

DMS Lympstone

Quality report

Commando Training Centre Royal Marines (CTCRM)
Lympstone,
Exmouth,
Devon,
EX8 5AR

Date of inspection visit:
19 July 2018

Date of publication:
8 October 2018

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, and information given to us by the practice and patients.

Ratings

Overall rating for this service

Good 

Are services safe?

Requires improvement 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Chief Inspector's Summary

This practice is rated as good overall.

The key questions are rated as:

Are services safe? – Requires Improvement

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

Letter from the Chief Inspector of General Practice

We carried out an announced inspection at DMS Lympstone (known as CTCRM throughout this report) on 19 July 2018. Overall, the practice is rated as good. Our key findings across all the areas we inspected were as follows:

- There was an open and transparent approach to safety. All staff knew how to raise and report an incident and were fully supported to do so. We saw the management of significant events had been identified by the practice as needing improvement in the past and saw clear indication that they were managed well, actions identified were addressed and actions put in place to reduce the likelihood of re-occurrence.
- The assessment and management of risks was comprehensive, well embedded and recognised as the responsibility of all staff. The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).
- At the time of the inspection not all equipment at the practice was sufficient to treat patients and meet their needs. This was addressed shortly after our inspection and new equipment which was fit for purpose was in place.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- The practice had a good chronic disease management plan in place. Patients were recalled appropriately and patients received effective, individually personalised care. However, Read coding needed addressing as inaccuracies were hindering the effective management of the current patient population.
- There was good evidence to show collaborative working and sharing of best practice to promote better health outcomes for patients.
- There was substantial evidence to demonstrate quality improvement was embedded in practice, including a comprehensive programme of clinical audit and quality initiatives used to drive improvements in patient outcomes. However, we noted that no audit had been undertaken for minor operations.
- The practice fostered an ethos of patient centred care. Staff involved and treated patients with compassion, kindness, dignity and respect.

- Feedback from CQC comment cards and patient surveys showed patients were treated with compassion, dignity and respect. We saw that the practice was highly responsive to patient's needs. Patients we spoke with said they found it easy to make an appointment with urgent appointments available the same day.
- Information about services and how to complain was available.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.
- There was an effective overarching governance framework in place which supported the delivery of good quality care. However, formal clarification was required where the practice was required to deliver outside standard Defence Primary Healthcare (DPHC) policy.
- There was a clear strong leadership structure and staff felt engaged, supported and valued by management.

We saw an area of notable practice:

- The practice had safety policies including adult and child safeguarding policies which were reviewed and communicated to staff. The practice worked to a bespoke supervisory care directive. It was a very clear and comprehensive policy which clarified the support channels and potential vulnerabilities of patients. It included information about cyber bullying, radicalisation, suicide and harassment.

The Chief Inspector recommends:

- Develop a system to ensure notes are up to date with the correct Read coding being used to accurately reflect the current needs of the patient population.
- Extend quality improvement work to include audit of minor surgery outcomes, in line with NICE guidelines.
- Ensure that all staff are appropriately trained by completing all inductions.
- Formal governance arrangements should be introduced to include the clinical activity undertaken at Lympstone Medical Centre which is beyond standard DPHC policy, specifically urgent care.

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice

Our inspection team

Our inspection team was led by a CQC inspector. The team included a CQC inspection manager, a GP specialist advisor, a nurse specialist advisor, a practice manager specialist advisor and a physiotherapist specialist advisor.

Background to DMS Lympstone - Commando Training Centre Royal Marines

DMS Lympstone known as Commando Training Centre Royal Marines (CTCRM) delivers all Phase 1 (initial), Phase 2 (continuation) and career course/specialist training to Royal Marines and Officers including initial training of the Royal Marines Band. All training is conducted under OFSTED auspices and is continually assured by internal and external agencies.

CTCRM provides the full spectrum of primary and intermediate health care for all entitled service personnel from all three services, and occupational care to entitled reservists across the South West region. CTCRM contains its own 20 bed low dependency ward, an X-ray department with reporting radiographer, a primary care rehabilitation facility (PCRF), dispensary and a large complex injury rehabilitation department.

There are no registered dependants and currently a small population of under 18-year olds. The majority of the population at risk are aged between 16 and 55 with a small number outside of this range. There is a high turnover of the patient population, which on the day of the inspection was approximately 652.

