Princess Royal Medical Centre, Gibraltar

Devils Tower, Gibraltar

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?	**Outstanding**	☆
Are services well-led?	**Good**	●

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Summary

About this inspection

We carried out this announced comprehensive inspection on 11 July 2023.

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

Are services safe? – good

Are services effective? – good

Are services caring? – good

Are services responsive to people's needs? – outstanding

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.

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.
- The practice provided a seamless tri-service approach to care and was responsive to the needs, at times differing needs, of the 3 services, and also to the large cohort of civilian patients.
- The leadership approach was collaborative and inclusive, which meant the smooth running of the practice was not dependent on any one individual.
- There was an open and transparent approach to safety. A well-developed system was in place for managing significant events. All significant events and incidents were subject to a thorough root cause analysis involving key staff.
- The practice worked collaboratively with internal and external stakeholders. In particular, the strong relationship with Gibraltar Health Authority (GHA) meant patients had timely access to GHA services such as diagnostics and secondary care.

- Although few patients were prescribed high risk medicines (HRM), the HRM register was not up-to-date.
- Healthcare governance processes were well-developed and routinely used to monitor service performance.
- Quality improvement activity was embedded in practice and was used to drive improvements in patient care. This could be progressed further by showcasing initiatives as quality improvement projects.

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

- The practice consistently and effectively used the clinical coding system as a safety net to ensure appropriate patient care and appropriate follow up. Specific codes were used by all clinicians for the monitoring and recall of all patients with a chronic disease. An agreed clinical management plan code was used for patients seen at A&E, which facilitated a daily search so patients' records were reviewed. The use of the clinical conference code meant all vulnerable patients were identified on DMICP (electronic patient record system) searches. Utilising the coding system in this way maximised the reliability of DMICP searches.

- The practice provided a highly responsive and accessible service for patients. For example, the emergency clinic in the morning was open to all patients and was not just for service personnel. Flexible appointments with doctors were accommodated late afternoon and after working hours to accommodate shift workers and school children. In addition, the practice opened on Gibraltar (non-UK) public/bank holidays to enhance access. Working patterns were often adapted with minimal notice to support the occupational needs of service personnel. For example the nursing team conducted a rabies vaccination clinic onboard ship for personnel deploying at short notice. Furthermore, demand fluctuated as ships docked. This particularly affected the Primary Care Rehabilitation Facility (PCRF) as ships do not have a physiotherapist on board. This meant the PCRF was highly responsive to the needs of patients, including adjusting workload at short notice.

The Chief Inspector recommends to Defence Primary Healthcare (DPHC):

Expediate the process for securing Disclosure and Barring Service (DBS) checks so that staff receive their DBS check in a timely way.

The Chief Inspector recommends to the practice:

- Review and update the high risk medicines register to ensure it is current.

- Develop a local working policy for access to the controlled drugs cupboard out-of-hours.

- Liaise with the unit/contractors to agree a process for the practice to have routine access to the infrastructure checks.

- Put in a place a record log to show when the serialised tag for the emergency trolley has been opened and replaced.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Healthcare

Our inspection team

The inspection team included 2 CQC inspectors and specialist advisors - a primary care doctor, practice nurse, pharmacist and physiotherapist. A member of the Defence Medical Services Regulator supported the inspection.

Background to Princess Royal Medical Centre

Princess Royal Medical Centre provides primary care, occupational health and a rehabilitation service to a patient population of 607 including service personnel, reservists and civilians. The service personnel cohort of patients fluctuates as Naval ships dock on the peninsula. Families of service personnel make up 46% of the patient population.

The practice is open Monday to Thursday from 08:00 to 16:30 hours and on Friday from 08:00 to 14:00 hours. Out-of-hours medical care is provided by St Bernard's Hospital. Patients that require medical attention report to A & E with their Gibraltar Health Authority (GHA) card. For urgent advice, patients can contact the Command Duty Officer.

The staff team

Primary care	Principal Medical Officer – military Deputy Principal Medical Officer – military Practice nurses x 2 – military Medic – force generation – military Medic – treatment room – military
Practice management and administration	Practice manager – military Deputy practice manager – military Receptionist x 2 – civilian Medical liaison – civilian Front office medic – military
Primary Care Rehabilitation Facility	Physiotherapist – military Exercise Rehabilitation Instructor – military
Dispensary	Pharmacy technician – military Medic - pharmacy support – military Medic - equipment care and operational support – military Store person – civilian
Infrastructure, safety and hospital liaison	Manager – civilian Patient administrator – civilian Administrator – military
Community child health (SSAFA)	Health visitor – civilian Personal assistant – civilian

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

The Principal Medical Officer (PMO) was the lead for adult and children safeguarding. The deputy PMO (DPMO) was the deputy lead for adult safeguarding and the SSAFA (Armed Forces charity) health visitor the deputy for child safeguarding. Staff had completed safeguarding training at a level appropriate to their role. A local safeguarding standard operating procedure (SOP) was in place and had been reviewed in June 2023. Safeguarding concerns were reported to the Gibraltar British Forces Social Work Services team (BFSWS).

Child health and welfare was overseen by the small SSAFA team based in the medical centre. Working closely with the primary health care team, the Welfare Officer and BFSWS, SSAFA provided early intervention in accordance with UK guidance and best practice. The SSAFA team had the flexibility to support families and children in various settings on the peninsula. The health visitor maintained a register of patients under the age of 18 and attended the practice multidisciplinary team meetings.

