinical audit was used to evaluate the quality of care and improve patient outcomes. Although there was evidence of audit and a central audit location on SharePoint, there was no integrated audit programme for the medical centre and PCRF. The practice planned to develop a programme of audit using titles from NICE Clinical Knowledge Summaries (concise summaries for primary care practitioners of current evidence based and best practice guidance). 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 HcG workbook with links to the completed document.

The nursing team audits were largely centred around LTCs and patient recall. There was an established peer review consultation audit repeated every 12 months as a minimum.

Quality assessment and improvement work (QIP) was undertaken by the practice and PCRF team. However, staff reported that staffing levels had prevented further work from being completed. For example, ongoing QIPs in the PCRF had not been written up due to administrative constraints. Recent best practice auditing in the PCRF had resulted in improved practice. Recent audits caried out by doctors included a periodic review of patients on antidepressants. This had produced a number of recommendations but there had only been a single cycle. Another audit on high blood pressure in patients without a diagnosis of hypertension produced some useful actions. Again this was a first cycle audit, repeat cycles were required to monitor progress against the initial benchmark.

Audit was a standing agenda item at practice meetings. QIPs were added to the DPHC HcG SharePoint platform to allow the data to be shared externally via regional leads. Links to the audits were included in the minutes.

Effective staffing

An induction pack was in place for new staff and included a checklist of 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 role specific inductions did not extend to the PCRF where there was nothing tailored to the department and links to specific training were omitted. This indicated a lack of awareness of the PCRF staff development requirement.

The SMO used the GP induction pack for locum doctors. This was a comprehensive document that was praised by locum doctors we spoke with. The specific induction pack for doctors was comprehensive and included specific military aspects such as the need for weapon handling risk assessments for patients.

A database detailed training status by individual and this was a standing agenda item at practice meetings. The status was reviewed regularly by the deputy practice manager in their role as training coordinator, and a notification email send to advise individual staff on training requirements. The currency of mandatory training was a challenge due to the gaps in staffing. Although protected time was set aside each week, we were told that this time was often used to catch up with essential administrative tasks. Lichfield Medical Centre (LMC) had managed to complete a catch up programme in the weeks before we inspected. This had not been possible at Birmingham Medical Facility (BMF) and mandatory training was out of date for some staff.

Staff had access to training specific to their lead and secondary roles. For example, one of the nurses was supported in studying for an asthma diploma and the staff who administered vaccinations received specific training and medics were signed up to complete the Defence Medical Services apprenticeship scheme. Staff with lead roles conducted the necessary training either through external courses or online. For example, military staff had completed promotion leadership courses and civil servants the line management course.

The skillset and qualifications within the doctors allowed patients to have driving and diving medicals. Nurses had completed courses in cervical screening, chronic disease management and smoking cessation. The PCRF team had personal continued professional development logs and were registered with regulatory bodies in their specialist area.

Supervision arrangements were in place, for example, the nurses engaged with other practice nurses for peer review and clinical supervision. We highlighted that there was a gap in oversight of the medics, specifically around reviewing their triage of on the day appointment requests. One of the senior medics did conduct reviews but these should be supported by a registered healthcare professional. After the inspection, we were told that reviews of on the day triage were reviewed by the duty doctor.

The medics were supported by the nurses when conducting blood clinics. They had received training and maintained clinical competency through supervision with the nurses. However, there was no formalised process to support this.

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, welfare and the padre who all provided positive feedback as part of this inspection. The SMO attended the monthly Commanders Monthly Case Review (CMCR) meeting. A member of the PCRF team attended CMCR meetings. At these meetings vulnerable patients were discussed along with an update on occupational health, injury and downgrade statistics.

The practice has linked in with local hospitals, hospice, palliative care service and the nearby 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. Complex patients would be given a doctor to doctor handover.

Helping patients to live healthier lives

The Band 7 nurse oversaw the health promotion programme supported by the Band 6 nurse at BMF. This was while the lead role was gapped awaiting an additional nurse to commence employment. 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 sexual health contact for screening, diabetes management, and lifestyle checks. Health promotion displays were changed dependant on the season and supported national initiatives. The effect of health promotion activity was not regularly audited for impact/outcome. This was due to 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 with the most recent focussed on smoking cessation and blood pressure.

