Coningsby Medical Centre

Defence Medical Services inspection

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

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

Contents

Summary

About this inspection

We carried out this announced comprehensive inspection on 31 October 2023.

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

The key questions are rated as:

Are services safe? – requires improvement
Are services effective? – good
Are services caring? – good
Are services responsive? – good
Are services well-led? – good

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

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

At this inspection we found:

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

The management of medicines given under Patient Group Directives (PGDs) and high-risk medicines (HRMs) management was good. However, repeat medicines requiring review required better management.

There was an effective programme in place to recall patients with long-term conditions.

Patients received effective care reflected in the timeliness of access to appointments, reviews, and screening/vaccination data. The care provided for children and families was accessible and effective.

The medical centre had good lines of communication with the unit, welfare team, local NHS, social services, and the Department of Community Mental Health to ensure the wellbeing of service personnel. They had particularly positive lines of communication with the squadrons and the station with the aim to ensure the wellbeing of service personnel.

All staff knew how to raise and report an incident and were fully supported to do so.

There was evidence of some clinical audit based on patient population need and adherence to national guidance. However, this required further development.

The implementation of the 'Total Triage' system had received positive feedback and showed patients were receiving timely care by the appropriate clinician.

Facilities and equipment at the medical centre were sufficient to treat patients and meet their needs.

The medical centre benefitted from a strong and inclusive leadership style, such that staff felt valued and able to contribute to improved ways of working. An inclusive whole-team approach was supported by all staff who worked collaboratively to provide a consistent and sustainable patient-centred service.

Staff were aware of the requirements of the duty of candour, (the duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). Examples we reviewed showed the medical centre complied with these requirements.

The governance systems were effective with all relevant information captured to monitor service performance.

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

Aircrew were offered appointments for their annual aircrew medical up to one year in advance. This was essential in ensuring the fast jet pilots were ready to operate and that their health and occupational medicine requirements were in date. This was achieved by assigning the duty doctor on a Friday to 2 aircrew specific medical slots. This had seen the aircrew medical recall remain at 100% throughout.

A quality improvement project had been initiated to change the way Force Generation risk assessments were conducted to streamline appointments for those deploying regularly. Requirements were pre checked and then appointments made if necessary. (Previously a double nurse's appointment was made for every deployment resulting in wasted clinical time as well as patient dissatisfaction). This was in response to patient and staff feedback.

The Chief Inspector recommends to Coningsby Medical Practice

Review the approach to peer review and clinical supervision to ensure all staff are adequately supported to deliver safe and effective patient care.

The process of managing external referrals should be reviewed, specifically the management of those patients requiring urgent referral (2 week waits).

Medicine reviews should take place regularly to ensure prescribing is in accordance with best practice guidelines and patients receive the necessary checks in line with their treatment plan.

Continue to develop the audit programme ensuring it drives improvement in services for patients.

Improve the waiting times for patients to see the exercise rehabilitation instructor (ERI). This should be in line with the primary purpose of ERIs contributing to an accelerated rehabilitation pathway.

Mitigate the risk of not being able to observe patients in the waiting room whilst waiting to be seen.

The Chief Inspector recommends to DPHC and the Station:

Station Executive should share clear information and resolve risks pertaining to water safety checks.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Hospitals and Interim Chief Inspector of Primary Medical Services

Our inspection team

The inspection team was led by a CQC inspector. The team included specialist advisors including a primary care doctor, a pharmacist, a practice manager, a physiotherapist, an exercise rehabilitation instructor and a nurse. In addition, two representatives from the Defence Medical Services Regulator team shadowed this inspection.

Background to Coningsby Medical Centre

Coningsby Medical Centre provides primary and emergency care to a practice population of 2300 patients. The population are predominantly aged between 18 and 55. The practice also provides medical care to service families, including approximately 48 children.

In addition to routine primary care services, the medical centre provides occupational health care to service personnel, including force preparation, diving medicals and aviation medicals. Family planning advice is available. Maternity and midwifery are provided by NHS practices and community teams.

A Primary Care Rehabilitation Facility (PCRF) is located on the premises, with physiotherapy and rehabilitation staff integrated within the medical centre.

The practice has a dispensary which is open Monday -Thursday 08:00–16:30, it is closed on Wednesday afternoon and daily from 10:00 -10:30 and 12:00-14:00pm. On a Friday it is open 08:30-16:00 hours.

The practice is open on Monday, Tuesday, Thursday and Friday 08:00-17:00, and from 17:00 -18:30 for urgent cases only. The practice is open on a Wednesday 08:00-12:00 and is closed in the afternoon for staff training but access to a GP for urgent cases is available.