Vulnerable patients were identified during consultations, DMICP searches and through referrals from other units, such as the welfare team. The use of the ‘clinical conference code’ meant all vulnerable patients were identified on DMICP searches. In addition, an alert was applied to the patient records and patients were added to the safeguarding/vulnerable patient register. Vulnerable patients and safeguarding concerns were discussed at the clinical meetings.

The chaperone policy was displayed throughout the premises and also outlined in the patient information leaflet. Clinical staff, including medics, had received chaperone training in June 2023.

Although the full range of recruitment records for permanent staff was held centrally, the practice could demonstrate that relevant safety checks had taken place at the point of recruitment, including formal safety checks to ensure staff were suitable to work with vulnerable adults and young people. The majority of staff had a current English Disclosure and Barring Service (DBS) check. A member of staff had a DBS equivalent Scottish Protecting Vulnerable Groups (PVG/Disclosure Scotland) certificate which was current. They had applied for a DBS check without success (due to different processes for each of the forces). The matter had been raised at the quarterly Defence Primary Healthcare (DPHC) Overseas meetings and added to the issues register. We were advised that it could take up to 8 months for a DBS check to be returned even though the application had been made in a timely way. Locally employed staff had a police check in line with Gibraltar processes. The professional registration of staff was monitored to ensure it was current. The nursing team monitored the vaccination status of staff.

An infection prevention and control (IPC) policy was in place. The Senior Nursing Officer (SNO) was the lead for IPC and had completed the required training for the role. The last annual IPC audit was undertaken in June 2023.

An environmental cleaning contract was established for the practice. The contract was monitored by the practice manager and deputy practice manager in conjunction with the cleaning supervisor. Enhanced cleaning was carried out twice a year and could be arranged more frequently if needed. The children's toys in the waiting area were cleaned each Friday. A statement of need had been submitted for all carpets to be removed in the non-clinical areas.

A lead was identified for the management of the clinical waste. The clinical waste protocol was reviewed in July 2023. Clinical waste was monitored by the duty medic each day. In accordance with DPHC policy, waste was secured, labelled, and stored safely in containers. A clinical waste register was maintained. On collection, the number of bags taken was cross referenced against the register to ensure accuracy. The last annual healthcare waste audit was conducted in June 2023 and no issues were identified.

Risks to patients

All staff we spoke with indicated staffing levels at the practice were sufficient to meet the needs of the patient population. To cover staff absence, a preferred list of regular locums was established. Locum staff received an induction and were required to complete the DPHC mandated training.

Staff were aware of where the emergency trolley, kits and medicines were located. Medicines in the emergency trolley had been checked monthly except in February and March 2023. With the exception of the chlorphenamine injection (to treat the symptoms of allergies), medicines and medical consumables were in-date. The oxygen cylinder was full and in-date. Although the emergency trolley was secured with a serialised tag, a record of when the tag was opened was not maintained. A blood glucose monitor was held on the trolley and regularly checked. The control test solutions were in-date. The ambient temperature was monitored in accordance with the DPHC SOP for temperature monitoring.

A comprehensive training programme was in place, including recognising the deteriorating patient and heat illness. The resuscitation lead from Sussex University Hospital delivered annual face-to-face basic life support, intermediate life support (ILS) and paediatric immediate life support. The training also included the use of an automated external defibrillator (AED) and emergency scenarios. ILS training was due to be delivered again in September 2023.

A lead was identified for the co-ordination of the Aeromedical Evacuation (AE) service; the medically supervised movement of patients by air to and between medical treatment facilities. A Digital Aeromed Referral Platform (DARP) was used to initiate and monitor AE. We were advised that effective lines of communication were in place with the AE team based in the UK. A total of 14 AEs had taken place between December 2022 and June

2023 with no undue delays. Other members of the team were trained to coordinate AE in the absence of the lead and guidance/instructions were available to reference.

Information to deliver safe care and treatment

Staff confirmed there were only occasional issues with accessing DMICP which did not pose a significant risk to continuity of patient care. In the event of an IT outage impacting DMICP access, staff referred to the business continuity plan. The practice would only see emergency patients. A process was in place to use paper documentation as a contingency which was later coded and scanned to the patient's record. As a failsafe, clinics planned for the next day were printed off at the end of every day in case there were issues with the clinical system the following day.

Access to DPHC systems was identified as a risk because systems, such as text messaging for appointment reminders did not work in Gibraltar. In addition, we were advised that eConsult was designed for military patients rather than civilians.

A process was in place for the summarisation of patient records. The doctors summarised the records for civilian patients and the nurses summarised those for military patients. Ninety-four per cent of records had been summarised at the time of the inspection.

Arrangements were established for the regular auditing of clinical record keeping. The doctors peer reviewed each other's records on an annual basis. Similarly, both the nurses reviewed each other's record keeping with the most recent review conducted in June 2023. Consultation records completed by medics were reviewed by the nurses. The physiotherapist had reviewed their own records in May 2023 as no exercise rehabilitation instructor (ERI) was in post at the time the audit was due. Although a self-audit is not best practice, the process used was in line with the organisational audit structure, including recommendations and discussion at the practice audit meeting in June 2023. The ERI's records had not been audited. They were due to leave and a new ERI was due to start. We reviewed a wide range of DMICP records and found record keeping was of a good standard.

A dedicated hospital liaison team managed the referrals to secondary care services, which could be to Gibraltar Health Authority (GHA), Spain or the UK. Referrals were sent via the Hospital Liaison Manager who actively followed up on the status of appointments and kept patients informed. The majority of referrals were made via the electronic referral system to GHA. A referrals tracker was maintained with 2-week-wait and urgent referrals highlighted so they were easily visible.

