







Raleigh Medical Centre

HMS Raleigh, Trevol Road, Torpoint, Cornwall PL11 2PD

Defence Medical Services inspection report

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

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

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Summary

About this inspection

We carried out this announced comprehensive inspection on 24 October 2023.

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

Are services safe? – requires improvement

Are services effective? – outstanding

Are services caring? – outstanding

Are services responsive to people's needs? – outstanding

Are services well-led? – outstanding

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

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

At this inspection we found:

- Feedback showed patients were treated with compassion and respect, had prompt access to the service and were involved in decisions about their treatment and care. The practice pro-actively responded to patient feedback and made improvements to the service as a result.
- Extensive safeguards were in place, including close working with the welfare team, to support vulnerable patients.
- The practice was well-led and the leadership team demonstrated they had the vision, capability and commitment to provide a patient-focused, caring and responsive service. The leadership approach was collaborative and inclusive.
- There was an open and transparent approach to safety. A well-developed system was in place for managing significant events. All significant events and incidents were subject to a thorough root cause analysis. Emerging themes were used as drivers for change.

- The practice worked collaboratively with internal units and departments to enhance the safety, welfare and wellbeing of trainees. Through networking with external providers, improvements had been made to services provided externally.
- The arrangements for managing medicines minimised risks to patient safety. High risk medicines were well managed.
- Healthcare governance processes were well-developed and routinely used to monitor service performance. Clinical audit was regularly used to monitor if healthcare was provided in accordance with standards.
- Staff consistently sought ways to develop and improve. Quality improvement activity was embedded in practice and was used to drive improvements in patient care. Quality improvement projects had been shared widely and some had been adopted by other Defence medical centres.

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

- Practice staff provided a caring service beyond what was expected of them. There were numerous occasions when staff had gone ‘the extra mile’ to support vulnerable/at risk patients and/or to provide compassionate care. Examples included, pro-actively addressing the increasing mental health needs of the Conqueror Division (rehabilitation unit for injured trainees), advocating on behalf of a patient so they could attend an external service, providing the option for young people to involve a parent remotely in consultations, providing home visits and ensuring care leavers had somewhere to go during leave periods.
- The practice was highly responsive to the needs of patients. Because trainees had limited access to their phones, paper QR codes were provided so they could access the patient survey. In addition, a touchscreen tablet was procured for the practice for patients to leave feedback. Period packs were given to all biological females on their first day. This greatly reduced patient embarrassment at being escorted to the shop to buy products. Furthermore, some trainees, including those from overseas, were not familiar with tampons (needed when menstruating during swim tests) so the Senior Nursing Officer (SNO) spent time explaining to individuals how to use these products. This had been identified as a quality improvement project (QIP).
- In response to a trend of significant events related to people failing spirometry, a new protocol was developed along with a diving specialist delivering a teaching session to clinical staff on achieving optimum spirometry. This work was raised as a QIP.
- A doctors’ induction questionnaire had been developed by the practice to guide and facilitate learning about the practice and issues unique to HMS Raleigh. One of the doctors said the questionnaire supported them with reflective practice and understanding issues specific to the patient population and service needs. This induction questionnaire was raised as a QIP.
- To address delayed communication from secondary care, the practice amended its acute referral letter to include a request for some immediate feedback from the clinician seeing the patient. As a result, the majority of secondary care specialities now provide written feedback immediately after assessment of the patient.

- Data loss from DMICP (patient electronic record) was identified as a major concern. Actions completed and saved on DMICP by clinicians were noted to be missing at a later stage. This loss of clinical information was transferred as a risk to Regional Headquarters (RHQ). The practice persistently pursued the matter resulting in headquarters undertaking a formal review of all Defence medical centres to determine if data loss had been an issue outside of nationally known incidents. RHQ confirmed it had so the national DMICP lead had taken this issue on. Although increasing the workload, the practice required all clinicians to check clinical records at the end of each day to ensure information had saved.
- Until recently the laboratory only accepted handwritten specimen forms, which led to an increase in errors and the patient required to provide further samples. The errors generated a large number of significant event reports. The SNO met with the laboratory manager resulting in the laboratory accepting forms generated by DMICP. This improvement was identified as a QIP.
- The practice was actively involved with the base diversity and inclusion (D&I) advisory group so D&I thinking was embedded across the practice team. The large D&I display provided information about protected characteristics, neurodiversity, pronouns, transgender, non-binary and inclusive language. Information was displayed about how to access 'Compass', the Royal Navy Sexual Orientation Gender Identity and Expression Network. With consideration for the privacy and dignity of trainees, particularly transgender trainees, the D&I advisory group had pursued the installation of shower curtains in the Phase 1 trainees' accommodation.
- An audit identified a deficit in the documenting of the offer/use of a chaperone. As a result, the chaperone policy was revised to include the person acting as chaperone documenting their role during an examination. The audit was repeated in October 2023 and improvement was identified.
- Staff identified that some candidates for diving training arrived without the appropriate medical clearances. To address this, the practice implemented a system to ensure all those candidates who the Royal Navy (RN) planned to train as occupational divers had the appropriate medical screening conducted prior to the start of Phase 1 training rather than at the end. Achieving this has required liaison with several RN stakeholders. This new approach has ensured only those fit for diving were enlisted into the service. In addition, it has prevented disappointment for service personnel whose intention it was to become divers and are not fit enough to do so.

The Chief Inspector recommends to Defence Primary Healthcare and wider organisation:

- Ensure the practice has access to the monitoring records which confirm the safety of the infrastructure, including water safety, gas and electrical checks/certificates. Ensure the practice has access to the environmental cleaning contract.
- Ensure the large number of outstanding infrastructure work requests are processed in a timely way.
- Improve the data quality of DMICP Population Manager.

The Chief Inspector recommends to the practice:

- Ensure all staff complete training in recognising the deteriorating patient/sepsis relevant to their role.
- The practice should ensure the medicine fridge temperatures are monitored in accordance with organisational policy.

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Chief Inspector of Healthcare

Our inspection team

The inspection was led by a CQC inspector supported by a team of specialist advisors including a primary care doctor, a practice nurse, pharmacist, physiotherapist and a practice manager.

Background to Raleigh Medical Centre

Raleigh Medical Centre provides primary care and occupational health to Royal Navy Phase 1 and 2 trainees and permanent members of staff on the base. In addition, the practice provides care to patients who are stationed at the base for the duration of short courses. Service provision also includes a Primary Care Rehabilitation Facility (PCRF).

There is a high turnover of the patients with up to 66 new trainees arriving at the base each week to commence training. At the time of the inspection the patient population was 1,212; this accounts for 4% of the Royal Navy.

The practice is open from Monday to Friday, between 07:00 and 16:00 hours. A duty medic and duty doctor are available on site until 18:00 hours. Out-of-hours emergencies are escalated to civilian emergency services on 999/2222. For non-emergencies patients can contact NHS 111.

The practice has a dispensary which is open Monday and Thursday 08:00 - 10:00, 10:30 - 12:00 and 13:30-16:00. Tuesday, Wednesday and Friday it is open 08:00 – 10:00 and 10:30-12:00. The dispensary is closed Wednesday afternoon.