The staff team

Senior Medical Officer (SMO)	1
Medical Officers	2
Civilian medical practitioner	1
Practice manager	1
Nurses	4
Pharmacy technician	2
Exercise rehabilitation instructors (ERI)	2
Physiotherapists	4
Administrator	2
Medics	14

Are services safe?

We rated the medical centre as requires improvement for providing safe services.

Safety systems and processes

The medical centre worked to the Defence Primary Care Healthcare (DPHC) Tri-Service safeguarding policies. The Senior Medical Officer (SMO) was the lead for safeguarding. All staff within the medical centre had received up-to-date safeguarding training at a level appropriate to their role. We saw that two new staff within the Primary Care Rehabilitation Facility (PCRF) required updated safeguarding training and this was planned. The medical centre's standard operating procedures (SOPs) for both adult and child safeguarding had been reviewed and included contact details for local safeguarding teams.

Safeguarding concerns were discussed at monthly 'care and concern' meetings. A vulnerable persons register, including patients under the age of 18, was maintained and a search of DMICP (electronic patient record system) was undertaken monthly. Quarterly meetings were held with representatives for Department of Community Mental Health. Monthly meetings were also held with the welfare team. We were given a good example where a vulnerable patient and their family had been supported during a difficult time and how their care was sensitively handed over to the local NHS practice when the patient de-registered.

The doctors had strong links with the welfare teams and were developing links with the local NHS practice including undertaking some joint training.

Notices advising patients of the chaperone service were displayed. There was a list of trained chaperones and chaperone training held regularly. Staff who acted as chaperones had received a Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

The full range of recruitment records for permanent staff was held centrally. However, 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.

There was a dedicated lead for infection prevention and control (IPC) and they had completed the IPC link training. Audits were undertaken monthly and actions taken as required. All staff were given half a day each quarter to complete updated training.

We noted whilst not part of the PCRF or medical centre, the fitness suite (owned by the station, not DPHC) was not clean and the general standard of cleanliness was not as would be expected within a DPHC owned facility. This had been acknowledged on the practice issues log and had been escalated to the facility owner. The PCRF should explore if additional control measures were warranted (wiping down equipment before and after use).

Environmental cleaning was provided by an external contractor. A written cleaning schedule was in place and these were signed off to confirm that cleaning tasks had been completed in line with the agreed frequency. Cleaning standards were monitored by the practice manager. Required arrangements were in place for deep cleaning, the last had been carried in August 2023.

The management of healthcare waste was overseen by one of the medics named as the responsible individual. Clinical waste was monitored daily and, when required, yellow bags containing waste were secured, labelled and locked in containers awaiting collection. Although consignment notes were held in the pharmacy at the time of the inspection, there was no clinical waste log in place to cross reference with consignment notes. The day after the inspection we received notice that a clinical waste log had been initiated and was in place on the Healthcare Governance workbook, alongside a local SOP for all staff to follow.

The medical centre had a system in place to distribute alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). Discussion took place at clinical meetings and was recorded in the minutes.

Risks to patients

There was a good balance of civilian and military staff which afforded continuity of care.

There had been much staff turbulence at Coningsby with 5 SMOs or Deputy Senior Medical Officers (DSMOs) in the past 5 years. Within the nursing team there had been 12 different personnel utilised in the past year to fill 5 posts. Within the PCRF there had been significant posts gapped in recent years but they were presently at the correct staffing levels. Medics were often newly recruited, there were 8 currently in their first posting meaning significant support and mentoring was required. The Practice Manager post was previously vacant for 18 months. Locum funding was available but the contracted agency were often unable to fill the assignments exacerbated by a lack of available accommodation on the Station.

We reviewed the medicines on the emergency trolley and found they were appropriate and in-date. Defibrillators were located in the medical centre and also in the gym. Oxygen was held and was accessible. There was appropriate signage in place.

All staff working in the medical centre had completed basic life support, anaphylaxis and defibrillator training. We noted 2 new staff within the PCRF were not up-to-date with refresher training but this had been planned. Information about sepsis was displayed in various areas of the medical centre. The sepsis recognition policy and aide memoire for prioritising patients were held at reception for easy reference. Clinical staff had received training in climatic illness. Doctors were Military Aviation Medical Examiner (MAME) trained.

The Practice Manager was a trained paramedic and delivered moulage training, they recently delivered a session on cardiac arrest including different scenarios. This was particularly useful prior to the ‘Station Families Day’.

