Waddington Combined Medical Practice

RAF Waddington, Lincoln LN5 9NB

RAF Cranwell, Sleaford, Lincolnshire, NG34 8HB

RAF Coningsby, Lincoln, LN4 4SY.

Defence Medical Services inspection report

This report describes our judgement of the quality of care at Waddington Combined Medical Practice. It is based on a combination of what we found through information provided about the service, patient feedback and through interviews with staff and others connected with the service. We carried out a visit to all 3 of the sites.

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

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Summary

About this inspection

We carried out this announced comprehensive inspection at Waddington Combined Medical Practice on 26, 27 and 28 November 2024.

As a result of the 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? – good

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 CQC's observations and recommendations.

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

At this inspection we found:

Regional Headquarters applied for Full Operating Capacity to be granted which was endorsed by Headquarters Defence Primary Healthcare in October 2024. We found that despite being granted full operational capability, many areas were not fully combined with the 3 sites operating in isolation.

The practice demonstrated a person-centred approach to accommodate the needs of individuals and squadrons. Patients were included in decisions about their treatment and care.

Whilst patients received their medicines in a safe way, some medicines management systems required strengthening, including the destruction of controlled drugs and the review and coding of patients prescribed repeat medicines.

Our review of records and processes to monitor care showed patients received effective and timely clinical care.

At the time of the inspection, staffing levels were adequate due to the availability of locum staff. However, stable leadership was lacking in key clinical leadership posts.

The combined practice had processes in place to mitigate the risks with the management of samples. Further measures could be put in place to simplify and streamline this process.

Patient feedback about the service was positive. It demonstrated patients were treated with compassion, dignity and respect.

Effective safeguarding arrangements were in place. Patients vulnerable due to their mental health were well managed and supported.

Flexible access and services were offered to patients with a caring responsibility.

The combined practice had good lines of communication with the unit, the welfare team, local NHS, social services, and the Department of Community Mental Health to ensure the wellbeing of service personnel.

Quality improvement was embedded in practice, including various approaches to monitor outputs and outcomes used to drive improvements in patient care. There was scope to develop clinical audit based on population need within the Primary Care Rehabilitation Facility.

The management of governance systems would benefit from further development to ensure all relevant combined practice systems and processes captures the relevant information to monitor service performance in an integrated way.

The Chief Inspector recommends to region/DPHC:

Review the policy that depicts searches for sodium valproate to include all registered patients not just service personnel.

Ensure staffing capacity and regional support mechanisms are adequate and timelines realistic to enable Waddington Combined Practice to standardise processes towards full integration. In addition, these measures will support with safeguarding the health and wellbeing of staff and minimise further staff burnout.'

The Chief Inspector recommends to Waddington Combined Medical Practice.

The governance arrangements should be reviewed with a view to fully integrating all systems and processes to support the group practice arrangements.

Ensure the destruction of accountable and controlled drugs is in accordance with policy, the destruction should be witnessed by the account holder (the SMO) and an individual external to the practice appointed by the commanding officer of the unit.

Control testing of the blood glucose monitor should be undertaken and recorded.

Ensure all patients on repeat medicines are reviewed and clinically coded correctly.

Address the back log in the summarisation of patients' clinical records.

The Health Assurance Framework and Management Action Plan should be reviewed to ensure they are up to date.

Review the standard operating procedures to support the policies and local protocols required for the operation of the combined group practice.

Produce Terms of Reference for the combined practice. These should include clear roles and responsibilities for all staff and include assigned secondary/lead roles.

Ensure all locum staff routinely have access to the ASER system for the reporting of significant events.

Ensure the measures taken to confirm the safety of the facilities are available to the practice. Liaise with the unit/contractors to secure evidence of routine infrastructure checks, including water safety checks.

Ensure the management of referrals is failsafe.

Develop quality improvement activity within the Primary Care Rehabilitation Facility (PCRF) with an emphasis on completing clinical audit based on population need.

Consider the use of Direct Access to Physiotherapy (DAP) in the Primary Care Rehabilitation Facility (PCRF).

Dr Chris Dzikiti

Interim Chief Inspector of Healthcare

Our inspection team

The inspection team was led by a CQC inspector and comprised specialist advisors including 2 primary care doctors, a nurse, physiotherapist, exercise rehabilitation instructor, practice manager, a pharmacy technician and a pharmacist. In addition, a representative from the DMSR observed the inspection and 4 new specialist advisors shadowed as part of their induction.

Background to Waddington Combined Medical Practice

As part of the Healthcare Improvement Programme, a Combining Operational Order was issued by Defence Primary Healthcare (East) on 15 December 2023 detailing a 3-phase approach for medical centres within the region to initiate combining in accordance with

higher authority directive. RAF Coningsby, RAF Cranwell and RAF Waddington were directed to form the Waddington Combined Practice and to achieve initial operating capability by 8 April 2024, which was to be achieved through amalgamation of information technology systems. The stated aims for combining are:

- Improve clinical outcomes for patients.
- Increased deployability for front line commands.
- A better working experience for Defence Medical Service staff.
- Greater value for money for defence.

DPHC aims to achieve this by sharing resources, data and services to increase healthcare access and delivery options, increased standardisation, enhanced best practice, improved efficiency, adaptability and resilience. The scaling of the combined practice resulted in the provision of a routine primary care service to a patient population of approximately 9,000 service personnel and also a number of dependants, including children. Full operating capability was set for 30 October 2024 and endorsed by Commander Defence Primary Healthcare on 10 October 2024 with patient lists and governance structures combined.

All 3 of the medical centres have a dispensary and provide a physiotherapy and rehabilitation service for service personnel. RAF Cranwell provides primary and emergency care to service personnel and their registered dependants. Service personnel include five flying squadrons, phase 1 and 2 trainees and air cadets. RAF Waddington and RAF Coningsby provides care to, amongst others, high volumes of aircrew delivering operationally focussed tasks.

Opening hours across the combined practice are Monday to Friday 08:00 – 17:00 hours. From 17:00 – 18:30 hours access to emergency medical cover (referred to as shoulder cover) is provided by each individual practice. Outside of these hours, including weekends and bank holidays, NHS 111 provides cover.

The combined practice team comprised of

Position	Numbers
Doctors	1 Senior Medical Officer (SMO) acting (post vacant) - also covering the Principal Medical Officer (PMO) role 3 military Deputy SMO 7 military Unit Medical Officers (UMO) 1 gapped 4 MOD GPs full time (1 gapped) 1 MOD GP part time

Nurses	2 Principal Nursing Manager (PNM) Waddington and Coningsby 1 Principal Nursing Officer (PNO) Cranwell 7 military nurses (2 gapped) 6 civilian nurses 1 healthcare assistant
Senior Management Team	3 Warrant Officers (WO) 3 practice managers 3 deputy practice managers
Pharmacy	3 military pharmacy technicians 3 civilian pharmacy technicians
Primary Care Rehabilitation Facility	3 Officer Commanding (OC) 1 Band 7 physiotherapists (2 gapped) 6 physiotherapists (1 position gapped) 7 exercise rehabilitation instructors (1 position gapped) 2 administrators
Administration Team	12
Medics*	20 (4 posts gapped)

*A medic is a unique role in the forces and 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 combined practice as requires improvement for providing safe services.

