Neptune Medical Centre

HM Naval Base Clyde, Faslane, Helensburgh, Argyll & Bute G84 8HL

Defence Medical Services inspection report

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

Overall rating for this service	**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**	●

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Summary

About this inspection

We carried out this announced comprehensive inspection on 21 March 2023.

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

Are services safe? – good

Are services effective? – good

Are services caring? – good

Are services responsive to people's needs? – good

Are services well-led? – good

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

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

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

- A samples and test results information leaflet had been developed and was given to patients. It provided clear detail about the process, including a guide to the length of time for return of various tests results and next steps once results were reviewed. This meant patients were clear about the timeframes to expect results.

- The practice worked in an integrative way with the Department of Community Mental Health (DCMH). The DCMH had a long waiting list so this collaborative working meant patients with mental health needs were safely supported as they were reviewed by their doctor every 4 to 6 weeks. Two-weekly meetings between the DCMH and practice doctors facilitated review of patients on the waiting list and discussion of new patients presenting with mental health needs to establish which service could best support their needs. If a patient's risk increased then they were given a higher priority on the DCMH waiting list. The DCMH team was available to provide practice doctors with guidance about managing patients, including prescribing. The 2 weekly meetings were also used to facilitate training in mental health issues for the doctors.

At this inspection we found:

- Feedback showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.
- There was scope for the practice to consider various options to prompt an increase in patient feedback.
- Processes were in place to provide flexible access and services to both patients and staff with a caring responsibility.
- The practice was well-led and the leadership team demonstrated they had the vision, capability and commitment to provide a patient-focused service and consistently sought ways to develop and improve.
- The practice worked collaboratively with both internal and external services including the satellite service, Kentigern House Medical Centre, the base units, Personal Support Group and local NHS services.
- The practice worked in an integrative way with the Department of Community Mental Health to maximise patient safety and ensure patients received ongoing support.
- There was an open and transparent approach to safety. An effective system was in place for managing significant events and staff knew how to report and record using this system.
- Patients received their medicines on time and in a safe way. There was scope to improve the governance in relation to how medicines were managed.
- The premises was clean and appropriate measures were in place to minimise the risk of infection. Clinical waste was managed well.
- There was an ethos of training and workforce development, reflected in the range of trainee placements. Trainees received effective support and supervision.
- Quality improvement activity was embedded in practice and was used to drive improvements in patient care. Successful patient-focused service changes had been made but had all not been recorded as quality improvements.

The Chief Inspector recommends to the practice:

- Ensure all emergency medicines are included in the monthly checks.
- Prioritise the planned audit of high risk medicines.
- Formalise the patient recall process for patients with abnormal test results and those who require repeat testing.
- Ensure the internal checks of controlled drugs are consistently undertaken in accordance with organisational policy.
- Review how quality improvement work is co-ordinated to ensure there is a systematic approach and that all quality improvement work, including clinical audits, are captured on the audit register.
- Put in place a structure for the auditing of nurses' clinical record keeping.

- Consider options to increase patient feedback about the service.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

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

Our inspection team

The inspection was led by a CQC inspector supported by a team of specialist advisors including a primary care doctor, a practice nurse, pharmacist, and a practice manager. A CQC administrator also supported with the inspection. We were unable to secure a physiotherapist specialist advisor, so the physiotherapy and rehabilitation service was not included in the inspection. The lead inspector interviewed patients by telephone on 16 and 17 March 2023.

Background to Neptune Medical Centre

Located in HM Naval Base Clyde, the largest military establishment in Scotland, Neptune Medical Centre provides a primary healthcare, occupational health, force protection and rehabilitation service to a patient population of 4,300. The practice supports a wide range of units and services including those based ashore, afloat and tenders (small ships). It also provides a service to a small transient population. There is a dispensary at the practice and a Primary Care Rehabilitation Facility (PCRF) is located on the base. The dental centre and Department of Community Mental Health are co-located with the medical centre.

The practice is open Monday to Thursday from 07:45 to 16:30 hours and on Friday from 07:45 to 12:00 hours. Duty staff are available daily from 07:00 to18:00 hours to respond to patients with an urgent medical need. NHS 24 provides access to urgent health care when the medical centre is closed.

Located in Glasgow, Kentigern House Medical Centre, a satellite service of Neptune Medical Centre, was inspected in November 2022 and was rated good overall and across all the key questions in accordance with CQC's inspection framework.

The staff team

Doctors	Military Principal Medical Officer Military Deputy Principal Medical Officer (Neptune) Military Deputy Principal Medical Officer (Submarines) Civilian medical practitioner x 3 General Duty Medical Officer x 2 GP (stage 3) trainee x 1
Business support manager	Civilian executive officer
Practice manager	Military Chief Petty Officer
Nurses	Civilian Band 7 advanced nurse practitioner Civilian Band 6 practice nurse Civilian Band 5 practice nurse **Vacancy** for civilian practice nurse x 2
Administrative officers	Civilian administrative officer x 6 **Vacancy** for civilian administrative officer x 1
Pharmacy Technicians	Civilian Band 5 pharmacy technician x 2
Physiotherapists	Civilian Band 7 Civilian Band 6
Exercise Rehabilitation Instructors	Civilian Band 5 Military Leading Hand **Vacancy** for Petty Officer x 1
Royal Navy Medical Assistants	Petty Officer x 3 Leading Hand x 5 Able Rating x 6 Trainees (Consolidation Training Period) x 2 **Vacancy** for Petty Officer x 1

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

One of the doctors was identified as the lead for safeguarding and vulnerable adults at the practice. In the absence of the lead, staff had access to the safeguarding lead and deputy at Kentigern House Medical Centre. All staff had access to the safeguarding adult/child policy that included details of local area safeguarding arrangements and contacts. Last reviewed in August 2022, staff were informed of safeguarding policy updates by email.