Waiting patients could be not observed at all times by staff working on the front desk. On the day of the inspection we noted this was not recorded on the issues log but it was added after the inspection.

Information to deliver safe care and treatment.

An SOP was in place to ensure summarisation of patients' records was undertaken in a safe and timely way. Patients registering at the medical centre completed a new patient questionnaire, which was submitted to the nursing team for scrutiny and summarising. This process identified any actions that required follow up.

Peer review was used to measure and ensure quality of care delivery across most of the staff team at the medical centre. However we noted the non-medical prescriber was not part of this process. There was a peer review process in place for the physiotherapists whereby each clinician was formally reviewed at regular intervals. The exercise rehabilitation instructor (ERI) had no formalised peer review, clinical supervision or mentoring on musculoskeletal assessment skills.

Supervision for the triage team was provided by the doctor for all clinical matters, they also had reach back to the other doctors at any time. There was a duty senior (Sergeant – Warrant Officer) to ensure the welfare of the team, deal with any administrative, of difficult matters and provide a conduit for the Station to link in any welfare patient of needed. However we noted the non-medical prescriber was not part of this process. There was a peer review process in place for the physiotherapists whereby each clinician was formally reviewed at regular intervals. The exercise rehabilitation instructor (ERI) had no formalised peer review, clinical supervision or mentoring on musculoskeletal assessment skills.

Physiotherapists were able to access all patient medical notes, but ERIs had limited access. This was a central issue and not exclusive to Coningsby.

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

The management of referrals was not failsafe. The dedicated referrals clerk retired in late 2022 and although a replacement referrals clerk has been recruited, they did not start employment until November 2023. The role was being covered by colleagues in the interim. Referrals were sent to a group task box on DMICP which a number of staff could access. The referrals register was held in a limited area on SharePoint. On review, it was clear that referrals were not being monitored for an appointment date, including those referred under the 2-week rule. We reviewed the register back to July 2023 and this issue was consistent throughout. It was not clear how referrals prior to January 2023 were being monitored. We noted that a significant event (ASER) had been raised in relation to referrals. During the inspection, all 2 week wait referrals were reviewed and all had either been seen or had an appointment scheduled. The day following the inspection we received an email detailing some improvements from the medical centre that had been made to the referral register.

An effective process was in place for the management of specimens and this was supported by an SOP. Samples taken were recorded on an online spreadsheet and results were returned via the PathLinks (electronic link between the pathology laboratory and healthcare professionals) inbox. These were then reviewed daily by the duty doctor to confirm receipt and action any urgent results. They were then allocated back to the requesting doctor for any further action.

Safe and appropriate use of medicines

Arrangements were established for the safe management of controlled drugs (CD), including destruction of unused CDs.

Emergency medicines were easily accessible to staff in a secure area of the medical centre and all staff knew of their location. Stocks were in line with Defence Primary Healthcare (DPHC) SOPs.

Medication requiring refrigeration was monitored twice a day to ensure it was stored within the correct temperature range. All staff who administered vaccines had received the immunisation training as well as the mandatory anaphylaxis training.

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.

Most Patient Group Directions (PGDs) had been signed off to allow appropriately trained staff to administer medicines in line with legislation. There were two PGDS that were out-of-date and required authorisation, these were then signed on the day by the SMO.

Requests for repeat prescriptions were managed in person or electronically in line with policy. A process was in place to update DMICP if changes to a patient's medication were made by secondary care or an out-of-hours service. The repeat prescription process was detailed in the medical centre leaflet.

We saw evidence to show that some patients' medicines were reviewed regularly and the doctors' notes in DMICP around medication changes were comprehensive. However we saw that out of 646 patients with repeat prescriptions in place, only 277 had been reviewed. Following the inspection the medical centre undertook a more detailed search and found that of the 646 patients 467 had been reviewed and 179 reviews were outstanding.

A process was established for the management of and monitoring of patients prescribed high risk medicines (HRM). The register of HRMs used at the medical centre was held on DMCIP and all doctors and relevant clinicians had access to this. We looked at a sample of patient records and saw that all had been coded or had shared care agreements in place.

Track record on safety

There was a designated health and safety lead and a board was displayed which was regularly externally audited. Measures to ensure the safety of facilities and equipment were in place. Electrical and gas safety checks were up-to-date. Water safety checks were regularly carried out but no records were available on the day. The medical centre had requested these from the Estate Facilities team but had received nothing back to date. A land equipment audit completed in 2022 achieved full compliance for equipment care.

A fire risk assessment of the building was undertaken annually. Firefighting equipment tests were current. Staff were up-to-date with fire safety training and were aware of the evacuation plan.

