Thorney Island Medical Centre

Baker Barracks, Emsworth P010 8DH

Defence Medical Services inspection

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

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

Contents

Summary

About this inspection

This practice is rated as good overall

The key questions are rated as:

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

We previously carried out an announced comprehensive inspection of Thorney Island Medical Centre on 9 February 2021. The medical centre received a requires improvement rating overall, with a rating of requires improvement in the safe domain and requires improvement in the effective and well-led domains. The caring and responsive domains were rated good.

An additional comprehensive announced inspection was undertaken on 18 January 2023 to see if improvements had been made.

A copy of the report from the previous inspection can be found at:

www.cqc.org.uk/dms

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

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

At this inspection we found:

- The practice had effective leadership, although this was hindered by staff shortages. Staff worked well as a team and said they were well supported and included in discussions about the development of the service.
- Despite the staffing challenges, patient feedback indicated staff responded promptly to ensure they received timely and effective care. Feedback indicated patients were treated with compassion, dignity and respect and were involved decisions about their care and treatment. Information about services and how to complain was available to patients.

- Patients found it easy to make an appointment and urgent appointments were available the same day.
- Risks were well managed.
- Mandated training for staff was up-to-date.
- The practice had good lines of communication with the unit, welfare team, local NHS services and the Department of Community Mental Health to ensure the wellbeing of service personnel.
- An inclusive whole-team approach was supported by all staff who worked collaboratively to provide a consistent and sustainable patient-centred service.
- A programme of quality improvement activity was in place and this was driving improvement in services for some patients.
- Arrangements were in place for managing medicines including high risk medicines.
- There was an effective programme in place to managed patients with long term conditions.
- The practice sought feedback from patients which it acted on. Feedback showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.
- Staff were aware of the requirements of the duty of candour, (the duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). Examples we reviewed showed the practice complied with these requirements.

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

To promote morale, education and integrated working relationships the practice arranged for the General to deliver a motivational speech addressing areas such as how to have a positive mindset within the workplace including how to remain focused and motivated in difficult situations. Also arranged is for an elite female cyclist (Army soldier) who was injured badly in an accident in America to deliver a motivational speech on adversity and triumphs following their accident.

The practice manager and one of a sergeants have sourced ‘high performance podcasts’ for all staff to listen to, both military and civilian – presently they are listening to Jake Humphrey’s High Performance podcast series which had inspired the team to help drive and improve performance. This was well received by staff and more will be incorporated into the 2023 training schedule.

The Chief Inspector recommends to Defence Primary Healthcare:

Undertake a baseline health needs assessment to ensure that staffing levels are adequate at all times to meet patient need

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

Our inspection team

The inspection team was led by a CQC inspector. The team comprised specialist advisors including a primary care doctor, a practice manager, a physiotherapist and a nurse. In addition, 3 new specialist advisors shadowed this inspection.

Background to Thorney Island Medical Centre

Thorney Island Medical Centre provides a routine primary care, occupational health and rehabilitation service to a patient population of 1,064 including service personnel and permanent staff for the camp. Most patients are aged between 18 and 44. At the time of the inspection, there were no registered patients under the age of 18.

A Primary Care Rehabilitation Facility (PCRF) is based in a building adjacent to the practice and provides a physiotherapy and rehabilitation service for patients. As there is no dispensary at the practice, there is a contract in place between Defence Primary Healthcare (DPHC) and a local pharmacy.

The practice is open from 08:00 hours to 16:30 hours Monday to Thursday and from 08:00 hours to 16:00 hours on a Friday. Between 16:30 hours and 18:30 hours cover is provided by Nelson Medical Centre. Outside of these hours, including weekends and bank holidays, cover is provided by NHS 111.

The staff team

Civilian Senior Medical officer (SMO)	1
Regimental Medical Officer (RMO)	2
Practice manager (civilian)	1
Nurses	2 (1 locum)
Exercise rehabilitation instructors (ERI)	1
Physiotherapists	1

Administrators	2
Combat medical technicians* (CMTs) (referred to as medics throughout this report)	8

*In the army, a medical sergeant and CMT 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 medical centres but with a broader scope of medical centre.