The medical centre has four GPs, two practice nurses, six ward nurses, a practice manager, deputy practice manager, 11 medics, a pharmacy technician and four administration assistants.

The PCRF has five physiotherapists and seven Exercise and Rehabilitation Instructors (ERI's). The staffing mix included a military officer in charge (OiC) as well as two civilian physiotherapists. The senior ERI also has a role as the specialist trade advisor for Royal Marine ERI's at other units.

The practice has a 20 bed overnight observation facility. This is run by the practice staff who provide 24 hour a day cover.

The Primary Care Rehabilitation Facility (PCRF) comprises of two clinical rooms in the medical centre and the larger 'Hunter Gym' which is approximately a three minute walk away. The larger Hunter Gym hosted rehabilitation for Hunter troop; Royal Marines that are injured temporarily join this troop to undergo a programme of rehabilitation before rejoining training and being prepared for front line combat duties.

In addition to routine GP services, the treatment facility offers physiotherapy and rehabilitation services. Family planning advice is available within the practice and maternity and midwifery services are provided by NHS practices and community teams. Mental Health referrals are made to HMS Drake located approximately 50 miles away.

The practice is open on Monday to Friday 0700 to 1630 hours for walk-in and pre-booked patients. It is staffed 24 hours a day, seven days a week during term time. Outside of these times it is staffed by a duty medic and a ward nurse, with a doctor and senior medic on call for emergencies. Outside of these times also, patients will be seen directly by the duty staff, or referred to local out of hours' services/Emergency Department, or seen by on-call staff.

Are services safe?	Requires improvement
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We rated the practice as requires improvement for providing safe services.

Safety systems and processes

- The practice had safety policies including adult and child safeguarding policies which were reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. Policies were regularly reviewed and were accessible to all staff, including locums. They outlined clearly who to go to for further guidance. The practice worked to a supervisory care directive. It was a very clear and comprehensive policy which clarified the support channels and potential vulnerabilities of patients. It included information about cyber bullying, radicalisation, suicide and harassment.

- There was a system to highlight vulnerable patients on records and a risk register of vulnerable patients.
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- There was an effective system to manage infection prevention and control.
- There were systems for safely managing healthcare waste.

Risks to patients

- The practice had recently introduced a failsafe system for the monitoring of laboratory results as they realised the previous system needed improvement. This was newly in place to ensure results recording was safe. As the system was new, we were unable to assess how it was working in practice.
- There were procedures in place for monitoring and managing risks to patient and staff safety. The practice had up to date fire risk assessments and carried out regular fire drills. The fire equipment was checked by an external contractor on a monthly basis. Fire alarms were tested weekly and all electrical equipment was checked on a regular basis to ensure the equipment was safe to use. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- The gym was visibly clean, and maintenance was good with all the rehabilitation equipment of a high standard. There was a considerable amount of equipment so a sample was checked for compliance. All machines checked had been serviced and maintained properly. There was a rolling five year plan for equipment replacement.
- Risks to patients suffering heat/cold injury were mitigated by the monitoring of the outside temperature so changes in the intensity of exercise and rehabilitation could be made, an example of this was seen on the inspection day.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage.
- There were alarms in all clinical areas, resuscitation and the ward including isolation rooms. These were tested on the day.
- The medical centre has a well-practised response to emergencies and this was regularly tested both in training and in real life saving scenarios. Emergency drills formed part of the induction for staff including locum GP's so they were aware of treatment for heat/cold injuries. The medical centre had access to a field ambulance to collect patients from the training areas. This vehicle was not bespoke for transfer of patients with suspected spinal injury. The vehicle did not have any specific medical equipment but medics/GPs responded with emergency bags. However, NHS transport could be called upon as required. There was a major incident plan in place.

