Commando Training Centre Royal Marines (CTCRM) Medical Centre

Defence Medical Services inspection

This report describes our judgement of the quality of care at this service. 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 services.

Overall rating for this service	**Good**	
Are services safe?	**Requires improvement**	
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 previously carried out an announced comprehensive inspection at Commando Training Centre Royal Marines Medical Centre on 23 May 2024. We rated the service as requires improvement overall with a rating of requires improvement for the safe and effective key questions. The caring, responsive and well led key questions were rated as good. A copy of the previous report can be found at:

https://www.cqc.org.uk/dms

We carried out this comprehensive announced follow up inspection on 2 July 2025. The report covers our findings in relation to the recommendations made and any additional improvements made since our last inspection. As a result of this inspection the medical centre is rated as good in accordance with the Care Quality Commission's (CQC) inspection framework.

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

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 observations and recommendations within this report.

This inspection is one of a programme of inspections that 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 medical centre had good lines of communication with the unit, the Primary Care Rehabilitation Facility (PCRF), the welfare team, the Padre, local NHS services and the Department of Community Mental Health to ensure the wellbeing of service personnel.
- Arrangements were in place for managing medicines, including obtaining, prescribing, recording, handling and disposal in the practice.
- Staff delivered care and treatment in line with evidence-based guidance and local guidelines.

- Training was provided for staff to ensure they had the skills and knowledge required to deliver effective care and treatment for patients.
- There was an effective and well-designed programme in place to manage patients with long-term conditions.
- Regular clinical audits were undertaken within the practice to drive improvement and future audits planned on identified needs.
- Feedback from patients was that they were treated with kindness, dignity and respect and were involved in decisions about their care. We spoke with patients on the bedding down unit who described the care they received as ‘first class’.
- Patients were able to access an appointment and urgent appointments were available the same day.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of patient feedback.
- Staffing numbers had increased within the nursing department which afforded improved primary care provision.
- Nurses working in the bedding down facility (BDF) provided a high level of care to patients and worked hard to ensure all the emotional and physical needs were met. However, there was lack of an experienced manager to oversee the facility and work together with the Senior Nursing Officer to provide comprehensive care across primary care and the bedding down facility.
- Quality improvement activity was embedded both within the medical centre, PCRF and Hunter Troop, including various approaches to monitor outputs and outcomes used to drive improvements in patient care.

Notable Practice
The PCRF staff ensured a holistic view of patients was taken, including mood, sleep and lifestyle. Project SATURN was adopted as business as usual by the training team. All recruits completed this daily survey to record their sleep quality and quantity, mood, motivation and comments, it was held centrally and was accessible to all members of the training team and medical departments. The use of this dashboard allowed targeted education sessions relating to sleep hygiene, lifestyle management and recovery.

Staff went the extra mile in personalised patient care. We saw 2 several examples of note:

- The exercise rehabilitation instructors (ERIs) had conducted short adventure training packages utilising skills they have gained through their work. This took a holistic approach to the recruits’ well-being (incorporating their mental wellbeing) as it was recognised that some of the recruits experienced reduced mood due to conducting solely exercise based sessions within the gymnasium. The exercise rehabilitation instructors (ERIs) and physiotherapists had identified recruits whose injuries would allow them to conduct activities such as hill walking and mountain biking. These recruits had then been given the opportunity to conduct these activities to raise their morale.

- The medics regularly collected clothes and toiletries for those patients on the bedding down unit to make their stay more comfortable.

The injury surveillance dashboard has steadily expanded in scope and sophistication. The dashboard highlighted performance against key performance indicators including the rehabilitation outcome, time to return to training and the course completion/ pass out rate. The dashboard had 8 years' worth of data so the team could see where changes were implemented and compare this data to ensure outcomes were moving in the right direction. This in-depth dashboard allowed the team to be responsive; it influenced how services were delivered and informed the training team to help shape future training.

The medical centre continued to strengthen their collaboration with specialist services; stronger local partnerships had been established with:

- Microbiology – for rapid diagnostic support
- ENT – for specialist referrals and ear, nose, and throat care
- Cardiology – for advanced cardiac evaluation
- Radiology – notably the use of MRI in bone stress detection

A patient information flow form had been introduced. A standardised form was issued to patients, increasing the likelihood of timely transmission of necessary information from the NHS to the medical centre.

The Chief Inspector recommends to Commando Training Centre Royal Marines (CTCRM) Medical Centre.

Evaluate whether the number of nursing hours, staffing ratios, skill distribution and leadership development within the team are sufficient to:

- Support effective peer and team management
- Safeguard staff wellbeing, ensuring a sustainable workload and adequate rest time for those nurses on the bedding down facility during the night.

The management and control testing of the blood glucose monitor should be improved.

Continue to ensure Patient Group Directive coding reflects the presenting complaint/reason for admission/treatment.

Review the process in place for the management and action of Medicines and Healthcare products Regulatory Agency (MHRA) and National Patient Safety alerts.

Exercise Rehabilitation Instructors should complete daily notes on their patients after they attended group therapy in line with DPHC policy.

Within the Primary Care Rehabilitation Facility, patients' notes should state if a chaperone was offered.

Ensure the management of the waste log continues to improve and shows consignment notes are cross referenced.

Significant events must prompt shared learning. All events should therefore be captured in the ASER log and be available for all staff to access.

The Chief Inspector recommends to DPHC:

Ensure the DPHC-wide clinical waste policy is updated in a timely way so the practice can confirm management of clinical waste that reflects the 2023 revisions made to HTM 07-01: Safe and sustainable disposal of healthcare waste.

Professor Aidan Fowler

Interim Chief Inspector of Healthcare, covering Secondary and Specialist Care and Primary and Community Care

Our inspection team

The inspection team was led by a CQC inspector. The team of specialist advisors included a primary care doctor, practice manager, pharmacist, physiotherapist, exercise rehabilitation instructor and a nurse. A representative from the Defence Medical Services Regulator also attended in a shadow capacity.

Background to Commando Training Centre Royal Marines (CTCRM) Medical Centre

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 the Office for Standards in Education, Children's Services and Skills (Ofsted) and is continually assured by internal and external agencies.

CTCRM provides the full spectrum of primary and intermediate health care for entitled service personnel from all 3 services, and occupational care to entitled reservists across the southwest region. CTCRM contains its own 18 bed low dependency bedding down facility (BDF) staffed by registered nurses 24 hours a day, an X-ray department with a reporting radiographer, a physiotherapy department, 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 patient population are aged between 16 and 55. There is a high turnover of the patient population, which on the day of the inspection was approximately 2000.

The Primary Care Rehabilitation Facility (PCRF) comprises both clinical rooms in the medical centre and the larger ‘Hunter gym’ which is approximately a 3-minute walk away. The Hunter gym hosts rehabilitation for Hunter Company; injured Royal Marines

temporarily join this unit to undergo a programme of rehabilitation before rejoining training and preparing for front line combat duties.

Family planning advice is available within the medical centre and maternity and midwifery services are provided by NHS practices and community teams. Mental health referrals are made to Department of Community Mental Health at HMS Drake located approximately 50 miles away.

The medical centre is open Monday to Friday 07:00-16:30 hours (summer hours; 08:00 in winter). It is staffed 24 hours a day 7 days a week (during term times) by a duty medic and BDF nurse, with a doctor and medic on call for emergencies. Outside of these times, patients are referred to NHS 111 or local out of hours' services

The staff team

Position	Numbers
Principal Medical Officer (PMO)	One (currently vacant)
Deputy Principal Medical Officer (DPMO)	One
Civilian medical practitioners (CMP)	Two (1.4 full-time equivalent)
Military Medical Officer (MO)	One
Senior Nursing Officer (SNO)	One
Ward nurses	Seven – (4 Royal Navy and 3 civilian)
Medics	Eleven (nine DPHC and two single service)
Practice manager	One
Exercise Rehabilitation Instructors	Seven (Non-Defence Primary Healthcare, six Royal Marines and one locum)
Physiotherapists	Six full time equivalent (FTE) plus one gapped, 1 x Army)
Pharmacy Technician	One
Deputy practice manager	One

*A medic is a unique role in the forces and their role is similar to that of a health care assistant in NHS GP practices but with a broader scope of practice.

