HMS Drake Medical Centre

Exmouth Block, Devonport, PL2 2BG

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	**Requires improvement**	
Are services safe?	**Inadequate**	
Are services effective	**Requires improvement**	
Are service caring?	**Good**	
Are services responsive to people's needs?	**Good**	
Are services well-led?	**Requires improvement**	

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Summary

About this inspection

We carried out this announced comprehensive inspection on 28 November 2023.

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

Are services safe? – inadequate

Are services effective? – requires improvement

Are services caring? – good

Are services responsive to people's needs? – good

Are services well-led? – requires improvement

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 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. However, they lacked the capacity and authority to resolve many of the known issues and had to prioritise patients over administrative tasks and monitoring as well as work excessive hours to safeguard patient safety.
- 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. However, patient safety was compromised due to the lack of visibility over the clinical records of patients on ships who became the responsibility of the practice when in dock. This is a known and long-term ongoing problem for the Royal Navy. The practice was aware of this and had taken steps to partially mitigate the risk. However, the responsibility to find a solution was at DPHC headquarters level.

- The practice worked collaboratively with internal and external stakeholders. Considerable efforts have been made to inform, quantify and articulate the challenges faced and the risks involved with the low staffing levels.
- There was a large backlog of notes that had not been summarised and there was no solution offered to resolve this or mitigate the risks involved.
- The arrangements for managing medicines required strengthening.
- Quality improvement activity took place despite the challenges with staffing levels. Of note, there was an embedded programme in the PCRF used to drive improvements in patient care.

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

- The Primary Care Rehabilitation Facility (PCRF) had implemented a health behaviour support programme for patients. Extra training had been provided to physiotherapists and to the exercise rehabilitation instructor (ERI) to enable them to support patients with adverse health behaviours during the time that patients were under their care. This included 'brief interventions', for diet and nutrition, sleep, physical activity and signposting for further support.

The Chief Inspector recommends to the practice:

- Ensure that all currently vulnerable patients are known to the medical centre team at all times and that the team is taking action to protect their health and welfare.
- Implement an effective plan to reduce the backlog of clinical notes that require summarising.
- Introduce a structured programme for the monitoring of doctors' clinical notes. This should include a review of treatment and care being delivered in accordance with clinical guidelines.
- Introduce safe and effective processes to monitor patients prescribed high risk medicines and to regularly review those on repeat medication.
- Ensure that a formal programme of targeted clinical improvement work (including clinical audit) is delivering improved outcomes for patients.

The Chief Inspector recommends to the base:

- Find resolution for the medical centre building such that it complies with the Health and Social Care Act 2008 code of practice on the prevention and control of infections and related guidance.
- Review the arrangements for sounding the alarm so that all clinicians could summon help and support if faced with a medical emergency.

The Chief Inspector recommends to DPHC:

- Urgently increase clinical and administrative capacity at Drake Medical Centre such that expectations on staff are reasonable and individuals feel adequately supported to provide primary healthcare. Clinical staff should not be routinely called upon to work hours in excess of either the Defence Instruction and Notice (DIN) or the Working Time Regulations (1998).
- Review and respond to the PMO's escalation of risks that have been formally escalated and attributed to insufficient staffing numbers.
- Urgently find a solution to the practice not being able to see the clinical records of patients they hold responsibility for.
- Review and revise the cleaning contract to ensure that the national standards of healthcare cleanliness 2021 are met.

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 and a team of specialist advisors, including a primary care doctor, practice nurse (remote), pharmacist, physiotherapist and practice manager.

Background to HMS Drake Medical Centre

Located within Devonport Naval Base in Plymouth, Devon, HMS Drake Medical Centre provides primary care, occupational health and a rehabilitation service to patient population of approximately 6,000 service personnel, along with those who are registered on the ships and submarines in the dockyard. Families and dependants are not registered at the practice and are signposted to local NHS practices. HMS Drake is home to the Southwest Personnel Support Group which is the parent unit for personnel who are unfit for their primary role and HASLER Naval Service Recovery Centre, which manages the most significant wounded, injured or sick personnel from across the Royal Navy. The majority of the patients are aged between 18 and 60 with a small number outside this range. Family planning advice is available within the practice. The practice provides maternity care shared with the named practice midwife at the local maternity centre. They also provide post-natal care to patients that remain in the Plymouth area for their maternity leave. The practice provides 365 days a year, 24-hour reach-back support for base port units, ships and submarines. For 2 months of the year, medical cover is provided to naval bases in the Southwest so there is no summer or Christmas shutdown at HMS Drake Medical Centre.

The practice is open Monday to Friday from 07:45 to 16:00 hours (15:00 on a Friday). Duty medical staff can triage patients out of hours and direct to the local out of hour providers as required. Outside of these hours, medical cover is provided until 1830 by HMS Raleigh Medical Centre and the Duty Fleet Medical Officer for Devonport and the Drake Duty Medic. From 18:30 hours weekdays, at weekends and for public holidays, patients are advised to use NHS 111. Patients requiring urgent care out-of-hours are also signposted to the hospital based Medical Assessment Unit in Plymouth and emergency care at Derriford Hospital.

The staff team

Doctors	Principal Medical Officer Deputy Principal Medical Officer 6 civilian medical practitioners – 4.4 whole time equivalent (WTE)
Nurse	Senior Nursing Officer – military 4 nurses (1 military)
Pharmacy technicians	1 military 1 civilian
Practice management	Medical Administration Officer – military Practice Manager – military
Lead medical assistants Petty Officer medical assistants Medical assistants	3 (2 posts not filled) 2 (1 post not filled) 3 (1 trainee)
Administration staff	8 WTE (2 full-time posts not filled)
PCRF	8 Physiotherapists – 6 WTE 4 Exercise Rehabilitation Instructor – (2 posts not filled) Administrator - 1

Are services safe?

We rated the practice as inadequate for providing safe services.