- There was a significant risk that the medical centre could not accurately assess or respond to heat/cold injuries with the current patient monitoring device they used. The device was not fit for purpose as it was not made to be splashed or submerged in water. GPs told us that the machines would often 'cut out' during use. The unit reported the equipment, as faulty however in reality it was not fit for purpose causing it not to work, as it was used for procedures that were outside of DPHC policy. We viewed a two-year history of correspondence, including significant events, and email conversations with DPHC and the Regional Clinical Director asking for replacement equipment that would meet the needs of the patients but no alternative equipment had been sourced.
- Following the inspection, we raised this with DPHC stating that an urgent review of practice and equipment was needed in order to ensure delivery of safe care. We have since seen that appropriate equipment has been loaned to the Medical Centre until the pending review of urgent care provision has been completed. Risks to patients have therefore been mitigated.
- We saw regular communication with the consultant at the local NHS Emergency Department (ED) around the best care for patients that were acutely ill with heat injuries. We saw minutes from a casualty debrief meeting held at the practice, following such an incident, which stated the ED consultant confirmed the patient was better being initially treated at CTCRM. Decisions to admit to the NHS hospital were made by GPs on an individual case basis. Where such urgent care was offered at the practice, staff were acting in the best interest of patients yet this was outside of DPHC policy. DPHC have triggered a review of the arrangements in place to ensure that local protocols are formalised and recognised.

Safe and appropriate use of medicines

- The arrangements for managing medicines, including emergency medicines and vaccines, was safe. This included arrangements for obtaining, prescribing, recording, handling, storing and the security of medicines. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.
- The dispensary was well managed by the pharmacy technician who had a good procedure in place for safe dispensing including good record keeping. We saw patients were informed of the side effects and were given good instruction by the pharmacy technician to ensure they took their medicines safely.
- The practice had a defibrillator available on the premises and oxygen with adult masks. A first aid kit and accident book were available.
- The practice carried out regular medicines audits for example an antibiotics audit, to ensure prescribing was in line with best practice guidelines for safe prescribing. We saw evidence to show the regional pharmacist had undertaken regular reviews.
- Prescription pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.

Track record on safety

There was a system in place for reporting and recording significant events (SEA).

- The deputy practice manager was the dedicated lead to oversee SEAs and staff said they would approach the lead if they were unsure of any issues in relation to significant events. All staff were familiar and confident with policy and with using the standardised Defence Medical Services (DMS) wide electronic system the practice used to report, investigate and learn from significant events, incidents and near misses.

- Despite all staff having access to the significant event system on the day, it was evident that several members of staff could not log onto the system. We saw evidence to show that in the past 12 months SEA's had not always been managed properly, with issues not being reported in a timely manner, no root cause analysis conducted, no lessons learned for many and a large number closed inappropriately. This had been recognised by the practice and they had improved the way incidents were tracked and by having meetings, which were minuted, events discussed and lessons were learnt and shared.
- We reviewed safety records and national patient safety alerts, including the minutes of meetings where these were discussed. The Medicines and Healthcare Products Regulatory Agency (MHRA) alerts were viewed by the pharmacy technician every day and disseminated to the appropriate member of staff. All alerts were checked against equipment registers and DMICP (Defence Medical Information Capability Programme) patient records/stock reports.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system and policy for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were good systems in place for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice.

Are services effective?	Good
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We rated the practice as good for providing effective services.

Effective needs assessment, care and treatment

- The practice assessed needs and delivered care in accordance with relevant and current evidence based guidance and standards.
- Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. Audits were undertaken stemming from NICE recommendations, for example, for the management of hypertension and guidance around sepsis.

Monitoring care and treatment

The practice used information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. QOF is a system intended to improve the quality of general practice and reward good practice. It is used across many NHS practices. The DMS have a responsibility to deliver the same quality of care as patients expect in the NHS. The QOF provides a useful way of measuring this for DMS. Because the numbers of patients with long term conditions are often significantly lower at DMS practices, we are not using NHS data as a comparator.

- At the time of our inspection there were no patients receiving high risk medicines. Searches for these patients were held monthly and processes put in place if required.
- The practice had a good chronic disease management plan in place managed by the practice nurses. Patients were recalled appropriately and patients received effective, individually personalised care. However, Read coding needed addressing as inaccuracies were hindering the effective management and care of the current patient population. For example, patients

who had historically been coded as having depression still had this active code attached to their clinical records even though their condition had improved and were no longer receiving treatment.

- The practice carried out chronic disease audits to ensure they provided care for patients with chronic disease in line with NICE guidelines. However, we noted that no audit had been undertaken of minor surgery outcomes.

The practice provided the following examples of patient outcomes data to us from their computer system on the day of the inspection.

