Poole Medical Centre

Hamworthy Barracks, Hamworthy, Dorset, BH15 4NQ

Defence Medical Services inspection report

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

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

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As a result of this inspection the practice is rated as outstanding overall

The key questions are rated as:

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

We carried out this announced inspection on 29 March 2022.

The CQC does not have the same statutory powers with regard to improvement action for 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 Defence Medical Services.

At this inspection we found:

- We were provided with examples of compassionate care where clinicians supported patients beyond what was required on their role.
- The leadership team had a clear understanding of key issues and a strong focus on tailoring services to meet patients' needs.
- The leadership team had implemented innovative strategies to drive improvement and tailored highly effective governance systems to monitor safe care and treatment.
- An effective system was in place for managing significant events and staff knew how to report and record using this system. This was supported by an open door culture.
- Risks to the service had been identified and mitigated.
- Arrangements were in place for infection prevention and control. These included steps taken to minimise the risks associated with COVID-19.
- Arrangements were in place for managing medicines, including obtaining, prescribing, recording, handling and disposal in the practice.

- Standard operating procedures had been developed to ensure that appropriate coding, outcomes and templates were consistently used by clinicians. Formal processes were established to ensure ongoing monitoring of clinical staff.
- 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 practice had a system to ensure that staff completed the required mandated training and held the appropriate professional registrations.
- Effective medical cover was in place to cover the times when the practice was closed. This was clearly communicated to patients.
- Staff understood the Mental Capacity Act (2005) and how it applied in the context of the service they provided.
- Staff and patients were able to give feedback (including anonymously) and the most recent survey showed a high level of patient satisfaction.
- Information systems and processes had been developed to deliver failsafe systems to support safe treatment and care.
- The building and equipment were sufficient to treat patients and meet their needs.
- The practice made use of privacy screens and curtains in the clinical rooms. Arrangements in the Primary Care Rehabilitation Facility (PCRF) were managed to ensure patient privacy and dignity was maintained.
- Staff understood and adhered to the duty of candour principles.

We identified the following area of notable practice:

- The ‘Commanding Officer’s efficiency award’ had been given to the Senior Medical Officer (SMO) in December 2021 for the running of the sickbay during the COVID pandemic.
- Guidance and contact details for patient support services had been consolidated into an A4 poster with quick review codes and a ‘mental health self-help guide’ leaflet had been developed. Throughout the inspection, a patient centred approach was demonstrated with the practice as the focal point to coordinate the lines of communication with the units and welfare team. Links had been developed both internally and externally to enhance the support provided to patients.
- Achievements in leadership and innovation had been recognised regionally and nominations had been made nationally. Awards had recently been given to the SMO and to the PCRF team.

The Chief Inspector recommends to the practice:

- Implement a programme of peer review for the work carried out by physiotherapists.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

This inspection was led by a CQC inspector and the inspection team comprised specialist advisors including a primary care doctor, nurse, physiotherapist, practice manager and a pharmacist.

Background to Poole Medical Centre

Located in Hamworthy Barracks, Poole Medical Centre provides a primary healthcare, occupational health and force protection service to a permanent patient population. A PCRF is located within the medical centre and provides a physiotherapy and rehabilitation service.

The staff team at the time of the inspection

Position	Numbers
Medical team	One Senior Medical Officer (SMO) who is a civilian medical practitioner (CMP) One Principal Medical Officer (PMO) Part time locum CMP
Nursing team	One senior practice nurse (prescriber) One practice nurse
Practice management	One practice manager
Administration team	Two administrative staff One hospital appointments clerk One pharmacy technician
PCRF team	Four physiotherapists (three whole time equivalent) Two exercise rehabilitation instructors (ERIs) One administrator

Leading Medical Assistant*(referred to as 'medic' in the report)	One post (gapped)

*In the army, a medic is a soldier who has received specialist training in field medicine. It is a unique role in the forces and their role is similar to that of a health care assistant in NHS GP practices but with a broader scope of practice.

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

The practice had safety policies in place including adult and child safeguarding policies. The local safeguarding standard operating procedure (SOP), reviewed in December 2021, referenced adults and children and included links to the local safeguarding team. Safeguarding arrangements were displayed on posters throughout the building and included essential contact details. Staff received safeguarding information as part of their induction and refresher training.

There was an appointed lead and deputy for safeguarding, both had completed level 3 safeguarding training. In addition, the Senior Medical Officer (SMO) had conducted online training from the Zero Suicide Alliance. All staff were in-date for safeguarding and safety training at a level appropriate to their role and knew how to identify and report concerns. The safeguarding register was held in an anonymised format with access limited to appropriate staff members.

Regular communication took place with the local NHS GP surgeries where most of the families of service personnel were registered.

There were no registered patients under the age of 18, but the safeguarding lead carried out a monthly check in accordance with Defence Primary Healthcare (DPHC) policy. Welfare meetings, known as carers' meetings in the Royal Navy, were held fortnightly and case conferences were arranged sooner if concerns were raised. A note of any discussion was added to the patient record. The Primary Care Rehabilitation Facility (PCRF) team participated in discussion on patient welfare.

Vulnerable patients were identified during consultations, through the new patient registration process or on referral from another department such as the wellbeing team. There was a risk register of vulnerable patients and a system to highlight them on the electronic patient record system (referred to as DMICP). Priority appointments were given when required. Searches were run monthly by the SMO, these included a search for any patients under 18 (at the time of inspection, there were no registered patients under the age of 18). Once identified, vulnerable patients were initially discussed at a case conference that involved the Chain of Command, welfare and padre. Care leavers were not currently identified or monitored until the age of 25 within the practice. The practice was not aware of this requirement but established a register after the inspection.

Staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or 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. All staff had completed chaperone training, and this was recorded on the staff database. There were chaperone posters throughout the building and a note in the practice information leaflet.