Safety systems and processes

The Principal Medical Officer (PMO) was the overall safeguarding lead supported by a civilian medical practitioner (CMP) and Deputy Principal Medical Officer (DPMO) who were the respective leads for children and adult safeguarding. Safeguarding was included as part of the induction and the induction pack contained details of the local teams. Staff had completed safeguarding training at a level appropriate to their role. There was a link to both the safeguarding children and young people policy and vulnerable adults standard operating procedures (SOPs) within the healthcare governance (HCG) workbook. Due to local contact/referral systems changing and being on the boundary of 3 different NHS teams, staff were encouraged to look up contact details on the internet at the time of needing them. Safeguarding was a standard agenda item at the weekly doctor's meeting and the PMO or DPMO attended the weekly 'carer support forum' which included a separate meeting to Personnel Support Group and HASLER Service Recovery Centre (NSRC, the most seriously ill, complex and long-term injured patients). One of the civilian doctors worked part-time in the NHS and brought this knowledge and experience into the clinical meetings. There were also links to the 'Plymouth vulnerable hotline' in every clinical room. Registered patients lived all over the UK and when not at sea often returned home. This made it more difficult to connect with local NHS safeguarding teams distributed all over the country.

A vulnerable patient register was in place and patients on the register had an alert added to their records on DMICP (the electronic clinical operating system). However, the register had not been consistently updated. No searches had been run recently to identify any missed carers or vulnerable patients.

The practice managed a cohort of vulnerable patients referred to as the 'NSRC'. These patients had significant needs (mental health, new significant diagnoses such as cancer) and approximately 90% were eventually discharged on medical grounds. The time to discharge averaged approximately 18 months and therefore put added pressure onto an already under resourced team. We saw examples of how well managed the NSRC was. This included reaching out to support the families of patients and developing links with safeguarding teams where patients lived in order to triangulate care.

There was a chaperone SOP displayed in clinical rooms and at reception. This included a list of chaperones, both male and female were available.The chaperone policy was outlined in the patient information leaflet. All staff had completed chaperone training and the SOP had last been reviewed in September 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 Disclosure and Barring Service (DBS) checks to ensure staff were suitable to work with vulnerable adults and young people. A process was in place to monitor the professional registration and vaccination status of staff. The practice manager completed a professional registration check monthly, which included any locums and GP

trainees working within the practice. Employability checks for locums were completed by the staff bank and these were checked by the Medical Administration Officer prior to employment. DBS dates for staff were held on the staff training database managed by the practice manager, the Regional Headquarters Assurance lead sent a reminder to the practice manager when they were due to expire. A database was held for the vaccination status of staff members. This was updated on arrival and managed by the Senior Nursing Officer (SNO) and one of the civilian nurses. All relevant staff had indemnity insurance.

An infection prevention and control (IPC) policy was in place. The SNO was the lead for IPC supported by a deputy from the nursing team, both had completed training for the role. The most recent IPC audit was completed in September 2023 ahead of the inspection. A 10-point action plan of minor non-compliance had been developed in October 2023. Points included a sink that was not plug-free, coved edges coming away from the wall, alcohol gel not being wall mounted and reception chairs not being wipeable. None of the non-compliance areas presented a serious risk to patient safety but they did prevent the building from being effectively cleaned. General environment, equipment and environmental sluice action plans were included in the main plan. There was no sluice so bodily fluids had to be discarded in the toilet. This issue had been transferred to the risk log. High-level curtains (covering large windows) were in some treatment rooms and were not included in any cleaning schedule. Staff were reluctant to remove them as the rooms were west facing and had no air conditioning so reached uncomfortable temperatures on hot days. The curtains served as a barrier to the sun. Timeframes and individual responsibility had been assigned against each action but many of the issues required external input and budgetary approval. The practice told us that a long-term resolution of a new building had been talked about but there was no known firm plans in place.

Acupuncture was provided by some of the physiotherapists and a policy and risk assessments supported its safe provision.

A contract and schedule was in place for environmental cleaning. The cleaning contract was centrally managed by the MOD and Drake Medical Centre did not have sight of the contract. Although the SNO monitored the cleaning and liaised regularly with the cleaning team, they had not been able to establish regular communication with their line manager. Therefore, issues highlighted internally were not being addressed in a timely manner. For example, the SNO had asked when deep cleaning was last carried out but had not received a response. As IPC lead, the SNO described the cleaning arrangements as unsuitable. Some areas on the cleaning schedule classed as very high risk had only a once daily clean. Although clinical rooms were cleaned daily with an additional check, the nursing team had to clean their own rooms between morning and afternoon clinics.

The pharmacy technician was the lead for clinical waste, the contract was managed by the Contract Monitoring Team for the base. Supported by a waste disposal policy, the management of clinical waste included a waste log. Consignment notes were uploaded electronically and could be accessed via a portal. We explained the requirement to login to gain access to view electronic consignment notes and disposal certificates. Clinical waste segregation posters were displayed. The clinical waste was secured and was external to the building. A clinical waste audit was undertaken in September 2023, no issues were noted.

Risks to patients

The PMO indicated that available medical and administrative hours were not sufficient to meet the needs of the patient population. These concerns had been articulated in a letter sent to the Regional Clinical Director and the Captain of the base in October 2023. The letter stated that with the expected increase in patient numbers within the next 6 months, safe care and treatment would not be possible with current staffing numbers and the use of short-term temporary healthcare workers. The PMO forecasted that the wait time to see a doctor for a routine appointment would be persistently greater than 20 days if no action was taken. This would result in risk from delayed treatment which was accentuated by the complexity of some of the patients managed. Concerns were also raised that this would have a negative impact on the wellbeing and retention of staff. We spoke with the Regional Clinical Director who supported the points raised by the PMO but was not able to authorise immediate action to address the gaps and increase the number of established posts. The letter also detailed that some elements of governance had been deprioritised to prioritise patient care. The practice supported naval bases in the region during periods of 'block' leave in August and during the Christmas period. Therefore, the risks extended to patients who became the responsibility of Drake Medical Centre during these times.

The medical emergency trolley and medicines were checked each month or if the trolley had been opened/used. Tags were in place with a list of expiry dates held. We checked all items, and they were in-date. Oxygen was held with the trolley, and it was full and in-date. The Entonox (a mixture of gas and air used for pain relief and control anxiety) cylinder was not full but the practice reported that it had been used on an emergency patient. Full and empty gas cylinders were stored appropriately in an area away from the building. We highlighted that the controlled drug (CD) and emergency drug cylinders were free standing (these should be tethered to the wall) and one of the hazardous chemical posters was missing.