- There were nine patients recorded as having high blood pressure. We reviewed the treatment and care offered to these patients and found that current NICE guidance had been followed. All had a record for their blood pressure in the past nine months. Of these patients with hypertension, eight had a blood pressure reading of 150/90 or less.
- There were six patients with a diagnosis of asthma. We reviewed the treatment and care offered to these patients and found that current NICE guidance had been followed. Five had received an asthma review in the preceding 12 months which included an assessment of asthma control using the three Royal College of Physicians questions.
- There were no patients with a new diagnosis of depression in the last 12 months. Records showed 33 patients were coded as having depression but this was historic data and the coding had not been altered to reflect this. This meant that the practice could not always reflect accurately their management of long terms conditions and mental health care.

Information from the Force Protection Dashboard, which uses statistics and data collected from military primary health care facilities, was also used to gauge performance. Data from the Force Protection Dashboard showed that instance of audiometric hearing assessment was higher compared to DMS practices regionally and nationally. Service personnel may encounter damaging noise sources throughout their career. It is therefore important that service personnel undertake an audiometric hearing assessment on a regular basis. Data from January 2018 showed:

- 100% of patients had a record of audiometric assessment, compared to 97% regionally and 99% for DPHC nationally.
- 83% of patients' audiometric assessments were in date (within the last two years) compared to 76% regionally and 85.5% for DPHC nationally.

Management, monitoring and improving outcomes for people

There was evidence of quality improvement work including clinical audit.

- From discussions with staff, it was clear the practice was working towards continual improvements for patients. A programme of audit was in place that focussed on the needs of the population and demonstrated a commitment to improving outcomes for patients. For example, an audit was undertaken around skin and soft tissue infection. This led to improved protocols for patients being introduced including an easy read 'danger signs' advice sheet. There was evidence of up to two cycles for some audits. Examples of completed clinical audits we looked at and discussed with staff included antibiotic prescribing, asthma and medicines management. The PCRf had also completed mandatory audits, including infection control.
- The base as a whole continually monitored injury rates, as well as outcomes (specifically return to training, and success in completing the course). This data was systematically analysed and shared with both the medical and training teams, as well as research working groups (for example, the injury prevention working group (IPWG) and the Institute of Naval Medicine (INM)). The outcomes of this analysis were continuously fed back to the clinical team to help

develop improved treatment guidelines (e.g. the stress fracture guideline), as well as enable the rehabilitation team to offer more accurate prognosis information to patients.

- There were several meetings where patients were discussed on a regular and frequent basis with other members of the healthcare team, as well the unit staff (with patient consent and with medical confidentiality respected). Every patient in the rehabilitation troop was reviewed at least once every three weeks. A meeting plan was seen, and an example of two patients were seen on DMICP where the meeting had resulted in outcomes that had been recorded in the patient notes, with appropriate actions.
- Following an emergency, all staff were part of a medical centre casualty debrief. We saw comprehensive minutes that included the background to the emergency, the initial actions taken, the overall actions and any lessons identified.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice had a lead member of staff responsible for the induction programme for all newly appointed staff, locum staff also had the same induction. This included topics such as safeguarding, infection prevention and control, fire safety, health and safety, information governance and Caldicott accountability. Though it was thorough in content, there was no system in place to ensure inductions were completed in a timely manner. The practice had recognised this and were going to co-ordinate and ensure all induction was monitored, completed and recorded.
- Within the PCRF, the staffing mix was managed to most appropriately utilise the available skill mix, by aligning each ERI to a specific rehabilitation area, for example spines or upper limbs.
- Staff had access to and made use of e-learning training modules and in-house training. Staff had all received mandatory training in subjects such as fire, basic life support and infection control. In addition, staff had received role-specific training. Mandatory training for staff was monitored by the training lead and reviewed weekly for deficiencies. Certificates were required as proof of training completion and recorded on staff data base. There were significant gaps on the database in regard to Caldicott training but there was currently an issue with access to the online training and DPHC were aware. The practice has conducted local Caldicott training and there have been no recorded issues involving Caldicott breaches.
- Medics ran urgent care clinics (fresh cases), vaccination clinics and force protection clinics. The medics used treatment room protocols and issued medication in line with current guidance. Competencies were reviewed regularly with the GP or senior nurse and were signed and held by the deputy practice manager and in the pharmacy. Medics were overseen by the nursing team clinics and their clinical notes reviewed by the duty doctor. Post emergency debriefs took place to share and discuss lessons learned.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, mentoring, clinical supervision and support for revalidation.
- Dispensary staff were appropriately qualified and their competence was assessed regularly. They could demonstrate how they kept up to date.