The staff team

Doctors	Military Principal Medical Officer Military Deputy Principal Medical Officer Civilian medical practitioner x 3
Practice manager	Military Chief Petty Officer
Nurses	Military Senior Nursing Officer Civilian Band 6 practice nurse Civilian Band 5 practice nurse x 2 (1 part time vacant post)
Administrators	Civilian administrative supervisor x 1 Civilian administrative support staff x 2 (1 vacant post)
Pharmacy Technician	Leading Medical pharmacy technician x 1
PCRF	Military physiotherapist Lead Royal Army Medical Corps Civilian Band 6 physiotherapist Civilian Band 6 physiotherapist

	Exercise rehabilitation instructors x 2
Royal Navy Medical Assistants	Petty Officer x 1 (1 vacant post) Leading Hand x 1 (1 vacant post) Able Rating x 3 (1 vacant post) Trainees on placement x 2

Are services safe?

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

Safety systems and processes

One of the civilian medical practitioners (CMP) was the lead for safeguarding and the Principal Medical Officer (PMO) deputised. A CMP had been selected as the lead to ensure continuity. Taking account of vulnerable adults, children and service personnel under the age of 18, the practice safeguarding policy was comprehensive and included the referral process and contact details for local safeguarding teams. Links to relevant organisational policies and standard operating procedures (SOP) were also included in the policy. In addition, practice policies were in place in relation to the management of deliberate self-harm, sexual violence and domestic abuse (including a screening questionnaire).

Information and contact details for local child and adult services, including for out-of-hours, was displayed throughout the practice. The practice team had access to the safeguarding app which provided details for all social services' teams in the country. The induction pack for doctors, including locums, provided details of the safeguarding arrangements for the practice and links to policies. All staff had completed safeguarding training at a level appropriate to their role.

The welfare team provided enhanced support to trainees and considered all trainees vulnerable regardless of their age. The practice had an effective working relationship with the welfare team with formal and informal discussions regarding vulnerable patients taking place frequently. The PMO attended the base weekly carers' forum at which the chaplain, a representative from the welfare team and the executive team attended. Vulnerable personnel (not just trainees) were discussed at this forum. We were provided with an example of the safeguarding lead requesting that a specific patient be included for discussion at the carers meeting. A central register was held of vulnerable personnel.

The PMO met regularly with the Primary Rehabilitation Facility (PCRF) team to discuss any potential safeguarding issues for trainees transferred to the Conqueror Unit for rehabilitation. Case conferences could be called by either the Chain of Command or the practice to discuss specific personnel who were considered vulnerable and at risk. Furthermore, the practice had good links with local safeguarding service.

A process was in place to ensure the monthly DMICP search was cross checked against the previous month to ensure any patients who had left the practice were captured so an appropriate handover could be given to the receiving military practice. An example provided in relation to a patient with complex vulnerable issues involved the safeguarding lead providing the receiving PMO with a hand over and documenting the contact, including a follow up email.

The meeting minutes for the weekly doctor' meetings demonstrated that vulnerable patients, those with safeguarding concerns and care leavers was a standing agenda. We were given an example of a vulnerable patient who had not had recent contact with the service so the doctors made a collective decision about what action to take.

Monthly DMICP searches were undertaken for vulnerable adults and children, under 18s and care leavers. Patients under the age of 18 and care leavers had an alert on their clinical record, which was confirmed by DMICP searches we undertook. The alert also prompted staff to offer a chaperone to patients under 18s. We noted not all U18 alerts had this alert in place. However, the practice was aware and the matter had been discussed at the doctors' meeting.

Practice staff were mindful that the families of patients could have issues. For example, alcohol misuse with children at home. These scenarios were discussed as a team and referred to the welfare team to provide family support. We were given an example of the action the practice took in relation to the safety of a child, including making contact with the local children's safeguarding service.

Only clinical staff acted as chaperones and the team completed training in May 2023. Notices informing patients of the availability of a chaperone were displayed throughout the building. As part of a consent and chaperone audit undertaken in June 2023 the range of examinations requiring the offer of a chaperone was evaluated. It identified a deficit in the documenting of the offer/use of a chaperone. The outcome of the audit was shared with the individual clinician it concerned and was also presented at the practice meeting. As a result the chaperone policy was revised to include the person acting as chaperone documenting their role during an examination. The audit was repeated in October 2023 and improvement was identified. This resulted in a further revision of the chaperone policy to maximise the use of consistent coding. Our DMICP search confirmed clinicians used appropriate codes for chaperones and that it was routine for all clinical staff groups to offer a chaperone. Where chaperones were used, the notes recorded the name of the chaperone.

Although the full range of recruitment records for permanent staff was held centrally, the practice could demonstrate that relevant safety checks had taken place at the point of recruitment, including Disclosure and Barring Service (DBS) checks to ensure staff were suitable to work with vulnerable adults and young people. One member of staff did not hold a current DBS check. A renewal application had been submitted and an appropriate line manager risk assessment was in place. DBS checks and the professional registration of staff were regularly monitored.

An infection prevention and control (IPC) policy was in place and the Senior Nursing Officer (SNO) was the IPC lead; they were due to undertake IPC link training in October 2023. A deputy lead was also identified. The practice followed the mandated Defence Primary Healthcare (DPHC) monthly rolling IPC audit programme that included the PCRF. From the rolling programme an action grid had been produced. Clinical privacy curtains were changed every 6 months.

The practice had detailed processes in place for identifying infectious diseases; these processes originated from COVID-19 and flu plans. Administrative staff highlighted to clinical staff if there was a concern that a patient arriving may have a transmissible infection and a separate entrance/exit was used. Two rooms with ensuite facilities could be used for isolating patients.

One of the physiotherapists provided acupuncture and worked to the DPHC SOP. IPC measures were taken when treating a patient with acupuncture, including sharps bins.

Staff advised the practice did not have a copy of the cleaning contract and this was being pursued with the contractor and Defence Infrastructure Organisation. A colour coded

cleaning schedule was displayed on the door of each room, which provided a quick reference for cleaning staff. There was 8 hours of cleaning allocated to the premises each weekday. Two hours of cleaning was provided on a Saturday and Sunday.

The level of environmental cleaning was of a very high standard. The carpeted areas in the non-clinical administrative areas were cleaned twice a year. In terms of a full practice deep clean, we received mixed responses so it was unclear how often the premises was deep cleaned. It was confirmed through factual accuracy that the premises was deep cleaned each day. Cleaning equipment materials were stored securely, although we noted mops heads were not stored correctly. The cleaning cupboard would benefit from a sign to indicate the storage of chemicals.

We were advised during the inspection there were concerns with the building. For example, the walls were painted with non-washable paint, which meant cleaning the cleaning of them was a challenge. We noted holes, cracks and flaking paints in some areas. The flooring was detaching from the walls and raised in some parts. Handwash facilities and a sluice were available in 1 of the 2 cleaning cupboards on the first floor. Just under a 100 works requests had been outstanding for some time. This had been identified on the issues log.

The facilities manager had oversight of clinical waste. Processes for the management of clinical waste included a risk assessment (June 2023), protocol (February 2023), IPC waste audit (September 2023), pre-acceptance audit (September 2023), clinical waste register and consignment notes. Although not secured to a wall/railing, the base was secure and the clinical waste bins were locked.