Are services safe?

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

Following our previous inspection, we rated the practice as requires improvement for providing safe services. We found shortfalls with:

- Incomplete staff training in recognising the deteriorating patient/sepsis relevant to their role.
- The capacity and capability of the nursing team required review to determine whether the nursing hours and skill mix are sufficient to meet the primary health care needs of the patient population.
- The access to emergency medicines and equipment within the bedding down facility (BDF) and the arrangements for administering medicines within the BDF.
- The doctors bag/crash kit was not kept securely.
- Temporary staff registered at the medical centre were not managed appropriately in accordance with Defence Primary Healthcare (DPHC) policy.
- The systems and processes for medicines management required review to ensure they were safe. This included a review of the management of Patient Group Directions and Patient Specific Directions and vaccine storage.
- Attention was needed to ensure the building was kept in good repair for the provision of primary healthcare and followed the guidelines issued by the Department of Health under the Health and Social Care Act 2008 infection and prevention and control of infections guidelines.

At this inspection we found all of the previous recommendations we made had been actioned.

Safety systems and processes

The Deputy Principal Medical Officer (DPMO) was the lead for safeguarding. Taking account of vulnerable adults and service personnel under the age of 18, the safeguarding policy was comprehensive and included the referral process and contact details for local safeguarding teams. Links to relevant organisational policies and standard operating procedures (SOPs) were also included in the policy. The policy had been reviewed in December 2024.

Information and contact details for local child and adult services, including for out-of-hours, was displayed throughout the medical centre, in all clinical rooms and throughout the Primary Care Rehabilitation Facility (PCRF). The induction pack for doctors, including locums, provided details of the safeguarding arrangements and links to policies.

All staff had completed safeguarding training at a level appropriate to their role. The welfare team provided enhanced support to recruits and considered all recruits vulnerable regardless of their age. The medical centre team had an open and responsive working

relationship with the welfare team with formal and informal discussions regarding vulnerable patients taking place frequently.

For patients under 18 using the bedding down facility (BDF), an alert was placed on their DMICP record (electronic patient record system). When admitted to the BDF, a specific bed space was used to identify them as under 18. The medical centre considered all new recruits as patients of concern and they were monitored closely with extra support readily available for patients who required it. Females admitted to the BDF primarily stayed within a designated isolation room with ensuite toilet facilities. Each of these rooms had a hard-wired call alarm to attract prompt attention.

Service personnel who were posted in from other units were identified at their new patient registration. Recruits presenting with acute mental illness were discussed with all doctors prior to the daily BDF round. There was also an opportunity to discuss all patients of concern at the weekly senior leadership meetings held every Wednesday.

The DPMO attended a fortnightly carers' meeting as the medical representative. This meeting was run by the unit with the Adjutant who was the designated safeguarding lead for the unit. It was also attended by the Commanding Officer (CO), Regimental Sergeant Major, padres and welfare team. The agenda for this was led by the unit and discussed the management of those service personnel on the Vulnerability Risk Management Information System as well as those who were sick at home.

The chaplaincy were visible within the medical centre, visiting the BDF regularly and also offered "Boots, Bible and Butty" sessions in order to provide support. The Senior Nursing Officer (SNO) said they found it easy to refer patients to welfare and chaplaincy. Patients we spoke with on the BDF said they felt well cared for and knew how to access any of the welfare support services.

A central register was held of vulnerable personnel. The DPMO updated the register from a DMICP search each month. There were separate tabs on the register for patients who were under 18 years old, vulnerable adults, carers, care leavers and adult safeguarding. In each clinical room there were safeguarding posters with relevant contact details displayed, there was also safeguarding information displayed in the waiting room.

The DPMO met regularly with the PCRF team to discuss any potential safeguarding issues for recruits transferred to Hunter Company for rehabilitation. Case conferences could be called by either the Chain of Command or the medical centre to discuss specific personnel who were considered vulnerable and at risk.

Notices advising patients of the chaperone service were displayed in each room, in the practice leaflet and in the reception area. The list identified the chaperones gender and the date their training had been completed. Within the PCRF there were no trained chaperones. They had a list of trained chaperones available in the medical centre should one be needed. The most recent notes audit had identified the lack of documentation as to whether a chaperone was offered, this was also identified in the last notes audit but had not been actioned.

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 full range of recruitment records for permanent staff was held centrally. The medical centre could demonstrate that relevant safety checks had taken place for the staff at the point of recruitment, including a DBS check to ensure staff were suitable to work with vulnerable adults and young people.

There was a dedicated lead for infection prevention and control (IPC) and they had had completed the IPC link practitioner training. An IPC audit was conducted annually, with the last being completed in May 2025. Actions were captured on the IPC audit tool management action pan (MAP). There was evidence on the MAP of completed and ongoing actions. Some actions required external support such as replacement taps and these had been added to the issues log. Within the PCRF the last IPC audit was undertaken in May 2025 and full compliance was found.

There were measures in place to minimise the spread of infectious diseases, including 6 isolation rooms designated to any patient with a suspected infection. There was a separate trolley that held personal protective equipment and a separate clinical waste bin in each room and in the corridor. There was an SOP in place to be used if patients requiring isolation overwhelmed the isolation wards (operation Overflow). There was also a comprehensive outbreak plan on SharePoint, the SNO and primary care nurse both independently described the infectious patient care pathway.

The SNO would liaise with accommodation for a dedicated floor for patients to use. Patients were assessed as to their suitability before this was used. The medical centre informed the kitchens who sent food. Patients were reviewed by medics or nurses in their accommodation at set times throughout the day.

Gym equipment in the PCRF treatment area was maintained and monitored. Checks on equipment were completed daily. The equipment was new and under warranty so had yet to require servicing. Parker Hall (rehabilitation gym) was well resourced with equipment to meet the physical rehabilitation and reconditioning needs of the patient population.

Staff within the PCRF provided acupuncture to patients. There was an acupuncture SOP and risk assessment in place that had been reviewed regularly and all staff were aware of. An acupuncture audit was completed annually. In addition, the PCRF offered injection therapy from within the medical centre where there was access to an emergency trolley. All staff had completed training in anaphylaxis.

Environmental cleaning of the medical centre and the PCRF was delivered by an external contractor; the cleaning contract was held by the unit and the medical centre has sight of this. A cleaning schedule was in place that the cleaner adhered to. The contractor conducted an internal audit every 6 months. Deep cleans were undertaken with the last being done in April 2025.

Healthcare waste was well managed. Waste was bagged and tagged with the practice code details. There were separate waste logs linked to the standard management tool (SMT) for the different types of waste. All consignment notes were held. However, we noted that at the time of the inspection, consignment notes were not being cross

referenced to the waste log. We received confirmation the following day showing an example sheet from the waste log showing that consignment notes were now being cross referenced and this was documented. All lines had not yet been completed but they had started to implement the new process. Following some key changes to the HTM 07-01 in December 2024, Defence Primary Healthcare (DPHC) practices await guidance around the treatment of clinical waste.

Risks to patients

There was a good balance of well-trained civilian and military staff which afforded continuity of care. There was an acting SNO in post supported by an experienced locum nurse. A new band 7 nurse had just been recruited and was undergoing their induction. In the absence of permanent staff, there was a reliance on locum team members. In the BDF all the nurses were Band 5, one of the nurses was the ward co-ordinator who took the lead nurse manager role, they had terms of reference (ToRs) in place to reflect this.

Two paramedics had been recruited to facilitate some of the pre-hospital emergency care both inside the medical centre and on exercise outside of the base. They were not yet fully in post but this was imminent, this would ease the burden on the medical team.