Are services safe?

We rated the practice as good for providing safe services.

Previously the practice was rated as requires improvement in the safe domain. This was in relation to the management of risk, insufficient numbers of clinical staff, staff induction, the medicines management system, including the management of patient safety alerts, and the monitoring of medicine expiry dates.

At this inspection we saw improvements had been made. However, risks due to reduced numbers of clinical staff remains a concern.

Safety systems and processes

A Regimental Medical Officer (RMO) was the lead for safeguarding and the Senior Medical Officer (SMO) was the deputy lead. All staff had received up-to-date safeguarding training at a level appropriate to their role. The nursing team had recently introduced HARK screening (Humiliation, Afraid, Rape, Kick) when dealing with a suspected case of domestic abuse.

There was a risk register of vulnerable patients and a system to highlight them on DMICP (electronic patient record system). Regular searches were undertaken to inform the register of vulnerable patients.

The doctors had strong links with unit welfare teams, unit health committee and the local clinical commissioning groups (CCG) including attending CCG meetings at Nelson Medical Centre.

The status of safeguarding and vulnerable patients was discussed at the weekly meetings with the Welfare Officers. In addition, the needs of vulnerable patients were discussed at monthly Commander Monthly Health Review (CMHR) meetings. We spoke with the two Welfare Officers for the camp who told us they provided a welfare service to military personnel. They confirmed they had a good relationship with the practice and praised the responsiveness of the doctors when urgent intervention was required.
Notices advising patients of the chaperone service were displayed. Practice staff had undertaken face to face chaperone training. The practice information leaflet included a link to the chaperone policy. Consultation audits included a check that patient records indicated the offer of a chaperone. Staff who acted as chaperones had received a Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. We noted 3 DBS checks that had been applied for were still outstanding, all had been applied for in August 2022 but they still had not been received, this was documented in the risk register and each individual had an individual risk assessment raised. The practice manager agreed to chase these up. The practice carried out staff checks, including checks of professional registration where relevant, at recruitment and on an ongoing basis.

The Band 6 nurse was the lead for infection prevention and control (IPC) and had completed the link practitioner training. All staff had completed for IPC training. Audits of IPC were undertaken every 6 months.

A contract was in place for environmental cleaning. Cleaning staff cleaned all areas of the medical centre and PCRF every evening, with additional cleaning of nurses clinical rooms and toilets at lunchtimes. 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 December 2022.

Acupuncture was not currently provided by Primary Care Rehabilitation (PCRF) staff. However, up to date risk assessments and SOP were present with sharps boxes in date.

Risks to patients

From a patient perspective, clinical staffing levels were sufficient as patients interviewed told us they had prompt access to a clinician. Waiting times for an appointment with a clinician confirmed this. However, there were potential risks with the capacity and consistency of clinical and administrative staffing levels with no long-term plan to remedy this. Regimental Aid Post (RAP) staff were available to support the delivery of primary healthcare but this fluctuated due to unit commitments. The SMO was the only doctor at the practice whilst the RMOs were deployed. The Band 6 nurse was the only permanent nurse, a locum nurse had been recruited on a rolling a 3-month period but there was little resilience to cover staff sickness or annual leave.

All staff, including locums, completed the Defence Primary Healthcare (DPHC) induction. The practice retained copies of competed induction packs.

An automated external defibrillator (AED) was available and all staff were clearly able to identify where it was located. Oxygen and emergency medicines were stored safely. There was an additional AED situated in Exercise Rehabilitation office, this was well signposted throughout the PCRF and gym as to its location.

Panic alarms were installed in the gym and all clinical rooms, these were linked to the medical centre for emergency use. Portable panic alarms were also available in clinical rooms and gym space for emergency use.