Risks to patients

Although there were staff vacancies in the nursing and Medical Assistant groups, staff said the practice had sufficient capacity to meet the needs of the patient population and service requirements. Despite this, leaders were mindful that the turnover of trainees meant little resilience for leave or sick absence. The greatest strain on the work force was providing cover until 18:00 hours each day. After this time, cover was provided by the Fleet Medical Officer with a duty Medical Assistant on base and duty senior available by telephone. A staff movement tracker was in place which was used by all staff to include planned staff absences. It supported with advance planning to fill staff gaps, particularly during vaccination clinics. The baseline standard was for 2 doctors each day apart from Wednesday when 3 doctors were available for re-scrutiny (review all new joiners in the first week of entry to ensure their fitness for the service).

There were 2 emergency medical trollies and both were identically equipped. One was located upstairs and the other downstairs. The kit, equipment and emergency medicines were checked as required by policy. A checking and sign off sheet was located on each trolley. We checked both trollies and they were secured with a numbered tag. All equipment was in-date and in good order, apart from the sharps bins as these were not labelled or secured to the trollies. This was rectified during the inspection. An emergency grab bag was kept in the sick bay. Oxygen was stored underneath the trollies. Two automated external defibrillators (AED) were held in the medical centre and an AED was located in the PCRf. Training in emergency procedures, including basic life support, anaphylaxis and the use of an AED was in-date for all staff.

A sepsis SOP was in place for the practice. Clinical staff we spoke with were aware of the signs/symptoms of sepsis and confirmed they had completed sepsis training. Although not DPHC mandated training, records showed 5 members of clinical staff were out-of-date for sepsis training. Administrative staff had completed training in recognition of the unwell patient.

The UK Sepsis Trust decision support tool was available in all clinical areas. Last updated in May 2023, a sepsis identification poster displayed in reception and the treatment room which directed staff to refer to a doctor if there were any concerns about a patient. Delivered by the PMO, staff attended heat illness training in June 2023.

Scenario-based training sessions were held regularly including post training action reviews (referred to as AAR) used for staff to provide feedback and improve ways of working. For example, stretcher training with suspected heat illness was held in August 2023 to assess external response times. One of the learning points was for the external team to call reception rather than the 'red' phone used for emergencies only. Casualty in the swimming pool training was facilitated in collaboration with lifeguards and the physical therapy team in May 2023 and a debrief was held with staff. In addition, the practice had experienced real-life situations so staff had the opportunity to engage with a Trauma Risk Management (referred to as Trim) practitioner. Administrative staff were involved in scenario-based training relevant to their scope of practice.

There were 2 monitors in reception to facilitate observation of patients in the main waiting area. The monitors also provided oversight of the ice therapy room, nurses' waiting area and observation room.

The emergency 'red' phone in reception was used to inform the practice of emergencies and casualties on the base. If the practice was contacted then the duty doctor and duty medic attended the scene.

A firearms licence and shotgun certificates audit was undertaken in May 2023, including the checking of coding and alerts. As a result, the practice SOP was revised.

Air conditioning was installed in the PCRf gym area. Wet Bulb Globe Temperature checks to indicate the likelihood of heat stress was carried out centrally.

Information to deliver safe care and treatment

The ASER (system for managing significant events) tracker highlighted that numerous significant events had been raised regarding DMICP outages in 2022. In particular, data loss from DMICP (10 events) was identified as a major concern. Actions completed and saved on DMICP by clinicians was later noted to be missing. This suggested to the practice a software failure and the absence of DMICP safeguards. We were provided with an example when a referral to a specialist service was lost which meant a 3 to 6 month delay for the patient. This risk with DMICP and loss of clinical information had been transferred as a risk to Regional Headquarters (RHQ). The practice had persistently pursued the matter resulting in headquarters undertaking a formal review of all Defence medical centres to determine if data loss had been an issue outside of nationally known incidents. RHQ confirmed it had so the national DMICP lead had taken this issue on. Although increasing the workload, the practice now requires all clinicians check clinical records at end of each day to ensure information has saved.

In addition to the data loss, the practice experienced regular IT outages. The impact to business continuity was not great as the outages had not lasted very long. This was captured in the business continuity plan (BCP). With a loss of DMICP access, only patients with an urgent need were seen and consultations were recorded on paper forms. These were later scanned to the patient's DMICP record. A log was maintained of any IT issues identified including the action taken.

Processes were in place for the summarisation of patients records. For new patients, the joiners questionnaire was initially checked by the medical history team. The nurses then reviewed the questionnaire and actioned issues, such as chronic disease and national screening. The doctors then carried out a review to check matters, such as the Joint Medical Employment Standards (referred to as JMES), referrals to secondary care, alerts and high risk medicines. The notes summary template was used, which generated doctor or nurse appointments needed. The questionnaire was scanned to the patient's record. Two questionnaires were awaiting processing at the time of the inspection.

A DMICP Population Manager search showed new patient summarisation was up-to-date. A further Population Manager search showed 239 sets had not been summarised in the preceding 3 years. We were advised that DMICP Population Manager does not always yield accurate data. The practice was actively monitoring record summarisation and acknowledged a backlog existed largely due to the highly transient patient population. Any patient safety risks arising from summary backlogs were mitigated by other practice systems, such as the chronic disease searches, national screening searches and regular review of repeat medications.

A process was in place for the auditing of clinicians records. The annual audit of doctors' record keeping was completed in May 2023. Specific feedback was given to each doctor and emerging themes were discussed at the doctors' meeting. A similar process was in place for nurses. Medics notes were checked at the end of each day by the duty doctor. If required, verbal discussion took place either at the time the patient was being seen or later in the day. A records audit was completed for PCRf staff in February 2023. It identified a lack of compliance with recording contraindications, which had since been addressed. The practice used a set list of clinical codes to maximise consistency with record keeping.

A detailed local policy relating to specimen management was in place. Until recently the laboratory only accepted handwritten specimen forms, which led to an increase in errors and the patient required to provide further samples. The errors generated a large number of significant event reports. The SNO met with the laboratory manager resulting in the laboratory accepting forms generated by DMCI. This improvement was identified as a quality improvement project. Further work was planned with the blood grouping service as this service also used handwritten forms.

Samples were recorded on the online sample log, which was checked each day by the duty medic to ensure results had been received. If required, the patient was recalled or the requesting doctor was tasked to follow up.

An effective system was in place to manage both internal and external referrals, including 2-week-wait referrals. The referrals log was checked weekly by one of the administration team who advised that 15 to 25 referrals were processed each week. As trainees were not allowed mobile phones, they were informed by letter of their referral date. The X-ray department at Lympstone and the Nuffield Military Clinic could be used if there was a delay with accessing local NHS services. To address unsatisfactory communication from

secondary care, the practice amended its acute referral letter to include a request for some immediate feedback from the clinician seeing the patient. As a result, the majority of secondary care specialities now provide written feedback immediately after assessment of the patient.

Safe and appropriate use of medicines

The deputy Principal Medical Officer (DPMO) was the lead for medicines management and the pharmacy technician was the deputy lead. These roles were reflected in their terms of reference.

The dispensary was secured when pharmacy technician was not present. A local working practice protocol for out-of-hours access to the dispensary was in place and measures were in place to ensure security of the dispensary keys. Access to the pharmacy was logged in the daily occurrence book as well as the dispensary access log. The occurrence log was checked daily by the pharmacy technician as part of the morning dispensary checks. Having the keys sealed in a bag would add an additional layer of security.

Prescriptions (Fmed296) were stored securely in the dispensary and the serial numbers of the prescriptions documented in a bound book. Clear processes were in place for the issuing of prescriptions. They were issued by serial number and clinicians signed and dated receipt of the prescriptions.