The PCRF could refer patients to either a physical training instructor 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.

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 Birmingham and Tamworth, which provided face-to-face appointments. Long-acting reversible contraception (referred to as LARC) were provided through local sexual health clinics. An arrangement was in place for pregnant service personnel to register with a local NHS GP practice for midwifery care.

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. Monthly searches were used to recall patients for cervical screening. Texts were sent to patients along with an email and letter explaining to the patient why they were eligible for screening. Ninety-six percent (438) of eligible patients were in-date for cervical screening. The NHS target was 80%.

The administration team oversaw the vaccination monitoring and recall for the units they were attached to. Monthly recalls had been in place but capacity (lack of nurses to administer the vaccinations) was preventing this from being a monthly task. As a contingency, patients had been captured for recall through pre-deployment checks and when presenting in clinic, the nurses would do a spot check whilst the patient was present. With the new Band 5 temporary health worker in place, monthly recalls were due to recommence. At the time of the inspection, the vaccination statistics for eligible service personnel was:

- 93% of patients were in-date for vaccination against diphtheria.
- 93% of patients were in-date for vaccination against polio.
- 97% of patients were in-date for vaccination against hepatitis B.
- 92% of patients were in-date for vaccination against hepatitis A.
- 93% of patients were in-date for vaccination against tetanus.
- 98% of patients were in-date for vaccination against measles, mumps and rubella.
- 100% of patients were in-date for vaccination against meningitis.

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. Consent was sought to release 'medical-in-confidence', usually in relation to the sharing of information with the unit Chain of Command.

An ongoing consent audit was in place but the data had yet to be collated. 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 received annual training on mental capacity and it had been discussed at

practice and nurse meetings. In addition, mental capacity was covered with specific areas applicable for nurses. We were given an example when a capacity assessment was considered due to alcohol dependence and abuse.

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. Nurses showed a good awareness of the guidelines although alerts had not been added to the records of all patients under 18 years.

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 31 patients. We reviewed the 17 responses received from the practice's most recent patient survey which Included feedback on the Primary Care Rehabilitation Facility. Feedback suggested staff were kind, understanding and compassionate. However, there was a theme of patients having to wait for appointments and a lack of continuity in terms of seeing the same clinician.

The practice responded positively to patient feedback. For example, repeat prescribing had been streamlined for patients with outsourcing contracts developed with external pharmacies that were closer to the main accommodation areas.

Staff provided various of examples of when the practice had 'gone the extra mile' to support patients. For example, a nurse had advocated for a patient following a bike accident and used connections with the Queen Elizabeth Hospital to facilitate quick plastic surgery involvement which resulted in a good cosmetic outcome. We spoke with a patient who gave us a detailed account on the exceptional care provided to them that included clinicians researching to gain a better understanding of a complex condition and consistent liaison with a number of secondary care providers.

Continuity was facilitated where possible, such as for rehabilitation. However, with the number of gapped posts being filled by temporary healthcare workers, we did hear from some patients that continuity of seeing the same clinician was an issue. 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 was 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 there had been no recent requirement to engage with the service. However, there clear instructions were displayed for staff to follow and the translation service was advertised in patient 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 29 carers identified had a clinical code and alert applied to their

record. There was no separate register maintained but there were plans to establish one. There was a standard operating procedure (SOP) that detailed how support should be provided and how carers should be identified on the system. We discussed the information added to alerts that detailed the caring responsibilities of the patient. This was not detailed in the SOP and the practice agreed to remove personal information that was visible to whoever accessed the patient record. Information for carers was displayed for patients to access. They were offered enhanced services, such as the flu vaccination. It was planned to set up annual heath checks on the wellbeing of carers. Information about support services was displayed in the waiting area and outlined in the practice's patient information leaflet.

Privacy and dignity

Patient consultations/assessments took place in clinical rooms with the door closed. 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 region. This was detailed on the new patient welcome email.