The arrangements in place to check and monitor the stock levels and expiry dates of emergency medicines were effective. The practice staff were fully trained in emergency procedures, including basic life support and the use of an AED and anaphylaxis training. Staff had recently completed thermal/climatic injury training and sepsis training. Training in emergency scenarios took place. The next planned training was in caring for the patient suffering with Anaphylaxis (life threatening severe allergic reaction).

The practice was working to a COVID-19 risk assessment. There was a protective screen at reception and hand sanitiser was available for staff and patients.

Waiting patients could not be observed at all times as the CCTV was not working. This had been identified and addressed by the practice and work was due to begin to fix the problem. In the meantime, we were told that the reception staff frequently checked on patients in the waiting room.

There was a dedicated resuscitation area located at the bottom of a corridor and had curtains to provide privacy. The practice manager and administrator’s offices were next to

this area where all suspected or COVID-19 positive were assessed. Staff assured us their doors would be closed if a patient was being treated.

Information to deliver safe care and treatment

A standard operating procedure (SOP) was in place to ensure summarisation of patients' records was undertaken in a safe and timely way; 94% had been completed. Patients registering at the practice completed a new patient questionnaire, which was submitted to the nursing team for scrutiny and summarising. This process identified any actions that required follow up.

Peer review of doctors DMICP consultation records was undertaken regularly and a consistent methodology was used. There was evidence of patient handovers between clinicians. Combat medical technicians (CMTs) supervision was carried out by the RMOs. Access to the CMT electronic task books was evidenced. It was the role of the duty doctor to check the DMICP records of any urgent cases the CMTs had seen that day. However, this responsibility was not formally documented in the terms of reference or peer review SOP. We looked at 4 CMT consultations conducted in January and we identified 3 consultations documenting symptoms or clinical observations that ought to have prompted referral to a doctor for review. The DMICP numbers for these patients were provided to the SMO during the inspection so follow up actions could be taken. Following the inspection, we received an updated SOP giving clear direction regarding the supervision requirements of CMTs when seeing clinical patients and all the doctors were aware of this.

A failsafe process was in place for the management of specimens. A record was maintained of all samples sent so when results were returned, they could be tracked and any missing results identified.

Staff confirmed that access to patient records was only occasionally a concern and did not pose a significant risk to continuity of patient care. In the event of a DPHC wide outage, the practice would revert to seeing emergency patients only. Hard copy forms were held in the practice for use in this scenario and documentation would be scanned onto DMICP when available.

There was a failsafe system in place to manage referrals. In the absence of an administrator the CSMO was responsible for this. The majority of external referrals were made via the NHS electronic referral system (eRS). The RMOs was also able to describe the process should they need to deputise in the absence of the CSMO. A referrals tracker with limited access was maintained and two week wait and urgent referrals were highlighted to be easily visible.

Safe and appropriate use of medicines

The SMO was the practice lead for medicines management. Dispensing was outsourced to a local pharmacy. Procedures for the safe management and storage of vaccines, medical gases, and emergency equipment were in place.

Arrangements were established for the safe management of controlled drugs (CD), including destruction of unused CDs. We saw that monthly and quarterly checks were completed.

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

All prescription pads were stored securely.

Patient Group Directions (PGD) had been signed off to allow appropriately trained staff to administer medicines in line with legislation. Medicines that had been supplied or administered under PGDs were in-date.

Patient Specific Directions (PSD) were also being used and we saw that details of medicines and patients being administered within a PSD had been maintained and staff competency was up-to-date. We reviewed 5 sets of patient's notes from August 2022 to November 2022 that identified several errors including medicines documented as authorised on DMICP 3 weeks prior to being used and PSDs showing no specific vaccination detail. Staff attended a PSD education session provided by DPHC overseas lead pharmacist in December 2022 and review of 2 sets of notes following this session showed full compliance.

Requests for repeat prescriptions were managed in person or by email in line with policy. 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.

We saw evidence to show that patients medicines were reviewed regularly. The doctor's notes in DMICP were comprehensive.