Patient Group Directions (PGD), which authorise practice nurses to administer medicines in line with legislation had been signed off. Nurses had completed the required training. Appropriate protocol templates and clinical coding were used. The practice had written authorisation from the Regional Clinical Director to deviate from the Patient Specific Directions (PSD) policy in order to streamline the process given the practice vaccinated approximately 200 patients a week. This deviation was recorded on the issues log. From a review of records and discussion with staff, we considered this deviation to be safe and the risk appropriately escalated. Although not in line with the DPHC SOP, the SNO signed off all medics as competent to give vaccinations. The PMO delegated this activity to the SNO. The Medics Issuing Protocols (referred to as MIPs) for all medics were assessed by DPMO.

A process was established for the management of repeat prescriptions. Patients could request a repeat prescription via eConsult or present the repeat portion of the prescription at the practice. Evidence was in place to show medication reviews took place. A local working practice policy was in place that outlined the updating of patient records following a change to a patient's medicines out-of-hours or by secondary care.

A wide-reaching high risk medicines (HRM) SOP was in place which was updated in April 2023. This included, not only shared care agreements (SCA) and red drugs, but also the Specialist Pharmacy Service list of drugs which have critical monitoring requirements. Managed by the DPMO, monthly searches were undertaken and the DPMO scrutinised every patient identified and added them to the HRM register. Doctors also sent tasks to the DPMO if they prescribed a patient an amber or red drug. An extensive review of HRMs had been undertaken and the practice was working on a list of all amber, shared care agreements (SCA) and red drugs based on the local formulary, DPHC guidance and national policies. DMICP Searches showed that all patients on a SCA or prescribed red

drugs were appropriately coded, had an alert, a SCA scanned to their record and were in-date monitoring. Our review of clinical records showed patients prescribed HRMs were well managed.

Patients were informed of side effects to medicines through the patient information leaflet provided. In addition, the pharmacy technician counselled each patient.

The medicines, vaccines and medical consumables we checked were all in-date. Although temperatures of the medicine fridges were monitored twice a day, records from previous months showed gaps in the temperature monitoring. The external thermometers were in-date. A process was in place for the management of stock with the medicines having the shortest time expiry placed at the front of the shelf.

Medicines held at the dispensary were stored securely. Controlled drugs (potentially addictive and harmful medicines subject to regulation) were kept in an appropriate controlled drugs (CD) cabinet. An SOP was in place regarding the security of CDs. We checked the stock and documentation and all was correct and accurate. The specimen signature log had been completed accurately by all involved in the accounting of these medicines. Internal monthly checks and quarterly external checks had been undertaken. CD destruction was appropriately undertaken with the exception of an occasion where an illicit drug from the police was destroyed in the medical centre. The correct procedure is that the police destroy the illicit drugs they seize.

From discussions with the pharmacy technicians, it was evident well defined processes were in place for the ordering and receipt of vaccines. All vaccines were in date and were routinely rotated in the fridge. There was sufficient space around the vaccine packages for air to circulate.

Valproate (medicine to treat epilepsy and bipolar disorder) searches were undertaken each month. An antimicrobial audit was completed in September 2023. Results showed 76% of antibiotics prescribed were indicated in line with guidelines. The audit was discussed at the doctors' meeting and action points identified.

Track record on safety

A risk register, retired risk log and an issues log were in place. The practice used the '4 T's' (transfer, tolerate, treat, terminate) approach to manage risks. A range of regularly reviewed risk assessments were in place to support safe working practices, including for lone working. The lead physiotherapist managed the risk assessments for the PCRF. The Control of Substances Hazardous to Health (referred to as COSHH) risk assessments were reviewed in May/June 2023. Weekly and monthly building checks were carried out. A base health and safety meeting (referred to as SHEF) was held each month and the practice sent a monthly report to the SHEF team.

The practice did not hold evidence of gas, electrical and water safety checks. Although requested during the inspection, the practice did not receive them before the inspection ended. Portable appliances had been checked.

A fire safety assessment was completed in March 2022. Regular checks of the fire system were undertaken by the SHEF team, including a weekly fire alarm test. Quarterly fire evacuation drills were held for staff.

A system was established for the management of all clinical/non-clinical equipment including an equipment maintenance register, faults log and equipment inspection log. An external inspection of medical equipment was undertaken in April 2023. Snap inspections were carried out by the practice, including a 10% equipment check each month. An equipment assessment (referred to as a LEA) was undertaken for the period January 2022 to January 2023 and no major concerns were identified.

One of the exercise rehabilitation instructors managed the PCRf equipment. A 5-year service plan including contracts for servicing was held on SharePoint. New PCRf equipment procured was serviced in October 2023 and existing equipment was serviced in September 2023.

An integrated alarm system was in place in clinical rooms. In other areas, staff had access to handheld personal alarms. The PCRf was in a separate building and lone working regularly occurred in the PCRf gym area. All PCRf staff carried personal alarms. However, the alarm was not audible outside of the building. A process was in place for staff working there to inform the practice when they were leaving at the end of the day. A CCTV system was used to ensure patients could be seen in the gym area. Signs were displayed to inform patients that CCTV was in operation.

Lessons learned and improvements made

All staff had access to the ASER system for recording and acting on significant events and incidents. ASER training was completed as part of the induction programme and refreshed as required. 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. A local ASER SOP and an ASER register was in place.

A root cause analysis (RCA) involving the relevant department/staff group was undertaken for each significant event. Significant events were discussed at the senior management meetings and trends were then discussed at the practice meeting.

The annual ASER trend analysis was last undertaken in July 2023 and recommendations to address the trends were identified, including escalating the risks to RHQ. A main trend identified was errors with blood samples. This had been addressed and improvements made.

We were provided with an example of a delayed diagnosis in 2021. A full RCA was undertaken. To minimise a recurrence, a detailed SOP was developed.

A process was in place for the management and action of alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) and Central Alerting System (CAS). An alert register was in place. Alerts were discussed at the senior management meetings. Staff has access to the alerts via Share Point.

Are services effective?

We rated the practice as outstanding for providing effective services.

Effective needs assessment, care and treatment

Processes were in place to support staff to keep up-to-date with clinical developments including National Institute for Health and Care Excellence guidance (NICE), the Scottish Intercollegiate Guidelines Network (SIGN), clinical pathways, current legislation, standards and other practice guidance. The NICE website for primary care was checked for updates, which were discussed at the doctors' meetings. Updates from the Defence Primary Healthcare (DPHC) newsletter were also discussed at the meeting. In addition, key updates were shared using 'parish notices'. These made reference to NICE and SIGN and were used to share information with the team at practice meetings.

Clinical audit was used to ensure care and treatment followed evidence-based guidelines. For example, chronic disease audits and a gout (type of arthritis) audit. As a result of the gout audit, patients with a historic gout diagnosis and unreviewed were invited for a review. A second cycle audit showed an improvement with patients re-engaging with treatment. In addition, clinicians pro-actively monitored for patients at risk of undiagnosed chronic obstructive pulmonary disease by reviewing records and invited patients for an assessment.

Patients with complex needs and the outcome of clinical audits were discussed at the doctors' meetings. The PMO held meetings with the Primary Care Rehabilitation Facility (PCRF) team to discuss the Conqueror Division. PCRF staff focused on lifestyle with the Conqueror Division by providing education related to diet, sleep, recovery and training techniques. The team were currently looking at producing an education booklet for this cohort of patients.

