Chivenor Medical Centre

Chivenor, Barnstaple, Devon, EX31 4AZ

Defence Medical Services inspection

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

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

Contents

Summary

About this inspection

We carried out this announced inspection on the 16 June 2022.

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

The key questions are rated as:

Are services safe? – good

Are services effective? – good

Are services caring? – good

Are services responsive? – good

Are services well-led? – good

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

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

At this inspection we found:

- The leadership team had a clear understanding of key issues and had developed plans to resolve or mitigate identified risks.
- Measures were in place to identify patients who were considered vulnerable, coding was consistently applied to identify patients under the age of 18.
- An effective system was in place for managing significant events and staff knew how to report and record using this system. Reporting events was supported by an open door and no blame culture.
- Risks had been identified, assessed and actions recorded when completed.
- Arrangements were in place for managing medicines, including obtaining, prescribing, recording, handling and disposal in the practice.

- The practice had good lines of communication with the unit, the Primary Care Rehabilitation Facility (PCRF), the welfare team.
- The practice had very strong links with the local services. This included close working links with secondary care, social services, community services, voluntary agencies and social enterprises.
- Standard operating procedures (SOPs) had been developed to ensure that appropriate coding, outcomes and templates are consistently used by clinicians.
- The practice had developed an improvement programme to drive best practice.
- There was an effective and well-designed programme in place to managed patients with long term conditions.
- The practice had a system to ensure that staff completed the required mandated training and held the appropriate professional registrations.
- Information systems and processes were in place to deliver safe treatment and care including referral tracking.
- The practice was an old building with limited space. The PCRF gym had been refurbished but this was not sufficient to meet all patient's needs.
- Formal peer review arrangements were in place for all clinical staff to include effective auditing of notes.
- Staff understood and adhered to the duty of candour principles.
- The practice sought feedback from patients which it acted on. Feedback showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.

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

The PCRF instigated Hellburg troop in January this year. The welfare troop is run by the Royal Marine Warrant Officer and the Royal Marine corporal exercise rehabilitation instructor who ran the physical activity for the welfare and recovery troops. It provided day to day recovery and support for those soldiers who were unable to work due to physical or mental illness. To date there has been around 40 ranks who have gone through the troop and there has been rapid improvement in the speed of upgrade with service personnel coming back fitter, stronger and more qualified, back to their respective Squadrons. This had been shared with the regional team. There were some excellent examples of rehabilitation with positive outcomes for patients with a focus on a vocational outcome, with troops benefitting from farming and land management courses, building courses, rehabilitation triathlons and spa days provided by a local hotel. The feedback from the patients has been excellent.

The practice introduced 'template safety plans' which were given to the patient and copied into the DMICP records. These were for the patient to record themselves if they felt they sometimes struggled with suicidal thoughts and included coping strategies to try and reduce pain and increase coping mechanisms. We saw evidence of the positive impact this had had on patient care. A patient suffering with severe depression was seen at the

practice by a doctor, together they used the safety plan to identify ways to reduce the risk of rapid decline, identify triggers and early warning signs of deterioration (for example negative conversations, reducing socialising or calling a friend). The use of the plan allowed the patient to have some control of their care and aid any health care professional in their support and management of future crisis points, it also helped when handing over to other services and team members. The safety plan was scanned into clinical notes and the patient had a copy.

The Chief Inspector recommends that the medical centre:

- Improvement is needed to ensure the cleaning contract is fit for purpose.
- Provides a bespoke induction for staff.

The Chief Inspector recommends to DPHC:

- Improving the infrastructure (PCRF gym) to ensure sufficient space for physical activity.
- The regional team keeps staffing levels and additional staff roles under review to ensure there is clinical resilience in the system.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

The inspection team comprised of one CQC inspector and specialist advisors including a primary care doctor, a practice manager, a physiotherapist and a pharmacist.

Background to Chivenor Medical Centre

Located near Barnstaple, Chivenor Medical Centre delivers a primary healthcare, occupational health and force protection service to a patient population of 945 regular service personnel.