A member of the hospital liaison team checked with GHA daily to establish if any patient had presented at A&E within the past 24 hours. If they had, then GHA forwarded the record to the practice and it was scanned and uploaded to the patient's DMICP record and tasked to the doctor for review. Referrals sent to the UK, such as those to the Multi-disciplinary Injury Assessment Clinic, were done so via the aeromedical lead. A referral tracker was maintained for referrals made by the physiotherapist to the Regional Rehabilitation Unit (RRU). All referrals were discussed at the RRU multidisciplinary team meeting, which the physiotherapist attended. Because of the different pathways for

referral, failsafe systems were established with several safety nets to ensure referrals were not missed.

A process was established for the management of samples. As no process similar to Path Links was available through GHA, all pathology results were printed, coded and scanned to DMICP. As a backup, the nurses made a record in DMICP and manually recorded on the hospital form to ensure all samples were received by pathology reception. Either the nurses or medics checked the pathology book daily to ensure all samples had been received. Once results were received, the doctor was tasked for follow-up with the patient as appropriate.

Safe and appropriate use of medicines

The DPMO was the lead for medicines management. The pharmacy technician (PT) was responsible for the day-to-day management of the dispensary and this was reflected in their terms of reference.

The dispensary was secured when the pharmacy technician was not present and a process was in place to ensure security of the dispensary keys. Prescriptions (FMED 296) were stored securely in the dispensary and the serial numbers documented in a bound book. Comprehensive processes were established for the issuing of prescriptions; issued by serial number with clinicians signing and dating for receipt of the prescriptions.

Patient Group Directions (PGD), which authorise practice nurses to administer medicines in line with legislation, had been signed off. We checked the PGD medicines and all were in-date. A check of DMICP confirmed that the PGD template was being used. Similarly, Patient Specific Directions had been fully completed and dates of validity corresponded with the dates of administration. DMICP records showed coding had been correctly applied by the prescriber. Both the nurses and health visitor were in-date for PGD training which was overseen by the PT through authority from the PMO. The nurses conducted PGD audits for each other.

Although a local working practice (LWP) for out-of-hours/secondary care prescribing was not in place, the process for the transfer of care from secondary to primary care was clear. We discussed the process with the PT and were assured that notification of changes to medicines by other services were scanned onto the patient's record and the nominated doctor tasked to action or review the patient. If notifications or changes were urgent, the patient was reviewed by a doctor.

An effective process was established for requesting and issuing repeat medicines. From discussion with the PT and a review of patient records, it was evident that the repeat prescription SOP was being followed correctly. The PT showed good awareness of their responsibilities, including when requests should be tasked to a doctor. Repeat prescriptions were only issued if the patient's review date was in-date and there were available repeat counts on the patients prescribing record. We witnessed the process for handing out prescriptions to patients and it was in-line with DPHC's SOP on handing out a prescription.

A check of dispensed repeat prescriptions showed that all repeat prescriptions were dispensed within 8 weeks. This indicated patients were informed when prescriptions were ready for collection. Uncollected medicines were returned to stock.

To ensure patients were informed of side effects to medicines, appropriate warning cards were held in the dispensary. We noted the NHS steroid emergency card was not available in the dispensary and this was rectified at the time of the inspection. We observed comprehensive counselling on medicines given by the PT when issuing prescriptions to patients.

From discussion with clinicians and a review of patient records, we were assured that patients' medicines were appropriately reviewed, including treatment and clinical medicine reviews.

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 fridges was monitored twice a day and the external thermometers were in-date.

We checked a range of prescription only medicines, vaccines and medical consumables and all items were in-date. Evidence of effective stock management was seen as the medicines with the shortest time expiry were placed at the front of the shelf. Time expiry reports were run a month in advance and stock due to expire within the month was separated from the main stock to minimise the risk errors. Expired medicines were destroyed using the appropriate pharmaceutical clinical bins.

Controlled and accountable medicines were kept in the controlled drug (CD) cupboard in the dispensary. A check of DMICP, physical stock and documentation in the CD register (BMed 12) showed accounting of controlled and accountable medicines was accurate. The specimen signature log in the register had been completed accurately by all those involved in the accounting of the controlled and accountable medicines

Internal monthly checks and external quarterly checks of CDs had been completed in accordance with DPHC policy. Although an LWP was not in place, arrangements were in place for access to the CD cupboard out-of-hours. An annual CD audit had been completed and an action plan developed. The destruction of CDs was undertaken in accordance with DPHC policy.

Patients prescribed a high risk medicine (HRM) were identified during consultations and added to the HRM register. Appropriate HRM alerts and shared care alerts were identified on the patients records we reviewed, and timely blood monitoring had been undertaken. The HRM register was not used to its full potential - as a tool to support the safe and comprehensive management of patients prescribed HRMs. The register was not current as dates for monitoring were incorrect. Because there were only 2 prescribers and very few patients prescribed HRMs at the time of the inspection, the risk associated with the register not being kept up-to-date was low. However, that risk could likely rise if there was an increase in patients prescribed HRMs. A HRM audit had been completed.

Valproate (medicine to treat epilepsy and bipolar disorder) searches were regularly undertaken. There were no patients prescribed this medicine at the time of the inspection. An antimicrobial audit was completed in February 2023.

Track record on safety

A designated health and safety lead for the practice was identified. Effective arrangements were in place to ensure the safety of the premises and equipment. A workplace health and safety inspection was completed for the timeframe January to July 2023. Health and safety checks were undertaken by a contractor. Despite repeated requests, the practice had not received copies of the checks from the contractor. However, it was confirmed that electrical checks had been completed in March 2022 and a full legionella risk assessment in June 2022. Water temperature checks were regularly undertaken. There was no piped gas to the building.