The full range of recruitment records for permanent staff was held centrally. However, the practice could demonstrate that relevant safety checks had taken place at the point of recruitment, including a DBS check to ensure staff, including locum staff, were suitable to work with vulnerable adults and young people. DBS checks were renewed every three years for civilian staff and every five years for military staff.

Arrangements were in place to monitor the registration status of clinical staff with their regulatory body. All staff had crown professional indemnity cover. DBS and the vaccination status of staff were recorded electronically in a folder with restricted access. There was a checklist which recorded progress and completion of induction. All new staff had commenced the process and all permanent staff had completed an induction. New doctors whether locums, civilian or military, were given an induction by the SMO using the GP DPHC induction tick list. There was a locum doctor pack available through the practice manager. The current locum doctor had been working at the practice for over 10 years and was aware of local policies and procedures.

The senior nurse led on infection prevention and control (IPC) and had completed role-specific training which was supplemented by an online annual refresher course. The staff team was up-to-date with mandated IPC training. An internal IPC audit had been undertaken in December 2021 and found the practice to be 95% overall compliant. IPC audits were repeated every six months by the IPC lead, practice manager and cleaning supervisor (when available). Areas of non-compliance had been acted on. For example, the environmental section scored 60% compliant due to lack of sluice. The nursing team had introduced the use of granules to support safe disposal of urine samples and washable lumbar support chairs were on order to replace fabric chairs in clinical areas.

Deep cleans were conducted quarterly, on request. The practice had three dedicated cleaning staff. Each room had a cleaning checklist which the cleaners were required to sign daily and these were retained by the practice manager. Deep cleans were recorded on this signature sheet. The practice manager maintained a cleaning folder which, in addition to the cleaning sheets, contained copies of all correspondence relating to cleaning matters.

There were systems for safely managing healthcare waste supported by a policy. Clinical waste and pre-acceptance audits were carried out annually, the most recent in October 2021 found the practice was 100% compliant. Clinical waste was bagged and labelled before being logged and stored for collection by an external contractor. External storage was in a lockable waste skip held in a secure area.

The practice had recently taken steps to ensure that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. The servicing of the gymnasium equipment was managed by an exercise rehabilitation instructor. There was a documented check of PCRF equipment and 10% of checks were being completed quarterly as per DPHC policy.

Risks to patients

Systems to assess, monitor and manage risks to patient safety were established to minimise any risk to patients.

The practice was appropriately established for the population at risk. As the majority of the staff were civilian, they were not impacted by deployments and therefore staff levels were maintained to provide better continuity. Staff coordinated leave and other absences to minimise disruption. Locum doctors were provided to cover for any doctor absence.

Clinicians adhered to military guidance around sickness periods for personnel. They communicated effectively with Chain of Command so that line managers knew which tasks personnel could safely undertake.

The practice was equipped to deal with medical emergencies. Emergency kit, including a defibrillator, oxygen with masks and emergency medicines were accessible to staff in a secure area of the practice; all staff knew of its location. Equipment was checked daily and the crash trolley checked monthly.

Staff had completed training in basic life support training, anaphylaxis (severe allergic reaction) and instruction on how to use the automated external defibrillator. Refresher updates were delivered annually by the SMO and senior nurse. Clinicians knew how to identify and manage patients with severe infections including sepsis. A poster was displayed to guide patients and staff in recognising the symptoms and sepsis flowcharts were displayed in clinical areas. A support template with prompts to help identify potential sepsis was built into DMICP.

The practice had not had to deal with any thermal injuries so specific training was not undertaken. However, a guide on how to deal with thermal injuries was available and heat and cold injury grab bags were situated in the resuscitation area. All staff were aware of National Early Warning Score (NEWS) system and received training on induction. Prompt posters were in each clinical area and an aide-memoire poster in reception supported reception staff in asking simple questions to identify clinically unwell attendees. The NEWS system is designed to alert staff to a sick patient who requires urgent clinical review.

Interactive scenario training sessions for clinicians were held monthly and included the pharmacy technician. These included possible injuries that occur on operational settings and on the firing range. The nursing team led a clinical supervision session ’reorganisation and familiarisation of resuscitation trolley’ in March 2022 to provide familiarisation and location of equipment to be used in an emergency.

Wet-bulb globe temperature (WBGT) testing was monitored in the PCRF gymnasium. There was no air conditioning system but fans and open doors were used to mitigate any rise in temperature. WBGT is a measure used to monitor environmental conditions during exercise.

A COVID-19 risk assessment had been completed. Measures introduced to minimise the risk of spreading infection during the COVID-19 pandemic included:

- The majority of appointments were done through telephone triage with face-to-face appointments offered only when required.
- Personnel suffering from any underlying health condition must seek medical approval before returning to work.
- A one-way system was implemented into the building.

- Signs placed throughout on walls and floors to encourage social distancing.
- Hand sanitiser dispensers placed throughout the building.
- A ‘red room’ was used for patients presenting with COVID-19 symptoms. This room could be accessed without having to walk through the main part of the building.
- Personal protective equipment was provided to staff. This included face masks that protect staff from airborne infection (known as FP3 masks) when seeing patients.

Information to deliver safe care and treatment

The clinical records we reviewed were sufficiently detailed and managed in a way that kept patients safe. Doctor and nursing records were regularly audited by the SMO. The SMO had their clinical records reviewed by a visiting RAF doctor in December 2021 who complimented the high standard of record keeping. For PCRF staff, the last clinical notes audit, undertaken in July 2021, showed required standards were being met. Areas to be improved upon were goals and review dates. There was no clear process in place for recommendations feedback and follow up although re-audit would look at improvements in these areas.

For new joiners to the practice, the medical records were summarised by the nurses or the SMO. The SMO monitored the requirement for three yearly summarising in accordance with DPHC policy. This was last reviewed in March 2022 and the practice was showing 100% of records were in-date for summarising.