A system for monitoring and recording the servicing of all clinical/non-clinical equipment was established, this included equipment in the PCRF.

Staff had adopted the current risk template as per DPHC guideline and used the 4Ts (treat, tolerate, transfer or terminate) to manage risk. The practice manager and the deputy practice manager had completed the necessary courses to conduct risk assessments and all risk assessments were in-date at the time of the inspection.

The Healthcare Governance workbook contained active and retired risk registers. The active risk register was reviewed regularly with risk management being a standing agenda item at the monthly practice meetings.

There was a Business Resilience Plan (BRP) in place that had been reviewed in March 2023. The BRP provided a means of ensuring the continuation of the medical centre's functions in the event of a peacetime disaster affecting the infrastructure and/or its personnel. Examples of a disaster could be fire, flood, total IT failure or terrorist attack.

The medical centre had a mixture of fixed alarms that sounded at the administration office and some rooms had handheld alarms. There was an alarm system checklist on the Healthcare Governance workbook which documented monthly testing. There was also a panic alarm in the corridor of the PCRF.

Staff had the information they needed to deliver safe care and treatment to patients. If there was an unplanned DMICP outage, the medical centre would use laptops and Wi-Fi if it was a local network server issue. The BRP plan detailed workaround steps should problems with connectivity continue.

Lessons learned and improvements made

All staff had access to the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events and incidents. All incidents reported were logged through the ASER system. They were discussed at weekly Heads of Department meetings and the practice meetings and an ASER register was maintained.

From interviews with staff and evidence provided, it was clear there was a culture of reporting incidents. Both clinical and non-clinical staff gave examples of incidents reported

through the ASER system including the improvements made as a result of the outcome of investigations. We saw a recent example regarding faulty syringes when an ASER was raised by a member of the nursing team.

Are services effective?

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

Effective needs assessment, care, and treatment

Clinicians had opportunities to attend regional forums, such as regional governance meetings and nurse development forums. Practice meetings were held every month in order to discuss practice issues. Clinical meetings were held monthly where National Institute for Health and Care Excellence (NICE) and the Scottish Intercollegiate Guidelines Network (SIGN) guidance were discussed. Examples of recent discussion were Otitis Media, Ectopic Pregnancy and Chronic Cough via the 'Red Whale' platform. It was planned that moving forward, the NICE updates discussed would be added as an annex, with links to the end of the full practice meeting minutes for all staff to see and read. Clinical discussion was varied and a programme was in place.

We noted that standard operating procedures (SOPs) of Defence Primary Healthcare (DPHC) that had been published were emailed out to all within the medical centre for awareness, however, these not captured in the Healthcare Governance meeting for discussion.

Week 1 – Practice Meeting
Week 2 – Chronic Disease (review of registers, learning points, action for recalls, template use, NICE updates etc)
Week 3 – Healthcare Governance (NICE guidelines, audit activity)
Week 4 – Care and Concern (safeguarding and welfare, review of listed patients)
Week 5 – Staff Development (NICE guidelines, teaching, wellbeing, FD, CPD)

Monitoring care and treatment

The nursing and doctor teams monitored patients with long-term conditions (LTC). A good local system had been developed to standardise the management of the reviews. There was evidence of recalls from the notes of active management of chronic disease.

All patients over the age of 40 were invited to a full health check including bloods and identifying risk factors. Lifestyle and health advice was provided as appropriate both verbally and written. This check was repeated every 3 to 5 years unless identified as a risk when patients were recalled annually for blood testing. All patients with a chronic disease had an annual screening including blood tests or more frequently if required.

There were 17 adult patients on the diabetic register. For 12 patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For 13 patients, the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.

There were 51 patients recorded as having high blood pressure. Forty-seven were recorded as having a blood pressure check in the past 9 months.

There were 31 patients with a diagnosis of asthma, 26 had an asthma review in the preceding 12 months.

Routine vaccination and audiometric recalls were managed by the medics. Audiology statistics showed 95% of patients had received an audiometric assessment within the last 2 years.

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 talking therapies, charities and with the Department of Community Mental Health.

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.

An audit calendar was in place and this extended to and integrated with the Primary Care Rehabilitation Facility (PCRF). We saw the most recent audits included, infection prevention and control and an antibiotic audit. Recent clinical audits were limited and could be extended. We saw an asthma audit had been completed in May 2020, a diabetes audit in July 2020 and a hypothyroidism in July 2021. The medical centre and the PCRF, had a plan to develop the practice's clinical audit work to identify local improvements that could be made to improve patient care. The exercise rehabilitation instructor (ERI) should be included in this programme.