A Primary Care Rehabilitation Facility (PCRF) is located next to the medical centre and provides regular service personnel with a physiotherapy and rehabilitation service.

As there is no dispensary at the practice, medicines are dispensed from a local pharmacy.

The medical centre is open from 08:00 – 16:00 hours Monday to Friday. Emergencies can be accommodated in the afternoons when it is closed. From 16:00 until 18:30 emergency

medical cover is provided by duty staff. Outside of these hours, including weekends and bank holidays, cover is provided by NHS 111.

The staff team

Civilian Senior Medical officer (SMO)	one
Regimental Medical Officer (RMO)	two
Civilian medical practitioner (CMP)	one
Practice manager	one
Deputy practice manager	one
Nurses (civilian)	one
Exercise rehabilitation instructors (ERI)	three
Physiotherapists	two plus one locum
Administrators	three
Combat medical technicians* (CMTs) (referred to as medics throughout this report)	one permanent plus four attached to the regiments.

*In the army, CMTs are soldiers who has received specialist training in field medicine. It is a unique role in the forces and their role is similar to that of a health care assistant in NHS GP medical centres but with a broader scope of medical centre.

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

One of the doctors was the lead for safeguarding. They attended meetings every two months with the local safeguarding team and shared relevant information and updates with the medical centre team. The practice had very good local links with local Clinical Commissioning Group and safeguarding teams. All staff had received up-to-date safeguarding training at a level appropriate to their role, including staff working within the Primary Care Rehabilitation Facility (PCRF). Clinicians were also undertaking domestic abuse training provided by local safeguarding services. All staff had the NHS Safeguarding app added to their phones in order to improve patient safety and awareness.

There was a vulnerable patient register on DMICP (electronic patient record system). All patients who were considered vulnerable were registered on this register and had the relevant Read code (clinical coding) on their notes. Rather than a 'vulnerable adult' alert being added to the summary page, each of these patients had an alert 'patient always to be offered a same day appointment'. All staff members were fully aware of this. The practice manager ran monthly searches and all patients were discussed at the monthly vulnerable patients meeting. Doctors, the nurse and a representative from the welfare team attended the meeting. The doctors had strong links with unit welfare teams and the commander's monthly health review (previously referred to as the unit health committee meeting).

Vulnerable patients under the care of the PCRF were discussed in weekly multidisciplinary meetings. Alerts were placed on DMCIP and the recovery troop (Hellberg) had defined links with the welfare team.

The Welfare Officers for the camp confirmed they had a good relationship with the practice and confirmed they had rapid access to the doctors when urgent intervention was required.

Notices advising patients of the chaperone service were displayed. Staff had conducted online chaperone training in May 2022. Information was included about chaperones in the practice leaflet. Staff who acted as chaperones had received a Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. All staff currently working in the practice had an up-to-date DBS certificate or a risk assessment in place in accordance with Defence Primary Healthcare (DPHC) policy.

The practice was clean and tidy throughout. A contract was in place for environmental cleaning, the regular hours contracted had been recently reduced due to lack of staff. There was no record of any deep cleaning being undertaken. This was being addressed

by the practice manager. The practice manager and nurse carried out regular checks of the premises and reported any issues to the cleaning contractors.

The nurse was the lead for infection prevention and control (IPC) within the practice and had completed the link practitioner training. The last IPC audit was undertaken in February 2022 resulting in a compliance score of 92%. Areas noted for improvement had been actioned. The PCRF conducted their own IPC audits and actioned any areas requiring improvement.

There were systems for safely managing healthcare waste supported by a policy. Clinical waste and pre-acceptance audits were carried out annually; the most recent in September 2021.

All equipment within the PCRF was maintained by the exercise rehabilitation instructor (ERI) and physiotherapist under the Ministry of Defence service plan. Maintenance was carried out once a year and was in date. All gymnasium equipment was maintained by the unit physical training instructors (PTIs). There was a close working relationship between the PTIs and PCRF. Any rehabilitation equipment that was broken was quarantined and reported in accordance with defence rehabilitation processes.