Safety systems and processes

The combined practice worked to the Defence Primary Care Healthcare (DPHC) Tri-Service safeguarding policies but this was not integrated as one across the 3 sites as each site operated in isolation. One of the doctors was the overall lead although they had only recently been assigned the lead role and were still learning what was required. Each site also had a safeguarding and vulnerable adult lead of their own. They attended their unit's welfare meetings monthly and kept their own lists of safeguarding and vulnerable patients. The 3 sites met monthly for a 'Care and Concern' meeting with the first part of the meeting used to discuss any cross-site patients of concern, then they split into their own local site specific meeting. Locum staff were invited to the monthly Care and Concern meeting. Routine searches of the clinical system (DMICP) for safeguarded or vulnerable patients were not routinely completed across the 3 sites. At 1 of the sites this was reliant on the doctors populating a list of patients or from patient registration documentation or information from the welfare team. The 3 sites had recently initiated a quarterly safeguarding working group meeting to discuss how they could combine and work more closely including combining searches and registers. All 3 sites were located within the catchment area of the same NHS trust and we saw standardised safeguarding contact details on a poster displayed in each consulting room and was available electronically. One of the doctors had attended the local NHS Lincolnshire safeguarding team forum which they described as very useful. There was also a regional meeting which the individual safeguarding leads attended.

There were no terms of reference (ToRs) for any lead roles within the combined practice. Staff across the 3 sites had received up-to-date safeguarding training at a level appropriate to their role. Safeguarding information was included in the induction pack for all new staff which included the safeguarding poster information sheet.

Staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or are on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. There was information for patients regarding chaperones in the practice leaflet and there were posters displayed in the waiting rooms and clinical rooms at all 3 sites. A review of consultations demonstrated that the nurses were offering a chaperone to patients requiring an intimate examination and this was documented in the consultation including if the patient declined.

The full range of recruitment records for permanent staff was held centrally. The practice could demonstrate that relevant safety checks had taken place for the staff, at the point of recruitment, including a DBS check to ensure staff were suitable to work with vulnerable adults and young people. An electronic record identified when each member of staff was

required to renew their professional registration. All staff had crown indemnity and professional registrations were recorded on the workforce training log.

Acupuncture was not currently practiced by any clinicians in the Primary Care Rehabilitation facility (PCRF) at Waddington or Cranwell, but a risk assessment and local working practice were in place for when a clinician practiced this in future. The local working practice in place at Coningsby had a medical checklist, consent form, and patient information included within it. Sharps bins were available for safe disposal of needles. No acupuncture audit has been completed this year.

As the military Exercise Rehabilitation Instructor (ERI) posts were vacant there was no clear equipment care lead at Waddington, which resulted in servicing going out-of-date recently, although rectified prior to the inspection. All equipment details were now on a joint spreadsheet across the sites but managed individually. The Officer Commanding (OC) Waddington arranged for the servicing to be done and liaised with the regional equipment lead, deciding the equipment could continue to be used as it was only a year old and the servicing had now been completed. Individuals were responsible for the equipment in their own clinical rooms, and for reporting any faults, which were recorded on a combined fault register. There were no equipment lead ToRs for the PCRFs.

Each site had a dedicated lead person for infection prevention and control (IPC). All staff update training was current in IPC across all 3 sites, one member of staff had completed role-specific training. All 3 sites had a scheduled deep clean. An IPC audit was undertaken by each team across the individual sites. All had associated action plans for any issues raised.

Environmental cleaning was provided by a different contractor at each site. The cleaning standards at Waddington were monitored and audited by the cleaning supervisor weekly with the outcomes recorded. There was evidence of regular and appropriate communication between the practice and the contracted cleaning supervisor. There was a cleaning tab on the healthcare governance workbook where issues could be added and monitored. Cleaning issues at Coningsby were being discussed in detail with the cleaning contractors, and at Cranwell, standards were also monitored and recorded.

Clinical waste was appropriately secured and identified with the practice code, recorded in a waste log and placed in a waste skip which was locked and secured at all 3 sites. The waste log was cross referenced to the consignment notes. At Waddington, the waste skip containing sharps was difficult to close and was open when inspected. This was secured during the inspection and a request was made for a replacement waste skip.

Risks to patients

Although there were approximately 26 vacant staff posts, many were filled by locum staff. Therefore, the permanent gaps represented about 7%; these were largely in key management posts. Equally, locum staff did not have additional roles other than clinical delivery and did not always have all the required skills, such as aviation medicine training, putting additional workload on the permanent clinical staff. Also, locums were limited to working 37 hours per week, with clinical daytime provision being priority, this did not allow

them to be available for shoulder cover between 17:00-18:30 hours. This had resulted in the military doctors covering a disproportionate amount of these shifts leading to fatigue and burnout. The senior leadership team said they had had their locum requests cut in half to 50% by headquarters Defence Primary Healthcare. An establishment review was not undertaken as part of the combining process and whilst the establishment numbers seemed sufficient to support the numbers of patients, consideration was not given to each site or the staff skill set required.

Coningsby was scaled for 4 military doctors and 1 civilian doctors. Two of the 5 military doctors positions were vacant and one of the Senior Medical Officer (SMO) posts had only recently been filled. There had been a significant increase in workload due to the combining process and this had reduced clinical output. The SMO was also covering the Principal Medical Officer (PMO) role and had line management responsibilities for doctors across all 3 sites due to SMO gaps at Waddington and Cranwell.

At Cranwell, the SMO post had been vacant since May 2024. A civilian doctors post had not been filled (though a part time, short term locum was there for a few weeks). The increased turbulence of change in combining the practices had resulted in increased time in meetings and a reduced number of clinics.

At Waddington, 2 of the 5 military doctors posts were vacant. The SMO post had been vacant since October 2024 and a Unit Medical Officer (UMO) post has been vacant since May 2024. One civilian doctor post was also vacant (since October 2024).
The arrangements in place to ensure the practice had sufficient clinical cover during periods of staff absence was provided where possible by locums, total triage, and by seeking support from other sites within the combined practice. However, routine waiting times had increased to 4-6 weeks. Workforce resources were stretched across all 3 sites.

Within the PCRF staffing levels were sufficient, long-term sickness at Waddington was covered by a locum. Two military ERI posts were vacant until 2026 but had been filled with locums. PCRF Cranwell was well staffed with the Band 7 post currently filled by a locum, and interviews planned for permanent position. An ERI was leaving in January 2025 and a locum had already been identified to cover the role during the recruitment process. At Coningsby, there was a Band 7 vacancy but no locum had been sourced to cover while the permanent job was being advertised, so the clinical requirement was covered with a Band 6 locum. As a result of staffing levels and locum support there was no wait for appointments at any sites currently.