We identified gaps in safeguarding training as records showed a small number of staff had either completed level 3 child or level 3 adult safeguarding but not both. Although evident the practice had followed safeguarding training requirements outlined in the Defence Primary Healthcare (DPHC) mandatory training policy (June 2022), we noted the policy was ambiguous and did not seem in accordance with national intercollegiate safeguarding guidance. Since the inspection, the practice has made the decision for all registered clinicians to complete level 3 (child and adult) training to eliminate ambiguity within the policy at a practice level. In addition, we have asked DPHC for clarification on the policy.

Vulnerable patients, including those under the age of 18, were identified in various ways, such as DMICP (patient electronic record) monthly searches, by clinicians during consultations and through the summarisation of records. In addition, one of the doctors represented the practice at the fortnightly unit Personnel Support Group meeting at which the service personnel vulnerable due to their circumstances were discussed. Alerts were applied to records for patients assessed as vulnerable and a practice vulnerable patients register was maintained. The register was reviewed each month at the clinical meeting.

The practice had developed relationships with the local NHS primary care practice so any concerns identified regarding children of registered patients was raised with local GP/NHS services.

A chaperone policy was in place along with a list of trained chaperones. Notices informing patients of the availability of a chaperone were displayed. Shortly after the inspection, the practice revised the policy to include the chaperone clinical codes for clinicians to use.

Although the full range of recruitment records for permanent staff was held centrally, the practice could demonstrate that relevant safety checks were in place including Protecting Vulnerable Groups (PVG/Disclosure Scotland) certificates to ensure staff were suitable to work with vulnerable adults and young people. Obtaining PVG checks in a timely way when staff moved to work in Scotland was a challenge. The issue had been added to the risk register as a transferred risk to Regional Headquarters (RHQ). Any staff awaiting a PVG certificate had an equivalent current English Disclosure and Barring Service check. This included medical staff from 2 units who worked periodically from the medical centre to maintain clinical currency.

The professional registration status for staff was identified on the staff database for monitoring purposes. However, we noted that civilian exercise rehabilitation instructors (ERI) were not included. In accordance with organisational policy, ERIs are required to

have professional membership with the British Association of Sport Rehabilitators and Trainers. The practice manager added confirmation of the ERIs professional membership to the database after the inspection.

An infection prevention and control (IPC) policy was in place and one of the practice nurses was the lead for IPC. The IPC audit completed in June 2022 showed good compliance and the actions identified had been addressed. In relation to COVID-19, masks were worn when new patients presented as unwell and if anyone presented with flu symptoms. Staff also had the option to wear a mask if they chose to do so.

A contract was in place for environmental cleaning and the IPC lead had a good relationship with the cleaning supervisor. A cleaning schedule was in place and there was evidence that deep cleaning had been carried out.

A lead was identified for the management of clinical waste. Arrangements for the management of clinical waste included clear labelling, a waste register and waste transfer notes. Consignment notes were accessible on-line via the contractor's portal. Clinical waste was stored in a secure area of the building. A clinical waste audit had been completed. We noted one of the questions in the audit did not correspond with the business continuity plan (BCP) in the event that clinical waste was not collected. The practice manager said they would review and address this issue.

Risks to patients

All the patients we spoke with reported they could secure an appointment with a clinician promptly. Although there were clinical staff vacancies, notably in the nursing team, this had not had a direct impact for patients. The impact identified was with additional roles, such as capacity to carry out clinical audits and administrative tasks, such as record summarisation. The active staff planner and Monday meetings supported with reviewing staffing gaps each week so they could be effectively managed. Staff vacancies were captured on the risk register and the practice manager had liaised with RHQ regarding locum recruitment.

Locum staff completed the DPHC mandated locum induction programme on arrival at the practice. The programme had been modified to include the addition of role specific information.

Appropriate and sufficient medical emergency equipment and medicines was available at various points in the medical place, including oxygen and an automatic external defibrillator (AED). Recorded checks of the equipment were in place. We noted a list of the core medicines was not held on the emergency trolley. The practice addressed this deficit promptly after the inspection. Evidence indicated that the time expiry was not checked for all emergency medicines each month.

Overall, training in emergency procedures, including basic life support, anaphylaxis and the use of an AED was in-date for clinical and non-clinical staff; mitigating reasons were given for any gaps in training. Scenario-based training sessions were organised by the treatment room supervisor each Wednesday. We were provided with an actual example of a medical emergency from a patient's perspective and it was clear the practice acted promptly to ensure the patient was assessed and managed appropriately until the

ambulance arrived. In addition, we were given examples of other emergencies the practice had effectively managed, included those related to mental health.

Although not recorded, staff we spoke with were aware of the signs/symptoms of sepsis and confirmed they had completed sepsis awareness training. The 'General Practice Sepsis Screening and Action Tool' was displayed in clinical areas.

Continual supervision of Medical Assistants (MA) assessing and treating patients presenting on the day was overseen by a nominated clinician. Any patients appearing unwell to reception staff were flagged to the duty doctor. Clinical staff were working through eLearning heat injury prevention training and 14 staff had completed the training at the time of the inspection.

The practice was responsible for the health of the crew on ships. There was no medical support on the ships. The Lead Diver acted as the MA and had level 3 first aid training. A dedicated MA provided reach-back and the ships had access to the duty doctor. The MA was also responsible for ensuring the occupational health needs of crews was up-to-date, including vaccinations and audiology. There were various options in place to respond to a medical emergency at sea including contacting the coast guard, contacting the military base in Bahrain and the aeromedical service. We were informed that medical emergencies at sea were a rare occurrence.

Information to deliver safe care and treatment

In the event of an IT outage impacting DMICP access, staff referred to the BCP. Staff advised us that a DMICP outage happened occasionally. In the event of an outage, each clinic was reviewed and non-urgent appointments were re-scheduled accordingly. Only patients with an urgent need would be seen during this period. As a backup, reception staff printed the next day's clinic lists each evening in the event of an outage. Paper copies of consultation documentation were used by clinicians and scanned onto DMICP once the system was restored. If DMICP was compromised for several days, the practice had the option to relocate to Kentigern House Medical Centre in Glasgow and/or Edinburgh Medical Centre. Alternatively, patients could be offered a telephone consultation.