Within the BDF there was only 1 nurse working covering a 12-hour night shift, they were supported by a duty medic in the building (sleeping duty). We were told by the nurse that the medics never leave the building. However, we were told of one instance when the medic had to leave the building to attend to a casualty in the accommodation block although there was no evidence that this was anything other than a one-off occurrence. The nurse had no support to take a rest break, during the 12-hour night shift. The primary healthcare BDF handbook states that staffing levels must be 2 people at all times during silent hours and must not be a sleeping duty. The BDF nurses were trained in Basic Life Support (BLS) and 6 out of 7 nurses were trained in Immediate Life Support. It was accepted that the patients were mostly low dependency but staff welfare and safety was compromised.

The staff from the BDF could be called upon to support the enhanced treatment facility and support the delivery of primary care. This role had been incorporated into BDF staffs' ToRs. We saw a competency-based approach to upskilling had begun, for example, Patient Group Directives were utilised by some staff. Nurses working within the BDF had undertaken Yellow Fever and vaccination training to further support the primary care delivery at times of any mass deployment.

Within the BDF the nurses had recently completed a history taking and assessment course. A patient admitted to the BDF was seen by the duty doctor except for diarrhoea and vomiting (D&V) which was a nurse-led condition. All nurses had conducted intermediate life support and anaphylaxis training. Moulage training occurred in the medical centre and, if possible, the nurses attended but it was sometimes difficult to get all staff to attend the necessary training due to shift working. Emergency kit was available in both the BDF and the enhanced treatment room. Daily checks were carried out and all emergency trollies had tamper tags in place.

It was felt that there were not enough doctors when there were significant numbers of emergency cases. Currently all doctors attended all acute emergencies such as trauma/ heat injury/ sepsis. All other clinics stopped at this time. In 2024 they had 124 emergency

cases come into the medical centre via the emergency treatment room (ETR). In 2025, to date, there have been 75 emergency cases.

An emergency situation occurred on the day of the inspection, requiring clinicians to leave the building and attend a patient in the grounds. All the doctors and qualified medics left the practice to assist leaving only the nurses and trainee medics to see patients. One doctor quickly stood down and was able to then oversee trainee medics carrying out afternoon patient facing duties.

Within the PCRF staffing numbers were manageable and staffing was appropriate. The exercise rehabilitation instructors (ERIs) staffing was responsive to patient needs and population. ERI's were not part of the DPHC remit instead they were unit assets. ERI's were managed to ensure safe working practices and this could include adjusting class sizes.

All the staff team was up to date with BLS training, anaphylaxis, sepsis, heat illness and the use of an automated external defibrillator (AED). An AED was located in the medical centre, the PCRF and the Parker Hall. Both clinical and non-clinical staff we spoke with were aware of the signs and symptoms of the deteriorating patient and sepsis. There was a large sepsis display outside the clinical rooms in a corridor and posters were seen through both the medical centre and the PCRF.

An in-house training programme was run by the civilian medical practitioner and included moulages. All staff attended including those from the PCRF. The programme was determined by the most relevant topic at the time and seasonally based. The medical centre was a leading force in the management of exertional heat injuries (EHI) and had an enhanced treatment room. This had been specifically built due to the number of heat injuries and acute injuries seen due to the arduous nature of the training. Due to previous significant events they were also vigilant with sepsis management. Two patients were admitted with sepsis the previous week and the medical centre were able to respond swiftly and safely and these patients were managed in house. The medical centre had a bespoke antibiotic formulary developed in association with the local microbiology department.

Information to deliver safe care and treatment.

The medical centre identified that patients note summaries had not been fully completed (less than 20 sets of notes). They had started to address the issue and had received support from the wider region to address the backlog. The risk had been added to the risk register although the concern was limited as new recruits had minimal records and there were no families seen at the practice.

The medical centre monitored referrals using the DPHC tracker. Referrals were sent to a group task box on DMICP which several staff could access. A number of staff had eRS cards but most routine referrals were held until the dedicated referrals clerk was available. Due to the mandated stand down periods, staff absence was largely limited to those periods. All 2 week wait (2ww) referrals were managed well. At the time of the inspection, we conducted a review of all 2ww referrals and each had received an appointment within

an appropriate timeframe. Referrals were removed from the tracker when the clinic letter was received.

The doctors had recently completed a peer review of each other's clinical records. This was completed annually. There was an ongoing unofficial review of notes as all doctors rotated duty doctor tasks and reviewed ward patient note entries together. There was also an annual review of the medics notes and record keeping. Nurses had regular peer review and a recent notes audit was seen on SharePoint.

Clinicians within the PCRF undertook a yearly notes audit in line with DPHC guidance. However, we noted issues found from the previous audit had not been actioned (chaperone recording). There was a formal process in place for the ERIs to receive formalised peer review, clinical supervision and mentoring on musculoskeletal assessment skills.

We looked at the rehabilitation master template and also looked at some ERIs notes. We found that the ERIs did not complete daily notes on their patients after they attended group therapy if they had no change in symptoms, they instead completed a weekly summary. If the patient informed the ERI of a change of symptoms or required regression/progression, the ERI made a note of this. This was not in line with the DPHC SOP regarding the completion of notes. This was a legal requirement allowing for accurate recording of clinical activity. The Officer Commanding (OC) of the PCRF was aware that this was occurring and understood the risks that this posed but due to current numbers of recruits (100+), this was unobtainable.

Any individual patient appointments or clinical interactions outside of group therapy were recorded as a DMICP notes entry. Following the inspection, the issue was discussed with DPHC RHQ Regional Rehabilitation Advisor who has taken the issue for discussion with SO1 Rehabilitation DPHC HQ for Direction & Guidance. This was added to the CTCRM Risk Register

Within the PCRF there were extensive systems available for sharing information internally and with other clinical staff including:

- Hunter clinic – weekly clinic for complex patient care (physiotherapists and doctors).
- Permanent staff meeting – weekly meeting between the PCRF physiotherapists and ERIs.
- Weekly group reviews – joint between physiotherapist and group ERI's.
- Weekly multidisciplinary meeting – holistic management of recruits alongside training team (non-medical only).
- Soft-tissue and medical ERI joint clinic with a doctor every 2 weeks.
- A physiotherapist was assigned to a specific ERI group to enable regular discussion of patient care.

Each morning all doctors attended a ward round together which allowed time for a discussion of all patients currently in hospital elsewhere. They also used this as an opportunity to discuss any patients of concern. They had a policy of discussing all recruits within 24 hours who were presenting with acute mental health symptoms. There was a

formal monthly case-based discussion meeting which was minuted and logged. The lead physiotherapist also attended these meetings. Urgent mental health issues could be seen by the Department of Community Mental Health on the same day.

The senior leadership team, including the OC physiotherapist, met weekly to discuss the week of training including injury rates.

Pathology specimens were taken to the Royal Devon and Exeter Hospital; they were taken at least once a day by a military driver. In urgent cases the medical centre could contact a local pathology courier service. The unit provided the transport and there was no report of logistical issues. There was a log of samples sent and received which the nurses tracked. Results were usually received within 1-2 days. All doctors checked the results; it was also part of the duty doctor's schedule to review all incoming results. There was a close working relationship with the microbiology department who they spoke to regularly via telephone and email as there had been recent concern with issues such as Panton Valentine Leukocidin (PVL), sepsis and a case of Chlamydia pneumonia. This had resulted in an annual visit to the camp by one of the consultants and a bespoke antimicrobial formulary.

Posters were in place giving the "What Three Words" location so more accurate directions could be given to emergency services should they need to be called. This meant that casualties could be located around the camp even if no guardroom escort vehicle was available.

Safe and appropriate use of medicines

The PMO was the lead for medicines management, in their absence the DPMO was the lead. We noted this was not reflected in their terms of reference but was corrected on the day. The pharmacy technician was the deputy lead. All receipt and supply of prescriptions (Fmed 296) was correctly recorded and accounted for. Prescriptions were held securely in the dispensary and monitored by the pharmacy technician.