Regular communication between the senior leaders took place on a weekly basis to highlight gaps in staffing and discuss the ability to cross-cover where possible. Recognising this needed to be balanced against unit specific requirements including occupational medicine and paediatric care.

Families were only able to register at Cranwell and children under the age of 12 would only be seen by a doctor. If a new doctor was posted in or provided cross-cover, and they needed support/supervision then the GP trainers (2 on site at Cranwell) were engaged to explore the best package of support and supervision to ensure the doctors skills, if required, were updated to treat children. At times when Coningsby or Waddington

provided group cover, there was always a nominated doctor from Cranwell on-call and available to see children and family members.

All staff had received updated training in emergency procedures, including basic life support (BLS), paediatric life support, automated external defibrillator (AED) and anaphylaxis. Three nurses had completed Immediate Life Support. Clinical staff had completed hot/cold injury mandatory training and sepsis training. Some emergency scenarios had been delivered to the combined practice staff by a member of staff who was a qualified paramedic. The most recent scenarios included the care and management of a child who was choking and respiratory and cardiac arrest.

Within the PCRF staff said they felt confident they knew where the panic alarms were, where the emergency trolley was located, and that they would be supported by medical colleagues. An actual scenario with an unwell patient had occurred at PCRF Waddington (the only site not co-located with the medical centre) and a thorough debrief session was held to talk through what went well and what needed to be learnt. A comprehensive action plan was developed because of this, identifying learning points. For example, the alarms were not loud enough to be heard in other rooms (has been reported through ASER system and escalated to region, reported as a building fault, and alternative personal alarms trialled); staff were unsure of the medical centre response to an emergency in the PCRF so the standard operating procedure (SOP) and the lone working policy was also reviewed. Waddington had also changed their posters with emergency contact information onto brightly coloured signs so they really stood out on clinical room noticeboards.

A Military Assistance to Civilian Authority (referred to as MACA) exercise had taken place at Waddington in January 2024. This was where military and civilian emergency staff test responses to a major incident. Waddington and Coningsby tested a simulation of an aircraft crash in August 2024. Coningsby conducted moulage scenario training with junior medics as part of their induction and during BLS and AED training. There were also regular placements with East Midlands Ambulance Service on ambulance shifts with the Coningsby and Cranwell practice managers who were both current paramedics. Cranwell did a moulage scenario in August 2024 with the fire section simulating a helicopter crash.

All staff knew where the emergency medicines were located at each site. We found all medicines on the emergency trolley were appropriate and in-date. An AED was available at each site at Cranwell and Coningsby (co-located with the medical centre) the AED was on the emergency trolley, at Waddington there was an AED within the medical centre and the PCRF.

The areas used by the PCRF were climate controlled. Minimal outdoor activity was undertaken with the exception of Cranwell where they occasionally had late physical training sessions, when this happened the activity and risk was informed by wet globe bulb test monitoring readings from the station gym.

Information to deliver safe care and treatment

Staff at each of the 3 sites described how they would utilise their business continuity plan during DMICP outages, there were still 3 individual plans in place having not yet been

combined into one. A hard copy of the following day's clinics was printed so staff knew which patients were scheduled to attend. Only urgent patients would be seen during the outage and paper records would be produced. Paper records were scanned onto the DMICP health record when available.

At the time of the inspection, the practice only had 35% of patient records in-date for a summarising review. The future plan was to summarise records when patients register using the e-form but there was no plan to address the backlog of summaries. Families notes for Cranwell patients were received at Waddington and sent to Cranwell for summarising; we were assured that there was no backlog for families notes.

Systems were in place for sharing information internally with other clinical staff. Weekly multidisciplinary team meetings were held at each site between the medical centres and the PCRF staff where clinical cases were discussed, and all staff were encouraged to highlight cases for discussion. Staff at all sites reported it was easy to get hold of their medical colleagues to discuss any patients.

Across the 3 sites a process of peer review/audit of clinical records was in place, in which clinicians cross checked each other's record keeping, including evidence-based practice, quality of clinical records and use of templates. Nurses told us that they informally reviewed clinical records daily and always after out-of-hours telephone consultations and again when seeing the patient face-to-face. Wound care records were checked every time the patient attended for review. Chronic disease management records were regularly reviewed and feedback given between colleagues. Clinical discussion also took place at the monthly nurse meetings. More formal peer reviews were carried out using a template although these were not formally scheduled; this was planned for the future.

Staff from all 3 PCRFs had completed their own notes reviews. A full notes audit was completed in 2023 by Waddington but was overdue for review. Staff were aware of this and it was planned to be completed in early 2025. Cranwell PRCF had completed a recent notes audit, and staff also had their notes audited shortly after starting with individual feedback received. The appropriate DPHC notes audit tool was being used for completing this audit.

There were 2 dedicated referrals clerks for the 3 sites and the new DPHC mandated referrals tracker was in use. There were separate task boxes on DMICP for each site but multiple staff could access them to provide resilience. From our review of the DPHC tracker, it was apparent that 2-week-wait urgent referrals at Waddington had not been updated and there were referrals up to 42 weeks old that had not been managed. We were assured on day 2 of the inspection that this backlog had been reviewed and no concerns were identified. The practice manager assured us that they would complete a monthly check to ensure this does not occur again. There were no concerns identified at Cranwell or Coningsby.

There was a system in place to ensure specimen samples were taken safely, appropriately recorded on DMICP and results reviewed and actioned by a clinician within 7 days. Staff described the new combined system adopted as onerous and time consuming, we were told it had introduced additional process steps which increased the risk of a mistakes occurring.

When specimens left one of the sites, they were logged on a register by the medic or nurse. Results were returned via the pathology links inbox. Some were automatically filed to the requesting doctor's inbox, but this was not reliable and most ended up in the wrong place (due to the incompatibility of the NHS system and DMICP). A doctor was allocated to sort through the inbox to ensure specimens results had been received by cross-checking with the register and updated the spreadsheet. They then moved results into the inbox of the requesting doctor and also put a comment on the result to leave an audit trail that the result had been initially seen. The requesting doctor then filed the result. On a Friday afternoon the duty doctor reviews the spreadsheet for their own location ensuring no results have been missed. One of the doctors told us that the previous week they were on the rota to complete this process twice meaning over a period of 5 days they spent a whole day reviewing, filing, checking and updating results instead of seeing patients.

They then moved results into the inbox of the requesting doctor and also put a comment on the result to leave an audit trail that the result had been initially seen. The requesting doctor then filed the result. On a Friday afternoon the duty doctor cleared out the global inbox, filing all remaining results. One of the doctors told us that the previous week they were on the rota to complete this process twice meaning over a period of 5 days they spent a whole day reviewing, filing, checking and updating results instead of seeing patients.