The staff team was up to date with training in emergency procedures, including basic life support, anaphylaxis (a life-threatening allergic reaction) and the use of an automated external defibrillator (AED). Administration staff told us they had completed sepsis training; however, this was not recorded anywhere. All required staff completed the mandatory heat illness protection and cold injury prevention training online, the medics completed additional training. The practice had a member of staff that was BATLs (Battlefield Advance Trauma Life Support) trained who conducted training sessions with staff. There had been several medical emergencies on base including an open fracture and cardiac arrest which a doctor and medic had responded to. The practice used these situations as training opportunities. Following the incident, the PMO completed a walkthrough of the medical emergency and the team discussed why they gave the treatment they did and what could be done better.

The PCRF had 2 exercise rehabilitation instructor positions, but the patient list size required four (using a scaling model). This reduced capacity had impacted the delivery of some exercise classes. The priority was on transition from rehabilitation to military fitness. The increased future demands (from the planned increase of 600 patients) had been put on the risk register and highlighted the increase in submariners (increased requirement for treatment due to longer deployments in a confined space).

Wet Bulb Globe Temperature checks to indicate the likelihood of heat stress were undertaken. An AED was in place in the PCRF building.

Information to deliver safe care and treatment

In the event of an IT outage impacting DMICP access, staff referred to the business continuity plan. Staff advised that there were occasional issues with accessing DMICP, but it did not impact patient care. However, we were told that the instability of the system had resulted in documents not saving or updating as well as tasks sent electronically not being reliable. A process was in place to use paper documentation as a contingency which was later coded and scanned to the patient's record. The following day's clinics are printed off in case of any outages.

There was no summarising process in place, which meant their backlog was 1,695 notes that required summarising. We were told that this was due to the lack of capacity of clinicians to complete the work systematically. Staff were aware of the risks this presented in that the management of new patients relied on them arriving with the correct information, clinical coding (to allow them to be captured on relevant clinical searches) and appropriate alerts being in place. All new patients completed the new joiner's registration form through a quick review or 'QR' code received by email to the administration office and actioned by the Lead Medical Assistant. There was currently no way to identify if there were patients that had been posted to HMS Drake but had not registered with the practice. This has been identified by the management team and they planned to liaise with the Unit Personnel Office (UPO) to try and capture all new joiners.

No arrangements were in place for the auditing of doctor's record keeping. This was again attributed to a lack of clinical capacity to carry out the work. We reviewed a wide range of DMICP records and found record keeping was of a good standard. The nursing team had recently conducted a peer review of clinical records and were due to discuss the findings in December 2023. This had not previously been done due to a lack of nursing staff. The PCRF had implemented a peer review of clinical records and used them as an opportunity to bring patients in for a joint assessment. This was captured within the supervision/mentorship process.

One of the administrators had the lead for managing referrals. A system was in place to manage referrals, DMICP numbers were used to promote confidentiality and access to the document was restricted to staff assigned to monitor referral status. The tracker had separate tabs on the spreadsheet, for example for urgent referrals and internal referrals. The PCRF referral monitoring was integrated into the system. The Devon Formulary website was used and the PMO received local NHS updates that gave an indication of wait times. We discussed that best practice would be to track the referrals beyond the confirmation of appointment by continuing until the practice received a letter back from the hospital post attendance. The practice did not have the capabilities to receive documents electronically from secondary care. The local hospital had moved to an electronic only system so administration staff often had the additional task of having to manually request a hard copy of letters.

A process was established for the management of samples. All samples must be entered into the treatment room specimen/sample log before being sent. A second checker had been added to the log due to the number of samples that had historically been rejected or were said to have never been received. The duty nurse maintained an oversight of the register by checking the previous three days' status of samples and the laboratory was contacted if there was any delay with the return of results. Requesting clinicians reviewed results through Path Links (NHS clinical pathology network). The PMO explained that

informing patients of results was complex due to the different platforms/locations (ships, submarines, firm base). Patients were informed of any abnormal result but not routinely informed of a normal result. Should patients wish to discuss results, they were advised to book an appointment with the requesting clinician leaving a suitable time gap to ensure the results were returned. The PMO recognised that this was not an ideal situation and was uncomfortable with the process. A patient satisfaction response saw an error in the communication of a result was made. Staff were informed verbally and the issue was discussed at the practice meeting but a reliable process had not been identified.

Safe and appropriate use of medicines

The PMO was the lead for medicines management supported by the DPMO. It was understood that day to day responsibilities had been delegated to the pharmacy technicians but this was not reflected clearly in their terms of reference. The patient could collect the prescription from the dispensary or from a nominated community pharmacy (with this option, there is a charge at private prescription rate but the cost could be claimed back).

Prescription forms were effectively managed. Prescriptions and related documentation were locked away in the dispensary and entered onto a log sheet upon receipt and upon issue to individual prescribers. In this way, any unaccounted prescriptions could be linked to a prescriber but we highlighted than a running total of prescriptions would help with monitoring stock levels. A register for prescriptions for controlled drugs (medicines with a potential for misuse) was maintained and the prescriptions were kept in the safe. All details were recorded as specified in the controlled drug (CD) book for receipt and issue. This included a record of who had collected the item when not the patient prescribed to. A check showed that the running total correlated with the physical balance. The keys were kept separately but were not sealed and there was no log to record access to the cabinet. We highlighted that to maintain security, access to the CD cabinet, keys and dispensary keys should be logged in line with policy (JSP 950 leaflet 9-2-1). Quarterly and annual CD returns had been completed. Destruction of CDs had been carried out in accordance with policy and certificates were retained.

Vaccines were stored in fridges and the stock (including the expiry date) recorded on DMICP. Fridge temperature checks were undertaken in accordance with policy. The nurses were aware of actions to take if temperature excursion occurred. Stock was in-date and stored according to expiry dates. Stock was being stored at the bottom of the fridge preventing air flow but this was corrected on the day and all stock was placed on shelves. The treatment room fridge was not locked, and nor was the door to the room. However, new lockable fridges were on order.