The PCRF had the necessary equipment and space needed to deliver an effective service. There were 3 treatment rooms in the medical centre as well as further 2 treatment rooms in the PCRF, a short walk away. The gym area within the PCRF had space for cardiovascular and strength equipment as well as space for floor based activities. Staff had access to the base swimming pool for classes.

PCRF staff used the mandated patient reported outcome measures, including the musculoskeletal health questionnaire (MSK-HQ), Functional Activities Assessment and STarT Back Screening Tool. The MSK-HQ was used at start and end of each episode of care. Individual functional assessment measures were also used, including single leg press, calf raise and the Knee-to-Wall Test. There was no evidence provided that these had been reviewed as a group in terms of service evaluations linked to best practice guidance or national guidelines. All staff used the master Rehabilitation Menu Template, which had embedded clinical codes for specific patient reported outcome measures.

Rehab Guru (software for rehabilitation exercise therapy) was used, which provided patients with injury prevention information and templates. Handwritten exercise sheets were also provided when necessary.

Staff identified that some candidates for diving training arrived without the appropriate medical clearances. To address this, the practice implemented a system to ensure all those candidates who the Royal Navy (RN) planned to train as occupational divers had the appropriate medical screening conducted prior to the start of Phase 1 training rather than at the end. Achieving this has required liaison with several RN stakeholders. This new approach has ensured only those fit for diving were enlisted into the service. In addition, it has prevented disappointment for service personnel whose intention it was to become divers and are not fit enough to do so.

Monitoring care and treatment

One of the nurses was the lead for the management of chronic conditions and the Principal Medical Officer (PMO) was the deputy lead. A comprehensive chronic disease register was maintained with a separate section for each condition. DMICP searches were undertaken monthly by the lead, which tracked the monitoring of each patient. If there was any concern, then the patient was recalled for a review with the doctor. The Chronic Disease Management Tool was used to ensure consistent management and it included links to the chronic disease standard operating procedures (SOP). The Senior Nursing Officer (SNO), PMO and lead nurse reviewed the management of chronic diseases quarterly. We looked at a wide range of records for patients with asthma, diabetes, high blood pressure and all showed patients were well managed.

The patient population included 153 personnel over the age of 40. Of this number, 147 had been offered an over-40's health check and 116 had attended the practice for a check. Six patients were new to the practice and 31 did not respond or refused. The practice planned to contact them again in 12 months.

Audiology statistics showed 79% of patients had received an audiometric assessment within the last 2 years. Only 16 high risk individuals were out-of-date for an assessment. DMICP searches showed that all patients were appropriately graded where an audiometric assessment indicated a change in Joint Medical Employment Standards (referred to as JMES) grade.

Doctors saw many trainees who were not mentally unwell but were struggling with the adjustment of joining the Royal Navy. This adjustment was key for Phase 1 trainees who were required to stay for 28 days. Doctors needed to determine whether the patient was mentally unwell or whether they were adjusting. To maintain continuity, patients saw the same doctor. The mental health questionnaire had been adapted so the questions were less threatening. In addition, the reading age calculator was used to ensure accessibility for all.

Doctors provided Step 1 of the mental health intervention programme. Resources included an introductory self-help course in cognitive behavioural therapy. Doctors completed the DMICP Department of Community Mental Health (DCMH) referral check list prior to referral to ensure the criteria were met. Patients presenting with neurodiversity (autistic traits) were signposted to the learning resource centre for the educational psychologist to consider reasonable modifications to support with coping strategies. In addition, patients had access to the Coaching Advisory Support Team available on the base. The chaplains and the welfare team were represented at the weekly carers forum so personnel struggling with mental health and/or adjustment could be discussed. We reviewed a range of records

for patients being treated for mental health issues and the review demonstrated patients were receiving good quality and timely care.

The extensive audit register showed a broad range of data searches and clinical audits, including repeat audits. Topics were chosen based on population need, significant events, new policy and practice demands. We looked at 4 clinical audits in detail; gout, asthma, infection prevention and control and Patient Group Directions. All were full cycle audits with evidence of appropriate criteria and standards setting. The audits were of a high standard and showed the action taken and any changes made. Clinical audits undertaken by the PCRf included injury surveillance and bone stress injuries. The injury surveillance audit led to changes in relation to the load carried during training. Learning was discussed with the team after each cycle and actions agreed. Quality improvement projects (QIP) and audit was a standing agenda item at the doctors' meetings.

QIPS and improvements in practice were shared across the region. For example, the doctors induction questionnaire and new bloods process were shared at the regional QIP meeting. There was evidence that 4 other medical centres had adopted some of the initiatives and improvements made at the practice.

Effective staffing

The practice used the DPHC mandated induction programme which included role specific elements. New staff also completed an HMS Raleigh base induction and a DPHC online induction. A specific induction was in place for staff new to the PCRf. A doctors' induction questionnaire had been developed by the practice to guide and facilitate learning about the practice and issues unique to HMS Raleigh. The questionnaire was relevant to Raleigh Medical Centre and required the doctor to read policies/protocols in order to be able to complete the questionnaire. The most recently recruited doctor said the questionnaire supported with reflective practice and understanding issues specific to the patient population and service needs. This induction questionnaire was raised as a QIP.

Mandated training was monitored by one of the Medical Assistants (MA). Staff were prompted when training was due to expire. Training records showed a high level of compliance across all staff groups with a 100% completion rate for the top 10 training topics. Role specific training was provided for clinical staff with certain responsibilities or lead roles so collectively, clinicians had a wide-range of qualifications and experience to meet the needs of the patient population. For example, the majority of the doctors were trained to carry out diving medicals and all of the nurses were trained in yellow fever. We were advised that funding had not been available for Sexually Transmitted Infections Foundation (STIF) training so the nurses were not formally trained in this area. The SNO was pursuing funding direct from Regional Headquarters.

In response to a trend of significant events related to patients incorrectly performing spirometry leading to poor outcomes, a new SOP was developed along with diving specialist MAs delivering a teaching session to clinical staff on achieving optimum spirometry. This work was raised as a QIP.

Practice staff keep all their training certificates in Microsoft OneNote (digital notebook app) which meant their certificates were accessible when they moved or changed location. The certificates could be retrieved when on board ships.

An active in-service training register was in place which provided a forecast of planned training. In-service training (IST) was delivered each week and supported staff with continuing professional development (CPD). Clinicians were responsible for maintaining their own CPD portfolio. Appraisal and revalidation were in-date for all clinical staff.

Staff described good access to clinical supervision and said support was available from both nursing and medical colleagues. Two of the nurses were clinical supervisors. Staff could use this in-service supervision and/or participate in group supervision within the region. The MA clinics were reviewed each day by the duty doctor and this was confirmed by an entry for 'health care supervision' on DMICP. It was the same for any other trainees on placement, including General Duty Medical Officers (GDMO). Regional GDMOs provided training for MAs which supported the requirements of their workbooks. The practice was also engaged with the Devon Training Hub, an education and development forum for the Devon Primary Care Workforce. In addition to attending practice IST sessions, the PCRf team participated in the Plymouth-wide IST sessions and regional IST held twice a year.

Coordinating care and treatment

The practice had strong links with local NHS services. For example, one of the doctors was a representative on the Local Medical Committee. This engagement was of benefit to the practice in terms of addressing issues, such as cross-boundary referrals and access to services for patients with potential neurodiverse conditions that did not meet the criteria for referral to the DCMH.