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 generally satisfied with the responsiveness of the service. A walk in triage system was run using the medics or a nurse as solely for on-the-day appointment requests. A standard form was used to detail the patient's symptoms and basic tests (blood pressure, temperature) were taken. Patients were encouraged to use eConsults, a system that included a few text section for the patient to describe their symptoms. Video consultations were not offered but telephone appointments were an option, for example, given to long-term condition patients when the required information such as blood test results had been received. In such cases, the follow up could then be done via telephone.

Nurse clinics were not provided in the afternoon to provide protected time for administrative tasks. Urgent patients would be seen and we highlighted that this could be better communicated as some feedback from patients suggested there was a lack of awareness. However, afternoon clinics were provided for new intakes (4 times per annum) to provide the required surge in capacity.

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 most notably at the Birmingham Medical Facility (BMF) where attention was given to shift patterns worked at the hospital. Occupational health appointments were available within 5 days.

The patient information leaflet detailed the types of clinics available and the clinician the patient needed to book an appointment with. These extended to external services such as chiropody and eyesight tests.

We were given examples of when the practice had pro-actively responded to patient feedback. For example, delayed sick notes and an incorrect referral to trauma and orthopaedics had led to a complaint from a patient. The management of ruptured achillies injuries was discussed in a clinical meeting to re-educate clinicians.

The practice manager was the diversity, equality and inclusion (DE&I) lead for the practice deputised by the business manager. In line with the Equality Act 2010, an access audit for the building had been completed in December 2024 with a separate audit carried out on the primary care rehabilitation facility (PCRF) in the same month. There was ramp access to the front door and a regularly serviced lift to the upper floor at BMF where the practice was on the first floor. Induction loops were available for those patients with a hearing impairment and mobility aids (wheelchairs and crutches) were available. Disabled parking

spaces were available and staff were aware of the DPHC transgender standard operating procedure.

The building layout and infrastructure at BMF was not suitable for a primary care facility. The accessible toilet (part of the general hospital, not BMF, but could be used by a patient when required) had no effective means to call for assistance. The toilet was on the ground floor and any assistance would require a call for help from the patient which would be reliant on somebody walking past. The patient toilet at BMF had an unpleasant odour due to inadequate ventilation and being in such a cramped space. Signage to the medical centre was lacking and the inspection team had to rely on asking passers-by for directions.

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. The team were aware of and were awaiting the new Defence Primary Healthcare policy (standard operating procedure 1-4-5) for transgender patients. The Practice had picked up and raised an ASER when receiving a new patient who had not been managed in accordance with policy.

The practice staff were aware of the mandated training for learning disability and autism introduced in April 2024. Individual staff members were in the process of completing the tier 1 training,

Timely access to care and treatment

From patient feedback we confirmed patients were satisfied with timely access to a clinician. Medics described how they carried out an assessment on same day appointment requests. 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. Medics used a standard form to record the triage of patients.

Routine appointments with a doctor or nurse could be facilitated within a day. Same day urgent appointments were available with a nurse and within 1 day for a routine appointment. A routine physiotherapy new patient appointment was accommodated within 10 working days and follow-up appointments were available daily. An urgent physiotherapy appointment was available within 24 hours although staff reported such requests were rare.

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 2 weeks.

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 practice manager was the lead for complaints and the business manager deputised. Complaints were managed in accordance with the DPHC complaints policy and the practice standard operating procedure. There had been 5 complaints and 4 compliments raised in the last 12 months.

Both verbal and written complaints were logged onto a register and monitored. Complaints about clinical care were referred to the SMO. The practice manager managed complaints that related to the PCRF.

The SMO outlined 2 recent clinical complaints, which were appropriately managed well and to the satisfaction of the complainant. Minutes showed that complaints and compliments were a standing agenda item at practice meetings. There had not been any recent complaints audit due to staff shortages.

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.

Are services well-led?

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

Vision and strategy

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

> "….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."