The practice followed the DPHC protocol and local SOP for high risk medicines (HRM). The SMO carried out regular searches to identify patients on HRMs. We reviewed 3 sets of patients records who were prescribed HRMs and all were subject to a shared care agreement with secondary care. Medication reviews were in date in all cases with hospital prescribed medication listed on the medication screen and alerts added. For those where primary care monitoring was required, blood tests were in date and actioned appropriately.

The register of HRMs used at the practice was held on DMCIP and all doctors and relevant clinicians had access to this.

Track record on safety

The practice manager was the designated health and safety lead and a board was displayed near the reception and was regularly externally audited. Measures to ensure the safety of facilities and equipment were in place. Electrical and gas safety checks were up to date. Water safety measures were regularly carried out with a legionella inspection undertaken in February 2021. A fire risk assessment of the building was undertaken annually. Firefighting equipment tests were current. Staff were up-to-date with fire safety training and were aware of the evacuation plan.

We looked at the practice's arrangements for the provision of a safe service. A risk register was maintained that took account of the 'four T's' (transfer, tolerate, treat, terminate) to clearly indicate where and how risks were being managed. Risk was discussed as part of

the practice governance meeting which was held twice monthly. Insufficient staffing was the main risk and was articulated on the register.

The PCRF facilities were well provisioned to meet the specific needs of the patient population. A range of physical training, rehabilitation and medical equipment had been procured and was managed within servicing agreements. A faults register was in place and any work needed had been undertaken. Risk assessments were in place. Wet-bulb globe temperature (WBGT – a heat stress index) readings were taken in hot weather and activity managed accordingly.

There was an integrated alarm system in place throughout the practice and this was regularly tested.

Lessons learned and improvements made

Significant events and incidents were reported through the electronic organisational-wide system (referred to as ASER) in line with the DPHC ASER policy. A local ASER SOP was in place. All staff had access to the ASER system for recording and acting on significant events and incidents. The staff training database showed that all staff had received up-to-date training. The healthcare governance meeting minutes included details of the ASER and the lessons learned as a result. It was clear from the minutes the nature of the incident, any actions taken as a result, and details of whether duty of candour was applied.

The practice had a good system in place to distribute Medicines and Healthcare products Regulatory Agency (MHRA) alerts. The CAS (Central Alerting System) alert log was held on health governance workbook including detail of action taken. Alerts were also discussed at the practice meeting as a standing agenda item.

Are services effective?

We rated the practice as good for providing effective services.

Previously the practice was rated as requires improvement in the effective domain. This was in relation to staff training, the system for discussing and recording relevant and current evidence-based guidance and standards and the underdeveloped quality assurance processes.

At this inspection we saw improvements had been made.

Effective needs assessment, care and treatment

Clinical staff had a forum to keep up to date with national clinical guidance, including National Institute for Health and Care Excellence and the Scottish Intercollegiate Guidelines Network current guidance. We saw evidence to show Nice guidelines on gestational diabetes, had recently been reviewed.

The Defence Primary Healthcare (DPHC) team produced a newsletter that was circulated to clinicians providing further information and a summary of relevant safety updates. The regional nursing advisor sent out weekly updates that included any new guidelines.

Primary Care Rehabilitation Facility (PCRF) staff were familiar with Department of Defence Rehabilitation Guidance and provided examples of treatment provided based on evidence-based guidelines and care pathways. The PCRF used Rehab Guru (software for rehabilitation exercise therapy) and, if appropriate, was documented in the clinical records we looked at. The PCRF had 2 treatment rooms and gym. The space and equipment available was bespoke to meet patients' needs. There was a big focus on health promotion, including diet, injury and nutrition. The ERI was studying MSc in sports nutrition bringing these additional skills and adding into injury prevention and recovery for patients.