A practice lead was identified for equipment care and the equipment care board provided details of the arrangements to ensure the safety of equipment. An equipment assessment (referred to as a LEA) was undertaken in September 2022 and the recommendations had since been completed.

All the equipment in the Primary Care Rehabilitation Facility (PCRF) was new and had been installed in January 2023. One of the unit physical training instructors was responsible for PCRF equipment and arranging the servicing. Air conditioning was installed in the PCRF. However, Wet Bulb Globe Temperature checks to indicate the likelihood of heat stress were undertaken before rehabilitation classes.

The fire risk assessment was undertaken in October 2020 and next due in 2024. Firefighting equipment tests were current. Staff were up-to-date with fire safety training and were aware of the evacuation plan. The last fire evacuation drill was held in January 2023. The PCRF and administration offices were located on first floor. In the event of a fire resulting in the passenger lift out of use, evacuation of patients with mobility issues was identified as a risk. The matter had been added to the risk register. A business case had been submitted for the purchase of an evacuation chair and the fire risk plan had been updated accordingly.

The practice manager was the designated lead for risk management. A register of up-to-date risk assessments covering all aspects of patient/staff safety was in place, including lifting/handling, lone working, COVID-19 and Control of Substances Hazardous to Health (COSHH). COSHH products were stored appropriately. The exercise rehabilitation instructor carried out the risk assessments for the PCRF. The new ERI due to start in 2 weeks was on the waiting list for the risk assessors course.

A risk register and issues log was in place for the practice. Risks were appropriately managed in accordance with the ‘four T’s process’ (transfer, tolerate, treat, terminate). The register was reviewed each month and updated accordingly at the management meetings.

An integrated alarm system with warning lights outside each of the clinical rooms was installed on the ground floor and regularly tested. The same arrangement was not in place

for administrative and PCRF staff on the first floor. An SOP was in place to address lone working and the absence of an alarm system. The PCRF was located close to offices so staff would shout for support in the event of an emergency. We tested this by shouting for help during the inspection and staff promptly responded. The practice manager initiated the purchase of a handheld alarm for PCRF staff during the inspection. The fixed panic alarm at reception linked directly to the Gibratar Defence Police.

Lessons learned and improvements made

The Senior Nursing Officer was the lead for the management of significant events. All staff had access to the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events and incidents. A comprehensive ASER register was maintained and an ASER meeting was held each month. A trend analysis was undertaken at quarterly. A near miss log was also maintained.

From interviews with staff and evidence provided, it was clear there was a strong culture of reporting and analysing incidents with a view to making improvements. A thorough approach to ASER management was taken as each significant event or incident was discussed at the management meeting prior to the part 2 ASER report submission. This meant a full root cause analysis was undertaken involving key members of the team. The approach was evidenced through the ASER tracker, clinical meeting minutes and through interviews with a wide range of staff.

All staff we spoke with provided numerous and varied examples of incidents reported through the ASER system including the action taken and improvements made. For example, the Senior Nursing Officer (SNO) developed a detailed nurses' training programme and log as a result of an ASER raised in relation to training. The unique part of the training log was its ability to track when training was due to expire and also track continuing professional development requirements. The SNO was keen for this initiative to be adopted practice-wide. A further example related to a patient seen at A&E and reviewed by a medic the following day. However, the medic's actions were not reviewed by a nurse or doctor. As a result, a clinical management plan agreed code was applied to every new patient seen. The nursing team undertook a search of the code each day and performed a review on each of the patients identified.

An effective process was in place for the management and action of Medicines and Healthcare products Regulatory Agency (MHRA) and National Patient Safety alerts. The electronic MHRA alert register was current and a system was in place to ensure the practice received, disseminated, and actioned all alerts and information relevant to the practice. Practice meeting minutes showed alerts were discussed with a link to the register embedded in the minutes.

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 (NICE) guidance, clinical pathways, legislation and standards. New or updated guidance was reviewed at the monthly clinical meetings. In addition, staff were kept informed of clinical and medicines updates through the Defence Primary Healthcare (DPHC) newsletter circulated each month. Clinicians regularly referred to NICE Clinical Knowledge Summaries and updates to these were also discussed at the meetings. Patients with vulnerabilities and/or complex needs were discussed at the weekly multi-disciplinary team (MDT) meeting.

The primary care rehabilitation facility (PCRF) had the necessary equipment and space needed to deliver an effective service. Patients were assessed by physiotherapist in the PCRF and referred to exercise rehabilitation instructor (ERI) if required.

Regular musculoskeletal meetings were held which the physiotherapist, ERI and practice doctors attended. In addition, the physiotherapist had monthly MDT meetings with the Regional Band 7 physiotherapist and doctor for the Multidisciplinary Injury Assessment Clinic.

The physiotherapist referred to the Department of Defence Rehabilitation to ensure best practice guidance was being followed. The musculoskeletal health questionnaire (referred to as MSK-HQ) was routinely used and relevant clinical coding applied for audit purposes. In addition, the PCRF used the referral numbers, injury requiring treatment, wait times and discharge dates to monitor performance and trends. The PCRF consistently met its key performance indicators confirmed by a wait time audit for new patients in June 2023.

Step 1 of the mental health intervention programme was undertaken at the practice. For enhanced mental health support, clinicians could make remote referrals to the Department of Community Mental health (DCMH) in Lichfield. The psychiatrist could facilitate remote video consultations within a few days. Alternatively, patients could be referred to Gibraltar Health Authority for a face-to-face consultation with a psychiatrist. Other options for support included the Community Support Team, children's online services/school counsellors. All showed appropriate evidence-based management including assessment, diagnosis, clinical coding, prescribing and monitoring.