The Senior Medical Officer (SMO) and Warrant Officer led the quality improvement (QI) programme. The main QI work being conducted currently was the 'Total Triage' system. There was evidence of strong change management by the leadership/management team. This was in its infancy but plans to continually conduct patient feedback and tweak systems accordingly were in place. Other medical centres within DPHC had visited RAF Coningsby to view how the 'Total Triage' system had been implemented to benefit the staff and patients. Good practice was also shared across the Region at the quarterly Regional Clinical meeting.

Effective staffing

The medical centre had an extensive and bespoke induction programme, with a separate induction for locum staff. There was an induction register with completed induction check sheets scanned onto SharePoint. Both the DPHC induction and workplace induction were both recorded on the staff database.

All staff were reminded of the training they were required to complete with the 'course of the week' allowing staff to prioritise key training with 5 days for them to provide evidence that the training has been completed. Staff were also allowed a half day per quarter to complete mandatory training if required. There was good compliance with mandatory across all required courses with the exception of two new staff who had safeguarding update training planned in.

The doctors and nurses had the appropriate skills for their role and were working within their scope of practice. Performance appraisals were conducted by line managers for all staff. All doctors were in-date for appraisal and all doctors and nurses had completed timely revalidation.

Clinical staff kept up-to-date with their own continual professional development (CPD) and revalidation. Staff could access CPD funding by an application to the Regional Headquarters. Staff were able to be released for placements to maintain clinical competence such as overseas exercises and Derby hospital.

There was role-specific training for relevant staff. For example, the Warrant Officer had competed the Institution of Occupational Safety and Health course (IOSH). The deputy practice manager was also IOSH trained and had a degree in health and social care. The practice manager was a paramedic and attended the mandated 50 clinical sessions per year. All doctors were MAME qualified for Aviation medicine. Nurses were trained in spirometry for post solder exposure health surveillance.

Staff administering vaccines had received specific training which included an assessment of competence. Staff who administered vaccines could demonstrate how they kept up-to-date with changes to the immunisation programmes, for example, by access to online resources and discussion at nurses' meetings.

Coordinating care and treatment

The medical centre staff met with welfare teams and line managers to discuss vulnerable patients. Staff told us that they had forged some good links with other stakeholders, including the local NHS Midwifery and Health Visiting service, and voluntary organisations. The local safeguarding partnership had attendance by a representative from the 'network' being either RAF Coningsby with RAF Waddington or RAF Cranwell.

It was clear that the PCRF were an integral part of the medical centre. There were good streams of communication with staff in the PCRF, meetings were inclusive and governance structures integrated.

The doctors conducted regular handovers to other practices (including NHS) appropriately, this usually took the form of direct discussion with an appropriate clinician.

Ad hoc conversations with the Chain of Command were had for any patients of concern. We spoke with one of the Squadron Commanders who said there was good communication with the medical centre and especially when concerns arose regarding personnel. The SMO wanted to further improve the practice's engagement with the unit. This work had begun with several other examples given of good communication and engagement with them. For example, meetings were held every 6 weeks with the Squadrons to discuss any concerns and health promotion sessions were run. There was good engagement from the medical centre for the stations Mental Health and Wellbeing Day.

For patients leaving the military, pre-release and final medicals were offered. During the pre-release phase, the patient received an examination and a medication review. A

summary print-out was provided for the patient to give to the receiving doctor, and a letter if the patient was mid-way through an episode of care. An individual handover was given for any of patients of concern. Several examples were given of when specific handovers were arranged with the NHS local practice for patients with clinical complexity.

Helping patients to live healthier lives

Health promotion was run from the National Health promotion calendar with information posters displayed. The health promotion displays were comprehensive, clear and positioned strategically to target the most relevant cohort of patients. For example, well man and well woman health promotion information was displayed in the respective male and female toilets. At the time of the inspection there was mental health and wellbeing information and 'Movember' posters on display. The practice was engaged with the planning and delivery of the Station Mental Health and Wellbeing Day.

None of the nurses had specific sexual health training (STIF), instead they provided sexual health support, including chlamydia and gonorrhoea screening. Advice was readily available and patients were signposted to a local NHS sexual health clinic for treatment. Free condoms were available at reception.

All eligible female patients are on the national cervical screening database and were recalled by the nurse. The latest data confirmed a 97% 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.

An effective process was in place to recall patients for their vaccinations. Vaccination statistics were identified as follows:

88% of patients were in-date for vaccination against diphtheria.