There were arrangements in place for the safe management of controlled drugs (CD). A review of the most recent destruction certificate confirmed that accountable and controlled drugs were not being consistently destroyed in accordance with policy. We discussed this with the DPMO and the pharmacy technician and were assured that the policy would be completely adhered to moving forward. All stock checks of CDs were completed on time and the stocks at the last external checks were correct.

Emergency medicines were easily accessible to staff in a secure area of the medical centre and all staff knew of their location. Stocks were in line with DPHC SOPs.

Patient Group Directions (PGDs) had been signed off to allow appropriately trained staff to administer medicines in line with legislation. The nurses on the BDF used PGDs if they were confident and capable. We noted that items supplied under PGDs had been coded incorrect as 'inpatient care'. The coding should reflect the presenting complaint/reason for admission/treatment. The issue had been noted by the department upon completion of an audit in June 2025 and had put a plan in place address this. Patient Specific Directions were being completed correctly.

Medics were issuing medication in accordance with their medics issuing protocols (referred to as MIPs) these were recorded in the patients' notes and logged in a register. Medication requiring refrigeration was monitored twice a day to ensure it was stored within the correct temperature range. Storage arrangements for the vaccinations were secure.

Within the BDF improvements had been made for the administration of medicines. There was formal governance in place to govern patients to self-medicate.

There were clear and thorough processes in place for the requesting and issuing of repeat medication. Through discussion and review of DMICP records, it was evident that there was a clear audit trail for the request of repeat medication. Upon review of DMICP records, we found 158 patients were eligible for repeat medication but only 67 had been reviewed. We looked at a range of these records and found them mostly to be historic requests and the records had not been updated. This was immediately rectified by the medical centre and a full review of patients on repeat medicines was undertaken.

The blood glucose monitor was kept in the emergency treatment room, we noted there was no record of control checks for 2 weeks out of 4 in June and the control solution had expired.

Requests for repeat prescriptions were managed in person or electronically 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.

The medical centre closed completely during periods of block leave with no duty staff available either within the building or on call. As such, the 2 refrigeration units outside of the treatment room and the 2 within the dispensary were not monitored. There was a detailed SOP in place outlining arrangements for vaccine management. During block leave, the vaccination holdings would be run down to ensure that in the event of a fridge outage, minimal stock was lost. Data loggers were in place and on return from any periods of block leave, all vaccines were to be considered quarantined until the pharmacy technician had carried out full minimum and maximum temperature checks on all pharmaceutical fridges. Any units which showed a breach in temperature were to have the contents quarantined and the data logger analysed by Regional Headquarters and actions decided upon.

A process was established for the management of and monitoring of patients prescribed high risk medicines (HRM). The register of HRMs used at the medical centre was held on DMCIP and all doctors and relevant clinicians had access to this. We looked at a sample of patient records and saw that all had been coded or had shared care agreements in place. However, we also noted that there were patients listed that were no longer taking HRMs and had not been removed from the register. This was rectified following the inspection.

A process was in place for the management and action of Medicines and Healthcare products Regulatory Agency (MHRA) and National Patient Safety alerts. The electronic MHRA alert register was current and a system was in place to ensure the practice received and disseminated them. However, there was no description recorded to state which of the alerts had been discussed at the team management meeting and what actions had been taken upon receipt. The practice agreed to address this moving forward.

Valproate (medicine to treat epilepsy and bipolar disorder) searches had not been regularly undertaken. Following discussion, a record to record the searches was put in place. There were no patients prescribed this medicine at the time of the inspection.

Track record on safety

There was a designated health and safety lead and a board was displayed which was regularly externally audited. Measures to ensure the safety of facilities and equipment were in place. Electrical and gas safety checks were up-to-date. Water safety checks were regularly carried out. A legionella risk assessment had been completed in April 2020.

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.

A system for monitoring and recording the servicing of all clinical/non-clinical equipment was established, this included equipment in the PCRF.

There were active and retired risk and issues registers. The 4T's have been applied to the risks and all had been given a review date. The active risk register included risks transferred to Regional Headquarters and all the main risks identified by the management team.

At the time of the inspection the practice did not have any Control of Substances Hazardous to Health (referred to as COSHH) risk assessments in place. These were completed and sent through by email the day after the inspection.

The PCRF facility was well provisioned to meet the specific needs of the patient population. The rehabilitation syllabus had been designed to maximise the delivery of rehabilitation activity. Space was a limiting factor in the type of rehabilitation that could be delivered, for instance space to deliver agility drills was limited. The lead ERI was currently pursuing having an additional space built for this type of training.

The lead ERI was responsible for equipment maintenance and servicing. A record of all servicing and maintenance activity was maintained. A system was in place for fault reporting. Non-DPHC equipment was used to rehabilitate patients, this was checked to ensure maintenance and servicing was in-date. The lead ERI had begun the process of applying for DPHC funding to purchase new equipment and then provide the continual upkeep.

Daily wet bulb monitoring took place outside of Parker Hall with a headquarters announcement of changes to training daily in accordance with policy.

Lone working was avoided where possible. There was no lone working with patients in Parker Hall, ERIs had a strict policy in place to avoid this which was part of medical centres and Parker Hall's lone worker policy. Where it could not be avoided, it was risk

assessed by their line manager and incorporated into Parker Hall generic activity risk assessment.

All clinical spaces within the medical centre had personal alarms. The alarms were last audited in June 2025. Each personal alarm was tested to ensure that it was working properly. This was conducted annually.

Lessons learned and improvements made

All staff worked to the DPHC policy for reporting and managing significant events (SE), incidents and near-misses, which were recorded on the electronic organisational wide system (referred to as ASER). There was an ASER log on the SMT and this was cross referenced to the duty of candour log. ASERs were discussed at week 1 and 3 of the Senior Leadership Team meetings. Lessons learned were being discussed but were not being captured on the ASER log and therefore not available for all staff. All staff we spoke with knew how to raise an SE or incident.

We were given a recent example of a change made as a result of a significant event.

A recruit had managed to return to training whilst still medically downgraded. An ASER was formally raised. The analysis found lack of clear communication as the cause, and the sharing of information between the physiotherapists and the ERI's. Actions have now been taken to ensure there are clear set boundaries to avoid the accidental progression of recruits back to training.

A number of vaccination errors occurred due to the way mass vaccination clinics were being run. All vaccinations for each individual were prepared in a tray in advance. This process was sometimes rushed and did not always have appropriate supervision. As a result, different treatment rooms now give a different vaccine, this had resolved the ongoing issues and had now been submitted as a quality improvement project.

Are services effective?

We rated the practice as good for providing effective services.

Following our previous inspection, we rated the practice as requires improvement for providing effective services. We found shortfalls with:

Staff training

Recall of patients with long-term conditions.

At this inspection we found that these had improved.

Effective needs assessment, care, and treatment

All doctors were signed up to receive the National Institute for Health and Care Excellence (NICE) and the Scottish Intercollegiate Guidelines Network (SIGN) clinical update emails. These were discussed at clinical meetings and other informal forums provided a good opportunity for peer support, including opportunistic sharing of relevant patient information.

Each morning all doctors attended a visit of the Bedding Down Facility (BDF) which allowed time for a discussion of all patients. They also used this as an opportunity to discuss any patients of concern. They had a policy of discussing all recruits presenting with acute mental health symptoms within 24 hours and alongside this there was a formal monthly case-based discussion meeting which was minuted and logged. Later in the afternoon a doctor re-visited the BDF to assess patients further to support the nurses working throughout the evening and overnight and discussed and implemented any alteration needed to the treatment plans.

Nurses' meetings were held monthly and included reviewing Defence Primary Healthcare (DPHC) newsletters, staffing updates, significant events, Patient Group Directives (PGD's) and any other topics of interest. These were minuted so could be referred to following the meeting.

There was a Primary Care Rehabilitation Facility (PCRF) meeting scheduled every 6 weeks, there was an agenda item for NICE/Best Practice Guidelines (BPG) updates. Weekly time designated for in-service training enabled fast dissemination of information.

Due to the uniqueness of the Royal Marine training pathway there were a number of in-house standard operating procedures (SOP's) and best practice guidance which were routinely updated. The PCRF staff were also kept up-to-date about wider defence rehabilitation and DPHC issues.