Staff described occasional loss of connectivity with DMICP, meaning clinics could be delayed. If this happened, the business resilience plan was followed, and only urgent patients were seen. Consultation notes were recorded on to paper copies and scanned onto DMICP at a later date. The practice had Wi-Fi and new laptops with updated software that allowed for remote working and a contingency for times of power outage.

A system was in place for the management of external and internal referrals. The practice had a dedicated referrals clerk who was covered by the practice manager during periods of absence. Referrals were actioned using the NHS e-Referral service (e-RS) or by email. There was a referrals register in a limited folder on SharePoint which was password protected. There were a number of personal identifiers on the register and therefore it was recorded on the information asset register. The referrals register was colour coded and clear; all urgent and two week wait referrals had been completed or appropriately progressed. All follow up actions were recorded on DMICP. Internal referrals such as Department of Community Mental Health and occupational health were also included on the register and the PCRF administrator monitored referrals to the Regional Rehabilitation Unit. Entries on the referral register were moved to a completed sheet once the appointment date has been reached. If the patient did not attend their appointment, it was moved back to the live spreadsheet and the doctor informed

There was an effective system in place to ensure specimen samples were taken safely, appropriately recorded on DMICP and results reviewed and actioned by a clinician within seven days. This was supported by an SOP. The system had a cross check to make it failsafe, nurses kept a paper log of outstanding results and looked them up themselves on

DMICP. When results were returned, they were recorded in the log and any abnormal results flagged up to a doctor. In parallel with this, the SMO checked each morning for any results that were back on DMICP using the electronic pathology network, known as 'Path Links'. The SMO phoned patients with their results and actioned any abnormal results. When the SMO was on leave, Path Links was checked by the locum doctor in the same way.

Safe and appropriate use of medicines

A lead and deputy were identified as the subject matter experts for medicines management. The lead was listed as the SMO with the day-to-day management of medicines delegated to the pharmacy technician. Safe procedures were in place for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment. We found all items were within date and appropriately stored.

Dispensing was mainly carried out by the pharmacy technician from stock held in the dispensary. A small number of regular use items were stored in the nurse's room. Medication requiring refrigeration was monitored daily to ensure it was stored within the correct temperature range. The practice used a data loggers to record minimum and maximum temperatures. Readings for an temperature that fell outside of the parameters would go straight to regional pharmacists, stock within the fridge was then quarantined whilst awaiting instruction. Dispensing outsourced to a local community pharmacy was supported by an SOP which ensured a failsafe system. A record was maintained of checks at every stage of the process from sending the prescription through to receipt of the dispensed item.

Appropriate arrangements were established for the safety of controlled drugs (CD), including destruction of unused CDs. Monitoring and storage arrangements were in accordance with guidelines and policy. The SMO had overall responsibility for CDs and was supported by the pharmacy technician who was responsible for stock in the dispensary. Monthly checks were carried out by the SMO, lead nurse or regular locum doctor. Quarterly checks were provided by the duty officer.

There was a process for the management of and monitoring of patients prescribed high risk medicines (HRMs). Monitoring was done by the SMO. We reviewed the clinical records of patients prescribed an HRM. We noted that alerts were in place and monitoring was carried out in accordance with the recommended frequency. Shared care agreements (SCA) were in place for the patients that required them. SCAs are important to provide clear responsibilities between clinicians involved in the patient's care.

SOPs were in place to support safe dispensing practice. Staff who were prescribers had signed the SOPs applicable to them.

Staff had access to British National Formulary and prescribing formulary. We saw that the prescribers were working to both local and national guidelines for prescribing. A structured programme of audit, including an audit of antibiotic prescribing, had been implemented. A review of the most recent antibiotic audit carried out in January 2022, showed 100% (20 out of 20) compliance with local guidelines produced by the Clinical Commissioning Group.

A separate audit reviewed antibiotic prescribing by the senior nurse and found 89% compliance (eight out of nine).

Patient Group Directions (PGDs) had been developed to allow nurses to administer medicines in line with legislation. The PGDs were current and signed, evidenced in the results of an audit carried out in February 2022. Patient Specific Directions (PSDs) were not used and medics administered medication from an individual patient prescription. PGDs are a written instruction allowing non-prescribing clinicians to administer certain medicines to a group of patients. PSDs must be signed in advance of a medicine being administered to a named patient after the prescriber has assessed the patient on an individual basis.

The practice's arrangements for the access, storage and monitoring of prescription stationary were effective. Blank prescription pads and prescription paper were stored securely and an effective tracking system was followed.

Requests for repeat prescriptions were safely managed. Telephone requests were accepted but the requestor was required to complete a three point identification check in accordance with the DPHC SOP. The process for repeat prescriptions was maintained and monitored by the SMO. A process was in place to update DMICP if changes to a patient's medication was made by secondary care or an out-of-hours service. Prescriptions were signed before medicines were dispensed and handed out to patients.

Track record on safety

Measures to ensure the safety of facilities and equipment were in place. Risk assessments included both clinical and non-clinical risks. For example, needle stick injury, trips and falls, manual handling, legionella management and lone working.

There were registers maintained of both active and retired risks, and a separate register was used for the PCRF. The '4Ts' (tolerate, terminate, treat and transfer) principles applied to each risk each, and discussion about risk was a standing agenda item at the practice meeting.

The practice manager was the lead for health and safety and was supported by the unit lead. The safety certificates for water, electric and legionella were held by the station safety team and copies were made available or had been requested by the practice. We viewed those for fire, gas, water and legionella on the inspection visit and found them to be in-date. A programme was in place to flush taps weekly in order to prevent the build-up of bacteria that can lead to legionella.

The station lead for health and safety carried out an annual assessment. Equipment checks, including the testing of portable electrical appliances were in-date.

There was a fixed alarm system in the resuscitation bay and treatment room, a pull cord in the accessible toilet and handheld alarms elsewhere. All alarms were tested weekly and a record of the checks retained by the practice manager.

Staff working on reception had full view of the waiting room so patients could continue to be observed whilst waiting to be seen.