Patients were informed of their results by text message sent via GOV.UK Notify unless agreed otherwise with the patient (or they had opted out). In which case they may be contacted by letter/email/telephone call.

Safe and appropriate use of medicines

Dispensing was carried out at all 3 of the sites. There was no lead identified for medicines management across the combined practice. One of the doctors was the lead for High Risk Medicines (HRMs). We noted that the ToRs did not reflect who (the SMO) was the lead for medicines management and that the day-to-day responsibility was delegated to the pharmacy technicians; this was rectified on the day of the inspection.

Safe procedures were in place for managing and storing medicines, including vaccines, emergency medicines and equipment. We found all items were within their expiry date and appropriately stored.

A controlled drugs (CD) audit and the annual declaration had been completed and submitted to headquarters. The CD keys were kept separate from the dispensary keys. There were clear processes in place for the access to CDs out-of-hours. A review of the most recent destruction certificate confirmed that accountable and controlled drugs were not being destroyed in accordance with policy as the destruction should be witnessed by the account holder (the SMO) and an individual external to the practice appointed by the commanding officer of the unit. We checked the CDs and they were fully correct and accounted for.

The medical emergency trolley and medicines were checked daily and monthly or if the trolley had been opened/used. Tags were in place with a list of expiry dates held. We noted that risk assessments were missing at Coningsby for 2 medicines held on the trolley, staff agreed to action this immediately. Emergency trolleys across the 3 sites were not standardised but managed locally by each site.

We checked all the emergency medicines and kit and these were in-date, including medical gases, which were at sufficient capacity and appropriate signage was in place. We noted at Coningsby the gas store required attention as it had had paint heavily peeling from the ceiling and a large build-up of leaves at the entrance.

Medication requiring refrigeration was monitored twice a day to ensure it was stored within the correct temperature range.

Across the 3 sites an effective process was in place for the management and action of Medicines and Healthcare products Regulatory Agency (MHRA) and National Patient Safety alerts. The electronic MHRA alert register was current and a system was in place to ensure the practice received, disseminated, and actioned all alerts and information relevant to them.

Both at Cranwell and Coningsby the blood glucose monitor control checks were not in line with recommendations. There was no indication of the date that control solutions had been opened. We brought this to the staff's attention and they dated and added new control solution to the emergency trolley.

All staff who administered vaccines had received the immunisation training as well as the mandatory anaphylaxis training.

Practice nurses used Patient Group Directions (PGDs) for immunisations and primary care treatments. Nurses were authorised to use the PGDs using the correct policy and documentation. They were aware of the policy and of the importance of consulting the PGD when immunising or supplying medicines through the PGDs. Audits were competed monthly. Patient Specific Directions were not used.

There were clear processes in place for the requesting and issuing of repeat medication.

Through discussion and review of DMICP records, it was evident that there was a clear audit trail for the request of repeat medication. Our review of DMICP records showed 1,398 patients across the combined practice were eligible for repeat medication but only 575 were identified as having been reviewed. On further investigation, we found some of these had been reviewed but had not been coded correctly.

Prescription pads were stored securely. There was a system to track their issue and usage so all prescription numbers could be traced to the prescriber.

Valproate (medicine to treat epilepsy and bipolar disorder) searches were regularly undertaken. We noted that one patient had no recorded consultation to state that they had been given advice about contraception. This was acknowledged by the practice and they

agreed to ensure this was done. We noted that the search was set for military personnel only and not for civilians registered.

A process was established for the management and monitoring of patients prescribed HRM. The HRM lead ran searches monthly, maintained a register and tracked patients ensuring they had had the appropriate reviews and monitoring. A HRM audit was undertaken for the combined practice in August 2024 with 10 patients audited form each site. The results were shared at the next combined clinical governance meeting.

Track record on safety

There was a combined risk register on the healthcare governance workbook with active and retired risks, which could be identified by a filter. The 4Ts principles had been applied to all risks and the register included both combined risks and those that were site specific. There was a range of both clinical and non-clinical risk assessments including lone working.

As part of the inspection, we requested the dates of safety certificates for each of the 3 sites. These included certificates for water, gas (where applicable), fire risk assessment, electrical safety, portable appliance testing and legionella. Safety certificates were in-date for Coningsby and Waddington but at Cranwell we highlighted some gaps. The certificates were held by the contractor and had been requested. There were a range of control of substances hazardous to health (COSHH) risk assessments in place which covered all the known COSHH products across the 3 sites.

Within the PCRF, clinicians were only allowed to complete administrative work when they were the only ones in the department. The lone working policy was clear that no patients were to be seen when only 1 staff member was present. Emergency alarms were present in all clinical rooms, but these were not loud enough to be heard in other rooms (only at Waddington, where there were individual rooms). This was identified during an incident in the department and had been reported as an ASER and escalated to region (as well as via the fault reporting system). Mitigations had been put in place to keep the doors to the gym and reception open to aid noise to travel and, on the day of the inspection, the PCRF administrator was able to hear and respond to the alarm. An alarm system was also available at PCRF Cranwell and Coningsby, which sounded elsewhere in the medical centre. Across the 3 medical centres there was a mix of fixed and handheld alarms in place which were tested weekly. The alarm that was tested was recorded on the healthcare governance workbook.

Across all 3 PCRF sites there was a good appreciation of patients' occupational requirements. Staff at Cranwell had an in-depth knowledge of the training courses for phase 1 students. At Waddington, it was planned to conduct occupational insight days with resident squadrons.

Lessons learned and improvements made

There was a lead member of staff for significant event (referred to as ASERs) management and there was a system and policy for recording and acting on them. The combined practice did not have a local SOP protocol in place for ASER management. Staff would refer to DPHC guidance if required. Staff understood their duty to raise concerns and report incidents and near misses and leaders and managers supported them when they did so. All permanent staff had an ASER login. Locum staff within the medical centres did not routinely have a login to the ASER system. However they did within the PCRFs.

There was a combined ASER log on the healthcare governance workbook which included details of how many had been submitted for each of the 3 sites. The meeting minutes where these were discussed included the ASER number and brief details of the nature of the ASER and progress. The log included details of lessons learned which all staff could access.

Are services effective?

We rated the combined practice as good for providing effective services.

Effective needs assessment, care and treatment

Clinicians were aware of relevant and current evidence-based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. NICE guidelines were discussed at the regularly held clinical meetings. Clinical policy updates were received via the Defence Primary Healthcare (DPHC) newsletter and disseminated via email. Each clinician had also signed up to the NICE newsletter for primary healthcare email updates. Clinicians used the DPHC toolkit consistently at reviews, standards were audited for chronic disease and peer review provided another opportunity for assurance. DMICP templates were consistently used. Our review of patients' notes showed that NICE guidelines was being followed. The peer review notes audit also included a check that evidence-based guidance was being followed. Nurses had monthly meetings and specific in-service training and clinical updates were included in both.