For PCRF clinicians practising acupuncture, arrangements were in place for the safe provision of this treatment, including a standard operating procedure (SOP) that referenced national guidance and a consent form signed prior to any treatment. A specific acupuncture patient information leaflet was provided for patients, so they understood the process and any risks. Patient consent was sought and recorded on DMICP. Sharps boxes in treatment room were in date and correctly stored.

Risks to patients

From a patient perspective, clinical staffing levels were sufficient as patients interviewed told us they had prompt access to a clinician. Waiting times for an appointment with a clinician confirmed this. However, there were potential risks with the capacity and consistency of clinical staffing levels moving forward. The practice was only funded for a single military nurse who was due to go on operational duties requiring their role to be covered by a locum for prolonged periods.

The PCRF had a vacant post for a physiotherapist, this had been temporarily filled with a locum. The ERI who was responsible for the Hellberg rehabilitation group was deploying, and there was no funding available for a locum. The Hellberg rehabilitation group was a daily run programme that was reliant on the ERI for the recovery of downgraded personnel. To ensure this continued, the ERI from the PCRF was to relocate to cover the short fall. This meant the workload that the ERI had (short term injury group) would have to be distributed and could affect patient care.

There were appropriate risk assessments in place to ensure physical activity was conducted safely. Wet-bulb globe temperature (WBGT – a heat stress index) readings were taken in hot weather and activity managed accordingly.

An automated external defibrillator (AED) was available and all staff were clearly able to identify where it was located. No oxygen or other emergency drugs were stored on site, these were held in the practice. Staff advised that they followed the routine response

process as well as placing a call to the practice to get support whilst waiting for an ambulance if required.

The arrangements in place to check and monitor the stock levels and expiry dates of emergency medicines were effective. The practice staff were fully trained in emergency procedures, including basic life support and the use of an AED and anaphylaxis training. Staff had recently completed thermal/climatic injury training and sepsis training. Credit card sized cards with warnings about sepsis were given to patients with low level infections to advise them of signs of sepsis and what to do if they are concerned.

We saw measures in place that had been introduced to minimise the risk of spreading infection during the COVID-19 pandemic. These included

- signs placed throughout to encourage social distancing,
- hand gel was readily available
- personal protective equipment was provided to staff when required. This included face masks that protect staff from airborne infection.

The main waiting room could be seen by reception staff and a television was in the waiting area to try and ensure conversations were not overheard.

Information to deliver safe care and treatment

On arrival, new patients complete a new joiner form. The notes and new patient forms were reviewed by the practice nurse for clinical summary. There was no backlog.

There was evidence of effective patient handovers between clinicians. There was regular communication between clinical staff to ensure clinical problems were highlighted and handed-over when required. The practice had numerous regular face-to-face meetings which were held on a monthly rotation on a Wednesday afternoon. For example, these included practice, governance, medicine management, welfare, clinical and muscular skeletal meetings. Information was also shared via email and tasks on the clinical IT system.

Staff confirmed that access to patient records was occasionally a concern and did not pose a significant risk to continuity of patient care. However, it was noted that the MODNET system was particularly slow. In accordance with DPHC policy, in the event of a DMICP outage, all routine work ceased and only emergencies were dealt with. These records were handwritten and later scanned onto DMICP and coded appropriately. The practice also had laptops that could be used.

A programme was in place for the regular auditing/peer review of each clinician's DMICP consultation recordkeeping. All clinicians had received an audit in the last 12 months. Within the PCRF, time was allocated for regular peer case review, in which clinicians discussed complex cases with another clinician within the PCRF team. The PCRF participated in both ERI and physiotherapist notes audits using the DHPC template.

PCRF staff were following routine DMICP processes specifically the use of the administration list which was used to track referrals and discharges to the department.