Lessons learned and improvements made

The practice shared learning and made improvements when things went wrong.

There was a system and policy for recording and acting on significant events and incidents (referred to as ASER). This was supported by an SOP and staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.

There was evidence that the practice learned and shared lessons and took action to improve safety in the practice. Staff we spoke with could recall the learning from a recent significant event when a sample was found in the specimen container which had been there several days and not sent to the laboratory. The practice reviewed their protocol and introduced a system whereby the nurses sign a log to confirm they have checked the specimen container twice daily. ASERs were discussed at the first practice meeting each month. Although the practice was reviewing ASERs and making improvements as a result, lessons learned were not captured in meeting minutes or on the ASER log and therefore staff not attending the practice meeting would potentially be unaware of any changes.

The pharmacy technician was responsible for managing medicine and safety alerts. In their absence, the responsibility fell to the practice manager. Alerts were sent from regional headquarters and the pharmacy technician and practice manager were also registered to receive alerts direct from the Medicines and Healthcare products Regulatory Agency website. We checked recent alerts and found they had been received and actioned. We reviewed two recent alerts (one of which was non-applicable) and found appropriate action had been taken and recorded. Alerts considered relevant to the practice were discussed at the practice meeting. Significant entries were also included in the ‘Bogbrief’ (a rolling newsletter with key updates that deployed staff could read on their return, so called as it was displayed on the back of doors in the toilets for captive reading). The pharmacy technician emailed the SMO, practice manager and lead nurse with details of actions taken as result of alerts.

Are services effective?

We rated the practice as good for providing effective services.

Effective needs assessment, care and treatment

Clinicians were aware of relevant and current evidence-based guidance and standards, including the Scottish Intercollegiate Guidelines Network and National Institute for Health and Care Excellence (NICE) best practice guidelines. Our review of patients' notes showed that best practice guidelines were being followed. Clinical guidelines was a standard agenda item at the weekly healthcare governance meeting. Staff we spoke with referred to and gave examples of updates they had acted on. For example, in response to NICE guidance issued in December 2021, the practice had implemented a checking template that listed the signs and symptoms of severe COVID-19. If a military doctor was away for a few months, they could review recent issues of the BogBrief to catch up. These included updates on clinical guidance an online version, found via 'MedPage', was hyperlinked for ease of use. 'MedPage' was an electronic library developed by the Senior Medical Officer (SMO) that allowed shared and quick access to documents.

The Defence Primary Healthcare (DPHC) team produced a newsletter that was circulated to clinicians providing further information and a summary of relevant safety updates.

We looked at a sample of clinical records from the Primary Care Rehabilitation Facility (PCRF). Templates that included the musculoskeletal health questionnaire (MSK-HQ) were used on all new patients. MSK-HQ is a tool developed to allow patients to report their symptoms and outcomes from treatment in a standardised way. Outcomes were used for individual patients and progress was reviewed though patient care committees. PCRF staff were aware of best practice guidelines but had not audited against them to determine their conformity.

Monitoring care and treatment

The Defence Medical Services (DMS) have a responsibility to deliver the same quality of care as patients expect in the NHS. Because the numbers of patients with long-term conditions (LTCs) are often significantly lower at DPHC practices, we are not using NHS data as a comparator. The senior nurse was the lead for the management of patients with LTCs. The population manager facility (referred to as 'popman') was used to identify and monitor patients with an LTC. The register was checked monthly by the senior nurse and, in their absence, by the practice nurse.

All patients recorded as having high blood pressure had a record of their blood pressure being checked in the last 12 months. Five out of the six patients had a follow-up blood pressure reading of 150/90 or less (this is in an indicator for mild hypertension). All patients with high blood pressure had a treatment plan in place.

There were low patient numbers on the diabetic register and a review of clinical notes showed good management with regular recall and monitoring. All new patients were

offered at their nurse-led ‘New Patient Appointment’ screening (AUSDRISK) if over 25 and non-Caucasian or over 40 and Caucasian, and offered an HbA1c blood test (blood glucose levels) if moderate risk or higher. All patients previously assessed as pre-diabetic (at risk of developing diabetes where intervention could result in prevention) or diagnosed with gestational diabetes were offered an annual blood test. Opportunistic testing was done if patients were concerned about excessive weight gain or loss.

There were nine patients on the asthma register and all had been reviewed in the last 12 months. A consistent template had been implemented and included the appropriate Read codes to be used. Read codes are a comprehensive list of clinical terms used by healthcare professionals to describe the care and treatment given to patients.

In addition to the mandated LTCs, patients with thyroid disease, inflammatory bowel disease and hyperlipidaemia (when the blood has too many fats such as cholesterol and triglycerides) were also monitored and recalled. Due to the small numbers of patients on these lists the nursing team had the capacity to telephone each patient in addition to sending out three invite letters. The recall of these patients is important when the population is transient

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

Information from the Force Protection Dashboard, which uses statistics and data collected from military primary health care facilities, was also used to gauge performance. Service personnel may encounter damaging noise sources throughout their career. It is therefore important that service personnel undertake an audiometric hearing assessment on a regular basis (every two years). Audiometric assessments were in date for 69% of patients. A catch up programme had commenced; there was clear evidence of opportunistic assessments for patients attending for vaccinations or other reasons.

The SMO was the overall audit lead and the practice had implemented a calendar that included mandatory DPHC audits. The audit programme was established and consisted of repeat cycles. Audits completed included:

- treatment for hypertension
- antibiotic prescribing
- treatment for diabetes
- infection prevention and control (IPC) and handwashing
- specimen results handling
- PCRF injury surveillance
- consent
- pre-acceptance healthcare waste.