One of the Deputy Principal Medical Officers (DPMO) was the lead for the summarisation of patient records. A clear process was in place for records scrutiny and summarisation for new patients registering at the practice. A quick response or QR code for access to new joiner medical forms was available at reception and also sent to all new personnel to the base. Once received back, treatment room staff coded the medical and vaccination data. This was then forwarded to the nursing team and, from there, to the doctor.

Due to a de-prioritisation during COVID-19, a recent practice audit identified that 85% of patient records were outstanding for 3-yearly summarisation. An SOP had been developed to manage the backlog. It involved an MA dedicated full time to completing part 1 scrutiny with the DPMO having oversight of all notes scrutinised. A plan was in place to assign a General Duties Medical Officer due to join the practice with part 2 of the summarisation process. The backlog with summarisation had been added to the issues register.

An audit of doctors' record keeping was completed in August 2022 and MAs' records in July 2022. There was evidence that the outcome of the audits were discussed and action taken to address gaps or emerging themes. A formal audit of nurses' records had not been

undertaken in the last 12 months. However, informal peer review took place between the nurses and we were provided with examples of case discussions that took place. We reviewed a wide range of DMICP records and found record keeping was of a good standard.

Unlike its satellite practice, Kentigern House Medical Centre, Neptune Medical Centre did not have access to electronic referrals via NHS Scotland SCI Gateway due to lack of connectivity. SCI Gateway is a national system in Scotland that integrates primary and secondary care systems. Therefore, referrals were managed by a dedicated staff team who provided cover in their absence. A comprehensive spreadsheet was maintained detailing whether the referral was internal or external, and clearly highlighted the urgent referrals. Differing processes were in place for external referrals depending on where the patient was referred to and staff provided a clear account of how each was managed. Due to delays with access to NHS secondary services, a process was in place to apply for funding for referral to private healthcare. The referral spreadsheet was monitored daily and a thorough process was established to ensure referrals were followed up. This meant the practice had very few occasions whereby patients did not attend their appointment.

An SOP was in place for the management of samples. Samples were sent by 12:00 hours each day and recorded on a spreadsheet. Receipt of the sample was confirmed by the laboratory. The spreadsheet was checked weekly to ensure results had been returned. If not, SCI Gateway was contacted. As the practice did not have full access to SCI Gateway, results were sent by mail, screened by the practice nurse, uploaded to DMICP and tasked to the doctor who requested the test. If abnormal, the result was flagged to the duty doctor.

The practice recognised that insufficient connectivity with SCI Gateway generating reliance on physical records for laboratory results, referral letters and other correspondence was a challenge and risked delay to patient care. This risk had been escalated to regional headquarters. In addition, limited access to SCI Gateway created additional administration work for the staff.

A samples and test results information leaflet was given to patients. It provided clear detail about the process, including a guide to the length of time for return of various tests results and next steps once the results were reviewed. It provided guidance for patients about what to do if they were due to deploy.

There was no formal process for the recall of patients with abnormal test results and those who require repeat testing for various reasons, such as a change in medicine or a lifestyle change. Without a consistent approach there is a risk patients could be missed. A formalised process also provides clinicians new to the practice with clear guidance about the circumstances in which patients are recalled for testing.

Safe and appropriate use of medicines

The Principal Medical Officer (PMO) was the lead for medicines management and the medical account holder. The 2 pharmacy technicians were responsible for the day-to-day management of the dispensary and this was reflected in their terms of reference.

The dispensary was secured when pharmacy technicians were not present. A local working practice protocol for out-of-hours access to the dispensary was in place. A process was in place to ensure security of the dispensary keys. We highlighted that

security could be enhanced by holding the dispensary code in a serialised tamper evidence bag.

Prescriptions (Fmed296) were stored securely in the dispensary and the serial numbers of the prescriptions documented in a bound book. Clear processes were in place for the issuing of prescriptions. They were issued by serial number and clinicians signed and dated receipt of the prescriptions. We discussed with pharmacy technicians the value of adding the signature/initials of clinicians to the FMed296 log.

The non-medical prescribing authority letter was out-of-date for an annual renewal. We were advised that it was with DPHC headquarters for sign off. An email trail provided confirmation until the letter was processed. Shortly after the inspection, the practice confirmed the signed authority letter had been received.

Patient Group Directions (PGD), which authorise practice nurses to administer medicines in line with legislation had been signed off. Nurses had completed the appropriate training and used PGDs for smoking cessation, yellow fever and vaccinations. PGD stock was checked each week and forwarded to dispensary staff to restock. We checked the PGD medicines and all were in-date.

Due to a reported near miss with Patient Specific Directions (PSD) for vaccinations, all medicines issued under PSD had ceased until the process was reviewed to ensure doctors had sufficient capacity to review PSDs before signing them. In addition, PSDs were planned to be re-introduced when staff, including dispensary staff, received training in the new PSD form and coding of checks. To maximise safety, MAs on the boats were no longer issuing vaccinations via PSDs as nurses were undertaking this task via PGD.

A process was established for the management of information about changes to a patient's medicines received from other services. Evidence of the Local Working Practice (LWP) for out of hours/secondary care medication changes was in place and a flow chart was displayed in the dispensary. In line with the LWP, any changes to a patient's medication by other services such as out-of-hours, hospital discharge letters and out-patient appointments were scanned onto the patient's notes and the nominated doctor tasked to action or review the patient. If notifications or changes were urgent, the patient was given an appointment to see a doctor for a medical review.

An SOP was in place for the management of repeat prescriptions. Through discussion with staff and a review of patient records, it was clear the SOP was followed correctly. We checked dispensed repeat prescriptions and found that all repeat prescriptions had been dispensed within 8 weeks, which indicated pharmacy technicians informed patients that their prescriptions were ready for collection. Uncollected medicines were returned to stock if not collected within 8 weeks.

A Population Management (referred to as Popman) system search indicated that 82% of patients on repeat medicines had not had a medication review with 62% of patients on 4 or more repeat medicines not having had a review. The PMO reviewed the search and confirmed medication reviews had taken place, evidenced by the dates amended on repeat medications and patient consultations with the doctor. The PMO suggested this discrepancy was likely related to the application of inconsistent clinical coding. They advised that a data cleanse was planned starting with the coding for patients on 4 or more medicines and then those with fewer repeat medicines.