88% of patients were in-date for vaccination against polio.

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

91% of patients were in-date for vaccination against hepatitis A.

88% of patients were in-date for vaccination against tetanus.

7% of patients were in-date for vaccination against MMR.

43% 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) (i.e., three doses of DTaP/IPV/Hib/Hepatitis B) was 90%.

The percentage of children aged 2 who had received their booster immunisation for Pneumococcal infection (i.e., received Pneumococcal booster) (PCV booster) was 90%.

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 67%.

Consent to care and treatment

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

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. A review of patient notes evidenced that verbal consent was recorded and coded appropriately on DMICP. Clinicians advised us that implied consent was accepted for basic procedures such as the taking of blood pressure. Written consent was taken for more intimate examinations and this was regularly audited.

Are services caring?

We rated the medical centre as good providing caring services.

Kindness, respect, and compassion

In advance of the inspection, patient feedback cards were sent to the medical centre. A total of 9 patients responded and feedback was positive about the care and kindness shown and the helpfulness of staff. We also observed staff being courteous and respectful to patients in person and on the telephone. The last patient survey, undertaken by the medical centre between September and October 2023, showed 98% (of the 42 patients asked) said they were treated with kindness and compassion.

Through discussion with staff we learnt how medical staff centre routinely went the extra mile to ensure that the mental health and holistic needs of patients were met in a timely, respectful and compassionate way. This included extended registration of families to ensure consistency and continued support, working routinely with overseas colleagues to assist families whose loved ones had needed medical care. We saw 2 examples whereby the medical centre had helped patients with their occupational needs with clinicians working closely with secondary care to get the best outcome for the patients.

Patients could access the welfare team and various support networks for assistance and guidance. Information regarding these services was available in the waiting areas and the clinical staff were fully aware of these services to signpost patients if required. We spoke with one member of the welfare service, who said staff at the medical centre were always available when needed and were kind and compassionate.

Involvement in decisions about care and treatment

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

Patients identified with a caring responsibility were captured on a DMICP register. It included what had been discussed at the monthly practice/clinical meeting and any actions identified. There was a practice leaflet which included information for carers. Alerts were made on individual patient’s notes to ensure that longer appointments were given if needed, there were 2 carers aged under 18 registered. Searches were conducted to ensure that flu vaccine offered appropriately.

Staff explained that they occasionally saw patients who spoke English as a second language. They could access a translation service if they needed it. Some information posters in reception were also written in Arabic.

Privacy and dignity

Patient feedback showed that they were confident that the medical centre would keep information about them confidential. All stated that they felt that their dignity and privacy were upheld by medical centre staff. Consultations took place in clinic rooms with the door closed. Patients were offered a private room if they wanted to discuss something in private or appeared distressed, there was a card available at reception that patients could hand in without having to verbally ask.

The treatment area within the Primary Care Rehabilitation Facility was open plan with curtains so conversations could be overheard. This had been mitigated by having music playing. Staff also have the option to use a private office for confidential conversations. Staff also worked in other rooms if not seeing patients to allow staff to have more privacy when doing patient assessments.

All staff had completed the Defence Information Management Passport training which incorporated the Caldicott principles.

Are services responsive to people's needs?

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

Responding to and meeting people's needs

In July 2023, the medical centre introduced a 'Total Triage' system to streamline and shorten care timelines and apportion duty contacts appropriately. There were 2 'Total Triage' sessions (am and pm) every working day except Wednesday and Friday where there was 1 morning session only. Outside of the 'Total Triage' sessions, the 'Total Triage' phone line had a voicemail to call back at the next session time unless urgent. At the initial point of patient contact, the Triage Coordinator would perform an initial triage to place the patient in a call back 'bucket'. This would be by either the medic, nurse or doctor depending on the nature of the problem. An initial triage question set was used, these were lifted directly from NHS documents and the team were trained in their use. They included questioning about medical emergencies including NHS flag symptoms for stroke.

Once triaged into 'buckets', patients would be called back by a triage clinician. Those marked as urgent would be called first, otherwise they will be called in time order. The potential outcomes of these calls were;

- Care completed (no face to face or follow up appointment required)
- Urgent appointment booked (with MO, nurse, medic or physio)
- Priority appointment with a doctor booked
- Routine appointment booked (with doctor, nurse or physio)
- Doctor follow up appointment booked
- Other appointment type booked (e.g. Medical Board)

Appointment waiting times. Target appointment waiting times were;

- Urgent appointment – same day
- Priority appointment – within 72 hours
- Routine appointment – within 2 weeks

Patients 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.