Monitoring care and treatment

We found that chronic conditions were managed well. Standard operating procedure (SOPs) outlining the management and monitoring arrangements for long term conditions were in place. Monthly searches were run by the Senior Medical Officer (SMO). Patients were recalled by letter or email and followed up by a telephone call if needed.

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

There were very low numbers of patients on the diabetic register and their care indicated positive control of both cholesterol control and blood pressure. Patients at risk of developing diabetes were identified through the over 40's screening, which included relevant testing (HbA1c -average blood glucose (sugar) levels). There were low numbers of patients recorded as having high blood pressure. All were recorded as having a blood

pressure check in the past 9 months. There were low numbers of patients with a diagnosis of asthma and all had an asthma review in the preceding 12 months.

Audiology statistics showed 95% of patients had received an audiometric assessment within the last 2 years.

Through review of clinical records and discussions with the doctors, we were assured that the care of patients with a mental illness and/or depressive symptoms was being effectively and safely managed, often in conjunction talking therapies, charities and with the Department of Community Mental Health.

An audit log was in place and all staff participated in the quality improvement programme. A wide variety of clinical audits were in place and more than one cycle had been undertaken for most. Examples of recent audits included high risk medicines, prescribing, pathology and health promotion. We saw a recent audit had been completed to check if screening had been undertaken for patients with chronic kidney disease (CKD). The audit showed initially there was poor compliance, following the audit we saw 90% of patients with CKD had been recalled and had the appropriate testing and review.

PCRF audit work was an integral part of the medical centre audit programme. Recent audits included infection prevention and control, disability access audit and a clinical notes audit. We saw evidence that findings had been recorded in the healthcare governance workbook and was fed back at practice meetings, the work had led to clear improvements in patient care delivery.

Effective staffing

All staff completed the DPHC mandated induction. Much work had been done to further develop this for new staff to be more role specific. Mandated staff training was monitored, and all staff were up to date.

The SMO, PCRF staff and nurses had the appropriate skills for their role and were working within their scope of practice. Clinical staff kept up to date with their own continual professional development and revalidation. Performance appraisals were conducted by line managers for all staff. All doctors were in date for appraisal and all doctors and nurses had completed timely revalidation. A peer/notes review for PCRF staff and GPs had been completed.

A nurse colleague at a neighbouring medical centre had recently introduced clinical supervision for the nursing team within the Primary Care Network. These occurred monthly/bimonthly on a Tuesday afternoon. The locum nurse was also invited, but it was not always possible for them to attend. The nursing team met regularly on an informal basis to discuss best practice issues.

Internal and external training sessions were available to staff. For example, the practice manager was had recently completed the Institute of Occupational Safety and Health course.

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

Coordinating care and treatment

The practice met with welfare teams and line managers to discuss vulnerable patients. Staff told us that they had forged some good links with other stakeholders, including the local NHS, social services and voluntary organisations.

For patients leaving the military, pre-release and final medicals were offered. During the pre-release phase the patient received an examination and a medication review. A summary print-out was provided for the patient to give to the receiving doctor, and a letter if the patient was mid-way through an episode of care. A structured mental health questionnaire was also completed.

Patients were referred to the multi-disciplinary injury assessment clinic when required and staff commented that the wait to be seen was currently around two months. We noted that multi-disciplinary discussion took place for any patients awaiting assessment and that this involved physiotherapists, ERIs, doctors and nurses. Patients were offered interim support to manage any injury in the interim and Chain of Command were made aware if personnel needed to be downgraded whilst they awaited assessment and treatment.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred or after they were discharged from hospital. Information was shared between services and we saw that a full copy of findings from investigations and any further treatment requirements were sent to the practice to update the patient's records.

Patients who were considered vulnerable were discussed at least monthly in multi-disciplinary meetings. Those moving to new units were handed over as part of a case conference with the receiving unit (clinicians from both units also attended this and additional clinical handover took place if required). Monthly vulnerable adult searches were cross checked with the vulnerable adults register to highlight any patients who had deregistered with the practice to identify any who might have been missed.