Coordinating care and treatment

- The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.
- Discharge and hospital letters were received by the medical centre and there was an effective system in place to ensure that a clinician reviewed and actioned these, including an audit trail to record what had been done. We saw an audit had been completed in October 2017 which confirmed there were good processes in place and that the processes were safe.
- There were good examples seen of with regular meetings arranged between the medical centre staff, the rehabilitation staff and the chain of command. If these meetings were about patients (for example, patient injury management clinic (PIM) we saw evidence of this been accurately recorded in the patient DMICP notes, with appropriate actions.

Helping patients to live healthier lives

- All new patients were asked to complete a proforma on arrival. The practice nurse followed up any areas of concern, such as raised blood pressure.
- The practice identified patients who may be in need of extra support and signposted them to relevant services. For example, those requiring advice on their alcohol consumption.
- Patients were given nutritional advice, including advice to enable them to keep their weight above 65kg which is the required weight for recruits. The practice identified all those recruits who weighed less than 67kg and educated them on the principles of eating well and kept them under regular review.
- The practice offered basic sexual health advice including the issue of free condoms and referred on to local clinics in the community for more comprehensive services including family planning.
- Patients had access to appropriate health assessments and checks. A monthly search was undertaken for all patients aged 50 to 64 years who were entitled to breast screening. The practice also engaged with all national screening programmes and had a mechanism to ensure that eligible patients were referred into the bowel cancer or abdominal aortic aneurysm (AAA) screening programs. All patients over 50 who had not had cholesterol check in the past five years were called in to be tested. Flu vaccinations had been offered to all patients who were eligible.

There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using public health information posters and they ensured a female sample taker was always available. The number of women aged 25 to 49 and 50 to 64 whose notes recorded that a cervical smear had been performed in the last three to five years was 91%. The NHS target was 80%. We saw that cervical cytology audit had been undertaken that showed good outcomes for patients with good recall systems in place and good uptake on screening.

It is important that military personnel have sufficient immunity against the risk of contracting certain diseases. The World Health Organisation sets a target of 95% for vaccination against diphtheria, tetanus, pertussis and polio and measles, mumps and rubella. The data below from January 2018 provides vaccination data for patients using this practice:

- 94% of patients were recorded as being up to date with vaccination against diphtheria compared to 94% regionally and 95% for DPHC nationally.

- 94% of patients were recorded as being up to date with vaccination against polio compared to 94% regionally and 95% for DPHC nationally.
- 84% of patients were recorded as being up to date with vaccination against Hepatitis B compared to 78% regionally and 77% for DPHC nationally.
- 93.5% of patients were recorded as being up to date with vaccination against Hepatitis A, compared to 90% regionally and 91% nationally.
- 94% of patients were recorded as being up to date with vaccination against Tetanus, compared to 94% regionally and 95% for DPHC nationally.
- 81% of patients were recorded as being up to date with vaccination against Typhoid, compared to 79% regionally and 52% for DPHC nationally.

Consent to care and treatment

- Staff sought patients' consent to care and treatment in line with legislation and guidance. All liaison with recruits aged under 18 next of kin was undertaken with the patients consent unless under exceptional circumstances, if it was considered necessary in order to protect their health, safety or welfare.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

Are services caring?	Good
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We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- During our inspection we observed that members of staff were courteous and helpful to patients and treated them with dignity and respect.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- We received 14 patient Care Quality Commission comment cards in total. Of these, 12 were entirely positive about the service experienced, two included negative comments about the dispensary opening hours.
- Staff were observed interacting with patients and were seen to be caring, enthusiastic and engaging. We spoke to four patients, who reported that staff were very approachable and caring, and they felt had the right level of clinical input. All four said morale in the rehabilitation troop (Hunter Troop) was high, and staff helped promote morale by innovative suggestions, such as dragon boat racing and other competitions.
- The practice had an information network available to all members of the service community, known as HIVE. This provided a range of information to patients who had relocated to the base and surrounding area. Information included what was available from the local unit and from civilian facilities, including healthcare facilities. The information also signposted learning centres, for patients who may want to increase their fluency in English.