The high risk medicines (HRM) register supported the safe and comprehensive management of some patients prescribed HRMs. However, further work by all clinicians

was required to ensure that the register was used as a tool to safely manage patients prescribed HRMs. Appropriate HRM and shared care alerts were raised on the patient's DMICP record, and timely blood monitoring had been undertaken. From the patient records we reviewed, shared care agreements were in place as required. We checked 10 DMICP records and there were concerns identified with a small number, notably in relation to coding and the patient's DMICP medicines list. Although an SOP was in place, the medicines management lead acknowledged after the inspection that it had not been followed consistently by clinicians. The lead confirmed that clinicians had since been informed by email of the medication coding process with a plan to further discuss the issue at the next clinical meeting. An HRM audit was planned to determine whether further intervention was necessary. In accordance with DPHC policy, the HRM register was revised shortly after the inspection to include additional medicines. Furthermore, the practice raised a significant event for the 2 patients identified with alerts for HRMs as the medicines supplied by secondary care were not identified on the DMICP medicines list.

The medicines, vaccines and medical consumables we checked were all in-date. A process was in place for the management of stock with the medicines having the shortest time expiry placed at the front of the shelf. Time expiry reports were run one month in advance and stock due to expire within the month was separated from the main stock to minimise the risk errors.

Medicines held at the dispensary were stored securely. Controlled drugs (potentially addictive and harmful medicines subject to regulation) were kept in an appropriate controlled drugs (CD) cabinet. We checked the stock and documentation and all was correct and accurate. The specimen signature log had been completed accurately by all those involved in the accounting of these medicines. Internal monthly checks had been completed but the checks for January and February 2023 were not in accordance with organisational policy (JSP950 9-2-1). An annual CD audit had been undertaken and an action plan developed.

From discussions with the pharmacy technicians, it was evident well defined processes were in place for the ordering and receipt of vaccines. All vaccines were in date and were routinely rotated in the fridge. There was sufficient space around the vaccine packages for air to circulate. The temperature of the pharmaceutical fridges were monitored twice a day and the external thermometers were in-date.

Valproate (medicine to treat epilepsy and bipolar disorder) searches were undertaken with the most recent in February 2023. The valproate pregnancy prevention programme information pack was available in the dispensary.

An antimicrobial audit was completed in August 2022 and indicated 95% compliance in line with local and national guidance. There was evidence that other medicines had been audited in 2022 and action taken as a result of the audits.

Track record on safety

A risk register, retired risk log and an issues log were in place. The practice used the '4 T's' (transfer, tolerate, treat, terminate) approach to manage risks. A range of regularly reviewed risk assessments were in place to support safe working practices, including for lone working and the management of COVID-19. Risk management was a standing

agenda item at the monthly practice meeting. The practice manager stated that no Control of Substances Hazardous to Health (referred to as COSHH) items were held at the practice.

The practice was unable to confirm when the last periodic electrical inspection took place as this was organised by the base. Portable appliance testing was completed annually and appliances were last tested in October 2022. An email was issued by the contractor stating the building held no individual gas appliances and was supplied from a central gas system which served the whole of the base. The practice had experienced disruptions to the central heating system as when one area of the system was interrupted then the gas supply line was shut down for the base. The practice had acquired several electrical heaters for the clinical rooms in the event of interruptions in the heating system. This issue regarding the central boiler was high on the agenda for the new Naval Base Commander to address.

A fire safety assessment was completed in February 2023 and no actions were identified. Checks of the fire system were undertaken monthly. Staff confirmed they participated in a fire evacuation drill within the last 12 months. A legionella risk assessment was undertaken in July 2022. The last water safety check was completed in January 2023 and no actions were identified.

A system was established for the management of all clinical/non-clinical equipment including an equipment maintenance register, faults log and equipment inspection log. An equipment assessment (referred to as a LEA) was undertaken in November 2022. The practice was working through the actions identified. A faults log was in place and periodic checks of equipment were undertaken. Clinical privacy curtains were changed every 6 months.

In the absence of an integrated alarm system, the practice used a ‘Red Alert Alarm Handheld System’, which was linked to the control panel situated within the main reception. During the inspection we activated the alarm in the practice manager’s office. After 5 mins there was no response to the alarm. On review of the dashboard in the reception it stated that the alarm had been activated in the ‘GF GDMO 1’ room. Practice staff had responded to the alarm but were unaware of this location and had canvassed the entire building in search for the location. The practice manager confirmed after the inspection that a doctor’s room had been reassigned as the practice manager’s office. The matter had since been rectified.

Lessons learned and improvements made

An internal assurance review in September 2022 identified that significant events were effectively managed with an open culture of learning and sharing lessons

Staff had access to the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events and incidents. ASER training was completed as part of the induction programme and refreshed as required. From interviews with staff and evidence provided, it was clear there was a culture of reporting incidents. Both clinical and non-clinical staff gave examples of incidents reported through the ASER system including the improvements made as a result of the outcome of investigations. A local ASER policy was in place and reviewed in March 2022.

One of the doctors was the lead for significant events and presented any events raised at the group practice meeting. A root cause analysis involving the relevant department/staff group was undertaken for each significant event.

An ASER register was maintained and included the agreed actions. We identified during the inspection that the register could be enhanced by minor improvements. Promptly after the inspection the practice manager actioned this, including clearly identifying whether a significant event was open or closed. In addition, a 'Learning from Experience log' was developed to capture lessons learnt identified from various sources including significant events, complaints and patient feedback.

An ASER audit had not been completed. After the inspection, the practice confirmed the audit programme had been up updated to include an ASER audit in line with the recently released (March 2023) 'DPHC Healthcare Audits SOP (9-6-1)'.

An effective system was in place for the management and action of alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). An up-to-date electronic MHRA alert register was in place and there was a system to manage the receipt, distribution and action taken regarding all alerts relevant to the practice. Staff were also informed of alerts through the DPHC newsletter.