The PCRF across all sites were using the combined peer review SOP with a record of regular peer reviews completed and regular supervision occurring for both physiotherapists and ERIs. This supervision was effective across sites and appropriate documentation was used. Staff stated it was useful and targeted to their individual needs. Nurse ensured care and treatment was delivered and followed evidence-based guidelines. For example as well as receiving clinical updates via NICE, they also fed back from meetings to the wider team for shared learning, including chronic disease management updates. Nurses attending practice nurse forums and received the practice nursing magazine. At Cranwell doctors and nurses attended a monthly journal club where an individual presented a topic for others to learn and update.

The range of Primary Care Rehabilitation Facility (PCRF) clinical records we looked at showed evidence of multidisciplinary team discussion. The Musculoskeletal Health Questionnaire (MSK-HQ) was the standardised outcome measure for patients to report their symptoms and quality of life. The rehabilitation dashboard suggested that completion rates were lower than average for Cranwell and Waddington, but significantly higher than average for Coningsby. Coningsby handed out their questionnaires to all new patients and this had been effective in capturing information. It is unclear why completion was lower at the other sites as clinicians thought they were being completed, particularly at initial appointments. The use of the MSK-HQ was clinically coded via the DMICP template. Rehab Guru (software for rehabilitation exercise therapy) was in use to monitor individual patient progress.

The PCRF team ensured a holistic view of patients' needs was taken, including mood, sleep and lifestyle. At Cranwell they had a booklet for cadets, which covers lifestyle elements of sleep and nutrition and their role in recovery from injury. They had also been involved in health and wellbeing days on the station and promoted the using a service for Lincolnshire which provided weight management assistance and stop smoking services.

Waddington didn't have any current involvement in health fairs or health promotion but there was evidence in the notes that lifestyle elements were discussed with patients across the sites.

Waddington had an excellent gym space and individual clinical rooms with all the required resources. Cranwell had good gym equipment, but the gym-space limited the number of users who could access it at the same time; they could use the station gym to deliver some sessions if necessary. Coningsby was the most limited for space and equipment but the re-purposing of a building to a rehabilitation gym was underway and completion was intended in the early part of 2025. This would significantly increase the resources and equipment and would also free up space in the existing PCRF, which would improve the clinical space. Staff at all sites were making the best use of the space they had available and were able to deliver safe and effective care.

Waddington PCRF had some challenges with its cleaning schedule and it did not currently have a deep clean in its contract. The Officer Command (OC) was working on this and, following the inspection, added it to issues register. In the interim, staff did all they could to keep the area and equipment clean.

Monitoring care and treatment

Defence Medical Services had responsibility to deliver the same quality of care as patients expect in the NHS. Because the numbers of patients with long-term conditions (LTCs) are often significantly lower at DPHC practices, we did not use NHS data as a comparator. All LTCs were recorded on a combined chronic disease register with all patients recalled in their birthday month. A different nurse from each site was in charge of a different LTC. All nurses across all 3 sites have access to chronic disease register. A monthly chronic disease meeting was held and this was attended by nurses and doctors.

There were 52 adults and 2 children on the diabetic register. For 25 patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For 47 patients with diabetes, the last blood pressure reading was 150/90 or less which is an indicator of good blood pressure control.

There were 229 patients recorded as having high blood pressure and 215 had had their blood pressure taken in the past 12 months. Of these, 169 patients had a blood pressure reading of 150/90 or less.

There were 146 patients with a diagnosis of asthma. Of these, 62 had received a review in the past 12 months. We asked why this number was lower than expected and nurses explained that the searches used also included historic childhood asthma.

We looked at a range of patient records and were assured that the care of patients with a mental illness and/or depressive symptoms was being effectively and safely managed. Patients presenting with a mild to moderate anxiety or low mood were assessed in accordance with the pathway and treated initially at the practice (step 1) or referred to the Department of Community Mental Health (DCMH) team if their clinical need was assessed as greater than what step 1 could provide. Patients were reviewed monthly with

medication prescribed only for a month to ensure the patients were regularly reviewed. New patients were put on the duty doctor clinic and the level of risk assessed. The Lincolnshire Crisis Team were able to undertake home assessments in 24-48 hours if high risk was established. In addition, patients could be referred to the welfare team, SSAFA, the RAF Benevolent Fund, and the Padre for additional support. Medium and high risk patients were put on the vulnerable adults register. There was a multidisciplinary team meeting every month where patients were discussed.

Information from the force protection dashboard, which uses statistics and data collected from military primary health care facilities, was also used to gauge performance. Service personnel may encounter damaging noise sources throughout their career. It is therefore important that they undertake an audiometric hearing assessment on a regular basis (every 2 years). Audiometric assessments were in date for patients.

RAF Coningsby: 75%

RAF Waddington: 78%

RAF Cranwell: 72%

There was a comprehensive combined practice audit programme in place alongside an annual schedule kept on the healthcare governance workbook, all staff were involved in the audit process. Clinical audit was used to ensure care and treatment followed evidence based guidelines. Audits undertaken included high risk medicines, LTCs, cytology, infection prevention and control, notes and consent audits.

The Patient Sensor Support Group was formed following RAF Waddington's medical centre annual HbA1c audit looking at all diabetic’s glycaemia (blood sugar level) control. Based on the use of a Libre Sensor flash glucose monitoring system through patients using an app on their personnel mobile phone, an audit in February 2022 identified that there were 8 patients who had type 1 diabetes. There were now 15 patients with type 1 diabetes. The group had grown from strength to strength and was well supported, patient feedback was positive. In the future the group aimed to increase awareness, specifically for line managers, develop focus groups, develop the security elements of the Sensor/Reader and expand the group into the disability and carers network for wider support across AIR.

All 3 PCRFs had completed notes audits and peer reviews but there was no evidence of any clinical audits being completed. Staff confirmed the impact of senior leaders being absent through deployments, illness, vacant posts and the demands of combining practices over the last year meant they not had not had the capacity for other service development work.

A service evaluation had been completed by an exercise rehabilitation instructor (ERI) at Cranwell to look at injury trends amongst cadets. The findings had been presented to the college and this had resulted in a change in training. The evaluation was only completed in the last few months, so the impact had yet to be measured but the intent was to re-evaluate in 6-months’ time.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up-to-date.

At Waddington, induction for new staff was facilitated through a generic induction pack, which included all DPHC mandatory training and evidence was observed. The generic induction pack was then supplemented with a role specific bolt-on induction pack, including a specific locum induction pack. The specific locum induction pack included the required checklists for pre-employment checks. All induction packs were retained by individuals. At Cranwell and Coningsby there were role-specific induction packs.

Staff mandated training was overseen by a training lead at each site. Evidence of mandated training records were observed, and all staff mandated training was recorded on the regional staff training database. All staff mandated training was recorded at 100%, apart from the following:

Waddington:

Protecting Personal Data – 86% were in date.

Records Management Awareness – 86% were in date.