Involvement in decisions about care and treatment

- Interpretation services were available for patients who did not have English as a first language and staff knew how to access them.
- The practice proactively identified patients who were also carers, there were two registered at the time of the inspection. There were systems in place which, when patients identified themselves as carers, a code was added to their records in order to make them identifiable and so that extra support or healthcare could be offered as required. The SNO attended welfare meetings every two weeks with other health professionals to discuss where extra support and care were needed.
- Patient information leaflets and notices were available in the patient waiting area advising patients how to access a number of organisations. We saw that information that was age appropriate and relevant to the patient demographic was prominently displayed and accessible.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Curtains were provided in all but one consulting room to maintain patients' privacy and dignity during examinations, investigations and treatments. Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- The Hunter gym had several treatment cubicles that were separated from the main gym only by a curtain, and this was a noisy environment, as well as limited privacy, if there were rehabilitation classes underway in the gym. The computer screens in the main gym had privacy screens, but these were not always effective. A request was made in March 2018 through DPHC Chain of Command for improvements to be made to the PCRf, this was still outstanding.

Are services responsive to people's needs?

Good

We rated the practice as good for providing responsive services

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- A wide range of services and clinics were available to service personnel. For example, minor operations, physiotherapy and travel advice.
- Patients could have 15 minute appointments with the GP and up to 30 minute appointments with the practice nurse, longer appointments were available if needed.
- Patients were able to receive travel vaccines when required.
- Same day appointments were available for those patients who needed to be seen quickly.
- There were accessible facilities which included interpretation services when required. Transport for patients to hospital appointments was available if needed.
- Eye care and spectacles vouchers were available to service personnel from the medical centre.

- The practice were able to access fast-track Magnetic Resonance Imaging (MRI) for patients with suspected stress fracture.
- The practice had its own radiology department and reporting radiographer to enable immediate access for X-Ray.

Timely access to care and treatment

The practice was open on Monday to Friday 0700-1630 hours for walk-in and pre-booked patients. It was staffed 24 hours a day, seven days a week during term time. Outside of these times it is staffed by a duty medic and a ward nurse, with a doctor and senior medic on call for emergencies. Outside of these times also, patients will be seen directly by the duty staff, or referred to local out of hours' services/Emergency Department, or seen by on-call staff.

The practice held urgent care clinics twice a day, during the week and once a day in the morning at weekends. All patients were triaged by medics who referred on to a nurse or GP as required. (A military medic delivers healthcare similar to a healthcare assistant in the NHS but has a greater scope of duties).

The PCRf was open 0800 to 1700 hours. The four patients we spoke with all said this fitted their requirements. The patient satisfaction survey completed across two patient groups showed 77% and 89% of patients were happy with the length of time they had to wait for their appointment. On the day of the inspection there was a physiotherapist and ERI appointment available within five working days but they aim to see them sooner, within 24 or 48 hours.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

DPHC had an established policy and the practice adhered to this. The practice manager was the designated responsible person who handled all complaints in the practice. We saw that information was available to help patients understand the complaints system. There had been no complaints raised in the past year. We saw that there were processes in place to share learning from complaints.

Are services well-led?	Good
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We rated the practice as good for providing a well-led service.

Leadership capacity and capability

- On the day of inspection the leaders in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Everything we saw on the inspection day, and communications with the practice following the inspection, supported this.
- There was a clear leadership structure and staff felt supported by management. Staff told us the practice leaders were approachable and always took the time to listen to all members of staff.
- There were clearly allocated responsibilities in the practice with named deputies for cross coverage and resilience in the event of absence from the practice.

Vision and strategy

- The practice had a clear vision and strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values in place built around the DPHC mission statement, South West, 'DPHC is 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 maximising fighting power.
- The practice had a realistic strategy and supporting business plans to achieve priorities.
- The practice developed its vision, values and strategy jointly with patients, staff and other units such as the PCRF and welfare teams.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The medical centre planned its services to meet the needs of the practice population.