Are services effective?

We rated the practice as good for providing effective services.

Effective needs assessment, care and treatment

Processes were in place to support staff to keep up-to-date with clinical developments including National Institute for Health and Care Excellence guidance, the Scottish Intercollegiate Guidelines Network, clinical pathways, current legislation, standards and other practice guidance. Staff were kept informed of clinical and medicines updates through the Defence Primary Healthcare (DPHC) newsletter. Topics from the newsletter were discussed at the weekly practice meeting.

New or updated clinical guidance relevant to the practice was discussed in detail at the monthly clinical meetings and action taken if appropriate. For example, a non-alcoholic fatty liver disease audit was being undertaken in response to guidance. Diving-specific guidance was forwarded to clinical staff for consideration at the diving Practice Based Small Group Learning (PBSGL) forum. Patients with complex needs, including those with a diagnosis of cancer, were reviewed at the clinical meetings.

Monitoring care and treatment

One of the doctors was the lead for the management of chronic conditions. The nursing team managed the recall and monitoring of patients. A register was in place and a standard operating procedure (SOP) - adaption of the Leuchars Medical Centre chronic disease management pathway. System searches were undertaken each month to ensure the register was current and included newly diagnosed patients. Alerts were added to patient's records if there had been no response to the recall invitation and/or the patient was out-of-date for a review. Any concerns identified from the search were referred to the doctor.

Prior to COVID-19 patients had face-to-face appointments for bloods tests, observations and to discuss results. During the pandemic results were discussed with the patient by telephone. Patients perceived the ability to have the second part of the process remotely as a positive improvement so the practice had maintained this change.

Eighty one patients were recorded as having high blood pressure. Seventy patients had a record for their blood pressure taken in the past 12 months; the remaining 11 had been invited for a review. Sixty patients had a blood pressure reading of 150/90 or less.

The DMICP asthma template was used to review patients. Thirty three patients were diagnosed with asthma. Twenty nine patients had been reviewed in the last 12 months; the remaining patients had been invited for a review. An asthma control test was applied at all annual reviews.

There were 10 patients on the diabetic register. For 7 patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For 9

patients, the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control. All patients had had a foot risk assessment.

Measures were in place to identify patients at risk of diabetes including a clinical code and a re-call 6 monthly or annually. The practice facilitated Well Man Clinics and encouraged patients over 40 to attend for a health check.

Monthly meetings were held between doctors and nurses to discuss patients with complex needs. A register was held of all the patients and a DMICP entry made after each meeting. Patients with cancer and a suspicion of cancer were also included for discussion.

Audiology statistics showed 50% of patients had received an audiometric assessment within the last two years. Joint Medical Employment Standards (referred to as JMES) were appropriately managed. A health force protection display provided patients with information about the hearing conservation programme.

Co-located with the medical centre, the Department of Community Mental Health (DCMH) had a long waiting list so close working with the practice doctors meant patients with mental health needs were safely supported. The consultant psychiatrist and practice doctors met every 2 weeks and patients referred were discussed to establish which service could best support their needs. There was an agreement in place that patients on the DCMH waiting list were reviewed by their doctor every 4 to 6 weeks. If their risk increased then they were given a higher priority on the waiting list. Patients we spoke with as part of the inspection described how they valued their doctor regularly checking in with them while they awaited an appointment at the DCMH. We were provided with a number of examples where the practice, often in liaison with the DCMH, followed up on patients they were concerned about.

The consultant psychiatrist indicated that this close working relationship with the practice meant the risk for patients on the waiting list was minimised as patients were being regularly monitored and supported. The DCMH team was available to provide practice doctors with guidance about managing patients, including prescribing. The doctors had completed the mental health masterclass and attended Step 1 of the mental health intervention programme each year. The 2-weekly meetings were also used to facilitate training in mental health issues for the doctors. The practice had strong links with the Personnel Support Group and had a range of informative mental health resources for patients to use and contact details for local services.

We looked at a wide range of patient records and they demonstrated patients were receiving good quality and timely care. In particular, mental health record keeping showed an excellent standard of care was provided. For example, objective scoring was used for depression and patients were appropriately referred to the DCMH and occupational medicals undertaken as necessary.

One of the Deputy Principal Medical Officers (DPMO) was the lead for quality improvement and they presented an audit or quality improvement project to the team each month at the integrated quality improvement meeting. The DPMO indicated there was an enthusiasm for audit activity across whole practice. The audit register showed a range of data searches and clinical audits, including repeat audits. The approach to quality improvement activity was not systematic as many audits were self-directed, instigated by significant events and complaints rather than a planned approach. The register did not include scheduled mandated DPHC audits and there was minimal auditing of chronic conditions. Not all audits undertaken were recorded on the audit register. In 20 March

2023, version 1 of the 'DPHC Healthcare Audits SOP (9-6-1)' was released. This SOP clarifies the DPHC mandated audits including frequency of each audit and the standardised approach to undertaking the audits. The practice confirmed shortly after the inspection that the audit register had been revised to take account of the audit requirements outlined in the DPHC SOP.

Effective staffing

The practice had an induction pack for permanent members of staff and one for temporary healthcare workers, which all new members of staff were required to complete on arrival. In addition, new staff were also assigned a mentor within the practice. Based on the DPHC mandated induction, modifications had been made to include information pertinent to the practice and role specific elements.

Mandated training was monitored by the practice manager and staff were emailed when training was due to expire. Training was also a standing agenda item at the practice meeting. Role specific training was provided for clinical staff with specific responsibilities or lead roles. An active in-service training register was in place which provided a forecast of planned training.

A range of processes were in place to support staff with clinical development, continual professional development (CPD) and revalidation. For example, doctors participated in CPD through PBSGL and also had designated time to prepare for appraisal. The advanced nurse practitioner was supervised by a doctor. Doctors facilitated supervision for nurses and the nurses had designated protected time for clinical supervision with the regional nurse advisor. They also had the opportunity to participate in the nurses' regional forum. A clinician was available to provide Medical Assistants (MA) with clinical and managerial supervision when they were conducting clinics, and for case reflection post-clinic.