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

Safe and appropriate use of medicines

A doctor was the lead for medicines management at the practice. Safe procedures were in place for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment.

Emergency medicines were easily accessible to staff in a secure area and all staff knew of their location.

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

A doctor conducted an annual antibiotic audit in line with local and national guidance. The results of this were discussed at the monthly clinical meeting. The last audit was completed in April 2022. Additionally, annual audits were completed on the use of any controlled drugs, non-steroidal anti-inflammatory drugs, dermatology drugs, repeat medications and prescriptions.

All staff who administered vaccines had received the immunisation training as well as the mandatory anaphylaxis training.

Patient Group Directions (PGD) had been signed off to allow appropriately trained staff to administer medicines in line with legislation. The PGDs were current and signed off correctly. A PGD audit had been completed in April 2022. Medicines that had been supplied or administered under PGDs were in date.
Requests for repeat prescriptions were managed in person or by email, in line with policy. A process was in place to update DMICP if changes to a patient's medication was made by secondary care or an out-of-hours service. All prescription pads were stored securely.

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

Processes for the management of high-risk medicines were in place. We saw a process was established for the management of and monitoring of patients prescribed high risk medicines (HRM). The register of HRMs used at the practice was held on DMCIP and all doctors and relevant clinicians had access to this. We looked at a sample of patient records and all had been coded or had shared care agreements in place.

Track record on safety

Health and safety was managed well within the practice. All relevant risk assessments were in place. Measures to ensure the safety of facilities and equipment were in place. Electrical and gas safety checks were up-to-date. Water safety measures were regularly carried out with a legionella inspection undertaken in 2021.

A fire risk assessment of the building was undertaken annually. Firefighting equipment tests were current. Staff were up-to-date with fire safety training and were aware of the evacuation plan.

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

In the absence of an integrated alarm system, staff used personal portable alarms. These were tested regularly.

Lessons learned and improvements made

Significant events and incidents were reported through the electronic organisational-wide system (referred to as ASER) in line with the DPHC ASER policy. A local ASER SOP was in place. All staff had access to the ASER system for recording and acting on significant events and incidents. The staff training database showed that all staff had received up-to-date training.

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

Are services effective?

We rated the practice as good for providing effective services.

Effective needs assessment, care and treatment

Processes were in place to support clinical staff to keep up to date with developments in clinical care including National Institute for Health and Care Excellence (NICE) guidance, clinical pathways, current legislation, standards and other practice guidance. Staff were kept informed of clinical and medicines updates through the Defence Primary Healthcare (DPHC) newsletter circulated to staff each month. Updates were also discussed at multi-disciplinary clinical governance meetings

Doctors attended regular update sessions. Much of this had been online due to the pandemic and the geographical location of the practice. The Senior Medical Officer (SMO) was the honorary chair for BASEM (British Association for Sport and Exercise Medicine). The clinicians held a journal club when they have capacity, a recent example was discussions about cervicogenic headaches.

Primary Care Rehabilitation Facility (PCRF) staff were familiar with Department of Defence Rehabilitation Guidance and provided examples of treatment provided based on evidence-based guidelines and care pathways. The PCRF used the MSK-HQ (musculoskeletal health questionnaire) via the DMICP template and this was seen in a notes audit.

The exercise rehabilitation instructor (ERI) made effective use of objective outcome measures when planning and progressing patient care. This was measured at the start of treatment, reviewed every four to six weeks and measured again on completion of rehabilitation. There was clear evidence of using objective markers from best practice guidelines.

The PCRF instigated Hellburg troop in January this year. The welfare troop is run by the Royal Marine Warrant Officer and the Royal Marine corporal ERI who ran the physical activity for the welfare and recovery troops. It provided day to day recovery and support for those soldiers who were unable to work due to physical or mental illness. To date there has been around 40 ranks who have gone through the troop and there has been rapid improvement in the speed of upgrade with service personnel coming back fitter, stronger and more qualified, back to their respective Squadrons. This had been shared with the regional team. There were some excellent examples of rehabilitation with positive outcomes for patients with a focus on a vocational outcome, with troops benefitting from farming and land management courses, building courses, rehabilitation triathlons and spa days provided by a local hotel. The feedback from the patients has been excellent.