An internal quality assurance tool, the Defence Medical Services (DMS) Common Assurance Framework (eCAF) was used to monitor safety and performance. The DMS eCAF was formally introduced in September 2009 and since that time has been the standard healthcare governance assurance tool utilised by DMS practices to assure the standards of health care delivery within DMS. The practice was migrating to a new system known as the Healthcare Assurance Framework . This had almost been completed at the time of inspection.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff who conducted the Standard Underwater Medicine Course had their qualifications checked by the SMO on induction and were required to complete a refresher update training course every five years. Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

The practice understood the learning needs of staff and provided protected time and training to meet them. Up-to-date records of skills, qualifications and training were maintained. The practice had developed processes to provide staff with ongoing support through one day ‘hot topic’ courses held annually. Military aviation medical examiner qualified doctors sat on the monthly RAF dial-in, attended the annual RAF aviation symposium and accrued at least 10 hours of continued professional development annually. Support for all staff included one-to-one meetings and appraisals. Clinical staff received mentoring, clinical supervision and support for revalidation.

The practice manager monitored mandatory training using the staff database and raised at the practice meeting when training courses were due to be renewed. All staff had protected time to complete mandatory training or take part in scheduled group training. The practice database showed 90% compliance for staff having completed mandatory training.

Medics maintained their own portfolios and the SMO maintained oversight by regular review of their consultations.

The senior nurse completed the mid-year and end of year reviews the nurse and the pharmacy technician as mandated by DPHC. Validation support was given by nurses form nearby military medical centres within the region. The senior nurse also offered Nursing and Midwifery Council validation support and clinical supervision to nurses from the neighbouring military medical centres. Internal and external training sessions were available to staff. For example, the practice manager had completed the DMICP administrators course.

Physiotherapist appraisals were performed by a Band 7 physiotherapist. PCRF staff were supported with revalidation and had a portfolio of evidence to present from the last two years to support professional development. However, there had been no physiotherapist work peer reviewed in the last 12 months. There was a formal process to peer review the

clinical work carried out by the exercise rehabilitation instructors. This was referenced in training records on the healthcare governance workbook.

Coordinating care and treatment

Staff worked together and with other care professionals to deliver effective care and treatment. The practice met with welfare teams and line managers to discuss vulnerable patients. The practice had established links with the three welfare officers assigned to the barracks. Vulnerable patients were discussed on the first and third Wednesday of every month at the carers' meeting which involved the Chain of Command, welfare and the padre. All temporarily downgraded patients were discussed at least monthly in this same forum. For personnel with more complicated needs, a case conference was generally convened, sometimes at short notice. The Unit Health Committee dealt more with statistics and trends; individual patients were not discussed in this forum.

The practice had established links with local NHS services. There was a good working relationship with local consultants for common medical issues, this is evidenced on the consultant's referral diagram. Consultants used regularly were invited to an open day at the barracks, held every two years.

On leaving the military patients underwent a release medical and summary of their clinical notes. Signposting and information on civilian life had been consolidated into a handout that contained information on key services available. Any ongoing concerns were flagged to the receiving GP and a handover summary letter was given to the patient to be handed over at the first civilian appointment.

There was good communication between the PCRF staff and unit physical training instructors and comprehensive programmes to follow for injury recovery and maintenance.

Helping patients to live healthier lives

The practice identified patients who may need extra support and signposted them to relevant services. For example, patients at risk of developing an LTC and those requiring advice on their diet, smoking and alcohol cessation. Patients identified as pre-diabetic were recalled for annual blood tests.

The senior nurse had the lead for health promotion and was passionate about the role and finding innovative ways to engage with the patients. Health promotion boards were displayed throughout the practice, these were updated monthly. We were shown photographs of the boards over the past eight months displaying relevant and up-to-date information. The practice team had undertaken cake sales to promote different topics to their population. Although no health fairs had taken place over the pandemic, the 2022 fair was currently being planned and advertised within the medical centre. The theme of this year's health fair was 'treasure your health', a pirate-based event where attendees will have a treasure map which will be stamped at each station. There was evidence of collaboration with external agencies such as the sexual health team at Dorset sexual health service, dental team, PCRF, physical training instructors and welfare teams. Yoga

sessions were also available to all staff at lunch times. Previous fairs had included "vintage" days where classic cars were brought onto camp to encourage attendance.

The senior nurse was trained to foundation level in sexual health and the practice nurse had completed a Faculty of Sexual and Reproductive Health 'Essentials for Primary Care' study day in 2021. Therefore, routine asymptomatic sexual health screening was available at the practice. Patients were signposted to local NHS clinics in Poole and Bournemouth for level two sexual health services. Telephone numbers for these services available at reception. Dorset sexual health team had attended previous health fairs and the senior nurse had established links with a company to provide free condoms. A consultant led specialist sexual health services was available in Birmingham.

We saw that PCRF staff included questions about lifestyle as part of their assessment and used wellness measures on Rehab Guru (software for rehabilitation exercise therapy) to monitor lifestyle and wellness activity. Injury prevention work was heavily involved as part of the rehabilitation troop run by the PCRF and also within the human performance team separate to that of the PCRF. Obesity was less of an issue compared to other units and the PCRF were involved in more the high performance end of health promotion and this was factored into the treatment plans.

The practice offered preventative health checks to identify any conditions that patients may be at risk of and could be avoided by treatment and lifestyle choices. There was a structured approach to patient recall; a catch up programme had been implemented post-COVID and remaining patients were included in a recall programme.

A monthly search was undertaken for all patients aged 50 to 64 years who were entitled to breast screening. The practice also engaged with all national screening programmes and had a mechanism to ensure that eligible patients were referred into the bowel cancer or abdominal aortic aneurysm screening programs. At the time of the inspection there were no patients overdue and a small number of eligible patients due for screening.

The number of women aged 25 to 49 (there were no women patients aged 50 to 64) whose notes recorded that a cervical smear had been performed in the last three to five years was 29 out of 31 eligible women. This represented an achievement of 94%. The NHS target was 80%. Invite letters were sent out and followed up if not responded to, the nurses contacted patients by telephone.