It was evident that the team were proactively working towards achieving the mission and that they were highly responsive to the needs of individual patients and the occupational needs of the units, faced with the current challenges. Staff at both practices and the primary care rehabilitation facility (PCRF) worked hard to deliver the best possible care to patients.

The leadership team worked on improving collaboration between the practices, for example though 'white space' days: but this was challenging with the sites being approximately 1 hour apart and the significant differences between the patients' needs at each site. Therefore, there was a movement to build pride of location with cross practice support and utilise the combining to improve efficiency of processes where possible. It was an aim to establish a doctor per site in order to build relations with the units at each location. We recognised that developing the combined practice was a time consuming process for the acting Senior Medical Officer (SMO) who was a 0.6 full time equivalent. A new SMO commenced in post on the day of inspection. There was a combined practice action plan in place which was continually reviewed.

The regional team visited regularly and provided support. We met the regional team as part of the inspection and discussed the sustainability of services in light of the staffing gaps. The practice had continued in trying to provide the full range of services during a sustained period of being under resourced and it was evident that this had impacted staff, most notably there was low morale amongst the team at Birmingham Medical Facility (BMF).

Although no formal PCRF development plan for 2025 in place, there was a focus on delivering the care to patients and time for other matters was constrained. However, there were indications throughout the inspection that there could be better integration of PCRF within the practice. This was not helped by the department being in a separate building at Lichfield Medical Centre and rehabilitation temporarily ceased at BMF due to issues with the infrastructure.

To address environmental sustainability, recycling was encouraged and procedures were in place to conserve energy by switching off lights, closing windows to retain heat in the building and minimise the use of the heating system. Recycle bins were available in each

communal room and there were processes designed to reduce the use of paper. There was an environmental health care board and the practice manager attended biannual Station meetings as the climatic champion.

Leadership, capacity and capability

Since August 2024, the leadership team comprised of a part-time acting SMO and a practice manager. This had resulted in a lack of capacity to cover both sites and full operational capability as a combined practice had not been granted until October 2024. The work to achieve this had put further pressure on resource and time constraints. The result was a combined practice that lacked the capacity to explore the synergies that may be available. Of note, BMF had been through a period of not having visible leadership in place and there was some confusion over the line management of military staff. Although attempts had been made to combine meetings using technology, the two sites presented as a disparate merger which did not function effectively. The new SMO would provide essential additional leadership resource and facilitate the planned deputy civilian SMO role in BMF. However the continued absence of a deputy practice manager added continuing pressure to the system.

The dependence on medics to support clinical provision and to cover DPHC staffing gaps was not a risk as they were protected from being recalled by the unit at any point. However, the aspirations of medics to develop their clinical skills was being hindered by the requirement for them to cover administrative staffing gaps. There was a risk that they would deskill clinically.

Despite this staffing context over the last 12 months and the resultant strain, we recognised that staff were committed to their tasks and prioritised safe care and treatment. The dedicated approach to work saw staff continue to perform despite the challenges.

Staff described how the practice was well supported by Regional Headquarters. For example, the area manager was providing support to the nurses. The Regional Clinical Director, regional nurse advisor, regional healthcare governance (HcG) lead and regional quality assurance lead all provided support and visited regularly. Funding for temporary healthcare workers was available but it had proven difficult to find temporary staff.

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 leadership at BMF. The medics had taken on additional

duties, which at times impacted their continued professional development. Infrastructure changes at BMF resulted in the staff room being removed. Although we were told post inspection that there was access to staff room facilities, some of the team ate their lunch in the waiting area which was not appropriate.

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 at both sites for awareness.

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. DoC searches were run weekly and any Caldicott breach recorded on the DoC tab within the HcG workbook and discussed at HcG meetings (5 recorded in 2024, all were raised as an ASER). Staff members registered at either practice had an alert added to their registration. A search was available to cross check for assurance purposes, this included the military dental staff. Staff who had military family members registered at either practice also had an alert added to ensure unnecessary access.

Governance arrangements

There was a clear staffing structure in place and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. Terms of Reference were in place to support job roles, including staff who had lead roles for specific areas. Resilience was provided by appointed leads having named deputies (if applicable) who were sufficiently trained to deputise.