Culture

- The practice had a culture of high-quality sustainable care.
- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- There were positive relationships between staff and teams.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. However, we noted some gaps where additional work was required and identified the need for formal governance arrangements around the urgent care arrangements in place at this practice. This outlined the structures and procedures and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Policies from the national framework were implemented and were available to all staff. These were updated and reviewed regularly.
- An understanding of the performance of the practice was maintained. The practice manager used the Common Assessment Framework (CAF) as an effective governance tool. Practice meetings were held regularly and were used as an additional governance communication tool, for example to remind staff to complete all paperwork in respect of significant events. Learning needs were discussed at practice meetings and appropriate training was requested and

delivered through this forum. The meetings were also used for forward planning, for example, to ensure that patient needs were met during busy clinic times and periods of staff sickness. This approach supported staff with learning about how the performance of the practice could be improved and how each staff member could contribute to those improvements. Minutes were comprehensive and were available for practice staff to view. In addition, regular health care governance meetings were held and minutes were produced of all matters discussed. Fortnightly meetings were held to discuss vulnerable and at risk patients.

- There was clear evidence from minutes of meetings that lessons learned from significant events, complaints and other investigations led to change and improvement in practice.
- A comprehensive programme of quality improvement, including clinical and administrative audit, was used to monitor quality and to drive improvements.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. This included plans developed each year that took account of manning levels at the practice due to deployment of some staff.
- The PCRf was led by a military member of staff, assisted by a senior ERI, oversaw the care both in the PCRf attached to the medical centre and the Hunter gym. The PCRf was aligned to the governance structure of the medical centre, although some elements were held separately in the rehabilitation gym (for example the training and induction information for the ERI staff). All areas were managed well and had good communication with the medical centre at all times both informally and formally at scheduled meetings.

Managing risks, issues and performance

There were clear and effective processes for managing many risks, issues and performance.

- We saw the practice were committed to the care and well-being of their patients, responding immediately when an emergency arose. However, when managing acute injuries, such as heat illness, the practice was working to its own practice policy which was not consistent with DPHC policy and was conflicting in its content. Following our inspection, we raised this issue with DPHC, and in response they arranged a visit to the practice by an Emergency Medicine Consultant to make an initial assessment on patient safety. They found the practice had been providing 'active cooling' to what they maintained was best practice for rapid cooling – namely partial immersion in cold water/ice. They were doing so on a verbal recommend from the Institute of Naval Medicine. The practice policy did not reflect an established protocol in line with DPHC policy. The interim decision made by DPHC was to continue and that the emergency care is not unsafe but required a formal review of practice. This was being undertaken and planned for the near future.

Appropriate and accurate information

- The practice had appropriate and accurate information.
- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- There were robust arrangements at the medical centre in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- Patients through the surveys and from any individual patient feedback received.
- Completed CQC comment cards from patients supported our findings, that there was an open door policy when it came to patient input and feedback.

Continuous improvement and innovation

- There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking. From minutes of meetings we reviewed, we noted that the leadership of the practice focussed on improving the speed and quality of delivery of care for all patients. Improvements implemented were evident from the quality improvement projects. For example, the research undertaken by one of the GPs and the University of Exeter looking into the biomechanical factors associated with increased injury risk for Royal Marine recruits during their 32 week training programme. On the basis of the study in 2017 it was found that the original standard issue footwear given to recruits was linked to injury. As a result, these were removed from service. Further studies and assessments had been completed and as a result all new recruits underwent foot pressure scanning. This data is then used for the immediate recommendation of footwear and possibly a referral to the podiatrist.
- The practice was also involved in an ongoing study of taking Vitamin D supplements' The Institute of Naval Medicine (INM) worked with CTCRM to evaluate the effectiveness of vitamin D supplementation to reduce stress fracture risk and susceptibility to respiratory infection in Royal Marine recruits undertaking the 32-week recruit training course. Patients were either given a placebo or a Vitamin D supplement. The study showed the supplementation maintained vitamin D status more effectively during the 32 weeks of recruit training. The incidence of stress fracture was 6.8% in the group of recruits who were given a placebo and 3.9% in the group given the supplement. The trial was ongoing.

The PCRf was involved in many improvements programmes. Some examples were;

- The introduction of a bespoke stress fracture protocol specific to the base.
- the development of heat and concussion and graduated return to physical activity protocols.
- They set up a specific injury prevention working group which involved staff from both the medical, rehabilitation and unit command and instructor staff.