Patients with complex needs under the care of the PCRF were discussed at 2 weekly meetings with the Regional Rehabilitation Unit at Portsmouth, this included a sports medicine consultant and a physiotherapist.

Helping patients to live healthier lives

One of the nurses was the lead for health promotion. We saw information leaflets were available in the treatment rooms. There were notice boards located in various places around the practice, some example topics covered included, sepsis, smoking, alcohol and safeguarding.

The nurse had the appropriate sexual health training and provided sexual health support and advice. Patients were signposted to local sexual health services for procedures not undertaken at the practice.

All eligible female patients are on the national cervical screening database and were recalled by the nurse. The latest data confirmed a 93% uptake. Regular searches were undertaken to identify patients who required screening for bowel, breast and abdominal aortic aneurysm in line with national programmes. At the time of the inspection, there were

a small number of patients identified that met the criteria for bowel screening. Alerts were added to their DMICP record which allowed for opportunistic discussion with a health professional. DMICP searches had been created for all national screening.

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

- 96% of patients were in-date for vaccination against polio.
- 85% of patients were in-date for vaccination against hepatitis B.
- 87% of patients were in-date for vaccination against hepatitis A.
- 91% of patients were in-date for vaccination against tetanus.
- 95% of patients were in-date for vaccination against MMR.
- 92% of patients were recorded as being up to date with vaccination against diphtheria.

Consent to care and treatment

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. They understood the Mental Capacity Act (2005) and how it would apply to the population group.

Clinicians advised us that implied consent was accepted for basic procedures such as the taking of blood pressure. Written consent was taken for more intimate examinations and this was regularly audited. The last audit showed compliance of 61.3%; a second audit cycle showed improvement to 89%. A chaperone audit was also completed that identified not all staff had documented the offer of a chaperone. Following this all staff were made familiar with the policy, an annual repeat of the audit evidenced improvement.

Are services caring?

We rated the practice as good providing caring services.

Kindness, respect and compassion

We spoke with 2 patients on the day of the inspection and 10 patients by email after the inspection. They all described their care as good and all said staff were patient, friendly and kind. In addition, the results from the patient experience survey undertaken in November and December 2022 showed 31 patients described their healthcare provided by the medical centre as excellent or good (30 excellent).

Patients were offered a private room if they wanted to discuss something in private or appeared distressed.

We interviewed the majority of staff working in the medical centre at the time of the inspection. All staff told us that the medical centre was a happy place to work and that they could rely on their work team to discuss and mitigate any concerns they faced. They spoke about colleagues who were supportive, compassionate and caring.

Involvement in decisions about care and treatment

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

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).

Patients identified with a caring responsibility were captured on a DMICP register, it included what had been discussed at the monthly practice/clinical meeting and any actions identified. The practice has a practice leaflet which included information for carers.

Staff explained that they occasionally saw patients who spoke English as a second language. They could access a translation service if they needed it. Staff told us about a recent instance where ‘The Big Word’ was used to provide a translation service during consultation.

Privacy and dignity

Patients who provided feedback about the service said their privacy and dignity was met at the practice.

All consultations were conducted in clinic rooms with the door closed. All clinical rooms had a separate screened area for intimate examinations.

The waiting room had a television on so that conversations from reception could not be overheard.

The practice only had male doctors and a female nurse; patients were offered a chaperone routinely. Patients had access to a clinician of their preferred gender at Nelson Medical Centre if required. Similarly, the ERI and physiotherapist were both male, patients were given the option to see a female physiotherapist at Nelson if they required, this was offered at the time of them booking their appointment.

Are services responsive to people's needs?

We rated the practice as good for providing responsive services.

Responding to and meeting people's needs

The practice understood the needs of its patient population and tailored services in response to those needs. Appointments slots were organised to meet the needs of specific population groups. Telephone consultations and eConsult appointments were alternative options for patients who required an appointment.