It is important that that military personnel have sufficient immunity against the risk of contracting certain diseases. The World Health Organisation sets a target of 95% for vaccination against diphtheria, tetanus, pertussis and polio and measles, mumps and rubella. The data below from March 2022 provides vaccination data for patients using this practice (regional and national comparisons were not available): military personnel have sufficient immunity against the risk of contracting certain diseases.

- 95% of patients were recorded as being up-to-date with vaccination against diphtheria.
- 95% of patients were recorded as being up-to-date with vaccination against polio.
- 86% of patients were recorded as being up-to-date with vaccination against Hepatitis B.

- 99% of patients were recorded as being up-to-date with vaccination against Hepatitis A.
- 95% of patients were recorded as being up to date with vaccination against Tetanus.
- 98% of patients were recorded as in date for vaccination against MMR.
- 99% of patients were recorded as in date for vaccination against meningitis.

Units were responsible for ensuring their personnel kept up-to-date with vaccinations. The practice worked collaboratively with Chain of Command to ensure all personnel requiring additional immunisations in line with operational requirements were identified and vaccinated within an appropriate timeframe. Monthly searches were undertaken to recall patients for vaccinations.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance. For example, verbal consent was recorded in DMICP. Acupuncture was administered by staff in the PCRF. There was a standard operating procedure which included a written consent form.

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

Although there were no patients aged between 16 and 18 years, staff understood how to carry out assessments of capacity to consent in line with relevant guidance. Clinical staff were aware of the protocols and were supported and were supported by DMICP templates.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

Patient welfare was central to the strategy and the practice consistently demonstrated that services were tailored to provide a high level of care.

From our interviews, we established the practice, Primary Care Rehabilitation Facility , welfare officers and the unit had developed an effective relationship that was underpinned by a person-centred approach. They worked closely to ensure the best care for each individual taking account of their occupational and health requirements. ‘Be the Best You Can Be’ posters were displayed throughout the barracks to promote mutual support and provide contact details for support services both internally and externally.

The practice gave patients timely support and information. A translation service was available and promoted at reception and in the patient waiting area. Staff told us that it had been recently used to translate a hospital letter into Spanish and they found the service to be effective.

Involvement in decisions about care and treatment

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

The e-referral service had been implemented and was used to support patient choice as appropriate (e-referral is a national electronic referral service which gives patients the choice of date and time for their first outpatient appointment in a hospital).

Results from the practice’s Patient Experience Survey conducted by the Defence Medical Services Regulator in the weeks before this inspection (23 responses were collated) indicated:

- 96% described their overall experience as very good.
- The 16 patients who responded to the question said that they were treated with care and concern (7 patients gave no response).

The data presented by the practice was not benchmarked against regional and national averages for Defence Medical Services, or against the previous year’s performance.

Notices were displayed in the patient waiting area which told patients how to access a number of organisations. Information was prominently displayed and accessible and we

saw that it was age appropriate and relevant to the patient demographic. Mental health support services were promoted and campaigns were run during the year to give greater emphasis.

The practice acted in a compassionate way toward any patient who was discharged on health grounds. We saw that the practice reassured these patients and signposted them to personnel within the military who could guide them through the exit process and transition to NHS care and other support functions.

The practice maintained a register of patients who were also carers and provided extra support as required. Carers were identified as part of the new patient registration process. Carers and cared for patients were Read coded and recalled for annual flu immunisations and had been prioritised for COVID-19 vaccinations. Staff knew of services that carers could be signposted to and notices for carers were displayed in the waiting room. The Band 6 nurse was the carers' lead and contacted patients on the carers register to offer support if required. Carers were also given priority access and flexibility for appointments and alerts on their notes highlighted this to reception staff.

Privacy and dignity

The practice respected patients' privacy and dignity.

Privacy screening was provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. Clinic room doors were closed during consultations and conversations could not be overheard.

Physiotherapists used an open clinical area with curtains between cubicles to offer privacy during consultations and treatment. Background music reduced the likelihood of conversations being overheard. If requested when seeing a physiotherapist or an ERI for treatment, privacy was provided by using one of the clinical rooms.

Privacy for patients when speaking with receptionists was supported by the layout with the waiting area set away from the desk. Signage invited patients to ask a member of staff should they want a conversation in private, staff at the reception desk advised patients that a private room would be offered should they wish to discuss sensitive issues. Background noise (television) had been introduced to assist with privacy.

The practice could facilitate patients who wished to see a clinician of a specific gender as there was a mixture of male and female clinicians including in the PCRF. Male patients could be signposted to the local sexual health clinic to be seen by a male clinician for sexual health screening.

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 organised and delivered services to meet patients' needs and to account for preferences.

The practice understood the needs of its population and tailored services in response to those needs. Staff worked a condensed working pattern to mirror the camp working hours and open early at 07:30 hours each day; the practice opened even earlier at 07:00 hours for a very unwell patient so they could have bloods taken without coming into contact with other patients. The practice ensured there was cover available to respond to the doorbell over lunchtime and same day appointments were available to support urgent operational requirements. Telephone consultations and eConsult appointments were alternative options for patients who required an appointment. A wide range of specialist medicals were provided by the clinical team.

An Equality Access Audit as defined in the Equality Act 2010 was completed for the premises in November 2021 and no significant concerns were identified. The audit identified two areas of non-compliance; both had been actioned.

The practice had a policy available to staff or patients that stated home visits would be provided in exceptional circumstances when patients were unable to attend without difficulty. A record of home visits was maintained by the hospital admissions clerk.

The practice manager was the Diversity & Inclusion (D&I) lead for the practice. All staff had completed the mandated D&I training which was recorded on the staff database. There was a D&I notice board close to the staff room which included contact details for the host unit D&I lead.