While the PCRF delivered a safe service, it was not as effective as it could be due to the infrastructure. The PCRF gym had a recent upgrade, however, the space was small with low ceiling heights which made it unfit for purpose and prevented some rehabilitation classes from being undertaken there. The low ceiling height made some exercises difficult for a taller patient and alternative arrangements had to be made to accommodate this. As

a result of the limited space, the PCRF were not fully scaled for equipment as they had nowhere to store it.

Monitoring care and treatment

We found that chronic conditions were managed well. A standard operating procedure (SOP) outlining the management and monitoring arrangements for chronic conditions was in place. Monthly searches were run by the nurse to ensure recalls were not missed. Patients were recalled by letter or email and followed up by a telephone call if needed.

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

There were five patients on the diabetic register and their care indicated positive control of both cholesterol control and blood pressure.

There were eight patients recorded as having high blood pressure. All were recorded as having a blood pressure check in the past nine months.

There were two patients with a diagnosis of asthma, and all had an asthma review in the preceding 12 months.

Audiology statistics showed 58% of patients had received an audiometric assessment within the last two years. During COVID-19 routine audiometry had ceased in line the April 2020 DPHC directive. The practice had resumed audiometry as restrictions relaxed. We were advised the unit managed audiology recalls and prioritised those with a high readiness for deployment and those most at risk.

Where mental health needs were identified for a patient, the unified care pathway was followed. Supportive management and prevention strategies as well as psychological intervention were offered to patients who could benefit from them. The practice delivered step 1 interventions and provided wider guidance, advice and support, including diagnostics and how to deliver these interactions. The practice also used ‘template safety plans’ which were given to the patient and copied into the DMICP records. These were for the patient to record themselves if they felt they sometimes struggled with suicidal thoughts and included coping strategies to try and reduce pain and increase coping mechanisms. These were not mandated but showed both caring and safety for patients with mental health illness. Step 2 referrals were sent to the Department of Community Mental Health (DCMH) in Plymouth. The waiting time was approximately three months for routine appointments. The Brigade community psychiatric nurse was in the process of developing resilience workshops for personnel to attend while waiting for further treatment. The practice also had access to ‘Talkworks’ which was a local charitable framework available online and in person for those who required additional support while waiting for DCMH appointments.

Twenty-six registered patients responded to the DMSR patient satisfaction survey which complemented this inspection. The survey included a question about whether the patient felt that their healthcare professional had recognised and/or understood their mental health needs. Of the 26 respondents, 18 stated that they had had a mental health need. Of

these, 100% said that the healthcare professional had understood their mental health needs and felt listened to.

A quality improvement programme was in place which had been designed for optimal relevance to the patient population. We saw audits were in place spanning clinical, administrative and managerial topics. More than one cycle had been undertaken in many instances and there was evidence of positive outcomes. The PCRF had its own audit programme. Some examples we saw include a health and wellbeing audit around the Hellberg rehabilitation group and another regarding the management of Anterior Cruciate Ligament (in the knee) injuries.

Effective staffing

We looked at the practice induction process for new and existing staff. There was generic induction in place for permanent staff that was not role specific. The PCRF adhered to the DPHC new starter SOP and had their own bespoke induction pack for new starters. One new member of staff told us they felt it was the best induction programme to a new facility that they had come across to date.

Mandatory training was recorded on the staff database. All staff had protected time for the completion of mandatory training and attendance at group training. Regular clinical supervision and reflection took place for doctors and nurses and medics. Physiotherapy staff received regular appraisals, attended regular multi-disciplinary team meetings and had clinical supervision. Peer review was well established through all clinical groups.