The PCRF measured its performance in terms of patient outcomes. The injury surveillance dashboard highlighted performance against key performance indicators including the rehabilitation outcome, time to return to training and the course completion/ pass out rate. The dashboard had 8 years' worth of data so the team could see where changes were implemented and compare this data to ensure outcomes were moving in the right

direction. This in-depth dashboard allowed the team to be responsive; it influenced how services were delivered and informed the training team to help shape future training.

Our review of PCRF patient records confirmed the physiotherapist used the Musculoskeletal Health Questionnaire (MSK-HQ) mostly for permanent staff. The MSK-HQ is the standardised outcome measure for patients to report their symptoms and quality of life. The MSK-HQ was used at the initial appointment and on discharge of the patient. The use of the MSK-HQ was clinically coded via the DMICP template.

Due to the nature of the training pathway for recruits and the key performance indicators being more outcome-driven, patient reported outcome measures were less frequently used. However there was a number of objective markers used to determine functional status in Parker Hall. The Visual Analogue Scale was used at each appointment to monitor pain and track condition progression.

A functional activity assessment was used at every appointment, this was a comprehensive evaluation of how well a person can perform everyday tasks and to what degree assistance was needed. It was not just about physical measurements (like strength or range of motion); it also examined quality of movement, independence, and personal or environmental factors that might have influenced performance.

The PCRF staff ensured a holistic view of patients was taken, including mood, sleep and lifestyle. Project SATURN was adopted as business as usual by the training team. All recruits completed this daily survey to record their sleep quality and quantity, mood, motivation and comments, it was held centrally and was accessible to all members of the training team and medical departments. The use of this dashboard allowed targeted education sessions relating to sleep hygiene, lifestyle management and recovery.

An example of this was the PCRF staff had highlighted (via the dashboard) the need for recruits to be de-loaded within the first few weeks due to a spike in injury rates. Due to this, the long weekend which the recruits initially had at week 12 has been moved to week 6. With the data they captured they have been able to show that this change in the policy/ leave schedule had led to a direct change in injury rates.

There was a graded programme of rehab delivery, with exercise programmes for patients to work with. There was a bespoke progressive impact loading programme; for example, this was tailored towards the week of training the recruits were going back into and was reviewed every time a new iteration of the training syllabus came out to ensure the recruits were returning to the appropriate level. There was also patient handouts and the rehabilitation booklet which had been adopted as best practice and audited to ensure adherence within Hunter Company. For other staff (not recruits) rehabilitation exercise programmes were provided through Rehab Guru (software for rehabilitation exercise therapy).

Monitoring care and treatment

The Deputy Principal Medical Officer (DPMO) delegated responsibility of monitoring long-term conditions (LTCs) to the long-term locum nurse. They managed the chronic disease register and highlighted what patients should be called in for, routine checks and

monitoring. The majority of patients were recruits and the level of chronic disease was low. The nurses carried out the DMICP searches and recalled patients via text message for bloods and other tests.

We conducted searches to identify patients with LTCs on the day of the inspection. Reviews were of good quality and the appropriate templates had been used.

There were 3 adult patients on the diabetic register. For 1 patient, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For all 3 patients with diabetes, the last blood pressure reading was 150/90 or less which is an indicator of good blood pressure control.

There were 23 patients on the hypertension register and 22 of these had had their blood pressure taken in the past 12 months. Of these, 17 patients had a blood pressure reading of 150/90 or less.

There were 7 patients with a diagnosis of asthma. Of these, all had received a review in the past 12 months.

Audiometry assessments were in date for 70% of the patient population. A review of patient records indicated appropriate Hearing Conservation Programme recalls were in place and patients were being managed in line with DPHC policy.

All patients over 40 years old were captured on the database and were offered an over 40s check. We saw the recall rate was 98%.

Through a review of clinical records and discussions with the doctors, we were assured that the care of patients with a mental illness and/or depressive symptoms was being effectively and safely managed, often in conjunction with the Department of Community Mental Health (DCMH). The medical centre followed the Defence Primary Healthcare (DPHC) guidance and provided Step 1 intervention and immediate referral for appropriate diagnoses. Patients with low mood were managed with Step1 therapy, although a referral was made to DCMH if Step 1 therapy was felt to be not clinically appropriate or there was a risk of deliberate self-harm. All clinicians stated that it was easy to have a discussion with the mental health team and urgent referrals could be seen within 24 hours. As well as open-source tools online such as Headspace, patients with mental health needs could be supported by the padre, unit welfare team and the Royal Marines Charity.

There was a complex audit programme with annual schedule on the governance log. This was overseen by the nurse locum and the doctor, it was discussed monthly at the meetings attended by the heads of departments. There was an ongoing plan and many quality improvement projects in place. Examples included a form which patients attending the emergency department at the NHS hospital got the NHS medical staff to complete giving a brief diagnosis, treatment and recommended management. This prevented delays in receiving a discharge summary via mail/email which could take several days.

The PCRF was conducting audits relevant to rehabilitation and clinical delivery. Audits conducted included:

- Royal Marines Band (RMB) audit; the audit identified high injury rates amongst RMB upon commencement of training this was fed back to the training team and the syllabus was re-designed. The re-audit showed improvement.
- Hunter Company injury audit; the rehabilitation syllabus was periodically re-design based upon injury surveillance data to identify reduced pass out rates amongst those returned to training from Hunter Company.

Also notes audits, acupuncture and injection audits were undertaken. Audits were shared via the Senior Leadership Team meeting, whole practice meeting, PCRF meeting and as needed between staff. Injury surveillance data was shared with the Chain of Command.

The medical centre followed the most recent guidance and swiftly incorporated any changes to clinical best practice around the treatment of heat illness. This was led by the civilian medical officer (CMP) and included development of the enhanced treatment room and training updates around the management of heat illness.

The medical centre was the only primary care facility with an in-house radiography service within DPHC. The reporting radiographer worked 26 hours a week. This hastened the diagnosis of bone injuries and led to a direct referral to orthopaedics when required. The medical centre had agreed a private service to obtain Magnetic Resonance Imaging (MRIs) within 4 weeks for suspected bone stress injuries; this was funded by the unit for Royal Marines in training.

All external radiology requests were triaged by the radiographer. They had external continual professional development timetabled to maintain currency and reporting outside the agreed parameters was done in Plymouth with radiographer assurance provided by a military radiologist.

Effective staffing

Staff had received an appropriate induction and appraisal. New members of staff were required to complete the DPHC mandated induction. The induction package was recorded on the staff training database managed by the practice manager. We saw new staff were allowed a period of time to be supernumerary in their role to ensure they felt confident.

The deputy practice manager was the lead for mandatory training and they sent monthly individual emails to staff advising of any training gaps. Mandatory training was a standing agenda item on the Senior Leadership Team meeting every week. Group training was scheduled for Monday afternoons and protected time was offered when staff need to complete any mandatory training. At the time of the inspection the training log showed high compliance with mandatory training requirements.

Protected time was allocated for continuing personal development (CPD). Staff were encouraged to apply for courses and were supported to do so. Some examples of extended training opportunities included the Senior Nursing Officer (SNO) completing the Link Practitioner training for their role as Infection Prevention and Control (IPC) lead. The practice manager had completed Institute of Occupational Health training for the health and safety lead role and they had also attended the Joint Practice Managers course.

The doctors all completed regular appraisal and revalidation. The nurses had completed their revalidation. All clinicians were aware of the CPD requirements and used clinical meetings, mandatory training, and practice meetings to support with meeting this requirement.

There was almost no requirement for aircrew medicals. In the event this was required, service personnel would be directed to Yeovilton medical centre. The incoming Principal Medical Officer was both aviation medicine and diving medicals trained. Two of the doctors were trained to complete underwater medicine/ diving medicals. The Deputy Principal Medical Officer was waiting to complete the diving medicine course in the next few months. One of the doctors had a diploma in line with the provision of prehospital emergency care.