'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 medical centre no longer provided the e-Consult service but had moved the repeat medication questions from the e-Consult template to a separate form to allow patients to easily request repeat medicines electronically.

The medical centre conducted medicals each afternoon and also offered separate well woman and chronic disease clinics. Telephone appointments were routinely available and there was a home visit log on the Healthcare Governance workbook. The medical centre also offered surge Force Generation clinics in support of large deployments of personnel.

Aircrew were offered appointments for their annual aircrew medical up to one year in advance. This was essential in ensuring the fast jet pilots were ready to operate and were up-to-date with their health and occupational medicine requirements. This was achieved by assigning the duty doctor on a Friday to 2 aircrew specific medical slots. This had seen the aircrew medical recall remain at 100% throughout.

A quality improvement project had been initiated to change the way Force Generation risk assessments were conducted to avoid repeated unnecessary appointments for those deploying regularly. Requirements were prechecked and then appointments made if necessary. (Previously a double nurse's appointment was made for every deployment resulting in wasted clinical time as well as patient irritation). This was in response to patient and staff feedback.

Squadron based briefs and set timings had been developed in response to recent changes of several larger group deployments. Squadron based requirements were considered and initiated to improve efficiency of resources used at the medical centre and to suit the needs of the Squadron.

The exercise rehabilitation instructors (ERIs) made opportunities and worked flexibility to provide supervised rehabilitation for the patients. For example, they changed the rehabilitation timings to facilitate night shift workers and aircrew so that the flying programme was not interrupted.

The practice manager was the lead for diversity and inclusion. There was good communication with the unit leads and nominated leads within the medical centre. An Equality Access Audit as defined in the Equality Act 2010 was completed for individual sites within the past year. Any points identified were discussed and put onto the issues register.

A policy was in place to guide staff in exploring the care pathway for patients transitioning gender.

Timely access to care and treatment

Details of how patients could access the doctor when the medical centre was closed were available through the station helpline. Details of the NHS 111 out of hours service was

outlined in the practice information leaflet. Shoulder cover was provided by the duty doctor until 18:30 hours then patients were directed to the NHS 111 service.

Urgent doctor and nurse appointments were available on the day. Routine doctor appointments were available within 2 weeks. Routine appointments to see a nurse were available within a few days. Urgent physiotherapy appointments were available within 1 day, a routine new patient physiotherapy appointment was available within 4 working days and a follow up appointment within 2 days.

Waiting times for ERIs were 2-3 weeks. This was not attuned with one of the primary purpose of ERIs of contributing to an accelerated rehabilitation pathway. There were only 10 new patient appointments per week between 2 ERIs. Defence Rehabilitation guidance states 2 new patient appointments should be made available each day for each ERI. Consideration should be given to whether the volume of group-based activities and supervised individual programme sessions was hampering the ability the see new patients in a timely manner.

Listening and learning from concerns and complaints

The practice manager was the lead who handled all complaints in the practice. The practice had implemented a process to manage complaints in accordance with the Defence Primary Healthcare complaints policy and procedure, 5 complaints had been recorded within the past 12 months with no obvious themes and timelines had been monitored as part of the complaints log.

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

Are services well-led?

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

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 medical centre 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'.

RAF Coningsby had their own mission statement which was:

> 'Develop the future, deliver the present and commemorate the past of the Royal Air Force's combat Air Power'.

The medical centre had developed a new vision, values and strategy to support business plans to achieve the practice priorities. An example of this was evidenced in the implementation of the 'total triage' system. It showed a good example of change management with the 'total triage' system implementation, with full engagement with relevant stakeholders (patients and staff) with plans to test and adjust according to feedback. This was developed to ensure the patients were seen at the right time by the right person. It showed an efficient use of clinician and patient time.

There was clear engagement and support from the medical centre to support the Primary Care Rehabilitation Facility (PCRF) priorities. With the uplift in workforce, there was a clear desire to engage more widely and regularly with the squadrons to support aircrew.

The medical centre were passionate about the protection of the environment. They actively promoted the need to recycle by a poster campaign and there were many recycling bins around the building. They also provided leaflets on schemes such as recycling used inhalers, batteries (including hearing aid) and printer cartridges.

Pre appointment assessment sheets were in a wipe clean format, cutting down on printing and paper wastage. This was also an approach taken with Patient Discharge summaries, where, if possible, these were sent electronically in a PDF format, saving thousands of reams of paper.

Every light switch had a reminder on it to switch off when not needed. The medical centre also followed the NHS in the promotion of only wearing gloves if there was a risk of exposure to bodily fluids or infection.