Clinicians had the appropriate skills for their role and were working within their scope of practice. Opportunities were in place to support clinical staff with continual professional development and revalidation. The SMO had a background in the NHS and rheumatology with experience in sports medicine; they were able to administer joint injections. The practice could not offer minor operations on a regular basis but one of the regular locum doctors was able to offer this ad hoc when they were working at the practice.

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

Coordinating care and treatment

Chivenor Medical Centre had very strong links with the local services. This included close working links with secondary care, social services, community services, voluntary agencies and social enterprises. Welfare meetings often resulted in multiagency discussions. There was one NHS GP practice which looked after the majority of the service families and the SMO had worked hard to ensure that there was a strong communication link with this practice.

For patients leaving the military, pre-release and final medicals were offered. During the pre-release phase the patient received an examination and a medication review. A

summary print-out was provided for the patient to give to the receiving doctor and a letter if the patient was mid-way through an episode of care. A structured mental health questionnaire was also completed.

Referrals from the PCRF were sent to Regional Rehabilitation Unit (RRU) or local NHS as required. Waiting times for the RRU were within the key performance indicators.

Helping patients to live healthier lives

The SMO had sexual health training (referred to as STIF) at level two and the nurse to level one. The nurse was the lead for health promotion. We saw information leaflets were available in the treatment rooms. There were notice boards located in various places around the medical centre, some example topics covered included smoking and alcohol.

The PCRF staff have also been involved with injury surveillance work that had been fed back to training teams in a bid to change training programmes and reduce injury. Another example of injury prevention was work carried out by the PCRF around musculoskeletal injuries and human performance in cold weather.

Cervical smears were not currently carried out at the practice, instead patients were asked to go to a local NHS provider. All eligible female patients were on the national cervical screening database and were recalled by the nurse. The latest data confirmed an 85% uptake. Regular searches were undertaken to identify patients who required screening for bowel, breast and abdominal aortic aneurysm in line with national programmes. Alerts were added to their DMICP record which allowed for opportunistic discussion with a health professional. DMICP searches had been created for all national screening.

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

- 96% of patients were in-date for vaccination against polio.
- 96% of patients were in-date for vaccination against hepatitis B.
- 95% of patients were in-date for vaccination against hepatitis A.
- 96% of patients were in-date for vaccination against diphtheria.
- 96% of patients were in-date for vaccination against MMR.
- 99% of patients were in-date for vaccination against meningitis.
- 95% of patients were in-date for vaccination against tetanus.

Consent to care and treatment

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

Clinicians advised us that implied consent was accepted for basic procedures such as the taking of blood pressure. Written consent was taken for more intimate examinations.

Are services caring?

We rated the practice as good providing caring services.

Kindness, respect and compassion

We spoke with seven patients as part of the inspection and feedback indicated staff treated patients with kindness, respect and compassion at all times. This included extended appointments, and wellbeing support.

We reviewed the records for a number of patients who were experiencing poor mental health. It was clear that clinicians were responding to patients with kindness and compassion, ensuring that patients had the space and time to talk when they needed to.

Twenty-six registered patients responded to the Defence Medical Services Regulator (DMSR) patient satisfaction survey which complemented this inspection. All patients who responded to the question about how well clinicians listened to them said that their experience was very good or good.

We were given numerous examples of when practice staff went over and above to ensure patients got the care they received. An example of this was of a patient who lived three hours away and was unable to receive their medication during the pandemic. The practice instigated a standard operating procedure in order to develop a ’medication’ delivery service for those individuals unable to attend the facility.

Involvement in decisions about care and treatment

The staff at the practice recognised that the personnel they provided care and treatment for could be making decisions about treatment that could have a major impact on their military career. Staff demonstrated how they gauged the level of understanding of patients, gave clear explanations of diagnoses and treatment, and encouraged and empowered patients to make decisions based on sound guidance and clinical facts. Twenty-six registered patients responded to the DMSR patient satisfaction survey which complemented this inspection. All patients said they involved them in their care.