Monitoring care and treatment

The Principal Medical Officer (PMO) was the lead for chronic disease. A standard operating procedure (SOP) was in place for each chronic disease to ensure consistency of management. A highly effective chronic disease management system was introduced in

March 2023. In addition to the use of a clinical code for specific conditions, a single DMICP code (66 – chronic disease monitoring) was applied on DMICP to all patients diagnosed with a chronic disease. This meant that one search identified all patients so was more efficient and minimised the risk of patients being missed. A DMICP search was undertaken each month. The nurses monitored the searches closely to promote patient uptake for reviews. As the mail system was not reliable, patients were recalled through telephone calls.

There were low numbers of patients diagnosed with diabetes and based on the indicator of positive blood pressure control, all were well managed. Patients at risk of developing diabetes (pre-diabetes and history of gestational diabetes) had the DMICP 66 diary entry added to their DMICP record to ensure their average blood glucose level was checked annually.

There were 22 patients recorded as having high blood pressure. Records showed 21 patients had their blood pressure taken in the past 12 months (1 had only recently registered at the practice). Of the 22 patients, 14 patients had a blood pressure reading of 150/90 or less. There were 23 patients with a diagnosis of asthma. All patients were offered an asthma review in the last 12 months but 4 declined and 3 had been recalled. A consistent asthma review template was used. Our review of a range of patient records showed patients with chronic conditions were recalled and monitored in a timely way appropriate to their needs.

We reviewed a wide range of clinical records including patients with a chronic condition and those diagnosed with a mental health need. Records were of a high standard. The practice effectively and consistently used the coding system as a safety net to ensure appropriate patient care and appropriate follow up. In addition to the chronic disease monitoring code, an agreed clinical management plan code, clinical conference code and general recall code were used by all clinicians. This meant reliability of DMICP searches was maximised.

Audiology statistics showed 82% of patients had received an audiometric assessment within the last 2 years. Our review of patient records showed Joint Medical Employment Standards (referred to as JMES) were appropriately managed.

The ERI was the lead for audit. An audit calendar was established for 2023, which captured the routine monthly audits and additional audits planned for each month. Some pre-planned audits had not been completed in recent months due to staff turnover and a re-focus to incorporate the mandated audits as outlined in the DPHC Healthcare Audits SOP (9-6-1).

The audits undertaken clearly demonstrated that quality improvement was embedded in the practice. All staff actively engaged with audit activity and the register indicated a balanced range of data searches, mandated audits and patient population-based clinical audits. We looked at a selection of audits - flu immunisation, management of diabetes, cancer/palliative care and a range of prescribing audits. All were of a good standard with some evidence of repeat audits. The PCRF team were in the process of completing a lower back pain audit. The outcome of audits, including planned actions/changes, were shared with the team at practice meetings.

Effective staffing

All staff who joined the practice were required to complete the DPHC mandated induction and the practice induction that included role specific elements. A clinical guide specific to health care access in Gibraltar was available. We spoke with a member of staff who recently joined the practice and they confirmed the induction process.

The practice manager monitored the status of mandatory training for the team. Training was uploaded on the DPHC Overseas spreadsheet and the practice also maintained a local training spreadsheet. Staff were emailed if training was due to expire and the status of training was discussed at the management meetings. We noted from the June 2023 minutes that staff were required to inform the practice manager of their training updates so the DPHC Overseas spreadsheet could be updated. There were some gaps in mandated training and this was mainly due to staff leave. Arrangements were in place for staff to complete the training on their return.

Clinicians had the appropriate qualifications to meet the needs of the patient population. For example, both doctors were qualified to undertake diving medicals and the deputy PMO (DPMO) was a Military Aviation Medical Examiner. As civilians were referred to the PCRF, the physiotherapist had completed a paediatrics and young people training day.

There was an active in-service (trade) training programme in place which was coordinated by the deputy practice manager. This training was facilitated one afternoon each week and supported staff with continuing professional development (CPD). A training log was maintained to document the training staff attended. Clinicians were responsible for maintaining their own CPD portfolio. Appraisal and revalidation were in-date for all clinical staff. Revalidation for the health visitor was facilitated by the Senior Nursing Officer.

The nurses facilitated peer review, mutual support and supervision for each and invited the medics to these sessions. Regular supervision and case discussion for the health visitor was through the public health lead. The physiotherapist had regular meetings with a physiotherapist at Portsmouth Regional Rehabilitation Unit, which involved a review of care to ensure appropriateness.

To ensure best practice, clinicians connected with primary healthcare (PHC) colleagues through events such as the annual DPHC Overseas conference which the PMO and SNO attended. The nurses were part of wider DPHC Overseas Primary Healthcare Nurses Network. Furthermore, the SNO was the Specialised Nurse Advisor for Royal Navy PHC and received/shared the latest updates with Defence PHC nurses.

Coordinating care and treatment

Discussions with staff indicated the practice had well developed links with local services, The PMO attended 6 monthly meetings with Gibraltar Health Authority (GHA). The practice had a GHA IT terminal which meant staff could request blooding tests, receive blood results and also request radiology services. The PMO attended Command Welfare meetings each month and the DPMO attended the Royal Gibraltar Regiment quarterly

welfare meetings. The SNO was exploring options for engagement with local civilian colleagues and had arranged a meeting with GHA and PHC nurse teams.