We were provided with examples of compassionate care where clinicians supported patients beyond what was required on their role. Examples included the 'Commanding Officer's efficiency award' given to the Senior Medical Officer in December 2021 for the running of the sickbay during the COVID-19 pandemic. A written compliment was received in March 2022 thanking staff for saving a patient's life. This was supported by a visit from the Commanding Officer to give a personal thank you to staff.

The practice was the central point of a joined up network that supported all members of the service through a proactive approach. Strong working relationships were established and a patient journey pathway programme had been developed with the unit to support patients with rehabilitation. Guidance and contact details for supporting services had been consolidated into an A4 poster with quick response codes. This provided a range of information that patients could capture confidentially and use when in private. In addition, a 'mental health self-help guide' leaflet had been developed. This included self-help books,

talking therapies, support services and charities. These extended to information to help with gambling, drug and alcohol addiction.

Timely access to care and treatment

Waiting times were short with a policy of 'doing today's work today'. The practice accommodated patients with an emergency need on the day they presented at the practice. Routine appointments with a doctor or nurse could be facilitated within one day. Urgent appointments to see a physiotherapist were available on the day and follow up appointments were available within two days. Appointments with an exercise rehabilitation instructor were available within three days and availability of rehabilitation classes was the next day. Patients could self-refer to see a physiotherapist using the Direct Access to physiotherapy service (referred to as DAP); 90% of referrals were made using DAP. Diving medicals were available the same day and aviation medicals within two days.

Outside of routine clinic hours, cover was provided up until 18:30 hours by the duty medic. There was a 'duty doctor' mobile phone number (owned by the Senior Medical Officer (SMO); this has been re-routed to their personal phone). Shoulder cover (access to a doctor once the practice was closed) was provided until 18:30 hours on weekdays using the duty doctor phone. The phone number was held by the guardroom and the communication centre but callers normally contacted the duty medic first. Outside these hours, NHS 111 was used but the SMO remained on call. When the SMO was on leave abroad, the duty doctor phone was held by one of the military doctors, usually the Principal Medical Officer. There was a separate psychiatric emergencies protocol and the SMO had attended outside of opening hours (including at weekends) to assess psychiatric emergencies who may need admission. From 18.30 hours, patients were diverted to the NHS 111 service and/or eConsult (a message could be left for the practice to follow up on the following working day if not urgent). When the practice closed in the afternoon for training purposes, patients could still access a doctor in an emergency. In this way, the practice ensured that patients could directly access a doctor between the hours of 08.00 hours and 18.30 hours, in line with DPHC's arrangement with NHS England.

The nearest accident and emergency department and minor injuries was located at the Poole Hospital (approximately 10 minutes away).

Results from the practice's patient experience survey (compiled between March 2021 and February 2022, 45 responses were received) showed that patient satisfaction levels with access to routine care and treatment were high;

- 100% of patients said they were able to access healthcare advice easily.

The practice leaflet provided comprehensive details for out-of-hours services.

Listening and learning from concerns and complaints

The practice manager was the designated responsible person who handled all complaints in the practice. The practice had a process to manage complaints in accordance with the

DPHC complaints policy and procedure. Both verbal and written complaints were recorded.

There had been no complaints received since 2018. However, staff were aware of processes to follow should a complaint be received and had responded to feedback from patients. For example, patients had fed back to the Chain of Command that the Community Psychiatric Nurse office was dark, small and depressing. The room was moved to an alternative location within the medical centre to an area that was large and airy with attractive wall art.

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 practice as outstanding for providing well-led services.

Leadership, capacity and capability

The leaders at the medical centre consistently demonstrated they had the knowledge to meet the challenges and provide a timely and effective service to the patients. The Senior Medical Officer (SMO) managed the transient nature of the military medical workforce by publishing a 'BogBrief' which was a rolling newsletter with key updates that deployed staff could read on their return. The SMO had recently received a Commanding Officer's efficiency award (December 2021) for the running of the medical centre and was a strong proponent of the Pygmalion Effect (high expectations leading to improved performance).

Leadership roles had been established for key responsibilities and staff were clear of their own role and those of colleagues. Staff felt that they could raise concerns if they had them and forums had been established where all staff could get together to share and learn from key messages. Staff spoke highly of internal communication. Leaders were knowledgeable about issues and priorities relating to the quality of services. In August 2021, The SMO introduced the Japanese idea of Kaizen or continuous incremental improvement within the practice. This has led to more quality improvement activity (QIP). Every idea of how improvements could be made was recorded in the Kaizen log. Any staff member could suggest something to improve, and this was a standing agenda point at the weekly management meeting.

The rehabilitation team spoke of good support and a close working relationship with the SMO and were fully integrated into the practice team. The Primary Care Rehabilitation Facility (PCRF) team had been presented with an in-year team award from region. This was in recognition of the department being fully operational throughout Covid-19 and the team having been flexible in their working to achieve this with the demand from the unit.

Terms of reference were in place and reflected the key responsibilities given to individuals. 'Desktop Instructions' provided a consolidated summary of responsibilities for each role.

Vision and strategy

The practice followed the Defence Primary Healthcare (DPHC) mission statement to "deliver a unified, safe, efficient and accountable primary healthcare and dental care services for entitled personnel to maximise their health and to deliver personnel medically fit for operations".

The SMO had produced a 'Strategic Vision' document. This listed future developments and aspirations. The strategy focussed on developing staff to support patients; for example, increased numbers of doctors qualified to provide aviation medicals. Further examples included the planned recruitment of a Medical Support Officer to free up the Principal Medical Officer to allow more time to clinical work. The practice was exploring the

potential to employ a private mental health nurse on a long-term basis using unit charity funding.

Staff were aware of and felt fully engaged in the vision, values and strategy and their role in achieving them. Key responsibilities had been and continued to be assigned throughout the team and all staff spoke positively about the inclusive approach.

The practice planned its services to meet the needs of the practice population and liaised with unit personnel to promote their vision and values. The practice staff were aware of specific medical requirements for trainees and we found strong links with the Welfare Officer and with the station executives.