There had not been any recent requirement for a translation service but staff could use ‘Language Learning’ if necessary.

Patients identified with a caring responsibility were captured on a DMICP register and identified as part of the new patient registration process. There were six carers identified.

There was an equality diversity and inclusion representative on the camp and the details for this person were on the staff notice board.

The practice also promoted ‘Freedom to Speak Up’ and information was displayed for staff to read.

Privacy and dignity

Patients who provided feedback about the service said their privacy and dignity was upheld at all times. All consultations were conducted in clinic rooms with the door closed. All clinical rooms had a separate screened area for intimate examinations.

The Primary Care Rehabilitation Facility staff worked from individual rooms which did not pose a risk to confidentiality. In the gym they used music and the sound of the TV for background noise to mitigate any risks to confidentiality. Chaperones were available and signage to this effect was in each room.

Arrangements were in place to maintain patient privacy when arriving at the medical centre. A room in the reception was available should patients request confidential conversation away from the desk. Chairs in the waiting area were set back sufficiently to prevent conversations from being overheard.

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 staff understood the needs of its patient population and tailored services in response to those needs.

The practice team were aware of the need to quickly identify and treat patients with mental health needs in order to ensure the best possible outcome. Access to mental health support was swift with trained staff members available to offer face-to-face care. The welfare service could refer patients for a same day appointment for those in need of urgent referral for a same day appointment with the duty doctor.

An Equality Access Audit for the premises was completed in November 2021. The building was accessible for people with mobility needs including an accessible toilet. A hearing loop was not required based on the current needs of people who used or accessed the building.

Timely access to care and treatment

Patients had the option of using eConsult. Face-to-face appointments were available as COVID-19 restrictions had relaxed. Urgent appointments with a doctor could be facilitated on the same day and a routine appointment within three days. Nurses could accommodate patients with an urgent need on the same day and a routine appointment within one day. Feedback, including the patients we spoke with, confirmed they received an appointment promptly and at their preferred time.

The Primary Care Rehabilitation Facility did not yet offer direct access to appointments, this was due to the high turnover of staff. There was capacity to see patients urgently on the same day if required. Appointments to see a physiotherapist were available within two to three days and to see the exercise rehabilitation instructor one week. There was no waiting list for rehabilitation classes.

Outside of routine clinic hours, cover was provided by the doctors up until 16:30 hours and then by a duty medic until 18:30 hours. From then, patients were diverted to the NHS 111 service.

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

Listening and learning from concerns and complaints

The practice manager was the designated responsible person who handled all complaints in the practice. The practice had implemented a process to manage complaints in accordance with Defence Primary Healthcare's complaints policy and procedure. The process included the recording of both written and verbal complaints.

There had been no complaints received within the past 12 months. Information was available to help patients understand the complaints system, including in the patient information leaflet and in the waiting room.

Are services well-led?

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

Vision and strategy

The medical centre had a clear vision and credible strategy to deliver high quality, sustainable care. Their aims and values were:

- To deliver high quality patient centred primary care to our PAR in line with DMS aims.
- To co-ordinate care and treatment in a consistent, safe and supportive way when referring to other health and social care providers both within the military and externally.
- To respond at short notice, to 3 Commando Brigade need for a medically fit workforce, ready to deploy worldwide on operations and exercises ensuring operational capability.
- Support medical centre staff in professional development and divisional needs.

Staff we spoke with were clear that their remit was to support patients to benefit from the best possible healthcare outcomes which, in turn, supported operational capability. This included a preventative approach which involved proactive health promotion support, lifestyle advice and prompt barrier-less access to mental health support.

The practice had forged close links with all the units it supported and tailored the service to their specific needs to support deployments such as force protection clinics. Duty doctors, nurses and medics were routinely on hand to facilitate urgent access to care.

Leadership, capacity and capability

The staff team at the practice worked hard to deliver the best possible care to patients. All staff we spoke with described a committed and able leadership team with a Senior Medical Officer (SMO) that led with an inclusive and responsive leadership style. Staff had terms of reference for their main role and separate terms of reference for any key lead roles that they undertook.