The practice provided release medicals for service personnel leaving the Royal Gibraltar Regiment. For patients remaining in the local area, a summary print out was provided to use when registering with a GHA primary care practice. If returning to the UK, patients could access their medical records on DMICP via a SAR (subject access request) from their UK practice.

Helping patients to live healthier lives

Clinical records we reviewed showed that supporting patients with healthy lifestyle options was routine to consultations where appropriate.

The practice had an integrated approach to health promotion, which was jointly run by the physiotherapist and practice nurse. Measures used to share health promotion information widely included through the mess, through the British Forces Broadcasting Services (BFBS) for Gibraltar and via the Facebook page for practice. In addition, the health visitor shared information and updates with the school and nursing teams. The unit physical training instructor coordinated the base health fairs with input from the practice and PCRF. The last health fair was held in January 2023.

Health and lifestyle information was available throughout the patient areas of the building. Displays included alcohol intake awareness, heat illness, mental health and physical activity. Specific information was available for parents of children, such as protection against various diseases and healthy bladder and bowels.

Both practice nurses were trained in sexual health having completed the Faculty of Sexual Health training. They could undertake screening or patients had the choice to attend the Well Person Unit at the local Gibraltar PHC centre. For terminations, patients returned to the UK or could go to a clinic in Spain. The doctors were responsible for the provision of family planning. The Well Person Unit provided contraceptive implants. Condoms were available in reception.

In line with national screening programmes, searches were undertaken for bowel (73 eligible patients), abdominal aortic aneurysm (small number) and breast (63 eligible patients). Women over the age of 40 are eligible for breast screening in Gibraltar. The number of eligible patients for breast screening was 142, of which 132 have had a smear in last 3 - 5 years which represented an achievement of 93%. The NHS target is 80%. Processes were in place to ensure patients were notified of their eligibility for screening. Similar to chronic diseases, a comprehensive programme of recall via DMICP searches with patients notified by telephone was in place.

The health visitor jointly ran the childhood vaccination programme in conjunction with the nursing team. The health visitor completed a summary of children immunisation on DMICP and advised parents when their child was due a vaccination.

Vaccination statistics for children:

- The percentage of children aged 1 who had completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (i.e., 3 doses of DTaP/IPV/Hib/Hepatitis B) was 100%.
- The percentage of children aged 2 who had received their booster immunisation for Pneumococcal infection was 100%.
- The percentage of children aged 2 who had received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e., received Hib/MenC booster) was 100%.
- The percentage of children aged 2 who had received immunisation for measles, mumps and rubella (one dose of MMR) was 100%.
- The percentage of children aged 5 who had received immunisation for measles, mumps and rubella (two doses of MMR) was 100%.

Vaccination statistics for service personnel:

- 94% of patients were in-date for vaccination against diphtheria.
- 94% of patients were in-date for vaccination against polio.
- 100% of patients were in-date for vaccination against hepatitis B.
- 98% of patients were in-date for vaccination against hepatitis A.
- 94% of patients were in-date for vaccination against tetanus.
- 99.5% of patients were in-date for vaccination against mumps, measles, rubella.
- 97.6% of patients were in-date for vaccination against meningitis.

The practice used a specific DMICP descriptor so when service personnel moved to new posting their immunological protection status was clear.

Consent to care and treatment

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. Implied consent was mainly used. The clinical records we looked at showed consent was obtained from patients where required. Consent was monitored as part of the record keeping audits.

Clinicians understood the Mental Capacity Act (2005) and how it would apply to the patient population group. Mental capacity was covered in the safeguarding training and a separate session had been scheduled as part of the in-service training programme. Clinicians were aware of both Gillick competence (young people under 16 with capacity to make a decision) and Fraser guidelines (advice/treatment focused on a young person’s sexual health).

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

Twenty-six patients provided feedback about the service as part of the inspection. All respondents indicated staff treated them with kindness, respect and compassion. We were provided with various examples of when practice staff had gone 'the extra mile' to support patients.

Staff had strong links with the welfare service, the health visitor service and Community Support team. Details about how service personnel and families could access the HIVE Information Centre was available, including through the Facebook page. The Community Support Team facilitated a youth club and social events for service personnel and their families.

The welfare team included the padre and 1 Unit Welfare Officer. In addition there were 2 Royal Gibraltar (RG) Regiment Welfare Officers. Command welfare meetings were held on a monthly basis and RG meetings held every 3 months. If there was a safeguarding concern then a meeting was called to ensure the patient was safe and receiving appropriate support. We spoke with the Padre and a Welfare Officer and both described the practice staff as caring and supportive.

Involvement in decisions about care and treatment

Our review of clinical records and patient feedback about the practice indicated patients were actively involved in the planning of their treatment and care.

A carers forum was held on a regular basis to discuss patients with a caring responsibility, particularly if they needed additional support. Staff were fully aware of the services and information was available in the waiting areas to signpost patients if required.

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

Privacy and dignity

A secluded area was available near reception if a patient needed a private discussion with reception or dispensary staff. The practice supported breast feeding and provided a quiet area if a patient wished to feed their baby in private.

All staff had completed the mandated Healthcare Governance and Assurance training as part of their induction. 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. There was a good gender mix within the team so patients could request to see a clinician of their preferred gender with the exception of physiotherapist. If a patient expressed a wish to see a male physiotherapist, they could be referred to Gibraltar Health Authority.

Are services responsive to people's needs?

We rated the practice as outstanding for providing responsive services.

Responding to and meeting people's needs

A highly responsive and flexible service was provided for all patients demonstrating that practice staff listened and acted on the feedback from patients and others to maximise the best service outcomes. For example, the emergency clinic in the morning was open to all patients, not just for service personnel. Flexible appointments with doctors were accommodated late afternoon and after working hours. In addition, the practice had recently started to open on Gibraltar (non-UK) public/bank holidays so was more flexible for patients. To support opening on these Gibraltar holidays, the practice had secured funding for environmental cleaning.