Internally practice staff had effective relationships with the base units and Chain of Command, particularly in relation to support for vulnerable patients. There was frequent engagement with the welfare team and other support services and groups. The practice and PCRf were represented at the Unit Health Committee meetings.

Effective arrangements were in place to handover patients to the next practice when service personnel moved on, either to another Defence medical centre or to an NHS primary care practice.

Helping patients to live healthier lives

Clinical records we reviewed showed that providing patients with healthy lifestyle options was routine during consultations if appropriate. The health promotion calendar developed by the practice had been raised as a QIP and has since been adopted by the DPHC as an organisation-wide approach. Health promotion boards were prominent in the practice and reviewed each month. On the day of the inspection, health promotion boards included running injuries, back pain, using condoms, vaccinations and obesity. A television screen in the waiting area provided health promotion information for patients. QR codes were available for patients to access a range of information, such as smoking cessation, sepsis awareness and alcohol awareness.

The practice participated with the base-wide health fairs held 3 times a year and co-ordinated to take place when new term trainees arrived. Led by the SNO, there had been a

drive to improve the quality of the fairs. Initiatives included an increase in external speakers, competitions to produce best stands. For example, how to make smoothies, driving model cars with beer goggles and testicle examinations. The exercise rehabilitation instructor represented the PCRf at the fairs and facilitated interactive sessions based around stretching and foam rolling. The base Commander commended the practice for the effort given to the fairs.

In the absence of a STIF trained nurse, one of the nurses had completed a locally provided mini STIF course facilitated by regional sexual health lead who was also accessible for advice. The sexual health board provided information about sexually transmitted infections and the contact details for the sexual health service in Plymouth. Doctors had the option to refer patients to the Military Advice and Sexual Health/HIV (MASHH) service at Birmingham for complex sexual health needs that could not be treated at the practice.

Monthly searches were undertaken for bowel, breast and abdominal aortic aneurysm screening in line with national programmes. The number of eligible women whose notes recorded that a cervical smear had been performed in the last 3-5 years was 159 which represented an achievement of 93%. The NHS target was 80%. Processes were in place in place to follow up on patients who had not responded to recall for screening. A register was used to track whether patients had been screened, had been sent recall letters and whether the patient refused screening.

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

- 96% of patients were in-date for vaccination against diphtheria and tetanus.
- 96% of patients were in-date for vaccination against polio.
- 72% of patients were in-date for vaccination against hepatitis B.
- 76% of patients were in-date for vaccination against hepatitis A.
- 67% of patients were in-date for vaccination against meningitis.
- 92% of patients were in-date for vaccination against mumps, measles and rubella.
- 68% of patients were in-date for vaccination against yellow fever.

Consent to care and treatment

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. A consent SOP was in place and implied and formal consent was used. Informed written consent was taken for acupuncture and then then scanned to the patient's DMICP record. A practice audit showed not all doctors were documenting consent to examination but were not always documenting that a chaperone had been offered. The outcome of the audit was discussed at the doctors' meeting and the practice meeting.

The doctors completed training in mental capacity as part of the safeguarding update training and understood how it would apply to the patient population group. We were provided with an example of when a doctor undertook an assessment as to whether a patient with heat injury could consent to an intimate procedure. We noted from the patient's record that completion of a formal mental capacity assessment (MCA) had not

been documented when the patient was unable to consent. We highlighted this to the PMO at the time of inspection and they confirmed a discussion would take place with the doctor and MA involved to ensure a retrospective note was added making it clear an MCA assessment was undertaken at the time.

Are services caring?

We rated the practice as outstanding for providing caring services.

Kindness, respect and compassion

Forty five patients provided feedback as part of the inspection, including direct interviews with patients and completed feedback cards. Feedback was positive and suggested staff treated patients with kindness, respect and compassion. It was clear from patient feedback, discussions with staff and quality improvement work that the practice team genuinely cared for the wellbeing and welfare of the patients. We were provided with numerous examples of when practice staff had gone 'the extra mile' to support vulnerable/at risk patients and/or to provide compassionate care that met the specific needs of the individual patient.

Examples provided by staff include:

- The practice had pro-actively worked to reduce the high level of mental health need within the Conqueror Division. Doctors focused on the psychological elements of recovery and spent time with trainees to encourage them to express how they felt. This work triggered transformation for the Conqueror Division. Training was revised to focus on what the trainees were able to do to progress through training. Morale improved amongst trainees and subsequently the mental health of trainees improved.
- Clinicians liaised with specialist nurses and NHS community care teams for a patient with complex health needs. The aim of this pro-active approach was to ensure the patient had a sufficient supply of medicines and consistent support during the transition to an NHS GP.
- A patient under 18 experienced a bereavement while at HMS Raleigh so the practice advocated on behalf of the patient by liaising with unit commanders to permit the patient to attend a civilian bereavement counselling centre. The patient was consistently supported by the doctor they had developed a rapport with.
- Home visits were provided to a patient following treatment by secondary care services. The aim of the home visits was to ensure the patient had sufficient medicines and had means to travel to collect prescriptions.
- Patients, particularly those under 18, were offered the option to involve their parent with a consultation. This was achieved by using the patient's mobile set to speaker phone.
- Checks were made during leave periods that care leavers had somewhere to go. They could be accommodated on the base if necessary.
- Following a patient's transfer to another medical centre, the practice received a hospital letter regarding the patient. The patient was noted to have attended 3 different hospitals over a couple of days for the same issue. All 3 hospitals were some distance apart and a distance from the patient's base. The safeguarding lead contacted the patient's new practice to raise concerns about the pattern of the patient's hospital attendance so ensured the new practice was aware of the concerns.

Service personnel could access the chaplaincy service, Hive Information Centre and various military/navy support networks for assistance and guidance. The base had 2 welfare team members and patients could access welfare directly rather than via the

national portal. There was also a women's' network where women could access specific information especially for serving at sea. The practice had access to the Coaching Advisory Support Team (CAST) team who provided support for personnel who were struggling with training, being away from family or getting their kit organised. CAST also ran weekly drop in sessions.

Involvement in decisions about care and treatment

Patients who provided feedback described how they were included in planning about their treatment and care. Clinical records showed patients were involved in their care with treatment options explained in a way they understood.

The practice took into account the needs of patients with a caring responsibility. Carers were identified either during the patient registration process, through monthly DMICP searches, via the unit, welfare team or through self-identification. A carers' standard operating procedure was in place and the doctor was identified as the lead maintained the carers' register. Clinical coding was applied to facilitate DMICP searches undertaken to monitor the number of patients who were carers; 7 at the time of the inspection. A QR code was displayed for carers to access extra support.

An interpretation service was available for patients who did not have English as a first language.

Privacy and dignity

Consultations took place in clinic rooms with the doors closed. Privacy curtains were used when patients were being examined. Telephone consultations were undertaken using headsets to maximise patient confidentiality. Privacy signs were displayed in the waiting area informing patients that private rooms were available for discussion if needed. A television was opposite the reception desk which supported with minimising conversations being overheard. All staff had completed the Data Security Awareness training, which included the Caldicott.

Patients could request to see a clinician of a preferred gender.

Are services responsive to people's needs?

We rated the practice as outstanding for providing responsive services.