Coordinating care and treatment

A range of structures were in place to ensure the effective coordination of patients' care. The medical centre had effective relationships with the camps Commanding Officers and the unit commanders so concerns about the health and wellbeing of patients was promptly addressed.

There was a longstanding link with the local microbiology team. Additionally, there was a clear pathway to the orthopaedic team in Exeter to ensure rapid management. They had also developed a rapid pathway for cardiology assessments via a private service which was funded by the unit with a 12-week average wait. They have also agreed a private service to obtain MRIs within 4 weeks for suspected bone stress injuries. Again, this was funded by the unit. The medical centre had close association with the Royal Marine Charity which was located on camp.

Clinical forums for multi-disciplinary discussions were in place to review patient treatment and joint care pathway planning. We saw that referrals to the Regional Rehabilitation Units and Multi-Disciplinary Injury Assessment Clinic were made promptly with manageable wait times for the permanent staff. Recruits were generally referred to local providers; this facilitated early multidisciplinary management of the patient pathway. A weekly meeting was in place for discussion of clinical cases and timelines for management. Patients were offered interim support to manage any injury in the interim and Chain of Command were made aware if personnel needed to be downgraded whilst they awaited assessment and treatment.

Helping patients to live healthier lives

The SNO was the lead for health promotion. The medical centre followed the NHS health promotion programme so health topics were refreshed regularly. There was a wide variety of thoughtful health promotion materials displayed in the waiting room including women and men's health boards, cervical screening, contraception and prostate cancer.

One of the doctors was the sexual health lead, none of the nurses were sexual health trained (known as STIF). All recruits were offered a sexual health screen on entry and

there was a 100% uptake on this. Patients could self-refer to local NHS sexual health services.

Monthly searches were carried out to identify patients eligible for the national screening programmes. Cervical screening was managed using the NHS CIS2 portal. Patients were sent 3 invitations for cytology screening. If there was no response then the nurse followed up with the patient to encourage the patient to engage with the screening programme. Outcome letters received from the NHS were forwarded to patients and scanned to the patient's DMICP record. The number of women who had a cervical smear in the last 3-5 years was 35 which represented 88% of the eligible population. The NHS target was 80%.

Currently there was no nurse trained for this role so patients went to HMS Drake in Plymouth for cytology. The new band 7 nurse would be taking on this role in the near future, they had a lot of experience in this field.

Monthly searches were undertaken for patient's due bowel, breast, AAA (abdominal aortic aneurysm) and cervical screening.

Newly registered patients' due vaccines were captured as part of the new joiners notes summarising. Patients were not recalled for vaccines but were captured opportunistically and as part of pre-deployment checks. The nurses were working through diary dates on DMICP to ensure vaccine data displayed on patients 'MyHealth' app was accurate these enabled patients to take responsibility for their own vaccine readiness. Statistics were as follows:

- 88% of patients were in-date for vaccination against diphtheria.
- 88% of patients were in-date for vaccination against polio.
- 95% of patients were in-date for vaccination against hepatitis B.
- 94% of patients were in-date for vaccination against hepatitis A.
- 88% of patients were in-date for vaccination against tetanus.
- 98% of patients were in-date for vaccination against MMR.
- 97% of patients were in-date for vaccination against meningitis.

Consent to care and treatment

Implied, verbal and written consent was taken depending on the procedure. DMICP templates captured consent. All the patient records we looked at indicated consent had been appropriately taken. Within the PCRF we saw consent was captured appropriately and was saved onto DMICP. This included acupuncture.

Clinicians understood the Mental Capacity Act (2005) and how it would apply to the patient population. Record keeping audits incorporated a review of consent.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect, and compassion

People were truly respected and valued as individuals and were empowered as partners in their care. Feedback from people who used the service was continually positive about the way staff treated them. We spoke with 6 patients in the Bedding Down facility (BDF) they told us staff went the extra mile and the care they received exceeded expectations. They told us that if needed, the medics regularly went and got clothes and toiletries for them to make their stay more comfortable.

The exercise rehabilitation instructors (ERIs) had conducted short adventure training packages utilising skills they have gained through the nature of their work. This took a holistic approach to the recruits' well-being incorporating their mental wellbeing as it was recognised that some of the recruits had a reduced mood by conducting solely exercise based sessions within the gymnasium. The ERIs had identified, alongside the physiotherapists, recruits whose injuries would allow them to conduct activities such as hill walking and mountain biking, they have then taken the recruits out for the day to conduct these activities to raise their morale.

A case was discussed where one of the nurses identified an individual who was struggling due to bereavement (though presented with a physical problem). A follow up appointment was offered, although not needed medically and through that longer appointment, the individual was able to be given compassionate time to travel home and support their wider family.

In advance of the inspection, patient feedback cards were sent to the medical centre, feedback was from patients that had been seen by the Primary Care Rehabilitation Facility (PCRF), the dispensary and the medical and administrative staff. A total of 50 patients from responded and feedback was positive including comments about the good level of care received.

Patients could access the welfare team, the padre and various support networks for assistance and guidance. We spoke to a member of the welfare team who described the medical centre team as responsive and always available to talk though any concerns regarding patients. Information regarding these services was available in the waiting areas and the clinical staff were fully aware of these services to signpost patients if required.

Involvement in decisions about care and treatment

The clinicians and staff at the practice recognised that the personnel receiving care and treatment could be making health care decisions 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 evidence-based guidance and clinical facts. We

spoke with 6 patients who were inpatients in the Bedding Down facility (BDF), all 6 said they were treated with absolute kindness and that their concerns about their careers and course participation were discussed fully with them and support given at every step.

The Deputy Principal Medical Officer (DPMO) was the carers' lead and all carers were included on the vulnerable persons register. There were 9 carers registered. Most carers were identified via the new patient registration form. There was a carers' standard operating procedure in place to support this. There was a practice leaflet which included information for carers. Alerts were made on individual patient's notes to ensure that longer appointments were given if needed. Searches were conducted to ensure that the flu vaccine was offered appropriately. There was a carers poster on display in the waiting area.

Within the PCRF patients feedback suggested patients were involved in decision making regarding their care. From the patient feedback dashboard, data showed only 5% felt that they were not given clear information about their condition, 7% did not understand their care pathway and 7% were not satisfied with their care. DMICP records showed examples of when patients had made decisions about their care.

From discussing with several recruits on the day, all agreed that they were kept informed and involved with the decisions surrounding their care. The recruits also mentioned that they were able to question why a certain pathway was being taken for their condition without the fear of any repercussion, they felt like training staff were approachable and would take time to give them an appropriate answer.

Care leavers were identified and discussed at the carers meeting; consideration was always given to those patients who may choose to stay on camp during times of block leave as they may not have a permanent home address to return to. These patients were offered extra support as needed.

Supported by a standard operating procedure, a translation service was available for patients who did not have English as a first language.

Privacy and dignity

Consultations took place in clinic rooms with the door closed. Patients were offered a private room if they wanted to discuss something in private or appeared distressed. Telephone conversations were undertaken in private to maximise patient confidentiality. Within the PCRF all patients were made aware they can have a private consultation room if required at any stage of treatment. Consent was gained for informal assessment within the gym, within this setting there was music playing to assist in maintaining confidentiality.

The reception area in the medical centre was large and there was radio playing to mute confidential conversations. A statement of need had been submitted to reconfigure and improve the waiting room.

There was a mix of male and female clinicians so patients had the option to see a doctor of a specific gender. Within the Bedding Down Facility there were male and female nurses employed.

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 needs of patients were considered when scheduling appointments. Through the use of DMICP alerts, vulnerable patients and carers were promptly identified and prioritised for an appointment. Extended appointment times could be facilitated. Even though eConsult and telephone appointments were available and utilised, the patient population preferred face-to-face consultations. Vaccination clinics were coordinated depending on the needs of the unit.

The practice staff were aware of the mandated training required by all healthcare providers in the support of patients with a learning disability and/or autism. Individual staff members were in the process of completing the training and approximately 90% had completed it.