A safe system was in place for repeat prescriptions; requested via e-Consult or through a direct request to the prescriber during consultation. No telephone or postal prescription requests were accepted. There was no proactive process (for example, the use of clinical searches to identify patients on repeat medication who are due a medication review) in place for medication reviews due to a lack of clinical capacity. Prescription and treatment reviews were undertaken when repeat medication was requested.

The SNO was a nurse prescriber and for efficiency, used PGDs for vaccinations. PGDs were in-date and had been appropriately authorised by the PMO. Five consultations were checked and all had used the DMICP template and were correctly recorded. An annual PGD audit had been completed.

Any recommended medication change advised by secondary care was scanned onto DMICP and tasked to the duty doctor.

There was no system, list or register in place for high-risk medicines (HRM) until a few weeks before the inspection when the PMO identified that there was no lead for medicines management. The DPMO and pharmacy technicians were now tackling this and had made good progress. The practice had obtained an agreed list of red/amber drugs as per the Devon formulary and had used the DMICP standard searches to identify patients. However, further work was required to ensure registers were accurate, patients were correctly coded and then embedding into routine searches to gain oversight and assurance of the required monitoring.

Shared care agreements (SCAs) with secondary care services were in place if indicated. However, on review we found that these were not complete. For example, a shared care guideline for Methotrexate (a medicine used to rheumatoid arthritis) was not in the patient notes and the SCA form did not provide the parameters for blood monitoring.

The search for patients prescribed valproate (medicine to treat epilepsy and bipolar disorder) was last undertaken in November 2023. However, there was no evidence of a programme of regular searches. An antibiotic audit had not been undertaken recently and this was attributed to the lack of clinical capacity.

Track record on safety

There was a nominated health and safety representative for the building with support provided by the contracted safety team for the base. The Health and Safety Executive poster was displayed on the safety board and included the named responsible individuals. Also displayed were the fire risk assessment, fire orders for the building and management plan. One of the staff team was identified as the fire safety representative. Staff advised us that regular fire drills were conducted.

Evidence was in place to confirm the contractor carried out water safety checks. The annual gas check and the 5-yearly electrical safety were in-date and managed externally by the safety team for the base.

A lead for equipment care were identified. An equipment assessment (referred to as a LEA) was undertaken in December 2022 and the minor recommendations had since been completed. Testing of portable appliances was carried out in September 2023. Rehabilitation equipment was in-date for servicing and well maintained.

The Petty Officer was the health and safety lead and had completed the building manager’s training course. The Medical Administration Officer was the designated lead for risk management and had signed up to do the risk assessor’s and managing safety courses. A register of up-to-date risk assessments covering all aspects of patient/staff safety was in place, including lone working and Control of Substances Hazardous to

Health (COSHH) risk assessments. COSHH products were stored appropriately. The Officer in Command for the PCRF managed the risk assessments and all were in-date.

The risk register identified 4 active risks managed by the practice to either 'treat' or 'tolerate'. The risk register was reviewed and updated each month at the healthcare governance meeting. Updates were sent to all staff for discussion at weekly departmental meetings and termly whole practice meetings.

There was no in-built alarm system in place and the practice utilised personal alarms to summon assistance in an emergency. There was also a tannoy system. However, both the personal alarms and tannoy system cannot be heard in all the areas. This had been a known issue for a number of years but had not been added to the practice issue register. The physiotherapy rooms had personal alarms and there was a cord pull alarm system in the gymnasium. There was an SOP for lone working that stated a minimum of two people minimum working in the PCRF and the gymnasium in order for them to be open.

Lessons learned and improvements made

All staff had access to the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events and incidents. An ASER register was maintained and an ASER overview was included as a standing agenda item at the practice meetings. ASER trends were discussed at the management meeting.

From interviews with staff and evidence provided, it was clear there was a culture of reporting incidents. All staff we spoke with gave examples of incidents reported through the ASER system including the improvements made following the outcome of investigations. For example, the ASER process was used to identify a trend in specimen sample rejections from the laboratory. This resulted in a second check being introduced to the sample log sheet and ongoing discussion with the hospital on how to improve the flow of information. Following a needlestick injury, the practice identified that the DPHC policy and Joint Services Publication on managing a contractor with a needlestick injury were different. This was highlighted and the DPHC SOP was updated.

Patient safety alerts were recorded together with a note of actions taken. Staff told us that only relevant alerts were discussed at governance meetings. However, minutes of these meetings did not include any record of discussion. We discussed the potential to improve the system by making a record of all alerts and adding a link on SharePoint to the spreadsheet where alerts are recorded.

Are services effective?

We rated the practice as requires improvement 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, the Scottish Intercollegiate Guidelines Network, clinical pathways, current legislation, standards and other practice guidance. New or updated guidance was discussed at the weekly clinical meetings. In addition, any change in process as a result of a change in guidance was discussed at the management meeting. The Principal Medical Officer (PMO) stated that there was insufficient clinical capacity to keep internal standard operating procedures (SOPs) up-to-date and to monitor adherence of guidelines through peer review.

Staff were kept informed of clinical and medicines updates through the Defence Primary Healthcare (DPHC) newsletter circulated each month. Patients with vulnerabilities and/or complex needs were discussed at clinical meetings and at the fortnightly carer's forum.

Patients with mental health needs were managed and supported in line with standard practice. The Department of Community Mental Health (DCMH) had provided doctors with training in Step 1 of the mental health intervention programme. Standardised clinical codes were applied and patients were regularly reviewed. The chain of command was involved if appropriate and the DCMH was available for additional advice and guidance. If referred to the DCMH, the patient had an initial assessment within 3 weeks or within 24 hours if urgent. Self-help booklets were held available in the consultation rooms and there was an electronic leaflet for patients. Local Community Psychiatric Nurses (CPNs, attached to the Surface Fleet to work in the prevention of mental illness, not in treatment) undertook a Step 1 workshop (out of the PCRF building) which patients could book onto, informal feedback had been positive.

Patients could also be signposted to SSAFA (Armed Forces Charity),Padre and to the welfare team. Our review of records for patients with a mental health need showed they were appropriately supported and managed. Consistent clinical coding was used.