Culture

Through discussion with practice staff, it was clear that the practice had fostered a ‘no blame’ culture. Key systems had been reviewed to make them more effective and staff we spoke with were aware of the whistle-blowing policy and freedom to speak up champion. The practice used civil service ‘in-year awards’ to financially reward hard work. Nominations had been received for The Royal Garden Party and for the South West Region Regional Clinical Director’s Award. The aim of the leadership was to ‘praise in public’. There was very low staff turnover which indicated morale was high. Staff members were highly complimentary about the leadership in the practice. They felt respected, supported and valued.

The practice focused on the needs of patients. There were strong links between the unit, welfare, padre and practice that evidenced a joined up approach throughout the inspection. Examples were given of how this approach had been effective in supporting individuals with particular needs.

Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. There was information displayed to advise staff on the freedom to speak up process and this included signposting to ‘Speak Out’ a confidential helpline to support those who felt bullied , harassed or discriminated against. The management team had an open door policy and the meeting structure was inclusive in providing all staff the opportunity to offer their opinion.

Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They spoke of how the culture was one where both suggestions and concerns would be both listened to and acted on.

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

Staff had completed equality and diversity training.

Governance arrangements

The leadership team had established responsibilities, roles and systems of accountability to support good governance and management. Key roles were supported by a named secondary person to provide resilience. Staffing levels were appropriate to support the patient population and their regular requirement to deploy at short notice. The secondary roles were shared across the team. The practice used 'MedPage', a 'one stop' document that contained links to all relevant healthcare governance documents. 'Medpage' was accessible to all staff and easily searched using key words and evidence. Examples of links included local registers and logs, protocols, clinical guidelines, key military policy documents. It was a live document, frequently updated by the SMO.

Through engagement, the practice had developed strong links with the welfare team, pastoral support and Chain of Command. Systems were in place to safeguard vulnerable personnel and ensure co-ordinated person-centred care for these individuals.

Practice leaders had reviewed, introduced and implemented a suite of policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. There were links to DPHC polices and some had been adapted to local policies.

An established calendar included a range of mandated and opportunistic audits that had led to positive outcomes. Repeat cycles were carried out to provide visibility on quality improvement. The practice also had a quality improvement and Kaizen register to record lower level improvements.

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

A meeting schedule was established and this included monthly healthcare governance, practice and welfare meetings. Weekly practice and clinical meetings and a rolling four week programme spanned all areas of healthcare governance. Discussion at each meeting was recorded and made available to those unable to attend.

Managing risks, issues and performance

Practice leaders had established a governance structure that provided oversight of risk and the quality of service. There was a risk register and a retired risk register; there was also a link to a separate PCRF risk register. Included as a standing agenda item, the practice meeting included any newly identified risk, and once a month, the register was reviewed in full.

There were clear and effective processes in place for managing risks, issues and performance. The 'four T's' (transfer, tolerate, treat, terminate) DPHC Guidance Note on managing risk was referenced on the risk register. The practice had a COVID-19 risk assessment in place and a number of other non-clinical risks including manual handling, lone working slips, trips and falls. There were no Control of Substances Hazardous to Health risk assessments or any relating to clinical risks such as sharps and specimens.

During the inspection the practice manager obtained copies of the required risk assessments from colleagues in DPHC and planned to introduce them imminently.

Although there had been no performance issues with staff, leaders were aware of policies to be followed and where to access support if advice was needed. All staff were in date for 'defence information passport' and 'data security awareness' training.

There was a business continuity plan which had last been reviewed in March 2022 and included the roles of medical centre staff in the event of a major incident, directions to follow in the event of extreme weather and interruption of power supply. All staff were recorded as having read the policy and a copy was available electronically should access to the building be restricted.

Appropriate and accurate information

A number of different meetings were held regularly and extended to the whole team. Clinical and practice wide meetings was held weekly and provided a forum for effective discussion and shared learning. Minutes from meetings we reviewed demonstrated that key agenda items had been discussed including safeguarding, national guidance and alerts. Meetings were used to keep staff updated on and included in the implementation of ongoing improvements.

The leadership team had mostly migrated from the 'Common Assurance Framework' to the new 'Health Assessment Framework', an effective governance tool used in military practices to monitor performance.

There were robust arrangements at the medical centre 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 involved patients, staff and external partners to support high-quality sustainable services.

There were various options in place to encourage patients to provide feedback on the service and contribute to the development of the service. A patient experience survey was undertaken throughout the year. Laminated quick response codes were available throughout the building for patient feedback via the 'General Practice Assessment Questionnaire'. Actions taken were communicated via the Chain of Command

Good and effective links with internal and external organisations were established, including with the welfare team, the local NHS Trust, Regional Rehabilitation Unit and with the local safeguarding team. There was a good working relationship with local consultants for common medical issues. Consultants used frequently by the unit were invited to an open day at Hamworthy Barracks in order to understand the working environment and

military activities of their patients. This was generally held every two years (next one was scheduled for 8 July 2022).

The management operated an open door policy and an inclusive meeting structure where they encouraged all staff to contribute. ‘Freedom to speak up’ was a standing agenda item at the weekly management meeting.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation. The practice had adopted the ‘Kaizen’ approach, an inclusive process of continued improvement through small incremental steps. Good examples of quality improvement work included:

- An aspiration to recruit a mental health nurse on a long-term basis using charitable funds.
- Staff in the PCRF had developed a ‘return to role’ criteria aimed at reducing re-injury or from returning from injury too soon. Injury clinics reached out and were run on operations to provide an improved update from early engagement.
- A local agreement and policy had been developed to allow shockwave therapy to be completed at Poole without patients having to travel to Portsmouth weekly for five weeks. Shockwave therapy is a non-surgical treatment used to treat pain and promote healing.
- A policy has been developed to allow priority access to the Multidisciplinary Injury Assessment Clinic appointments and imaging services via the Regional Rehabilitation Unit at Portsmouth.