An Equality Access Audit as defined in the Equality Act 2010 had been completed within the past year and 3 areas of concern were identified and statements of need submitted for new compliant front doors, a hearing loop and disabled parking spaces. It was hoped these requests would be funded and completed in late 2025.

The medical centre was able to confirm inclusive and supportive treatment for patients with gender dysphoria, should this be required. There had been occasion when they have offered extra support to patients for religious reasons. For example, supporting dietary requirements in Ramadan. They had also looked at how to support vegan patients get sufficient calorie intake while doing arduous training.

Following patient feedback on the Bedding Down Facility (BDF) there was an increase in food available to patients at the weekends.

Timely access to care and treatment

Feedback indicated patients were satisfied with access to a doctor or nurse. An urgent appointment with a doctor or nurse could be accommodated on the same day. Routine appointments with a doctor could be facilitated within 4 working days and for a nurse, within 3 days. A new patient appointment or follow up appointment with a physiotherapist or exercise rehabilitation instructor were available within 1 day. The PCRF ensured continuity of care where possible by patients seeing the same physiotherapist and ERI throughout their treatment. Patients were assigned to specific treatment groups based on their injury. These groups were run by the same ERI to maintain a level of consistency with the care.

Clinicians were flexible with their working hours (early start/late finish) to fit around unit activity, for example starting early when an arduous training run was planned for early morning.

Details of how patients could access the doctor when the medical centre was closed were available through the station helpline, put out on unit orders and on the answer phone message.

The practice was open Monday to Friday 07:00-16:30 hours. The medical centre was staffed 24 hours a day 7 days a week by a duty medic and ward nurse, with a doctor and medic on call for emergencies. Urgent care clinics (fresh cases) were held twice a day, during the week and at weekends: Saturdays at 08:00 and Sunday at 09:00. These clinics were medic led but there was also a duty senior medic and doctor in the building. A nurse was always available in the Bedding Down Facility. During the periods of stand down at Easter, summer and Christmas, primary care cover was provided by HMS Drake and this was documented in the unit leave instructions.

Direct Access Physio (DAP) clinics were not available for recruits: they would be seen promptly by one of the doctors and referred on if PCRF input was required on the same day. There was a DAP clinic for permanent staff which meant they could self-refer. Rapid access to PCRF support was available with patients being seen well within the key performance indicators (same day for acute referrals). Routine physiotherapy appointments were available within 1 day and follow up appointments within 5 days. To see an exercise rehabilitation instructor, a new patient appointment was available the same day and follow up appointments could also be accommodated within 1 day. The PCRF was co-located in the medical centre and had sufficient space for assessing and treating patients but limited space for rehabilitation. Recruits would usually transfer to Hunter Company if medically downgraded which allowed for access to appropriate space and equipment. Permanent staff who required rehabilitation and access to further equipment were able to use Parker Hall outside of recruit training times. This limited the times that permanent staff could undertake rehabilitation and had been raised as an issue by the PCRF. As a result the PCRF had opened during lunch time hours and at the end of the working day to improve permanent staff accessibility.

Listening and learning from concerns and complaints

The practice manager was the lead who handled all complaints. Complaints were managed in accordance with Defence Primary Healthcare policy complaints policy and local procedure. The complaints procedure was displayed in the practice leaflet, on daily orders and on a noticeboard in reception. We discussed a recent complaint and it had been well managed and included some actions for improvement. A complaints audit had been completed in July 2024 and no trends were identified.

Are services well-led?

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

Following our previous inspection, we rated the practice as requires improvement for providing well-led services. We found shortfalls with:

Improvements were required in relation to the management action plan (MAP) and the issues log on the healthcare governance framework.

Communication across the whole team.

The Business Continuity Plan.

Vision and strategy

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.

The medical centre followed the Defence Primary Healthcare (DPHC) Mission and Vision statement but have also developed a mission statement more relevant to their population.

> *Health as a normalised component of successful elite training and education*
>
> *Lympstone Medical Practice combines a range of capabilities all focussed on providing timely acute triage, assessment, care and rehabilitation according to the dynamic needs of a Command who places critical importance on a safe system of training and divisional care.*
>
> *Making safe decisions to keep healthy people in training.*
>
> *Recognising early those who need care or protection in Service.*

It was evident the medical centre was meeting its mission as we found the service was highly responsive to the needs of individual patients and the occupational needs of units. Integration was promoted, evident through the close working relationship between medical centre staff and the Primary Care Rehabilitation Facility (PCRF) team.

The medical team were focussed on providing the best possible care for their patient population with emphasis on providing quality primary care and on innovations in managing heat illness and acute injuries.

The needs of the patient population were considered with strategic planning, including when service changes were made. The changes were usually driven by the unit and the medical centre responded to their needs. For example, during hot weather, endurance activity times were altered to avoid the hottest part of the day. During the week of the inspection, the facility had opened at 06:00 on one day, to support an endurance run in the training areas.

To address environmental sustainability, the medical centre aimed to reduce the use of paper by communicating via email and the use of links rather than producing paper booklets. Staff were vigilant with switching off lights, closing windows and the use of heating. Recycling bins were positioned around the building.

Leadership, capacity, and capability

There had previously been some gaps in significant posts including the Principal Medical Officer (PMO) and the Senior Nursing Officer (SNO) but these roles had now been filled. Through discussion, we found that the doctors felt they were all acting up one rank although they hoped this would improve when the new PMO arrived in a few weeks. The practice manager post would now be vacant until September 2025. The remaining staff were working hard to ensure the medical centre continued to develop but this may not be sustainable. Due to the unique challenges that Lympstone Medical Centre faces, experience in the practice manager role was deemed essential. The workload was relentless and there was a high tempo of work all the time, this was witnessed on the inspection day. Some further civilian continuity would provide resilience within the Senior Leadership Team (SLT).

The relationship between the PCRF team and the medical centre was strong and inclusive, with regular contact via the weekly senior leadership team meeting. Communication with the Regional Clinical Director (RCD) was typically via the Regional Rehabilitation Advisor, who had visited soon after appointment and received an overview of care delivery to support contextual decision making. The RCD had attended several visits observing briefs delivered by Officer Command PCRF. The RCD had clear insight into the PCRF and was wholly supportive.

Within the nursing department, unit leadership was both effective and resilient. The acting Senior Nursing Officer (SNO) had oversight of 7 nurses across both the medical centre and the Bedding Down Facility (BDF), while also covering duty senior responsibilities. It was hoped that the return of the permanent SNO would improve the situation by allowing for increased clinical input and more focused attention on the management of the BDF.

Currently within the BDF, a nurse of the same grade as her colleagues was fulfilling the ward manager role and was managing the responsibilities competently. However, this setup was not sustainable in the long term, particularly in the absence of a defined supervisory structure, a formal leadership designation, or clear management differentiation, all of which were necessary for effective appraisal and performance oversight among peers.

Culture

From patient feedback, interviews with staff, a review of patient records and outcomes/outputs for patients, we confirmed holistic and person-centred care was key to the principles of the practice. Staff understood the specific needs of the patient population and organised the service to meet those needs. The team often went ‘above and beyond’ to support individual patients and squadrons/units.

The practice manager demonstrated numerous examples of team building activities. The day after the inspection, funding had been secured for a staff barbecue. Picnic benches had been procured for staff use and there had been a recent pizza night. A recent staff survey saw 75% of staff respond with 93% of those generally content. There were some themes of junior staff finding one of the doctors less approachable but the practice manager had offered to be an advocate for them if required. We saw evidence throughout the day that junior staff clearly felt comfortable approaching the practice manager with issues and concerns for guidance.

The staff survey demonstrated that staff were content with peer support and during a serious incident on the training area during the inspection; the response from the team was slick and effective; clearly a highly motivated and effective team.

The practice manager promoted an open culture at the medical centre; staff surveys and suggestion boxes, regular junior rank 'clear all decks' meetings, team building and a generous stand down for weekend duty staff. The high tempo environment sometimes hindered traditional processes such as 'whitespace' but the management team were constantly utilising any quieter periods to provide opportunities for staff to engage in sport, team building and other activities.