Practice staff pro-actively responded to the occupational needs of service personnel. For example, the nursing team facilitated a rabies vaccination clinic onboard ship for personnel deploying at short notice. In addition, the demand on the practice fluctuated as ships docked. This particularly affected the Primary Care Rehabilitation Facility (PCRF) as ships do not have a physiotherapist on board. This meant the PCRF was highly responsive to the needs of patients, including adjusting workload at short notice.

To minimise children missing lessons, dedicated appointment times for children were available outside of school hours. This initiative had led to an improvement with attendance for routine immunisations. A weekly child health drop-in clinic was held by the health visitor at the community centre and any concerns were raised at the practice multi-disciplinary meetings.

For patients referred to secondary care in Spain who did not speak Spanish, the Hospital Liaison Officer often accompanied patients to act a translator as they were fluent in the Spanish language.

Responding to patient feedback, funding was secured to make changes to the PCRF environment as feedback suggested the area was 'too clinical'. The response to this feedback and environmental improvements made were raised as a quality improvement project in March 2023.

Specific environmental health risks to the patient population were identified and information shared widely to minimise the risks. For example, the British Forces Broadcasting service covered jellyfish stings the day before the inspection. In addition, Gibraltar Health Authority facilitated a skin cancer screening day.

The practice was committed to meeting the principles of the Equality Act 2010, including safeguarding people with protected characteristics. Clinicians were aware of the organisational policy for the management of transgender personnel to ensure they received appropriate clinical care, support and early referral. No transgender services were available in Gibraltar so patients were referred to NHS services. We were advised

that service personnel were vetted prior to a posting in Gibraltar to ensure that primary care services could meet their needs.

An Equality Access Audit for the premises was completed in April 2022. An accessible toilet was available to patients and a hearing loop was available at reception. A business case had been submitted for an evacuation chair in the event the lift was out of use.

Timely access to care and treatment

All respondents to the CQC inspection feedback cards indicated it was easy to get an appointment that suited their needs. In addition to face-to-face consultations, telephone appointments and eConsult were regularly used. The medics facilitated an emergency clinic in the morning (referred to as sick parade) and the nurses were always available to review patients the medics had concerns about. Urgent same day appointments were available with a doctor on the day the patient requested. Routine appointments could be accommodated within 2 days. Same day appointments were available with the nurse. Although rarely requested, home visits were available.

Patients had the option to make a direct referral to physiotherapy. An urgent appointment with physiotherapist could be facilitated on the day the request was made and a routine appointment within 2 days. A new patient appointment with the exercise rehabilitation instructor (ERI) was available on the day it was requested. The ERI could see people a couple of times week if indicated. Often the physiotherapist and ERI carried out joint assessments. Two rehabilitation classes and 2 pool sessions were available each week. A podiatrist facilitated a clinic 3-4 times a year and could see civilian patients if there was capacity.

Occupational diving medicals could be accommodated within 1-2 weeks, sports diving medicals within 2-3 weeks and an aviation medical as and when requested. Royal Gibraltar Regiment recruitment medicals could be accessed promptly. There was a wait of 4 weeks for the Multidisciplinary Injury Assessment Clinic for patients who needed to be seen 'soon' and a wait of 6-7 weeks for a routine assessment. There was a 3-4 week wait for an MRI scan at Gibraltar Health Authority and the report usually followed 2-3 weeks later.

Out-of-hours (OOH) medical care was provided at the A&E department of St Bernard's Hospital. A&E communicated effectively with the practice regarding any patients seen OOH.

Listening and learning from concerns and complaints

The practice manager was the lead for complaints. Complaints were managed in accordance with Defence Primary Healthcare (DPHC) policy and local procedure. The complaints procedure was outlined in the practice leaflet and displayed in the patient waiting area.

Complaints were recorded on the centralised DPHC governance webpage. Two complaints had been received in the last 12 months. We discussed these with staff and it was clear they had been appropriately addressed and to the satisfaction of the complainants. Complaints were discussed at the healthcare governance meetings and at the practice meetings.

Are services well-led?

We rated the practice as good for providing well-led services.

Vision and strategy

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

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

The mission for DPHC Overseas (April 2023 – July 2023) was stated as:

- Continue to work safely in the context of the Covid-19 pandemic.
- Support operational capability of Headquarters British Forces (HQBF) Gibraltar subunits.
- Support operational units visiting Gibraltar where possible and report to DPHC and HQBF where this occurs.
- Develop coherence across the whole team delivering primary medical and rehab services
- Develop maturity in the eHAF monitoring system preparing for a potential CQC inspection.

Given the geographic isolation from other DPHC services and to ensure provision in accordance with the mission, the practice had developed strong and effective relationships with Gibraltar Health Authority (GHA). Importantly for patients, this meant access to health care out-of-hours. Furthermore, clinicians had access to a range of GHA services including diagnostics and secondary care. The Principal Medical Officer (PMO) attended regular meetings with GHA. For services GHA could not provide, the practice had an arrangement to refer patients to Spain or back to the UK.

Leadership, capacity and capability

We interviewed a wide range of staff throughout the inspection and all said leadership capacity was sufficient as leaders were visible with staff having prompt access to support and guidance if needed. They provided examples to demonstrate this support. In terms of capability, staff indicated they had every confidence in how the leaders managed the practice. They particularly made reference to how well the service was structured, integrated and how leaders invested in the staff team.