As part of the nurse meeting, the Defence Primary Healthcare (DPHC) newsletter was reviewed and this included updates on clinical guidelines. Nurses were encouraged to share any evidence-based practice and a member of the team who had recently attended a travel health study day had shared the slides and immunisation useful links and information with colleagues. It was planned for the nurses to attend the doctors' meeting once a month to discuss chronic disease with the lead nurse by condition in attendance to discuss those on the register.

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) in main gym.

The physiotherapists referred to the Defence Rehabilitation intranet site to ensure best practice guidance was being followed. The musculoskeletal health questionnaire (MSK-HQ) was routinely used and relevant clinical coding applied for audit purposes.

The physiotherapist used Rehab Guru (software for rehabilitation exercise therapy), which provided patients with injury prevention information and templates. The PCRF was consistently meeting all of its key performance indicators.

Monitoring care and treatment

The Senior Nursing Officer (SN) was the lead for chronic conditions and managed the registers and the patient recall. The Deputy Principal Medical Officer was the deputy for the chronic disease registers and the practice nurse deputised for the recall of patients. The management of patients with a long-term condition was under review. There was specific issues around the interface between Defence Medical Information Capability Programme (DMICP) fixed (used in firm base medical centres) and DMICP deployed (used for example on ships and submarines). Maintaining accountable oversight for patients who were deployed, particularly those with a chronic condition, was challenging when patients moved between two versions of the clinical recording system. As a result, not all patients who received care at the practice were registered with the practice and therefore it was challenging to search for and identify these patients. This was a known long-term issue for the Royal Navy that sat at headquarter level. The PMO recognised that there was a lot of unmanaged risk and needed additional capacity to track down patients who did not appear on the practice's patient list and in their searches. During the inspection, we discussed this being added to the risk register as patients with long-term conditions could not be managed in line with DPHC expectations.

We reviewed the delivery of care for known patients, registered at the practice, with a chronic condition including asthma, diabetes and high blood pressure. Our review of a range of patient records showed these patients were recalled and monitored in a timely way appropriate to their needs. Methods of identifying patients at risk to developing diabetes included opportunistic screening and a search for those with a raised blood sugar level (HbA1c test). Any patients found to be at risk were offered annual blood tests, check-ups and health promotion advice.

Audiology statistics showed 52% of patients had received an audiometric assessment within the last 2 years. The uptake was low but a catch up programme was planned and a locum healthcare assistant had been allocated to support the medical assistants in completing the work.

Due to the prioritising of 'see and treat' patients, clinical audit activity was minimal. DPHC audits had been completed but we discussed the potential to prioritise clinical audits over DPHC returns to help improve patient safety. There was an audit programme in the PCRF that included infection prevention and control, wellbeing (captured health behaviour) and clinical notes (included adherence to best practice guidelines, 38 out of 45 adhered to guidelines in the last cycle).

Effective staffing

Staff had received an appropriate induction and appraisal. New members of staff were sent a joining letter prior to arrival which included useful information about the base and

who their line manager would be. They were also added onto the staff training database and the mandatory training information was included in the welcome email. New members of staff were required to complete the DPHC mandated induction which had been modified to include role specific elements. Tabletop instructions were provided for all civilian administration roles. The induction package was recorded on the staff training database managed by the practice manager.

The PMO stated there was protected time allocated to support mandatory training and continued professional development (CPD) but this was limited by clinical capacity. However, the team were encouraged to prioritise this when capacity allowed. With the lack of capacity to do peer review, doctors determined their own educational needs. The PMO highlighted that this was not a sustainable way of working as it did not allow any skill gaps to be identified. The PMO did have a one to one with each doctor every 3 months when checks of current registration were caried out and support provided to achieve their CPD requirements in line with GMC appraisal. Otherwise, this was achieved on an ad-hoc bases, informal communication and discussions with colleagues and the team. To aid the doctors in the completion of CPD and their mandatory training, the doctors' meeting has been changed from weekly to fortnightly which allowed protected CPD time every other Wednesday.

Links to the training platforms were held on the staff training database which all staff could use to see what training was due and access the online courses using links. Completion of mandated training was managed by the practice manager using a database that showed completion by course for all staff. Clinicians had the appropriate qualifications to meet the needs of the patient population. PCRF staff had annual appraisals, attended regional training and the physiotherapists were trained to provide acupuncture and kept up-to-date through continued professional development (CPD) (10 hours over 2 years as recommended). All doctors were dive medicine trained and two doctors were Military Aviation Medical Examiner trained. Opportunities were available for staff to pursue special interests. However, this was prioritised so that it would benefit the needs of the patient population. For example, the demand for diving medicals was greater than for Heavy Goods Vehicle medicals.

Tuesday afternoons were designated to nurse training and there was an appointed lead to monitor progress and support trainees in accessing courses. All trainees were given a timetable at the start of their placement and were encouraged to work amongst other departments to increase clinical exposure. Within the team, specific training courses had been completed for sexual health, ear irrigation and infection prevention and control. The SNO was informed when updates and competencies were required and was aware of any gaps in clinical training. However, nurses told us that they often had to use protected time on Tuesday afternoon to catch up with administrative tasks.

Clinicians were responsible for maintaining their own CPD portfolio. Appraisal and revalidation were in-date for all clinical staff. The practice manager conducted a meeting with all medics on arrival to discuss promotion and development opportunities. The open-door policy was also discussed to make the medics aware that they can approach the management team with any issues or concerns.

Coordinating care and treatment

Discussions with staff indicated the practice had well developed links with internal teams and services. For example, the practice was represented at the Personnel Support Group who met weekly as the 'Carer's Forum' chaired by a Senior Divisional Officer. meeting and unit health committee meeting. We spoke with the Welfare Officer who complimented the practice for thinking beyond the medical requirements of patients and considering the social impact on patients. The practice had developed good links with the local NHS hospital in Plymouth. There was a local acute GP admission service and patients were sent to the local Medical Assessment Unit for advice, urgent care and investigations. Fast track reporting of X-rays was available with same-day result achievable. One of the doctors had developed good links with local obstetrics and gynaecology services.