The practice had a designated meeting matrix in place in the HcG workbook. All staff had access to the online document which included various registers and links to ensure the flow of communication and information. The practice manager managed the HcG workbook and had created a tool for all staff to use and navigate it in its simplest of form.

The electronic health assurance framework (eHAF) was used to document and evidence governance activity and had been extensively populated by the practice management and other key staff members. The management action plan (MAP) within the eHAF was used to delegate information requests and gather evidence for staff specific to their role. The MAP was discussed during each HcG meeting to ensure requests were met in a timely manner.

Formal and informal communication channels were established, including regular structured meetings. However, the logistics of having 2 sites an hour apart made full practice face to face meetings a challenge. Practice, clinical, PCRF and HcG meetings were held each month. The nursing team held their own departmental meetings and utilised the eHAF to record and monitor activity.

A programme of quality improvement activity to monitor the outcomes and outputs of clinical practice was being developed. The mandated DPHC audits were completed and provided an effective monitoring of administrative practice.

Managing risks, issues and performance

The HcG workbook contained the active and retired risk registers. The active risk register was reviewed regularly with risk management being a standing agenda item at the monthly practice and HcG meetings. The key risks for the service were the infrastructure, most notably at BMF where infection prevention control standards could not be met due to the building. A review of the risk register showed that workforce levels were included and the shortage of staff in the PCRF was logged as a separate risk. Although the register contained detail of plans on how risks could be mitigated, it was not clear if these had been escalated where appropriate. Some of the risks included could be categorised as issues to allow focus on the priorities. After the inspection, it was confirmed that risks had been escalated.

Risk assessments were in place and reviews were in-date. Significant events and incidents were discussed at practice meetings, including any improvements identified.

A combined business continuity plan (BCP) was in place. This had last been reviewed in January 2025 by the CSMO. The CBCP is held on the HcG Workbook. A major incident plan was tested using a tabletop exercise for both facilities in September 2024. All possible scenarios were discussed with action on how to mitigate. Both facilities kept a ‘battle box’ to enable quick response to viable scenarios. These included action cards that detailed the responsible person in each scenario.

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. A performance improvement plan was agreed between the line manager and the staff member and reviews set.

Appropriate and accurate information

An internal assurance review was undertaken in June 2024 and the rating was ‘substantial assurance’. A number of key recommendations were identified and an action plan developed. Many of the actions had been completed, including those related to medicines management. Thise that remained outstanding or in need of further work included the introduction and regular underrating of simulated or ‘moulage’ training and the identification of additional actions to create a compassionate and inclusive workplace culture.

The practice used the HcG workbook to manage and monitor governance activity. The practice manager updated the workbook so the evidence was consistently up-to-date. Reviews of the workbook were carried out at each HcG meeting and management action plans formulated.

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 deputised by the practice manager. Caldicott checks were carried out each week 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 accessed via a QR code, leave feedback on an electronic tablet or complete a paper form made available in the waiting area. Notice boards including in the PCRF provided patients with action the practice had taken in response to feedback.

A staff feedback survey was carried out in December 2023. 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.

Engagement with staff at BMF was highlighted as an issue. Travel distances made it challenging for leaders to have a presence, most notably in the last 6 months when gaps and absenteeism had left BMF without a regular point of reference.

Continuous improvement and innovation

Depleted staffing levels over the last 12 months had limited the capacity for quality improvement activity (QIPs). The practice had aspirations to improve the service and some early audit work was highlighting areas of focus. In time second cycles will help to improve outcomes.

We found examples of QIPS that had been initiated but not recorded due to a lack of administration time. Only 2 had been recorded since June 2023. We complimented the nursing team on their use of synonyms to help standardise record keeping and for the

development of a chronic disease management tool. There was an SOP that was working well across both sites. In addition, templates had been developed for Gov.notifications.

‘Practice manager’ and ‘RAF medic knowledge hubs’ provided on SharePoint. These platforms provided guidance and kept staff informed of changes across Defence Medical Services.