Responding to and meeting people's needs

The practice pro-actively responded to the specific needs of different patient groups. For example, clinics were structured to support all patients. Emergency clinics were held on a Saturday and Sunday for the Phase 1 trainees. Three emergency clinic sessions were facilitated each weekday to allow early access for trainees. Permanent staff had their own emergency clinic each morning. Blister clinics were held for Phase 1 trainees.

Phase 1 trainees were unable to access the shop for the first 4 weeks of training as this was a privilege they earned. For biological females this meant if they needed sanitary products they had to ask to be taken to the shop (often accompanied by a male). The Senior Nursing Officer (SNO) procured products and produced packs that included tampons, sanitary towels and pants. A pack was given to all biological females on their first day, which greatly reduced patient embarrassment and anxiety at being escorted to the shop. Furthermore, some trainees, including those from overseas, were not familiar with tampons (needed when menstruating during swim tests) so the SNO spent time explaining to individuals how to use tampons. This had been identified as a quality improvement project.

The internal assurance review in February 2022 noted that the practice was advocating for the provision of sports bras to female trainees on arrival.

The practice pro-actively responded to patient feedback. Examples include:

- Creation of a waiting area in the Primary Care Rehabilitation Facility.
- Due to lack of patient feedback, new appointment cards were created which included the quick response or QR code for the patient experience questionnaire.
- A request had been submitted to provide a room for 'quiet' yoga-based activities.
- Patients reported that the audio booth was in an area with a lot of external noise so it was moved to a quieter area.
- Paper QR codes were given to Phase 1 trainees so they could provide feedback as they had limited access to their phones. In addition, a touchscreen tablet was procured for the practice for patients to leave feedback.

The Principal Medical Officer (PMO) was the inclusion and diversity (D&I) lead and a Medical Assistant deputised. The PMO was actively involved in the base D&I advisory group and attended the quarterly meetings. The role of the group was to review D&I issues, identify trends, share best practice, consider policy changes and advise commanders. With consideration for the privacy and dignity needs of trainees, particularly transgender trainees, the group had pursued the installation of shower curtains in the Phase 1 trainees' accommodation. D&I thinking was embedded across the practice team. Staff we spoke with said racist, derogatory and offensive language and behaviour was not tolerated and would be immediately addressed. The large D&I display provided information about protected characteristics, neurodiversity, pronouns, transgender, non-binary and

inclusive language. Information was displayed about how to access 'Compass', the Royal Navy Sexual Orientation Gender Identity and Expression Network.

The practice had a policy for the management of transgender personnel to ensure personnel wishing to transition received appropriate clinical care, support and early referral. We were provided with an example of the support given in conjunction with the D&I lead for the base to a patient who was considering transitioning.

An Equality Access Audit for the premises was completed in October 2022. The medical centre was not fully accessible for people with mobility needs. For example, the building was not accessible for wheelchair users. Actions were recorded on the issues log or risk register and statements of need had been submitted for improvements in accessibility, although funding had not been confirmed. A plan was in place to submit a statement of need (SON) for additional accessible parking bays closer to the medical centre. The Primary Care Rehabilitation Facility (PCRF) had submitted a work request in for a ramp to access the building.

Timely access to care and treatment

Routine appointments with a doctor could be facilitated within 3 days, with a nurse within 2 days and on the same day with a Medical Assistant (MA). Urgent appointments for all clinicians could be accommodated on the same day. A routine appointment with a doctor or MA was available within 3 days and with a nurse it was 4 days. Feedback from patients confirmed they received an appointment promptly and at their preferred time. Diving medicals could be facilitated within 2 weeks. Aviation medicals were rarely needed but could be accessed via the local base port. Home visits to patients on the base were accommodated and were considered on an individual basis.

Direct Access Physiotherapy (DAP) was available for permanent staff and was underpinned by an SOP. We were advised DAP was not frequently used. An urgent or routine appointment with a physiotherapist be facilitated on the same day and a follow-up appointment within 2 days. A new or follow-up appointment with the exercise rehabilitation instructor (ERI) could be accommodated within 2 days. Rehabilitation classes facilitated by the ERI were only available for Phase 1 trainees and there were no waiting lists for classes. The PCRF had good links with the Multi-disciplinary Injury Assessment Clinic (MIAC) consultant so Phase 1 trainees had timely access to MIAC. The PCRF was meeting its key performance indicators as 100% of trainees were seen on the same or next day

A duty medic, duty senior and duty doctor are available until 18:00 hours. Out-of-hours emergencies were escalated to civilian emergency services on 999/2222. For non-emergencies, patients contacted NHS 111. Trainees, including under 18s, could attend the emergency clinic held each Saturday and Sunday from 08:00 until 10:00 hours.

Listening and learning from concerns and complaints

The practice manager was the leads for complaints. Complaints about clinical care were referred to the PMO or to another doctor if the complaint involved the PMO. Although there

had been no complaints in the last 12 months, complaints was a standing agenda item at the weekly senior management meeting and at the monthly practice meetings. There was also a complaints log held on SharePoint in a limited folder which could be accessed by the leadership team and Regional Headquarters.

The complaints process was highlighted in the main waiting areas and outlined in the patient information leaflet.

Are services well-led?

We rated the practice as outstanding for providing well led services.

Vision and strategy

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

“To provide and commission safe and effective healthcare which meets the needs of the patient and the Chain of Command in order to contribute to Fighting Power”.

The specific vision for the practice was outlined as:

“To enable personnel to complete their training in the shortest possible time, in the best possible health”.

Driven by the unique requirements of Phase 1 training, the practice was focussed on supporting trainees to progress through their training without delay and in the best health. Optimising recovery from injury and removing barriers to delays was a priority of the practice. It was clear from the evidence we gained that the practice was achieving its vision through the highly responsive approach taken to support trainees. The Conqueror Division transformation was an example of how barriers were removed to improve morale and progress training. In addition, developing strong links with internal and external services had led to service improvements. For example, the close working relationship with the welfare team meant the needs of vulnerable patients were identified early so support structures could be put in place. Meaningful engagement with external services had led to improvements in service provision and communication, such as the processing of samples and the timeliness of communication from secondary care doctors.

The Primary Care Rehabilitation Facility (PCRF) team utilised team meetings to decide on the priorities for the unit. Based on the predicated surge in the trainee intake, the team recently raised a successful business case to increase the equipment available within the department. A priority for the PCRF was to revise the Conqueror Division to support a change in delivery. This will involve a shift to early and late session for the delivery of rehabilitation. The PCRF team were aware of providing evidence including service evaluations to support these developments. The revision will also include production of educational material.

With strategic planning, the leadership team took the needs of the patient population into account. Until recently, an inpatient ward was attached to, and staffed, by the medical centre. Based on the needs of the unit, the ward was shut in liaison with Regional Headquarters and base commanders. Out-of-hours provision was then provided via the regional duty team. The practice identified risks with this arrangement as external staff were not aware of the unique needs of Phase 1 trainees so unintentionally did not always make appropriate decisions. Although taking back duty cover put pressure on practice staffing, a duty junior slept on the base during the week and a duty senior was on 1 hour recall at weekends.

To address environmental sustainability, the practice had pushed for work on the infrastructure, including replacing the double glazing. Sensor lighting was used throughout the building and recycling was encouraged. QR codes were used where possible.

Leadership, capacity and capability

We interviewed a wide range of staff throughout the inspection and all indicated leadership capacity was sufficient as leaders were visible with staff having prompt access to support and guidance if needed. In relation to capability, staff told us they had every confidence in how the leaders managed the practice. They particularly made reference to how the leadership team had a clear focus on the needs of trainees and how they invested in the staff team.