The practice was constantly ready to respond at very short notice to the occupational needs of patients who needed to deploy. Additional clinics were arranged at short notice in order to ensure that personnel could deploy at short notice. Patients and unit staff we spoke with confirmed how valuable this response was to support operational capability.

An Equality Access Audit as defined in the Equality Act 2010 was completed for the premises in November 2022 and no significant concerns were identified. There was no hearing loop but the practice stated that they had no patients on their register with hearing impairment.

The lead for diversity and inclusion was the practice manager, they had good links with the Unit diversity and inclusion lead. There was an information board in the practice providing information for staff and patients.

Timely access to care and treatment

Details of how patients could access the doctor when the medical centre was closed were available through the base helpline. Details of the NHS 111 out of hours service was outlined in the practice information leaflet.

Urgent doctor and nurse appointments were available on the day. Routine doctor appointments were available within 2 working days. Routine appointments to see a nurse were available within a few days.

Daily walk-in gym clinics were available in the PCRF and were arranged at different times to meet the shifts and working patterns of the patient population. Direct Access Physio (DAP) clinics were also accessible for patients. Patients we spoke with reported using the direct access clinic and that they had found it beneficial to them.

Rapid access to PCRF support was available with patients being seen well within the key performance indictors (within 1 day for acute referrals and within 5 days for routine referrals). A routine physiotherapy appointment was available within 5 days, a follow-up appointment within five days and an urgent appointment facilitated on the next day. For the ERI, a new patient appointment was available within 3 days and follow up appointment could be accommodated within three days.

Outside of routine clinic hours, cover was provided by the doctors from Nelson Medical Centre up until 18:30 hours. From then 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).

We spoke with 12 patients who had recently received care from the staff at the practice. They all told us that they could secure appointments when they needed them and were confident that they would be seen quickly if they had an urgent concern.

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 implemented a process to manage complaints in accordance with the Defence Primary Healthcare complaints policy and procedure. The process included the recording of both written and verbal complaints.

There had been 3 complaints received within the past 12 months and all 3 had been managed comprehensively and in accordance with policy.

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 good for providing well led services.

Previously the practice was rated as requires improvement in the well-led domain. This was in relation to the management of risk and governance processes that required strengthening. We found at this inspection that improvements had been made.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care. Their mission statement was;

> ” The Medical Centre will provide a comprehensive and professional service encompassing primary medical care, force protection (medical), medical examinations including occupational, aviation and underwater medicine. Provision will be flexible and responsive, tailored to the needs of the individual, Unit and Air Defence Group.”

Staff were aware of and understood the vision, values and strategy and their role in achieving them.

From our review of clinical care, including access to patient records and interviews with both patients and staff, we found practice staff were committed to delivering effective patient care. This focus showed patients were at the centre of practice delivery

Leadership, capacity and capability

Both the Senior Medical officer (SMO) and the practice manager were civilians and provided consistent leadership for the practice. We talked with the Regimental Medical Officers (RMO) throughout the day and they had a good understanding of the roles and responsibilities the Senior Medical Officer (SMO) undertook and demonstrated a good knowledge of these (including responsibilities such as referral tracking). The RMO was able to demonstrate that they had access to the key documents required to deputise these roles if required, for example in the event of short notice sickness absence). The nursing team were well supported by all doctors in the practice.

The practice had a strong leadership strategy and vision that all staff championed. The team were committed to delivering the best care through a culture of constant learning and improvement. They had a positive attitude towards learning from planned activity, experience, and feedback. There were ongoing quality improvements evident that were driven by the team, this was demonstrated by the improvements made since the previous CQC inspection. A business plan had been developed to drive healthcare governance performance over the next 12 months. There were plans underway for Thorney Island Medical Centre to become part of a bigger group practice; the practice priorities would be further developed once this was embedded.

Culture

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

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

We heard from staff that the culture was inclusive with an open-door policy with everyone having an equal voice, regardless of rank or grade. All were familiar with the whistleblowing policy and said they would feel comfortable raising any concerns.