Throughout this inspection we met with patients and unit staff who described a practice team that were kind and caring, who gave them the time they needed and provided a high level of care.

The support from the regional team was described as good. The practice was linked into the regional meetings and engaged about matters related to the practice e.g. staffing and recruiting.

Culture

Staff we spoke with described a strong team ethic across the medical centre whereby the patient's requirements were held at the centre of all decision making. The SMO and the whole staff team operated an open and honest meeting culture where all staff were encouraged to attend and offer suggestions or raise concerns. Leaders operated an open-door policy for staff to use. Staff were aware of the whistleblowing policy and were also aware of the Freedom to Speak Up process within the region.

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

Governance arrangements

The leadership team had defined responsibilities, roles and systems of accountability to support good governance and management. The healthcare governance workbook (HGW) was the overarching system used to bring together a range of governance activities, including the risk register, ASER tracker, training register, quality improvement projects and complaints.

The practice had a system to monitor all patients on high risk medicines (HRMs). Shared care protocols were in place for patients taking HRMs. Regular clinical searches were carried out to monitor patients on HRMs.

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

Practice leaders had reviewed, introduced and implemented a suite of policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. There were a wide range of standard operating procedures (SOPs) in place and available on the HGW. The SOPs were separated into administrative, clinical and Primary Care Rehabilitation Facility (PCRF) and included a review date.

The PCRF was well integrated with the medical centre. This included joint meetings/forums were for the whole practice and governance and assurance information consolidated into one central workbook.

A meeting schedule was established, and this included weekly clinical meetings and monthly healthcare governance, safeguarding, practice and the commander's monthly health review meetings.

Managing risks, issues and performance

There was a current and retired risk register on the HGW along with current and retired issues. The register articulated the main risks identified by the practice team including

staffing and the poor MODNET connectivity. The registers were regularly reviewed. There were a range of risk assessments in place including both clinical and non-clinical risks. The assessments included lone working, sharps safety and health and safety. There were processes were in place to monitor national and local safety alerts, incidents, and complaints.

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

There was a business resilience plan and a major incident plan that were reviewed regularly and tested through simulation. All staff were informed of updates to the business continuity plan.

Appropriate and accurate information

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

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

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

Engagement with patients, the public, staff and external partners

There were various options in place to encourage patients to provide feedback on the service and contribute to the development of the service. These included a patient experience survey that was undertaken throughout the year and the results used to make improvements.

The practice team stated that they felt well supported and had good communication streams with all units they supported. Welfare staff told us that their relationship with the practice team was positive. Communication channels with local NHS services, including the local NHS GP practice and the Clinical Commissioning Group were good.

Continuous improvement and innovation

The team continually explored ways to improve the quality and safety of the practice including:

The introduction and successful implementation of Hellburg Troop.

The practice used ‘template safety plans’ which were given to the patient and copied into the DMICP records. These were for the patient to record themselves if they felt they sometimes struggled with suicidal thoughts and included coping strategies to try and reduce pain and increase coping mechanisms. We saw evidence of the positive impact this had had on patient care. A patient suffering with severe depression was seen at the practice by a doctor, together they used the safety plan to identify ways to reduce the risk of rapid decline, identify triggers and early warning signs of deterioration (for example negative conversations, reducing socialising or calling a friend). The use of the plan allowed the patient to have some control of their care and aid any health care professional in their support and management of future crisis points, it also helped when handing over to other services and team members. The safety plan was scanned into clinical notes and the patient had a copy.

The practice had introduced the use of a mental health synonym to be used in the clinical record to provide prompts for a full safety assessment and a holistic assessment (sleep, stress, appetite, coping strategies). They were also developing a mental health digital support tool for patients with lots of tips and support, including links to charities and supportive apps.

The practice instigated an SOP in order to develop a ’medication’ delivery service for those individuals unable to attend the facility.