We found that the leadership team worked exceptionally well together and demonstrated high levels of experience, capability and resourcefulness to provide a person-centred, responsive and sustainable service for the patient population. Leaders took a pro-active approach to succession planning to ensure gaps in staffing were minimised and that staff

had adequate training, including staff new to the practice. The coherent and collaborative leadership approach meant the smooth running of the practice was not dependent on any one individual.

The leadership team described responsive and timely support from the regional team in the UK, even though the majority of the support was remote. The Principal Medical Officer (PMO) participated remotely in the DPHC Overseas Headquarters quarterly healthcare governance team meeting and attended the annual conference in person. In response to a request from HQBF, the practice aligned its working hours with UK public/bank holidays rather than those of Gibraltar. In addition to enhancing flexibility for patients, this change meant leaders were more flexible to engage with regional activities and events.

Culture

It was clear from patient feedback and interviews with staff that the needs of patients were central to the ethos of the practice. The team provided a seamless tri-service approach to care and were responsive to the needs, at times differing needs, of the 3 services, and also to the large cohort of civilian patients.

A responsive and patient-centred focus was clearly evident with this ethos embedded in practice. The team continually explored ways to improve the service for patients. This was reflected in developments and improvements made based on patient feedback, flexibility of access and recognising the needs of the patient population.

We heard there was an open-door policy with everyone treated equally regardless of service background, rank or grade. We were given many examples throughout the day of this ‘cohesive approach’. A message board was displayed and staff were encouraged to write ideas for improvements and record positive comments about colleagues.

All staff we spoke with indicated they had complete confidence and trust in the leadership team and would have no hesitation in raising professional standards issues with them. They were familiar with the whistleblowing policy. A ‘raising concerns and whistleblowing process’ flowchart was displayed for quick reference.

Processes were established to ensure compliance with the requirements of the duty of candour, including giving those affected reasonable support, information and a verbal and written apology. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. The practice maintained a duty of candour log. The Senior Nursing Officer facilitated duty of candour training for staff in July 2023.

Governance arrangements

There was a defined staff reporting structure in place. Staff were aware of their roles and responsibilities. Terms of reference were established for those with secondary roles. Staff with lead roles had protected time to carry out their additional duties.

The PMO was the for healthcare governance (HCG). A range of formal and informal meetings were held to ensure effective communication and information sharing across the staff team. A briefing meeting was held daily to ensure the smooth running of the service. The monthly meeting schedule included management, HCG, ASER/audit and clinical multidisciplinary meetings. In addition, a senior management weekly 'huddle' meeting was established. A Friday lunchtime meeting provided staff with a Command briefing, general update and a review of the message board. A quarterly whole-team meeting was held to provide staff with an update on HCG activity.

The practice manager was responsible for ensuring the HCG workbook was up-to-date. The workbook is an overarching system used to bring together a range of governance activities, including the risk register, medicine alerts, audit, health and safety and quality improvement. The workbook was clear and comprehensive and all staff had access to it.

The last second party internal assurance review took place in February 2022. The practice achieved limited assurance in the safe and caring domain and substantial assurance the effective, responsive and well-led domains. All the recommendations made had been completed. Although the recommendation regarding shared care agreements for high risk medicines had been addressed, we identified further gaps with the governance of these medicines.

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, kept under scrutiny by the practice manager and discussed at the HCG meetings. Risks were discussed with base Command on a quarterly basis. The top risks identified by the practice were in relation to the logistics of deliveries and DPHC processes that were not effective overseas, such as the text message reminder system.

Processes were in place to monitor national and local safety alerts, incidents, and complaints. This information was used to improve performance. Some of the governance processes had been enhanced to maximise safety, such as the management of significant events/incidents, use of clinical coding and the 'safety net' approach to referrals.

The business continuity plan (BCP) was reviewed in January 2023. It took account of all the likely generic system failures and had clear guidance for the need to relocate if required. Team table-top exercises had been undertaken to consider responses if the BCP was activated. A base-wide major incident plan was in place and was being reviewed at the time of the inspection.

The leadership team was familiar with the policy and processes for managing staff performance. Although not a concern that was indicated, were familiar with the range of processes to manage performance including welfare support, re-training, appraisal and disciplinary processes.

Appropriate and accurate information

The DPHC electronic health assurance framework (referred to as eHAF) was used in to monitor performance. It is an internal quality assurance governance tool to assure standards of health care delivery within defence healthcare. The PMO developed an eHAF plan each month, which involved a specific area allocated for the attention of the team to input.

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

Engagement with patients, the public, staff and external partners

Various options were available to engage with and prompt patients to provide their views on the service. A quick response or QR code was displayed in the patient waiting area to access the DPHC online survey. A separate QR code was displayed to access the Primary Care Rehabilitation Facility patient satisfaction questionnaire. In addition, a QR code was displayed for access to the SSAFA health visiting and school nursing Facebook group. Patient feedback was discussed at practice meetings. Previous attempts to set up a patient participation group had been unsuccessful. A further attempt was planned to take place in Autumn 2023.

Good and effective links were established with internal units and services including the welfare team and the units.

Continuous improvement and innovation

The audit and quality improvement registers clearly demonstrated that the practice continually sought to improve the service for patients. Although there was evidence of quality improvement activity, we identified various initiatives and areas of good practice which had not been raised as a quality improvement project (QIP). Raising QIPs and uploading them to the DPHC Healthcare Governance webpage showcases positive performance and also enables the sharing of good practice with other DPHC facilities. The efficient use of the clinical coding system is a good example of an initiative that would benefit from being raised as a QIP.