Information Knowledge and Awareness – 86% were in date.

Cranwell:

Records Management Awareness – 83% were in date.

Health and Safety – 86% were in date.

Coningsby:

Fraud, Bribery and Corruption (for managers) – 89% were in date.

Health and Safety – 72% were in date.

On investigation, there were mitigating circumstances for the training gaps as a small number of personnel were either deployed or had recently returned from out-of-area or maternity leave. Notwithstanding these mitigations, the combined practice Warrant Officer acknowledged an improvement was needed in the rates of personnel completing the elements relating to data protection training (Records Management Awareness & Protecting Personal Data).

Arrangements were in place for staff development and support to meet the requirements of professional revalidation. Regional in service training (IST) was organised and facilitated by the regional headquarters. The only cohort for which regional IST was not facilitated was for the medics. Evidence was observed that the combined practice provided internal IST, which was planned, and attendance recorded for RAF medic trade training. These

sessions covered a broad range of topics, including chaperone training. Work was underway for the RAF medics to have a placement at a hospital across the United Lincolnshire Hospital Trust. This was for medics from all 3 sites and would allow them to be employed at Band 3 providing them with patient exposure and contact within the emergency department, and acute admissions. Meetings were underway with an aim towards induction during March 2025, the aspiration being to always be providing 1 RAF medic to at least one of the hospitals involved in the scheme, Lincoln County, Boston Pilgram and Grantham and District hospitals.

Appraisals were recorded on the staff database and a tab to track professional registration and revalidation currency. Continual personal development opportunities were regularly circulated among staff, such as attendance at conferences, trawls, and application routes for courses. Peer review (including regional) was recorded and occurred frequently across all staffing groups.

Coordinating care and treatment

The staff met with welfare teams and line managers to discuss vulnerable patients. Staff told us that they had forged some good links with other stakeholders, for example the local health visitor and midwife, Lincolnshire Armed Forces and the Lincolnshire maternity care team, army welfare service, Relate and the DCMH.

There were good lines of communication established with the individual squadrons. Aviation Medicine dial-in calls were held every month.

It was clear that the PCRF teams were an integral part of the medical centres. There were good streams of communication with staff in the PCRF, meetings were inclusive and governance structures integrated. We saw that referrals to the Regional Rehabilitation Units and Multi-Disciplinary Injury Assessment Clinics (MIAC) were made promptly with manageable wait times for the patients.

Referrals tracking for the PCRF had some inconsistencies across sites with Cranwell and Coningsby having their referrals added to the medical centre tracker but Waddington having their own informal lists. All clinicians had regular caseload review time so felt they were checking individuals regularly and safety netting with the patient was observed during the inspection where the patient was clearly instructed to contact the physiotherapist or ERI if no appointment was received within 2 weeks.

All 3 sites met to have weekly multidisciplinary team meetings that included the PCRF and medical centres. There were weekly meetings attended by the PCRF staff and training staff from the college at Cranwell to discuss individuals who needed moving onto Cadet Support group, and the implications on course progression for those under rehabilitation.

The doctors conducted regular handovers to other practices (including NHS) appropriately, this usually took the form of direct discussion with an appropriate clinician. For patients leaving the military, pre-release and final medicals were offered. During the pre-release phase, all patients received a summary of their healthcare record, including immunisations

and medication and information on how to obtain a full copy of their records. An individual handover was given for any of patients of concern.

Helping patients to live healthier lives

The group practice identified patients who may need extra support and signposted them to relevant services. For example, patients at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.

The health promotion strategy had been formulated into a calendar for the next 12 months and was underpinned by national priorities and DPHC initiatives to improve the population's health. Promotions were refreshed in line with seasonal and/or topical demand. Information leaflets and booklets were on display at each of the 3 sites
One of the nurses was trained in sexual health (referred to as STIF). Patients could also be signposted to Lincolnshire sexual health services. Patients could also self-refer.

Staff attended unit open days and staffed stalls to provide health promotion information to personnel. PCRF staff at Cranwell and Coningsby sites attended station health and wellbeing fairs and promoted the use of local resources for weight management and other lifestyle interventions. The OC at Waddington intended to do more injury prevention work now they had more staff in the department.

Over 40 health checks were completed opportunistically or by direct patient request. The practice was not able to actively recall patients for the checks due to staffing constraints but every effort was made to review these patients when possible.

There was a detailed local working practice to support NHS screening. All eligible female patients were on the national cervical screening database and were recalled by the nurse. The latest data confirmed an 87% uptake, the NHS target was 80%. Regular searches were undertaken to identify patients who required screening for bowel, breast, and abdominal aortic aneurysm in line with national programmes. Alerts were added to their DMICP record which allowed for opportunistic discussion with a health professional. DMICP searches had been created for all national screening.

The practice conducted additional vaccination searches each month to ensure that specific demographics of patients had the appropriate vaccine protection.

Vaccination statistics were identified as follows:

90% of patients were in-date for vaccination against diphtheria.

90% of patients were in-date for vaccination against polio.

97% of patients were in-date for vaccination against hepatitis B.

95% of patients were in-date for vaccination against hepatitis A.

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

94% of patients were in-date for vaccination against meningitis.

Child Immunisation

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

The percentage of children aged 2 who had received their booster immunisation for Pneumococcal infection (i.e., received Pneumococcal booster) (PCV booster) was 100%.

The percentage of children aged 2 who had received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) was 100%.

The percentage of children aged 2 who had received immunisation for measles, mumps and rubella (one dose of MMR) was 100%.

The percentage of children aged 5 who had received immunisation for measles, mumps and rubella (two doses of MMR) was 100%

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance. Clinical staff were aware of the protocols and were supported by DMICP templates. We saw that consent was obtained and recorded appropriately. Written consent was recorded for minor operations undertaken by 1 doctor. The most recent audit undertaken was undertaken by the nursing team at Coningsby in March 2024 and showed positive results. An audit was planned for the combined practice in the new year.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to decide.

When providing care and treatment for young patients and when appropriate, staff carried out assessments of capacity to consent in line with relevant guidance. Clinicians demonstrated a good awareness and understanding of Gillick competence (used to assess a child's capability to make and understand their decisions and consent to their treatment) and Fraser guidelines (used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment).

Are services caring?

We rated the combined practice as good for providing caring services.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

The station HIVE provided information support to all members of the service community. They delivered information support on a wide variety of topics affecting their everyday service and personal life, including relocation, accommodation, health and wellbeing, finance, education, and local area information. Evidence was observed that the group practice Warrant Officer regularly communicated with the HIVE officer to publish medical centre notices to the population.

The combined practice had established links with the military maternity care navigator from the NHS Lincolnshire independent care board. They were the link between the service person, their families, and the NHS and the military. Their aim was to ensure that people posted into or away from the areas, who may be pregnant, or have recently given birth, or perhaps had medical issues that needed continuity of care, were connected to the appropriate healthcare professionals/teams.