We found that the leadership team worked well together and demonstrated high levels of experience, capability and resourcefulness to provide a person-centred, responsive and sustainable service for the patient population.

In the last year, the practice had focussed on succession planning and building resilience in management roles to address the turnover of military staff. Action taken included the restructure of the senior management team. For example, the training role was moved to a Leading Medical Assistant thereby creating a deputy practice manager role and facilities manager role. The practice anticipated that the creation of deputy roles will provide resilience should key staff move from the service.

The practice manager and Principal Medical Officer (PMO) were due to move from the service within the same month. The PMO had delayed their departure until this inspection had taken place. The new practice manager had taken up post. Given 2 key leaders were leaving within a similar timeframe, the incoming practice manager said they received a comprehensive hand over from the outgoing practice manager. The handover was over 2 months to ensure practice management continuity before the new PMO took up post. Through negotiation with the Regional Clinical Director (RCD), the deputy PMO (DPMO) was temporarily protected from deployment to provide continuity while the new PMO settled into the service.

The leadership team said they were very well supported by Regional Headquarters (RHQ). The RCD visited the practice regularly and the regional nurse advisor provided frequent updates to the nursing team. Additional staff training was encouraged and supported by RHQ.

Culture

It was clear from patient feedback, interviews with staff and quality improvement activity that the needs of patients were central to the ethos of the practice. A responsive and patient-centred focus was evident with this ethos embedded in practice. The team continually explored ways to improve the service for patients. This was reflected in developments and improvements made based on patient feedback, the unique needs of the patient population and the identification of trends from significant events and other governance systems.

We interviewed a wide range of staff who spoke highly of the practice leadership including the visibility of, and support, from key leaders. PCRf staff said they felt part of the team despite working in a separate building. We heard that leaders were approachable and promoted a diverse, inclusive and no-blame culture. Staff told us team morale was based on mutual respect. They felt part of the team, listened too and trusted. The practice manager carried out a daily walk-around and had regular welfare chats with individual staff.

All staff said they had an equal voice, regardless of rank or grade. This was particularly key for the administration team who were contracted staff. They said they were treated the same as permanent staff. The team participated in development days. Recent events included raft making and an obstacle course. A reward system was in place to acknowledge high levels of effort and work.

Staff were familiar with the practice whistleblowing policy and with the Freedom to Speak Up (FTSU) policy, including how to access FTSU representatives. Staff told us the open culture meant the leadership team was receptive to acceptable challenge.

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. The PMO was the lead for duty of candour and a log was maintained of any concerns raised. Where appropriate, duty of candour was applied to significant events raised through the ASER system. We were given an example of a duty of candour breach and the action taken to minimise a recurrence.

Governance arrangements

The leadership team adopted a whole team approach to governance activities. Lead or secondary roles were shared across the team for most staff groups. The PCRf team did not have key lead roles and it was suggested revising this may support them to feel part of the decision-making processes. Terms of reference were current for staff, including those with lead roles. There was a clear staff reporting structure in place and staff were aware of their roles and responsibilities.

A rotational schedule of meetings was in place for the practice. Weekly meetings took place for clinical leads, senior management, healthcare governance, the Conqueror Division, doctors, nurses, carers, the regional team and practice management. Whole practice meetings were held each month and also specific meetings to discuss significant events, risk and the Health Assurance Framework (HAF) used to monitor performance. Bi-monthly meetings were held for Medical Assistants and the PCRf. We reviewed a range of meeting minutes. They were comprehensive and followed the DPHC meeting structure.

The PMO was the lead for healthcare governance and the DPMO was the deputy. The practice used the Standardised Management Tool (SMT) as the overarching process to capture and monitor the broad range of range of governance activity for the practice, including the risk register, audit, health and safety and quality improvement. The SMT showed that mandated audits were indate. A traffic light alert system was used to alert

when an audit was due. In addition, the SMT demonstrated that a wide range of clinical audits were undertaken by all clinical staff groups. All staff had access to the SMT.

Non-attendance at appointments was closely monitored and followed up.

Managing risks, issues and performance

An effective process to identify, understand, monitor and address current and future risks, including risks to patient safety, was in place. The risk register clearly indicated the status and responsibility for each risk, including transferred risks to RHQ. Risk was reviewed as part of the senior management meeting. In addition, a monthly meeting was held with the Commander of the base to review risks to the service.

A business continuity plan (BCP) was in place and reviewed in June 2023. It took account of all the likely generic system failures. It was exercised in February 2023 during a gas leak in the building next to the medical centre. The practice relocated to the PCRf for the duration of the leak which was approximately 3 hours. Organised by the base, the practice participated in the 2 major incident exercises held each year.

Processes were in place to monitor national and local safety alerts, incidents, and complaints. This information was used to improve performance.

The military staff appraisal process supported the performance management process. The leadership team was familiar with the policy and procedures for managing staff performance and provided previous examples of how it been employed to address underperformance. On occasions, an advocate had been assigned to support colleagues who may be struggling. If supportive measures were not sufficient to provide improvement, then the disciplinary process was considered. If there were any concerns with the performance of contracted administrative staff then the practice discussed the matter with the contract manager.

Appropriate and accurate information

The HAF was used by the practice as a development tool and to monitor performance. Staff contributed to the HAF and, where their role required, had dedicated management time for this activity.

The regional team carried out an internal assurance review (IAR) in February 2022 and the practice was rated as having substantial assurance. A practice management action plan was in place and, from the evidence provided, the majority of actions had been completed. The IAR identified the need for including exercise rehabilitation instructors in the audit process and to formalise peer review for PCRf staff; both of these actions were outstanding.

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

Engagement with patients, the public, staff and external partners

As feedback was a key priority for the service, various options were in place to encourage patients to provide feedback and contribute to the development of the service. Although the QR code for the DPHC patient survey was displayed, Phase 1 trainees had limited access to their mobile phones. To overcome this barrier, the practice procured an electronic tablet. It was prominent at reception so patients could use it to leave feedback. Paper feedback forms were also available. There was clear evidence throughout the inspection that patient feedback was acted on.

The practice had well developed internal and external relationships including with the base Commander, units and the welfare team. These relationships meant vulnerable trainees were promptly identified and supported. In addition, improvements in diversity and inclusion matters had been made collectively, such as shower curtains in the Phase 1 accommodation. Effective links were established with external organisations, which again had led to improvements in processes.

Various options were available for staff to provide their views of the service. These included the 'Bravo Zulu' awards board, inviting ideas for improvements, feedback at meetings and the staff satisfaction survey. The leadership acted on staff feedback. For example, a member of staff reported feeling uncomfortable at their desk. This led to the remodelling of the reception desk and the procurement of specific equipment such as a desk riser. This response was raised as a quality improvement project (QIP). Furthermore, The staff survey in July 23 identified that staff were being disturbed during their lunch break so the leadership team introduced duty staff to cover break periods and they wear a different uniform for ease of identification.

Based on the quality improvement plan, a 'you said, we did' board was displayed so patients were aware of the measures the practice was taking to improve the service and patient experience.

Continuous improvement and innovation

It was clear by the extensive number and range of QIPs that the team continually and proactively took opportunities to improve the quality and safety of how they supported the patient population. The practice manager was the lead for QIP and QIPs were discussed at the senior management and practice meeting. Any potential QIPs were forwarded to RHQ.