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

Governance arrangements

The healthcare governance workbook (HGW) was the overarching system used to bring together a range of governance activities, including the risk register, ASER tracker, training register, standard operating procedures, quality improvement activity (QIA) and complaints.

Communication across the practice was strong and an appropriate meeting structure and healthcare governance approach was in place. This included regular clinical, practice, healthcare governance and unit healthcare committee meetings, chronic disease, safeguarding and Primary Care Rehabilitation Facility (PCRF) meetings.

The PCRF contributed to the medical centre's eHAF (Healthcare Assurance Framework) document which was reviewed with the PCRF regularly. The PCRF were involved in all key relevant meetings. The PCRF also attended the Regional Rehabilitation Unit (RRU)training sessions and the lead physiotherapist attended the RRU meetings.

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

Managing risks, issues and performance

The leadership team was mindful of risks to the service. The main risks identified were staffing levels/recruitment. During the inspection the SMO referred frequently to a lack of resilience in the service given the current size of the service and that this was set to increase further with limited staff.

Strategies were in place to ensure enough clinical cover was in place. For example, the SMO coordinated their annual leave around the availability of the RMOs.

There was a current and retired risk register on the HGW along with current and retired issues. The register articulated the main risks identified by the practice team including. The registers were regularly reviewed. There were a range of risk assessments in place including both clinical and non-clinical risks. The assessments included lone working, sharps safety and health and safety. There were processes were in place to monitor national and local safety alerts, incidents, and complaints.

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

All staff were in date for 'defence information passport' and 'data security awareness' training. When a member of staff left, smart cards were returned to the guard room and they were removed from having access.

Processes were in place for managing staff under-performance including external support for clinicians.

Appropriate and accurate information

The eHAF commonly used in Defence Primary Healthcare services to monitor performance is an internal quality assurance governance assurance tool to assure standards of health care delivery within defence healthcare. The practice manager referred to the eHAF to monitor the practice.

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

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

Engagement with patients, the public, staff and external partners

There were systems in place to encourage patients to provide feedback on the service and contribute to the development of the service. Patient experience surveys were also uploaded directly to Governance Assurance Performance and Quality (referred to as GPAQ). The most recent request to feedback via this route had no responses for the month of January. However, we did speak with 12 patients all of who spoke highly of the care they received from the team at the practice and of the kindness of staff.

Good and effective links were established with internal and external organisations including the Welfare Officer, Regional Rehabilitation Unit, Defence Primary Healthcare and local health services.

Continuous improvement and innovation

The medical centre team had worked extremely hard following last CQC inspection to advance and make improvements in all areas. Staff were highly motivated, given the challenges they have faced and continuous risk of staffing deficits. For example, significant improvements had been made to healthcare governance and the practice manager actively sought specialist support (via a regional specialist advisor) to upgrade working practices.

The practice had considered many options for further improvements, such as implementing a business development plan and a detailed training schedule to include scenario-based exercises.

To promote morale, education and integrated working relationships the practice arranged for the General to deliver a motivational speech addressing areas such as how to have a positive mindset within the workplace including how to remain focused and motivated in difficult situations. Also arranged is for an elite female cyclist (Army soldier) who was injured badly in an accident in America to deliver a motivational speech on adversity and triumphs following their accident.

The practice manager and one of a sergeants have sourced ‘high performance podcasts’ for all staff to listen to, both military and civilian – presently they are listening to Jake Humphrey’s High Performance podcast series which had inspired the team to help drive and improve performance. This was well received by staff and more will be incorporated into the 2023 training schedule.

Direct Access Physiotherapy has been a real success for the PCRF. Using an urgent on the day setup has been very well received by patients. The PCRF had linked in with the regional occupational health department as muscular skeletal and mental health were the two main reasons for downgraded personnel. Together they completed combined, ergonomic assessments and accessed visits both on camp and at other locations. Having a direct link with the occupational health department allowed for detailed planning on return to work program time frames and predicted recovery times.