We spoke with 27 patients, all were very complimentary about the staff, they felt their treatment was excellent and they were always treated with respect. We also sent out comment cards to all 3 sites prior to the inspection, we received 61 completed cards and all were highly complementary about the care they have received and the kindness of all staff, this included the medical centre, the dispensary and the Primary Care Rehabilitation Facility (PCRF). The patients we spoke with said they had not noticed any issues with the standard of care since the practices had combined.

All reception areas were clean and well maintained. There was a good range of information posters and leaflets available, including weight management, blood pressure, men’s health, chaperones and quitting smoking advice. There were face masks at the reception desks for patients who wanted to use them. There were TVs in the waiting areas which helped to prevent overhearing conversations at reception.

Involvement in decisions about care and treatment

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

Patients could access the welfare team and various support networks for assistance and guidance. Information regarding these services was available in the waiting areas and the clinical staff were fully aware of these services to signpost patients if required.

The combined practice maintained a register of patients who were also carers and provided extra support as required, such as liaison with welfare and with the Chain of Command. Carers were identified as part of the new patient registration process and recalled for seasonal vaccination against influenza. Carers and cared for patients were clinically coded and given more time during consultations. At the time of the inspection we identified the following number of carers;
Waddington – 34
Cranwell – 26
Coningsby - 20

Privacy and dignity

Privacy screening was provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. All clinical room doors were closed during consultations.

The PCRF at Waddington there were individual clinical rooms available to work with patients, whilst at Cranwell and Coningsby there were curtained cubicles, they had music playing at a suitable volume to assist with diffusing conversations, and all sites had rooms they could use for confidential consultations.

All sites had a mix of male and female staff so requests to see a clinician of a specific gender could be accommodated, patients could also be seen at a different site if required.

Are services responsive to people's needs?

We rated the combined practice as good for providing responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs and preferences. Despite combining into 1 practice, there were local site differences and specific patient needs. The total triage system was in use at all 3 sites of the combined practice. Patients at Coningsby who walked into the medical centre for an appointment were directed to use the 'total triage' phone line to make an appointment. If the patient stated it was urgent then triage would take place there and then. Patients at all 3 sites had access to eConsult and telephone consultations.

'Hot debriefs' were scheduled into each total triage session during the tea breaks and were be led by the triage doctor. This was an opportunity to discuss clinical cases, give feedback on triage processes and document suggested changes and improvements. Any cases or occurrences that would be beneficial for a practice wide discussion were added to the consultations for group reflection document held on Sharepoint and was discussed at the monthly practice meeting.

Children were automatically placed with the doctor for a call back unless it was triaged as a higher priority in which case the co-ordinator would speak directly with the doctor at the time of the call.

The patients at Waddington included a significant proportion of aircrew. Specific clinics were created to ensure the occupational requirements were dealt with on the appropriate clinic, such as aircrew periodical medical examinations. A specific clinic was in place for medical board patients, where occupational medical grading assessments occurred.

The nursing team worked core working hours with some specialist clinics for triage and women's' health. A mix of face-to-face and telephone consultations were available with longer appointments where required. A specific clinic existed for chronic disease management. The specific clinics offered longer appointments than routine clinics. A menopause clinic had been instigated following patient's requests. This was run by one of the nurses and was held at the HIVE.

Access audits as defined in the Equality Act 2010 had been completed at each site in 2024. Any issues had been actioned.

Training for staff in learning disability and autism was delivered through the McGowan training. A specific McGowan training session was delivered as a 'course of the week' attended by all staff and was recorded on the staff database.

Timely access to care and treatment

Patients at all 3 sites had access to eConsult and telephone consultations. Staff had identified that due to security restrictions at Waddington, some patients were not able to use their personal devices whilst in the workplace. Patients at Waddington were offered to choose their preferred method of communication.

Outside of routine clinic hours, cover was provided via a duty telephone and any calls were triaged by a medic who had access to a duty doctor should they be required. At Waddington patients could use eConsult (a message could be left for the practice to follow up on the following working day if not urgent).

Individual practice leaflets provided details for out-of-hours services and there was information displayed at the main entrance to each building.

A routine appointment with a doctor were as follows:

Coningsby 6 weeks (urgent appointments available on the day)
Cranwell 2-3 weeks – (urgent appointments available on the day)
Waddington 3-4 weeks (urgent appointments available on the day)
Appointments to see the nurse or medic could be accommodated on the same day.

Direct Access Physiotherapy (DAP), a DPHC requirement to support patient choice, was not available to all patients. There were inconsistencies in patients being able to access DAP across the 3 sites.

PCRF Waddington did not currently offer DAP. Patients could be referred directly from total triage but only once they have spoken to a doctor.

PCRF Cranwell allowed DAP for cadets but not for permanent staff (but like Waddington these could come through total triage).

Coningsby offered DAP for all patients via a form sent to the PCRF group mailbox (including aircrew).

New, urgent, follow up and routine physiotherapy appointments were available within a day. Waiting times for a new patient and follow up appointment to see the Exercise Rehabilitation Instructor was 1 day. There was no wait for rehabilitation classes.
Some of the patients we spoke with commented on the wait times, although mostly their appointments ran to time, sometimes appointments ran up to 30 minutes late. This was also reflected in a 'You said, we did board Waddington, which showed feedback from patients since July 2024. One of the most common comments was appointment wait times, with some patients mentioning waits of up to 40 minutes. The practice was addressing this by encouraging patients to book double or triple appointments if they had more than one issue to discuss.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care. The patient information leaflet, signage across the 3 sites and the Defence Connect page were all used to communicate the complaints process. At the time of inspection, the combined practice Warrant Officer was the medical complaints manager. All staff in the combined practice also used the same signature block on emails, this also contained information on the complaints process.

At the time of inspection, verbal complaints were not recorded. All patients making verbal complaints were encouraged to make a written complaint. Written complaints were recorded on the combined practice complaints register. The register included complaint serial numbers and tracking the status of the complaint. An example of a complaint was when a patient complained that during a medical board that information was released to the line manager without their+ consent. On investigation, the patient had given consent previously, and because there was no change to the limitations, the policy did not require the patient to give consent again. One of the practice managers introduced an amendment to the local working practice to introduce 2 additional checks for consent to ensure best practice.

Are services well-led?

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

Vision and strategy

Staff we spoke with were clear that their remit was to support patients to benefit from the best possible healthcare outcomes which, in turn, supported operational capability. The practice worked to the Defence Primary Healthcare (DPHC) mission statement which was:

“DPHC is to provide safe, effective healthcare to meet the needs of our patients and the chain of command to support force generation and sustain the physical and moral components of fighting power”.

They also intended to develop a combined mission statement by early 2025.

Full operating capability (FOC) had only recently been achieved (October 2024) so work to combine systems and processes was at the very early stages. Some key roles had been developed for staff members, although these were not fully embedded, to provide resilience and opportunities for staff development. Although the clinical staffing establishment was sufficient to manage the patient population, there was currently insufficient staff in management roles to complete all the required actions for true combining. Many processes remained as site specific as there has been insufficient time to review and collate into single processes and documents.