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. Patients were also made aware of an extensive list of services available to them when leaving the military and for veteran's services through a medical summary form (known as an FMed133) developed by Defence Primary Healthcare. The Welfare Officer spoke of an effective multidisciplinary approach that managed patients leaving the military and commended the medical centre staff for being a fundamental part in this process.

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 SNO was the lead for health promotion and one of the nursing team was deputy. Health and lifestyle information was displayed in the waiting area where a range of varied health promotion displays and leaflets were available. These took account of Public Health England and the NHS approach to health promotion. For example, there were displays specific to prostate cancer and alcohol awareness. The practice participated in unit-led health fairs. The last one was held in November 2023 was attended with an alcohol awareness stand.

One of the doctors was the lead for contraception and sexual health. Patients could self-refer to the local NHS sexual health service, which staff described as a good service. In addition, there was the option to refer patients to the Military Advice and Sexual Health/HIV (MASHH) service at Birmingham for more complex sexual health needs.

PCRF staff were involved with preventative health promotion work. Courses had been provided to support health behaviour change and the in-service training was linked to health and wellbeing (alcohol, sleep). The women's health physiotherapist had delivered training to the unit's maternity cell and the ERI had facilitated workshops on injury prevention for nearby units.

Monthly searches were undertaken for bowel, breast and abdominal aortic aneurysm screening in line with national programmes. Appropriate action was taken to prompt patients to uptake screening if eligible. Ninety-five per cent of eligible women had had a cervical smear in the last 3-5 years. The NHS target is 80%.

Due to staff shortages, there was no proactive approach to patient recall for vaccinations. Staff captured patients opportunistically when in the medical centre. Vaccination statistics suggested this approach was acceptable, noting that all routine vaccinations exceeded 85%. Statistics were as follows:

- 87% of patients were in-date for vaccination against diphtheria.
- 87% of patients were in-date for vaccination against polio.
- 84% of patients were in-date for vaccination against hepatitis B.
- 91% of patients were in-date for vaccination against hepatitis A.
- 87% of patients were in-date for vaccination against tetanus.
- 98% of patients were in-date for vaccination against meningitis.
- 92% of patients were in-date for vaccination against mumps, measles and rubella.

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 consistently obtained from patients where required, including for acupuncture. Written consent was taken for invasive procedures and implied consent for non-invasive examinations. The acupuncture form used included a section to record consent. Monitoring the appropriate recording of consent was not routinely carried out as it was part of the audit of clinicians' record keeping.

Clinicians understood the Mental Capacity Act (2005) and how it would apply to the patient population group. Staff training in mental capacity had been incorporated as part of the chaperone training. We were provided with an appropriate example of when a mental capacity assessment had been undertaken in collaboration with DCMH. However, MCA training was not undertaken as routine, clinicians were reliant on their foundation training.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

We referred to a variety of methods to establish patients' views of the service provided at HMS Drake Medical Centre. These included the Defence Primary Healthcare (DPHC) patient survey (23 responses received in 2023), the primary Care Rehabilitation Facility patient feedback survey and the feedback cards issued to the practice ahead of the inspection. All 25 respondents who completed a CQC comment card were positive about their experience and complimented staff on their friendly manner and caring approach.

The practice provided medical care for the HASLER Naval Service Recovery Centre (NSRC) and one doctor was assigned to this cohort of patients. A named doctor was assigned to each patient to provide a high level of personalised care. This included handing out a contact mobile number for ease of access. The doctor was described as having 'intense engagement' and providing a 'platinum level of service'. The purpose of the NSRC was to help patients transition into civilian life. Another doctor who was the lead for women's health had received the Order of St John.

A doctor with specialist knowledge was the nominated women's health lead and coordinated the care for patients who sought fertility investigation and treatment. They used and provided knowledge of local referral and secured financial support through funding pathways.

Involvement in decisions about care and treatment

Our review of clinical records and feedback about the practice demonstrated that patients were involved in planning their treatment and care.

Patients with a caring responsibility were flagged up though the carer's forum, during routine consultations or when an alert on DMICP records at the patient's previous practice. The PMO admitted that their oversight was not robust and was aware there should be a register, records coded and alerts present, but had lacked capacity to do the work. There was a register of 13 carers and carer information posters were visible within the building.

An interpretation service was available for patients who did not have English as a first language. Staff could not recall a time when the service had been required. International ships brought their own interpreters. Staff also had access to the various exchange officers working on the base for translation.

Privacy and dignity

Consultations took place in clinic rooms with the doors closed. Privacy curtains were used when patients were being examined. Telephone conversations took place away from the reception desk to maximise patient confidentiality. A television provided background noise and minimised the risk of conversations being overheard at reception. The PCRF was in a

separate building and confidentiality was supported with separate treatment rooms and a waiting area set away from the front desk.

In the event that a clinician of a preferred gender was not available patients could attend an alternative medical centre within the region.

Are services responsive to people's needs?

We rated the practice as good for providing responsive services.

Responding to and meeting people's needs

The practice had made changes to respond to the needs of patients. For example, early morning appointments between 07:45 and 08:15 hours were protected for patients to walk-in (referred to as 'fresh cases') and this was flexible to accommodate shift workers. Specific vaccination clinics were provided for patients on a ship that came alongside at HMS Drake.

The practice was committed to meeting the principles of the Equality Act 2010, including safeguarding people with protected characteristics. Clinicians worked in accordance with organisational policy for the management of transgender personnel to ensure they received appropriate clinical care, support and early referral. A Disability Access Audit for the premises was completed in November 2023. The building was accessible for people with mobility needs. The lack of emergency pullcords (due to them being disconnected when work was completed in the old ward) was highlighted and was on the issues log. This had been an issue for the past 3 years and had been reported through to the infrastructure team on base. However, work had not been completed to rectify this issue. A hearing loop was not required based on the current needs of people who used or accessed the building.

The practice separated all waste to promote recycling.