There was a strong culture of training and development within the team. The MAs we spoke with who were on placement at the practice said they were very well supported and had access to a dedicated clinician for advice and reflective practice.

The practice manager monitored the status of staff appraisals. All staff were up-to-date for their mid and end of year appraisal.

Coordinating care and treatment

The practice had strong links with local NHS services, enhanced by engagement with the local trainers group which supported the training programme for local NHS GP registrars. One of the local NHS GPs was ex-military and communicated with the practice regarding families and any safeguarding matters. The Principal Medical Officer undertook regular clinical sessions with the local NHS practice to support a GP registrar working there. In addition, the nurses collaborated and worked with NHS colleagues during COVID-19 on the vaccination scheme. Integrated nurse-led COVID-19 vaccination clinics were held on the base during the pandemic.

Effective communication processes were established with base units and the practice had been instrumental in re-establishing the Unit Health Committee meetings, which had ceased during the pandemic. The practice also had close links with the Personnel Support Group (PSG), who made contact with the practice regarding any safeguarding/vulnerability concerns for personnel. Patients at risk were also discussed at the unit Vulnerability Risk Management meetings. The practice was represented on the Clyde Community Focus Group and participated in base charity events.

Arrangements were in place to handover patients to the next practice when service personnel moved on. If the patient had complex/vulnerable needs a more enhanced handover was given, sometimes in conjunction with the PSG.

The practice provided release medicals for service personnel leaving the military. Following the release medical, the patient was issued with the appropriate paperwork, provided with sufficient medicines and the process for NHS registration was explained. The release medical was currently being reviewed as a QIP because it had been recognised that each clinician had a slightly different approach.

As part of the inspection, we spoke with some patients who were at different stages of leaving the military. All said they were being well supported with accessing relevant services to prepare them for the transition.

Helping patients to live healthier lives

Clinical records we reviewed showed that providing patients with healthy lifestyle options was routine during consultations if appropriate. A range of health lifestyle clinics were coordinated by the nursing team. One of the nurses was the health promotion lead and kept the health promotion displays up-to-date in accordance with the NHS England health promotion calendar. A range of varied health promotion material was available in the waiting area, including information regarding the use of antibiotics, women's health, climatic injury, weight management, diet and smoking. MAs and nurses provided support at the base health fairs, one of which was due to be held in April 2023.

One of the DPMOs was the lead for the sexual health with support from one of the nurses who had completed training in sexual health. Patients had access to the Helensburgh Sexual Health Clinic and information was displayed in the waiting area with the contact details. The lead was due to meet with the head consultant of the local sexual health service regarding commissioning issues impacting access for the practice patient population.

One of the nurses was the lead for screening. Monthly searches were undertaken for bowel (192 patients identified), breast (4 patients identified) and abdominal aortic aneurysm screening (2 patients identified) in line with national programmes. The number of eligible women whose notes recorded that a cervical smear had been performed in the last 3-5 years was 159 which represented an achievement of 91%. The NHS target was 80%.

A health force protection display provided information for patients about vaccinations, including the timelines for each vaccination. An effective process was in place to recall patients for their vaccinations. Vaccination statistics were identified as follows:

- 86% of patients were in-date for vaccination against diphtheria.
- 86% of patients were in-date for vaccination against polio.
- 86% of patients were in-date for vaccination against hepatitis B.
- 76 % of patients were in-date for vaccination against hepatitis A.
- 86% of patients were in-date for vaccination against tetanus.
- 26% of patients were in-date for vaccination against meningitis.
- 85% of patients were in-date for vaccination against mumps, measles and rubella.

Consent to care and treatment

Guidelines in relation to consent were displayed in clinical rooms. Clinicians understood the requirements of legislation and guidance when considering consent and decision making. Implied consent was mainly used. Consent was documented for intimate examinations. A log and written consent was maintained for minor surgical procedures. Verbal consent was taken for ingrown toenail procedures. The practice agreed to obtain written consent for this procedure in the future.

Clinicians had completed Mental Capacity Act (2005) training and understood how it would apply to the patient population group, including outlining an actual example when mental capacity had been considered.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

We used a variety of methods to capture patients' views of the service provided at Neptune Medical Centre. These included the Defence Medical Services Regulator (DMSR) patient satisfaction survey issued prior to the inspection (139 responses, although 8 patients had registered at the practice but not yet used the service), direct interviews with 10 patients and 4 feedback cards completed by patients as part of the inspection. All sources of feedback indicated staff treated patients with kindness, respect and compassion. We were provided with various examples of when practice staff had gone 'the extra mile' to support vulnerable/at risk patients and/or to provide compassionate care that met the specific needs of the individual patient.

Service personnel could access the welfare team and various military/navy support networks for assistance and guidance. The unit also used a charity which provided support on issues of a social or welfare nature. Information regarding these services was available in the waiting areas and the clinical staff were fully aware of these services to signpost patients if required.

Involvement in decisions about care and treatment

The patients we spoke with described how they were included in planning about their treatment and care. They said medical issues were explained to them in a way they clearly understood, included medicines and any potential side effects.

The practice took into account the needs of patients with a caring responsibility. Carers were identified either during the patient registration process, through DMICP searches, via the unit, welfare team or through self-identification. Codes were applied to facilitate DMICP searches undertaken to monitor the number of patients who were carers; 27 at the time of the inspection. Alerts were applied to some but not all patient records. Alerts are useful as they highlight to staff that the patient has caring responsibilities so flexibility with appointments can be ensured and enhanced services offered, such as the flu vaccinations. The records we looked at showed that carers had been offered the flu vaccinations and a health check. The practice was represented at the local carers forum in nearby Helensburgh.

An interpretation service was available for patients who did not have English as a first language. We were advised it had not needed to be used.

Privacy and dignity

Consultations took place in clinic rooms with the doors closed. Privacy curtains were used when patients were being examined. Telephone consultations were undertaken using headsets to maximise patient confidentiality. Privacy signs were displayed in the waiting area informing patients that private rooms were available for discussion if needed. A television was opposite the reception desk which supported with minimising conversations being overheard. To ensure awareness of handling personal information, staff were in the process of completing the Ministry of Defence 'Information and Knowledge Awareness' course introduced in February 2023. At the time of the inspection 46% of the staff team had completed the course.