Leadership, capacity and capability

Staff felt the intended benefit of the development of Waddington Combined Practice was never fully communicated to the 3 practices, therefore, there did not appear to have been full investment from the team. There was resistance to the combining project from senior leaders and they felt the timeline was imposed by regional headquarters and not aligned to the progress or stage at which the combining project had reached. We were told there was little support from regional staff with several staff telling us they rarely saw anyone from the regional team. FOC had been declared by regional headquarters when staff from all the practices agreed they were not anyway near that stage.

Multiple staff gaps had been present at various stages of the combining project, including key senior leadership posts being vacant, suggesting little coordination between the reginal headquarters direction to combine and those who managed staff movements, deployments and posting.

Staff across the 3 Primary Care Rehabilitation Facilities (PCRFs) said there was clear engagement and support from the combined practice team to support them, they felt integrated as part of the whole team. The nursing team felt patient care was at the centre

of core processes and felt safe and well supported by the management team and their peers. However, other than attending the quarterly regional nurse meetings, there was minimal contact from the regional team, generally having difficulty getting any replies to queries or requests.

Culture

We found the staff across all 3 sites to be dedicated and hardworking and the team were doing their best to ensure patient safety and good quality patient care. It was evident from our findings that the combining process was compromising this and leading to some staff stress, resentment and potentially burnout. All 3 former Senior Medical Officers had left primary care and 4 clinical staff at Cranwell had resigned.

Across all 3 PCRF sites strong supervision and mentoring, along with an effective induction, ensured that staff felt competent to do their work. Staff input was encouraged to determine how the departments were run and staff felt valued by their line managers and department heads although did not feel supported by regional headquarters. Staff morale appeared to be high across all sites with individuals enjoying being in work, feeling positive about their working environment and their teams. Locums had returned to the same sites when opportunities arose, and staff were happy to travel because they enjoyed their jobs so much.

Openness, honesty and transparency were demonstrated when responding to incidents and complaints. All staff were aware of and had systems to ensure compliance with the requirements of the duty of candour. The management team had an open door policy and the meeting structure was inclusive in providing all staff the opportunity to offer their opinion. The practice had developed ‘Lincolnshire Voice’, a dedicated group email whereby staff and patients could make suggestions, complaints or give compliments, this was widely advertised across the 3 sites.

Processes were in place to provide staff with professional development. This included appraisal and peer review. All staff received annual appraisals and were supported to meet the requirements of professional revalidation where necessary. Staff were encouraged to complete courses aimed at their professional development.

Staff wellbeing was given a high priority across the 3 sites. Each site arranging regular individual team events including, in addition there was a combined ‘whitespace event’ arranged every 5th Wednesday of the month which was well attended by all.

Governance arrangements

Communication across all 3 sites was strong and there was an extensive meeting schedule in place that included combined meetings involving all departments. The core practice management structure consisted of the Principal Medical Officer (PMO), practice managers, Band 7 nurse and the combined practice Warrant Officer who retained an overarching view over key areas that were termed as ‘pillars’. The pillars were administration, governance, clinical delivery, infrastructure and information, technology

and workforce. The PMO was also the lead of the governance pillar and all pillars included the PCRF.

There were terms of reference (ToRs) in place for practice specific roles but there were no ToRs for combined practice roles.

The combined practice had a system to monitor all patients on high risk medicines (HRMs). Shared care protocols were in place for patients taking high risk drugs. Regular clinical searches were carried out to monitor patients on HRMs.

Joint working with the welfare team, pastoral support and Chain of Command was in place with a view to safeguarding vulnerable personnel and ensuring co-ordinated person-centred care for these individuals.

A comprehensive and established audit programme was in place. Repeat cycles of the same audit had been completed or planned in many instances to monitor improvement and drive better outcomes.

Managing risks, issues and performance

There was a combined risk register and we saw that these were reviewed regularly and acted on. The 4T principles have been applied to all risks and the register includes both combined risks and those that were site specific. There was a range of both clinical and non-clinical risk assessments including lone working. The risk assessments were site specific and had not been combined.

Staff performance was managed well and leaders were aware of policies to be followed and where to access support if advice was needed. Staff would initially follow a supportive route considering welfare concerns, training needs, coaching and mentoring and ensuring appropriate objectives were in place. The annual appraisal process would be used alongside these processes. We were given a good example whereby this process had been followed and the staff member had been given objective support and feedback to improve.

There was a business resilience plan in place for each site and these had all been reviewed within the past 12 months.

Appropriate and accurate information

The healthcare governance workbook was integral to facilitate the day to day running of the combined practice. Some elements such as the ASER log and risk register were truly combined but other areas consisted of 3 workbooks of data working alongside each other. Documents such as the business continuity plans, policies, the healthcare assurance framework and ToRs had not yet been combined. There was a management action plan in place but this required a complete review.

There were robust arrangements in place that were in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. The practice managers conducted monthly Caldicott reviews on DMICP and documents and addressed issues.

Engagement with patients, the public, staff and external partners

Options were in place for patients to leave feedback about the service including information in the individual practice leaflets. All feedback was collated and discussed at the practice meetings every month. The Governance Assurance Performance and Quality dashboard was used to monitor and analyse patient feedback.

At each site there was a compliments book and a suggestions book in the waiting area, where patients could add their suggestions for improvements to the surgery. Waddington had actioned a suggestion to add a bin to the disabled toilets, although a repeated suggestion for a water dispenser in the waiting room was not yet actioned due to funding.

A staff survey had been completed, although not all staff were aware of this. The results were not available to us. All staff felt they could offer suggestions and feedback directly in 1-to-1 discussions or team meetings.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

A service evaluation has been completed by an Exercise Rehabilitation Instructor at Cranwell PCRF to look at injury trends amongst cadets and presenting the results to the college has resulted in a change in training. The evaluation was only done in the last few months, so the impact has yet to be measured but the intent is to re-evaluate in 6-months' time. Cranwell staff were due to meet with staff at Sandhurst who see a similar population in the army and were doing some similar work, so this has the potential to be a good piece of collaborative working.

Coningsby looked at the number of muscular skeletal injuries coming through the Total Triage service to determine whether physiotherapy involvement in this service would be beneficial – they determined it would be worth a trial but had not yet had the capacity to try this due to staffing and the demands placed on them by the combining process.

A menopause café was held the first Wednesday of each month to assist patients, friends, relatives and partners with information about management of symptoms and advice and support. Both clinical and non-clinical staff were there to help with all lines of enquiries.

Work was underway to place the RAF medics into hospitals across the United Lincolnshire Hospital Trust. This was for medics from all 3 sites and would allow them to be employed

at Band 3 providing them with patient exposure and contact within the emergency department, and acute admissions.