Timely access to care and treatment

Feedback from patients confirmed they received an appointment promptly and at their preferred time. Requests for medical advice and appointments could be arranged by eConsult (email communication), telephone or face-to-face consultations. Urgent appointments with a doctor, nurse or physiotherapist could be facilitated on the same day. A routine appointment with a doctor was available within 7 days and next day with a nurse. There was a wait of 20 working days for a specialist medical. Some specialist medicals (heavy goods vehicle, sports diving and boxing) were no longer offered to patients as they were deemed non-essential and clinical time was prioritised elsewhere. The practice highlighted that action had recently been taken to reduce the wait time to see a doctor which had up until recently been up to 5 weeks. Home visits were available but only by exception. The doctor who looked after the HASLER Naval Service Recovery Centre carried out home visits when managing significant clinical risk and the patients were unable to attend the practice. However, it was noted how time consuming this was for the visiting doctor. There was approximately 1 home visit every month.

Patients could not refer directly to physiotherapy as it was viewed as unnecessary due to low wait times and because occupational health input was provided prior to being seen in the PCRF. However, direct access to physiotherapy or 'DAP' was also designed to give the patient a choice of not having to be referred for rehabilitation by a doctor. An urgent

appointment could be accommodated the next day and both a routine and follow up appointments within a week. Appointments with an exercise rehabilitation instructor could be accommodated within 2 days. There was a 30 working day wait for the Multidisciplinary Injury Assessment Clinic.

Out-of-hours access to medical care was detailed in the practice leaflet, displayed on the front door of the practice and also outlined on the answering machine message. Emergency out-of-hours cover midweek was provided by HMS Raleigh Medical Centre from 16:00 (15:00 on a Friday) to 18:30 hours. Patients had access to the NHS111 from 18:30 hours on weekdays, at weekends and on public holidays. The practice had duty medics on call who could be accessed by calling the guardroom. There was also a 'duty fleet' doctor on call out-of-hours for ships and deployed units.

Listening and learning from concerns and complaints

The practice manager was the lead for complaints and any that related to the PCRF were integrated into the process. The PMO fed into the investigation when clinical interpretation/oversight was required and complex cases were involved (approximately 80% of complaints required involvement from the PMO). Complaints were managed in accordance with Defence Primary Healthcare policy complaints policy and local procedure. The complaints procedure was displayed in the practice leaflet, on station daily orders and on a noticeboard next to the reception desk. The complaint's manager investigated each complaint and sent a response to the patient. A recent complaint had been escalated to regional headquarters after the patient was not happy with the response sent to them by the practice. The Regional Clinical Director spoke with the patient and resolved the complaint which was then closed.

Complaints were recorded on the centralised Defence Primary Healthcare governance webpage. Complaints was a standing agenda item at the monthly practice meeting and any trends highlighted were raised at the management meetings.

Are services well-led?

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

Vision and strategy

The practice had adopted a strategy that focused on patient access. This targeted a reduction in the previous 4-5 week wait for a routine doctor's appointment down to 2 weeks. This has been at the expense of the governance activity. Prior to the implementation of this strategy, many of the staff had complained of stress and it was described as an 'unpleasant' work environment. The practice had established that when the 2 week wait for a doctor's appointment increased, eConsults and book on the day appointments increased. To enable the reduction in patient waiting times, meetings were reduced in frequency. The full practice meeting that took up a whole afternoon had gone from monthly to 3 times a year. Protected time for mandatory training and continued professional development had been prioritised over clinical audit activity. This had a positive impact on staff mental wellbeing and staff were reported to be less stressed.

The practice placed an emphasis on collective responsibility and support. This was demonstrated throughout the inspection with the leadership team galvanized by the challenges faced (an indicator of this was that staff absence rates were low).

Leadership, capacity and capability

A continued theme throughout the inspection was that there was insufficient capacity to deliver the service and manage the administrative tasks. The leadership capacity at the practice was impacted by a need to prioritise patient care over other tasks and duties. Staff gaps were part of the problem but the PMO had also mapped out that the workforce requirement would still not be sufficient should all posts be filled. There has been a deliberate plan prioritising timely access to care for patients, to help ensure patient safety, with some routine clinical governance work deprioritised. This plan had been fully briefed to the RCD and the Base Executives and had had their support. The Leadership team encourage all staff members to leave work on time and take TOIL if they work additional hours in order to manage their wellbeing and support patient safety. A request had been submitted for additional established posts to sustain the service. The request was supported by the regional headquarters but funding was not available so the service would continue to struggle unless headquarters action is taken to reduce workload or increase staffing to meet the demands placed on the service. Staff we spent time with spoke highly of the inclusive leadership approach, including the visibility and support provided by the Principal Medical Officer (PMO) but voiced concern about their wellbeing and excessive working hours (reported to us as being routinely 55 hours a week which was in breach of MOD policy. The PMO was delivering 5-6 clinical sessions per week, the Navy's average for a PMO was approximately 3). The nursing team felt that more could be done to help educate service personnel of a healthier lifestyle choices that ultimately promote physical heath and well wellbeing, mental resilience and therefore improve deployability.

The leadership team described how they had lost confidence in the impact of applying an opal status rating (a rating given to practices when they do not have sufficient staff to provide the full range of services in addition to completing essential administrative tasks). It was felt that the opal status reporting had no impact. The regional headquarters (RHQ) had been through a significant turnover of staff and there was scope for the regional team to provide more proactive support to the practice going forward.

PCRF staff were invited the practice meetings; also the PMO attend the PCRF departmental meetings. The lead for the PCRF had weekly meetings with PMO.

Culture

Patients were central to the ethos of the practice. Staff understood the specific needs of the patient population but did not have the resources to provide the treatment and care whilst also completing the required governance work. There had a been a deliberate prioritisation that made seeing patients the priority. However, this introduced risk to the wellbeing and effectiveness of individuals who worked excessive hours to deliver patient care.

Staff spoke highly of the culture and strong collaborative teamwork. They felt respected, supported and valued. For example, the nurses held group lunches in addition to their nurse meetings and spoke positively of the sense of teamwork and support throughout the team. Everyone had 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. The leadership team promoted an open-door policy and encouraged staff to share their views at meetings. Team away days were held and thank you awards given out in recognition of individual's contribution. Staff said they would feel comfortable raising any concerns and were familiar with the whistleblowing policy. They were familiar with the Freedom to Speak Up (FTSU) policy and were aware of how to access FTSU representatives.

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. There was a duty of candour log and we were given an example of how duty of candour breach had been effectively managed, including the patient being informed.