The management team operated an open-door policy and inclusive culture. Staff could also raise concerns anonymously through surveys and suggestion boxes. The team were also aware of the Whistleblowing policy and there was information displayed.

Processes were established to ensure compliance with the requirements of the duty of candour (DoC), including giving those affected reasonable support, information and a verbal and written apology. Displayed for staff to access, DoC is a set of specific legal requirements that services must follow when things go wrong with care and treatment. A DoC register was maintained and a DoC tab was included in the ASER log.

Governance arrangements

Communication was strong across all departments. There was an integrated governance approach for the medical centre and PCRF, for example there was:

- Integrated audit programme
- Joint meetings/forums for the whole practice
- Integrated systems (standard management tool) (SMT)

There was a clear staff reporting structure in place. Staff were aware of their roles and responsibilities. Staff with lead roles had protected time to carry out their additional duties. Most of the lead roles were shared across the management team but there were some with extra responsibilities. Staff had terms of reference for their main job with any associated lead roles contained within it.

There was a range of standard operating procedures (SOPs) in place for all key processes and these were kept under review. A thorough rotation of a range of meetings was in place to ensure effective communication and information sharing across the staff team. Whole

practice meetings were held 6 times a year and there was SLT meeting each week with a rolling 4-week agenda covering all healthcare governance and practice management requirements during the month. There were also clinical meetings each month and regular short ‘clear all decks’ meetings which included medics and administrative staff to disseminate essential information and offer them a platform to raise concerns.

The healthcare assurance framework (HAF) had been central to ensuring all actions identified during the previous CQC inspection had been addressed. There was a HAF tracker on the SMT, and HAF was a standing agenda item on week 4 of the SLT meeting. The HAF was used by all staff daily; it was comprehensive and linked all required information and data into one document

There was a management action plan (MAP) in place and alongside this there was a practice development plan. Examples included sexual heath (STIF) training for a nurse and implementation of the electronic SAR (subject access request) process.

One of the doctors was the audit and quality improvement (QIP) lead for the medical centre. There was an audit calendar on the SMT which included all ‘must’ and ‘should’ audits and some others relevant to the medical centre. Audits were only graded as green once the audit had been completed and shared with the team. There was also a QIP register on the SMT with 6 entries detailed for 2025.

Managing risks, issues and performance

There was a current and retired risk register in place along with current and retired issues. The register articulated the main risks identified by the practice team. All risks included detail of the four T’s: ‘treat, tolerate, transfer or terminate’ and had a review date.

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; Control of Substances Hazardous to Health risk assessments were developed during the inspection.

There were processes in place to monitor national and local safety alerts although this needed review, incidents, and complaints.

The Business Continuity Plan (BCP) had been reviewed and was exercised to ensure that staff knew what to do in an emergency. The BCP covered risks to the service. To accompany the BCP there was an SOP in place that referenced block leave and the management of vaccines.

The Deputy PMO was familiar with applying policy and processes for managing performance and ensuring staff were supported in a sensitive way taking account of their wellbeing. A good example was discussed where an individual had to be removed from the medical centre following a number of errors, the process was discussed and clearly understood by both the nursing and practice management leadership.

Appraisals were up-to-date for all staff.

The medical centre had a link to the unit major incident plan (MIP) and were clear about their role within it. There was a tracker on the SMT to capture when the MIP has been exercised and the BCP enabled. Examples included unit tabletop exercises for a road traffic accident and a missing person.

Appropriate and accurate information

An internal assurance review was undertaken in April 2023 and the rating was ‘substantial assurance’. The last CQC inspection took place in May 2024 and the medical centre was rated as ‘requires improvement’. The unit had an Ofsted inspection in November 2023 and they were rated ‘good’. Following the CQC inspection, a number of improvement points were identified and a detailed action plan developed. All of the actions had been completed and the action plan was reviewed at governance meetings.

Arrangements at the medical centre were in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. The Caldicott Principles, guidelines for the management of patient identifiable information, were followed. The practice manager was the lead for Caldicott and checks were carried out each month to ensure records were not being accessed inappropriately. Any concerns identified were promptly addressed. The staff team had completed Defence Information Management Passport training which incorporated the Caldicott principles.

Engagement with patients, the public, staff and external partners

The medical centre worked closely with the Chain of Command, Regional Rehabilitation Unit, the PCRF, local NHS services, Department of Community Mental health and welfare support services to ensure a collective approach to ensuring the health needs of the unit and with supporting vulnerable patients.

Patient feedback mechanisms were readily available to encourage patient’s views. Patients had the opportunity to complete the DPHC survey or provide input through compliment, complaint, and suggestion forms. Feedback from BDF patients indicated that the facility's doors were heavy and challenging to navigate when using crutches. In response, a statement of need was submitted for alterations to the doors, and this was currently awaiting action. Additionally, patients expressed a desire for better mental health information in the waiting area. In response, mental health leaflets were provided, and a dedicated mental health notice board was established to enhance information accessibility.

Within the PCRF, patient experience was captured through several channels: the standard DPHC Patient Experience Questionnaire, the Parker Hall patient experience questionnaire, and informal comments submitted via the daily wellbeing monitoring tool. Over the past six months, 92 completed questionnaires had been submitted; results were collated and could be viewed in the service’s feedback dashboard. Patient feedback was used to drive continuous improvement through a structured, termly review process. Each quarter, responses, both quantitative scores and qualitative comments were assessed

against the department's critical success factors. This informed the development of the quarterly Quality Improvement Plan (QIP), ensuring patient voices shaped strategic priorities.

Some examples were:

- Rehabilitation programme refinement (2024): Based on feedback, the rehabilitation syllabus was updated to include targeted mobility and flexibility sessions, addressing patient requests for more holistic recovery options.
- "You Said, We Did" board. The results were actively shared with patients via a prominently displayed board in the medical centre. This highlighted where feedback has led to changes, reinforcing patient engagement.

These actions demonstrate a commitment to listening to patient concerns and making improvements based on their feedback.

Staff feedback was actively encouraged to ensure that their voices were heard and valued. Staff members asked for more opportunities to engage in sports activities and for the implementation of rotating Fridays off to enhance work-life balance. Recognising the importance of physical activity in promoting employee well-being, the unit facilitated sports sessions when the training programme allowed. Additionally, the concept of rotating Fridays off was under consideration, with stand-down options being reviewed.

Continuous improvement and innovation

We found a number of examples of innovation and quality improvement projects that included:

- Enhanced treatment room and acute care provision. The emergency treatment room continued to support improved management of heat-related illnesses and acute injuries, bolstering the medical centre's pre-hospital care capabilities.
- Strengthened collaboration with specialist services, stronger local partnerships had been established with:
    - Microbiology – for rapid diagnostic support
    - ENT – for specialist referrals and ear, nose, and throat care
    - Cardiology – for advanced cardiac evaluation
    - Radiology – notably the use of MRI in bone stress detection
- Improved patient information flow form. A standardised form was issued to patients, increasing the likelihood of timely transmission of necessary information from the NHS to the medical centre.
- In-house best practice guidance (BPG) initiatives.
- Development of internal BPGs—such as "Return to Impact"—supports safer and more effective clinical decision-making.

The development of project SATURN which monitored recruits daily where possible by using self-reported measures such as sleep and wellness, this was continued if the recruit became injured and moved to Hunter Troop. This allowed an almost real time measurement of metrics, training was then adjusted if required allowing a much more comprehensive overview of the recruits.

The injury surveillance dashboard has steadily expanded in scope and sophistication. The dashboard highlighted performance against key performance indicators including the rehabilitation outcome, time to return to training and the course completion/ pass out rate. The dashboard had 8 years' worth of data so the team could see where changes were implemented and compare this data to ensure outcomes were moving in the right direction. This in-depth dashboard allowed the team to be responsive; it influenced how services were delivered and informed the training team to help shape future training.