In the event that a clinician of a preferred gender was not available patients could attend Kentigern House Medical Centre or another nearby DPHC medical centre.

Are services responsive to people's needs?

We rated the practice as good for providing caring services.

Responding to and meeting people's needs

The practice responded to the needs of patients. For example, submariners had difficulty accessing eConsult when on the boats so the practice provided telephone consultations as an alternative. An internal assurance review in September 2022 identified that the practice was focused on tailoring services to meet patients' needs.

Feedback from patients we spoke with indicated that the practice was responsive to their specific needs. This was particularly the case for patients with mental health needs.

The building was accessible for people with mobility needs including an accessible toilet. An Equality Access Audit for the premises was completed in April 2022. Actions were identified including consideration for a hearing loop. There was no evidence this action had been followed up. From our interviews with patients, we determined that there was a cohort of registered patients who used hearing aids. Promptly after the inspection, the practice confirmed a business case had been hastened requesting funding for an induction hearing loop.

The practice supported transgender patients in line with the Ministry of Defence policy for the recruitment and management of transgender personnel in the armed forces.

Timely access to care and treatment

Requests for medical advice and appointments could be arranged by telephone or via eConsult. The eConsult web address was included in the patient information leaflet and information was available in the waiting area. Routine appointments with a doctor could be facilitated within 7 days, with a nurse within 2 days and on the same day with a Medical Assistant. Urgent appointments for all clinicians could be accommodated on the same day. Feedback from patients confirmed they received an appointment promptly and at their preferred time.

Home visits to patients on the base were occasionally undertaken. A protocol was in place to support these visits - Medical Department Standing Orders (MEDSOs) Volume 2 – Duty Watch Instructions chapter 8.

Emergency out-of-hours cover midweek was provided by duty staff daily from 07:00 to18:00 hours to respond to patients with an urgent medical need. NHS 24 provided access to urgent health care when the medical centre was closed. An out-of-hours cover leaflet was available to all patients in the waiting areas. Information was also displayed at the main entrance informing patients. The practice advertised the out-of-hours service using the Clyde SharePoint page which was accessible to all service personnel on the unit.

Listening and learning from concerns and complaints

The practice manager was the leads for complaints. Complaints about clinical care were referred to the Principal Medical Officer (PMO) or to another doctor if the complaint involved the PMO. The complaints register showed 2 complaints has been raised since September 2022. Both were effectively managed in accordance with Defence Primary Healthcare policy (DPHC) complaints policy and local procedure. Improvements made following the complaints were evident. Complaints were a standing agenda item at the monthly practice meetings. A complaints audit had not been completed. After the inspection, the practice confirmed that the audit programme had been up updated to include a complaints audit in line with the recently released 'DPHC Healthcare Audits (SOP 9-6-1)'.

The complaints process was highlighted in the main waiting areas and also advertised on the Clyde SharePoint page accessible to all service personnel on unit. The complaints procedure was outlined in the patient information leaflet and complaints/compliment cards were available to patients at reception.

Are services well-led?

We rated the practice as good for providing caring services.

Vision and strategy

Neptune Medical Centre along with the satellite practice, Kentigern House Medical Centre, worked to the Defence Primary Healthcare (DPHC) mission statement defined as:

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

The strategic priorities were reviewed by the Principal Medical Officer (PMO) on a quarterly basis. They were most recently reviewed in April 2023 and identified as follows:

1. Regain on Force Health Protection statistics (vaccines and audiometry) post pandemic, including supporting hosted base port units to achieve the same aim whilst ensuring all relevant personnel have training in scrutinising and data cleansing the vaccination record.
2. Ensure all opportunities to accelerate recovery pathways are maximised for 'Pinch Point' trades, using Foundry for 100% of Joint Medical Employment Standard (JMES) review recalls and MODCAP as appropriate.
3. Complete outstanding mandatory training courses to ensure compliance with the DPHC mandatory training policy and ensure all new members of staff receive an effective induction to the practice.
4. Prosecute the staff training programme including GP and other allied health professionals led sessions for medical assistants' continuing professional development.
5. Be Prepared To (BPT) support further tasking in support of the Naval Base Commander (NBC) and Commander DPHC.

From our discussions with staff, it was clear the practice team was committed to providing and continually developing a service that embraced the mission and strategic priorities.

The leadership team acknowledged challenges to the service, including those related to workforce, information systems support and physical security. These challenges were kept under review and managed at service level if appropriate or escalated to a higher level.

An increase in the patient population by 2030 (Project HEADMARK) was planned. The leadership team was involved in the planning including a review of staffing levels; the practice had secured an additional doctor's post in anticipation. The PMO was working to make positive changes in the nursing team in terms of capacity, scope of practice, development and banding with the aim to enhance the nursing team and also so additional supervision could be provided for Medical Assistants (MA).

Leadership, capacity and capability

Despite vacancies, staff indicated there was sufficient leadership and management capacity across all staff departments to ensure the smooth running of the service. Staff managed leave with their deputies to ensure a management/leadership presence was always available. Having 2 Deputy PMOs (DPMO) allowed for different delegations and a focus on the individual units they were responsible for.

The PMO and practice manager were due to move from the service. Their replacements had been identified and succession planning was in progress to ensure a detailed and effective handover. The business services manager post had been vacant from August 2022 until the position was filled recently. During the absence of this key role, the management of civilian administrative staff was passed to one of the DPMOs. The leadership team were aware of the impact of this line management change and worked to ensure the DPMO was available as much as possible to support administrators.

The leadership said they were supported by region with the practice having a visit from the regional team each month. In particular, staff highlighted timely and responsive support from region in relation to the limitations with information systems.

Culture

It was clear from patient feedback and interviews with staff there was a patient-centred culture at the practice. This was also evident from our interviews with patients and observation of how patients were greeted at the reception. Staff understood the specific needs of the patient population and tailored the service to meet those needs.