Leadership, capacity, and capability

The practice had been through a time when a number of positions in the established team were not filled. This had impacted service delivery in the preceding 12 months. However, we found a team who had gained resilience and had focussed on providing the core services to keep patients safe whilst providing support to other medical centres within the region.

The staff spoke of a good working relationship with the regional team, the SMO and practice managers had regular dialogue with the Regional Clinical Director and Regional Headquarters.

The staff team at the medical centre worked with determination and collaboratively to deliver the best possible care to patients. All staff we spoke with described a committed and able leadership team with an SMO who demonstrated an inclusive and responsive leadership style.

Staff within the PCRF said they had an excellent relationship with the leadership team within the medical centre. They were very complimentary about the culture and atmosphere that has been created by the senior leadership team. They feel valued and included and free to have open dialogue.

Culture

A responsive and patient-centred focus was clearly evident with this ethos embedded in practice. Staff continually looked at ways to improve the service for patients.

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

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

Processes were established to ensure compliance with the requirements of the duty of candour, including giving those affected reasonable support, information, and a verbal and written apology. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. We were provided with examples of when duty of candour had been applied.

Governance arrangements

Communication across the practice was strong and an appropriate meeting structure and healthcare governance approach was in place. This included regular clinical, practice, healthcare governance and unit healthcare committee meetings, safeguarding and PCRF meetings.

A comprehensive understanding of the performance of the medical centre was maintained. The system took account of medicals, vaccinations, cytology, summarising and non-attendance.

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 (ToRs) were in place to support job roles, including staff who had lead roles for specific areas. Staff had lead/deputy roles and responsibilities with some having multiple associated duties due to their particular expertise and skill sets.

The medical centre had worked hard to maintain the Healthcare Governance workbook, it was extensive, well referenced and absolutely integral to the effective running of the service.

Managing risks, issues and performance

There was a current and retired risk register on the Healthcare Governance workbook along with current and retired issues. The register articulated the main risks identified by the practice team. The registers were regularly reviewed. There were a range of risk assessments in place including both clinical and non-clinical risks.

Staff who were not performing would be supported initially to identify any underlying cause and implement support structures. If performance did not improve then formal performance management processes, military or civilian, would be followed.

All staff were in-date for ‘defence information passport’ and ‘data security awareness’ training. Smart cards were personal issue but would be deactivated for access to the medical centre by the practice manager when staff leave. Temporary ID or access passes would be returned to the guard room when a member of staff left.

Appropriate and accurate information

The eHAF commonly used in DPHC services to monitor performance is an internal quality assurance governance assurance tool to assure standards of health care delivery within defence healthcare.

National quality and operational information were used to ensure and improve performance.

There were arrangements at the practice in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice had been utilising their patient feedback to produce actions that were documented on the 'You Said, We Did' board. These included the introduction of weekly, bookable aircrew medicals. All feedback was collated and discussed at the practice meetings every month. The Governance Assurance Performance and Quality (GPAQ) dashboard was used to monitor and analyse patient feedback. Quick Review or 'QR' codes were used throughout the medical centre to capture patient feedback. A patient survey was undertaken between September and October, 42 patients responded that included comments that praised the service provided and the staff who delivered it.

A staff survey was undertaken in May 2023, 16 people responded. The survey showed an overall positive response with people commenting that the felt well supported.

A patient survey on the 'Total Triage' service was undertaken In October 2023, 9 patients responded. When asked if it was easy to get through on the telephone 8 people said yes it was. All 9 patients stated they felt they had been triaged by the appropriate clinician.

One of the doctors had introduced a well-being session whereby staff could spend some time practising mindfulness and yoga.

Continuous improvement and innovation

There was much evidence of continuous improvement in the medical centre.

Aircrew were offered appointments for their annual aircrew medical up to one year in advance. This was essential in ensuring the fast jet pilots were ready to operate and were up-to-date with their health and occupational medicine requirements. This was achieved by assigning the duty doctor on a Friday to 2 aircrew specific medical slots. This had seen the aircrew medical recall remain at 100% throughout.

A quality improvement project had been initiated to change the way Force Generation risk assessments were conducted to avoid repeated unnecessary appointments for those deploying regularly. Requirements were prechecked and then appointments made if necessary. (Previously a double nurses appt was made for every deployment resulting in wasted clinical time as well as patient irritation). This was in response to patient and staff feedback.

The medical centre had adopted a practice leaflet which they provided QR codes as a link to all services provided. It was a comprehensive document and encompassed information about the PCRF, dispensary, self-help groups and local contacts and charities.