Governance arrangements

The doctors and nursing staffing levels had affected governance activity. The decision was taken by the PMO and management team to prioritise patient access over governance activity and this was in constant review between the PMO and the management team. All lead roles were documented on the master index spreadsheet. The practice management team identified that they needed to work more collaboratively, for example by involving more of the team when actioning ASERS.

The practice had two spreadsheets which were used for monitoring governance activity. The practice manager planned to merge the master index and the Drake healthcare governance standardised management tool into one document to have everything in one place and make it easier to use. Tabletop notes for all administration roles and for treatment room processes were utilised. Links to the practice's policies were available for all staff to access on the master index spreadsheet. Staff were required to read all policies on arrival, and this was captured as part of the induction. Any updates to policy were sent to all staff by email for awareness.

An understanding of the performance of the practice was maintained. The system took account of medicals, vaccinations, cytology, summarising and non-attendance. However, chronic disease tracking, vaccination status and screening data for the patient group was a significant challenge. The practice provided support to approximately 50 lodger units which included ships and submarines. Ships retained patients in their own DMICP 'practice' so none of the patients were visible on HMS Drake clinical searches. However, when in port, the patients accessed their mainland care from Drake (Navy mandate as Drake is a Base Port). The practice was reliant on the medics on ships to keep accurate records, track patients and maintain chronic disease registers. To part mitigate resultant risks, the nursing team visited the ships to work with their medical teams to help identify any gaps in patient registers or patients of concern.

Internal meetings had been established for individual departments to provide them with a forum to highlight any concerns. Doctors held weekly meetings and a dedicated nurse meeting took place once a month. Medics, administration staff and doctors met together for a fortnightly meeting. A representative from each of these meetings would bring any issues to the management meeting, held weekly. Full practice meetings were held every 4 months.

The practice manager attended a fortnightly Regional Warrant Officer (RWO) meeting, where any queries from the management meeting were posed to the RWO to answer and any pertinent points from the meeting were fed back to the practice at the management meeting. The DPMO attend the fortnightly carers' meetings. There was a weekly shareholders meeting attended by the Medical Administration Officer (MAO). Executives from the base attended this meeting and items such as deployments, courses and base activities were discussed. The MAO discussed the practice's challenges such as appointment shortage. The PMO attended a virtual weekly clinical leads' meeting with all other PMOs in the region run by the Regional Clinical Director. The PMO distributed a summary email to the management team to send out to relevant staff and for discussion at the management meeting.

The last Healthcare Governance Assurance Inspection took place in September 2022 and an overall grading of 'substantial assurance' was achieved.

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 the weekly management meetings. The practice manager reviewed and updated the risk register each

month and it was then discussed at the healthcare governance meetings. There was also an issues register with 7 live issues that had an appointed lead and were regularly reviewed.

The business continuity plan was reviewed in August 2023 and was available for all staff to access on a link on the master index spreadsheet. All new arrivals are required to read this document as part of their induction process and any updates were emailed out to all staff. It took account of all the likely generic system failures and had clear guidance for the need to relocate if required. There was no requirement to provide medical cover for the on-site helicopter landing site, the PMO had the requirement removed following consultation with the key stakeholders. Nuclear response on the base remained an unresolved issue. Babcock owned the port and therefore owned the nuclear response. A clear policy for the base that detailed any role for the medical centre was lacking but this was being actively pursued by the PMO who had raised the concern. The last base nuclear exercise was carried out in 2022.

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

The leadership team was familiar with the policy and processes for managing staff performance. Although not a concern that was indicated, the practice manager was 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 to monitor performance. The HAF is an internal quality assurance governance tool to assure standards of health care delivery within defence healthcare. Management staff had access to the eHAF.

The practice manager and MAO managed the completion of the eHAF and included it as one of the agenda items in the new rolling healthcare governance meeting topics. The management action plan was taken to the meeting, identifying areas for improvement. Management positions had access to the eHAF including pharmacy and clinicians and they utilised the task facility to assign actions to relevant individuals. However, the pause of much of the clinical governance activity had resulted in little engagement with the eHAF. This was attributed to insufficient staff capacity.

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

Engagement with patients, the public, staff and external partners

Various options were available to prompt patients to provide feedback on the service and the practice acted on feedback received.

The practice received twenty-three patient experience surveys in the last year. They had tried to increase the number of respondents by including the link/QR code on their signature block and having posters around the practice, but this had not resulted in an increase. An electronic tablet had been placed in the reception area for easy access to patients and supported by reminders from receptionists, an increase in feedback was achieved. There was a patient suggestion/comments box in main reception area. The practice also had a coin voting system which had questions changed regularly by the management team. The leadership team recognised that this could be utilised better in that they should review how often each question was live and ensure the information is collated and acted on.

We were given examples of changes made in response to patients' comments, suggestions and complaints. For example, in response to patient feedback the gymnasium opening times had been altered to improve accessibility.

Within the PCRF there was a suggestions box, a standardised patient feedback form and a patient satisfaction questionnaire. There was opportunity for staff to feedback at departmental meetings, strategy days and through a staff survey for civil servants.

There was good engagement with the base and both the MAO and PMO attended regular meetings with base executives. There was good engagement with the welfare team who were present at the carer's meetings. The DCMH was on base and multidisciplinary team meetings took place between practice and DCMH staff. Two of the doctors had access to a DCMH task list which had recently been created to save patients being sent to the medical centre to have changes to their Medical Employment Standard (a categorisation of medical fitness). The practice manager also had access and actioned if both doctors were away.

Continuous improvement and innovation

The practice was proactively working to maintain and improve standards within the facility following a deficit in staffing and with current constraints to the work staff balance. Prioritisation had been given to ensuring patient safety. Many QIPs had been made but not evidenced. For example, the improvements in the process for sending and receiving specimen samples and the introduction of a nurse competency/clinical skills register.

The PCRF had their own programme of QIPs. These included a women's health service, remote management of patients on ships, a first contact practitioner pilot (seeing a physiotherapist who is professionally qualified to treat patients without a referral from a doctor or other healthcare professional) and a health and wellbeing programme to support the holistic health of patients.