Staff we interviewed spoke highly of the leadership arrangements including the visibility of, and support, from key leaders. They said leaders were approachable and promoted an inclusive no-blame culture. They said they felt respected, supported and valued with everyone having an equal voice, regardless of rank or grade. Both formal and informal opportunities were in place so staff could contribute their views and ideas about how to develop the practice. Similarly, the internal assurance review in September 2022 identified the practice was well-led and the staff team cohesive and very well integrated.

Staff said they would feel comfortable raising any concerns and had completed ‘reasonable challenge training’ this year. Equally, staff were familiar with the whistleblowing policy and with the Freedom to Speak Up (FTSU) policy, including how to access FTSU representatives. Leaders acted on concerns raised. For example, an anonymised staff survey in 2022 suggested an element of separation of doctors from other staff and prioritisation of doctor activity over practice needs. Changes were made to ensure all staff teams were represented at the management meetings to ensure a better balance of views.

One of the DPMOs was the lead for staff who had caring responsibilities. The practice took a proactive approach in encouraging staff to be open if they had a caring role to avoid stress in the workplace and empower line managers to enable flexibility at work. Measures to support this included a Defence Instruction Notice and carers passport.

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. A duty of candour log was maintained. Where appropriate, duty of candour was applied to significant events raised through the ASER system.

Governance arrangements

The internal assurance review in September 2022 identified the practice had highly effective governance systems to monitor that the care and treatment was safe. There was a clear staff reporting structure in place and staff were aware of their roles and responsibilities, including secondary lead roles for specific areas. Terms of reference were established for those with secondary roles.

One of the DPMOs was the lead for healthcare governance and the advanced nurse practitioner was the deputy. The practice used the healthcare governance workbook; overarching system used to bring together a range of governance activities, including the risk register, audit, health and safety and quality improvement. The practice manager was responsible for oversight of the workbook and monitor it monthly. All staff had access to the workbook, which was a standing agenda item at practice meetings. Although there was good evidence of quality improvement work, how this was planned, coordinated and captured lacked a defined structure.

A rotational schedule of meetings was in place for the practice and staff from Kentigern House were invited to these meetings. The 5-week schedule covered incident management, healthcare governance, quality improvement, clinical and management. Staff who could not attend the meetings had access to the minutes. Any changes to policy or practice were confirmed to staff by email.

Although staff told us they completed training in topics such as sepsis, thermal injuries and duty of candour, and their knowledge demonstrated detailed understanding, training records did not reflect this. The practice manager has since added these topics to the training register and staff have been reminded at the practice meeting to confirm when they had completed training.

The regional team carried out an internal assurance visit in September 2022 and the practice was rated as having substantial assurance. Actions identified from the visit had either been completed or were in the process of being addressed.

Managing risks, issues and performance

An effective process to identify, understand, monitor and address current and future risks including risks to patient safety was in place. Risks to the service were well recognised, logged on the risk register and kept under scrutiny through review at meetings.

A business continuity plan was in place and reviewed in May 2022. Organised by the base, 2 major incident exercises were held each year.

Processes were in place to monitor national and local safety alerts, incidents, and complaints. This information was used to improve performance. Leaders were familiar with, and had experience of, the range of processes to manage staff performance.

Although a wider Royal Navy healthcare issue than just for Neptune Medical Centre, a cohort of patients the practice was responsible for were not registered on the practice's DMICP system; all submarines and tenders have patients registered on DMICP afloat which is not visible on base port searches. This presents a risk to patients especially for those on tenders that have no medical teams overseeing their care, unlike some submarines which have a MAs administering care. We previously escalated this matter and have done so again following the inspection of Neptune Medical Centre.

Appropriate and accurate information

The DPHC electronic Health Assurance Framework (referred to as eHAF) was used in to monitor performance. The eHAF is an internal quality assurance governance tool to assure standards of health care delivery within defence healthcare. There was a shared eHAF for Neptune Medical Centre and Kentigern House which was discussed each month at the integrated practice management meeting. All staff had access to the eHAF.

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.

The management action plan (MAP) from the eHAF was a standing agenda item at the practice meeting and was discussed with the staff team. It was evident from the MAP that a multi-disciplinary approach had been undertaken when addressing the actions.

Engagement with patients, the public, staff and external partners

A quarterly patient experience survey was undertaken. The patient survey from September 2022 to March 2023 yielded a low response rate which was not representative of the size of the patient population. There was not a suggestion box or similar means for patients to leave feedback unless they asked at reception feedback card. There was no information displayed to indicate this was an option. We noted the internal assurance review in September 2022 recommended the practice explore ways to improve patient feedback. The practice had ordered a notice board as a means to inform patients of changes made as a result of feedback received.

Patient feedback received was discussed at the monthly practice meetings. The unit was informed through weekly orders of any changes to the service, including changes a result of patient feedback. An example of a change made in response to feedback involved developing an alternative option to crews attending the medical centre for vaccination parades. A process was implemented to facility vaccination clinics being held on board the ship. An SOP was developed to support the process and risk assessments were

undertaken to ensure safe temperatures of the vaccines. This change meant the was able to continue with work duties while the clinic was in progress.

Good and effective links were established with internal and external organisations including the units, Patient Support Group, Department of Community Mental Health (DCMH), local primary care services and local sexual health services

Staff had were encouraged to provide feedback at the staff meetings or directly to their line manager. Staff feedback was considered and acted upon. For example, the timing of the weekly meetings was rearranged to ensure all staff could attend.

Continuous improvement and innovation

It was clear by the extensive number and range of quality improvement projects (QIP) that the team continually explored ways to improve the quality and safety of the practice. Fourteen QIPs were raised in 2022 and 4 in 2023. Despite this, we heard of additional or potential QIPs that had not been raised. For example, the collaborative working relationship the practice had with the DCMH. We noted that the QIPs had not been transferred to the DPHC Healthcare Governance webpage to showcase positive performance at the practice and also to enable the sharing of good practice with other DPHC facilities. This was actioned promptly during the inspection.