Thorney Island Medical Centre

Baker Barracks, Emsworth P010 8DH

Defence Medical Services inspection

This report describes our judgement of the quality of care at Thorney Island 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	**Requires improvement**	
Are services safe?	**Requires improvement**	
Are services effective	**Requires improvement**	
Are service caring?	**Good**	
Are services responsive to people's needs?	**Good**	
Are services well-led?	**Requires improvement**	

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This practice is rated as requires improvement overall

The key questions are rated as:

Are services safe? – Requires Improvement
Are services effective? – Requires improvement
Are services caring? – Good
Are services responsive? – Good
Are services well-led? - Requires improvement

We carried out this announced inspection on 8 February 2022. The Primary Care Rehabilitation Facility (PCRF) was not included as part of this inspection.

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 Defence Medical Services.

At this inspection we found:

- The practice had effective leadership although this was hindered by staff shortages. Staff worked well as a team and said they were well supported and included in discussions about the development of the service.
- Despite the staffing challenges patient feedback indicated staff responded promptly to ensure they received timely and effective care. It showed patients were treated with compassion, dignity and respect and were involved decisions about their care and treatment. Information about services and how to complain was available to patients.
- Patients found it easy to make an appointment and urgent appointments were available the same day.
- The recently appointed practice manager had identified shortfalls in risk management, and governance systems. They were pro-actively addressing these deficits and were realistic that it would take time to make all of the improvements required.
- Systems and processes to keep patients safe were not fully embedded at the practice; risk assessments required closer management.

- Leadership capacity was stretched given that leaders and staff in key positions had other unit commitments.
- Mandated training for staff was not up-to-date, including safeguarding training.
- The practice had good lines of communication with the unit, welfare team and the Department of Community Mental Health (DCMH) to ensure the wellbeing of service personnel.
- An inclusive whole-team approach was supported by all staff who worked collaboratively to provide a consistent and sustainable patient-centred service.
- The arrangements for managing medicines required strengthening, in particular, the processes around checking expiry dates of medicines.
- Quality improvement activity was evident but required improvement to drive improvements in patient care.
- 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.
- Staff were aware of the requirements of the duty of candour, (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). Examples we reviewed showed the practice complied with these requirements.

The Chief Inspector recommends that the medical centre:

- Review staff training to ensure staff are up-to-date with their mandated training, including safeguarding training at a level required for their role.
- Review the approach to risk management to ensure risk assessments and the risk register reflect the practice needs, are current and sufficiently detailed.
- Ensure all staff are engaged with the peer review process.
- Develop a more thorough and formal way of discussing and recording relevant and current evidence-based guidance and standards and ensure all staff have access to this.
- Further develop quality assurance processes.
- Ensure all aspects of the medicines management system are safe including the management of patient safety alerts and the monitoring of medicine expiry dates.
- Ensure all staff have a thorough role specific induction.

  Ensure safety systems are in place including an effective alarm system and a process to monitor national and local safety alerts.

The Chief Inspector recommends to DPHC:

- 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 was led by a CQC inspector. The team comprised specialist advisors including a primary care doctor, a practice manager and a nurse. The team included one observer from DPHC.

Background to Thorney Island Medical Centre

Thorney Island Medical Centre provides a routine primary care, occupational health and rehabilitation service to a patient population of 1,055 including service personnel and permanent staff for the camp. Most patients are aged between 18 and 44. At the time of the inspection, there were no registered patients under the age of 18.

A Primary Care Rehabilitation Facility (PCRF) is based in a building adjacent to the practice and provides a physiotherapy and rehabilitation service for patients but this was not inspected on this occasion as no specialist advisor was available. As there is no dispensary at the practice, there is a contract in place between Defence Primary Healthcare (DPHC) and a local pharmacy.

The practice is open from 08:00 hours to 16:30 hours Monday to Thursday and from 08:00 hours to 16:00 hours on a Friday. Between 16:30 hours and 18:30 hours cover is provided by Nelson Medical Centre. 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 (both deployed)
Locum civilian medical practitioner (CMP)	One (temporary)
Practice manager (civilian)	One
Nurses	One (plus one temporary part-time locum for three months)
Exercise rehabilitation instructors (ERI)	One
Physiotherapists	One (full-time locum)

Administrators	One
Combat medical technicians* (CMTs) (referred to as medics throughout this report)	Nine (two posts gapped)

*In the army, a medical sergeant and CMT is a soldier 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 requires improvement for providing safe services.

Safety systems and processes

A Regimental Medical Officer (RMO) was the lead for safeguarding and the Senior Medical Officer (SMO) was the deputy lead. At the time of the inspection not all staff had received up-to-date safeguarding training at a level appropriate to their role.

There was a risk register of vulnerable patients and a system to highlight them on DMICP (electronic patient record system). Regular searches were undertaken to inform the register of vulnerable patients.

The doctors had strong links with unit welfare teams, unit health committee and the local clinical commissioning groups (CCG) including attending CCG meetings at Nelson Medical Centre.

The status of safeguarding and vulnerable patients was discussed at the monthly meetings with the Welfare Officer. In addition, the needs of vulnerable patients were discussed at monthly multi-disciplinary meetings. We spoke with the Welfare Officer for the camp who told us they provided a welfare service to military personnel. They confirmed they had a good relationship with the practice and praised the responsiveness of the doctors when urgent intervention was required.

Notices advising patients of the chaperone service were displayed. Practice staff had conducted online chaperone training in June 2021. The practice had developed a new electronic practice information leaflet, which included a link to the chaperone policy. Consultation audits included a check that patient records included the offer of a chaperone. 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 clinical 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. Equally, professional registration of clinical staff was monitored.

The Band 6 nurse was the lead for infection prevention and control (IPC) and was waiting to begin the link practitioner training. On the day of the inspection we saw that three other members of staff were out-of-date for IPC training. The last IPC audit was undertaken in January 2022 and the practice achieved a compliance score of 90%.

A contract was in place for environmental cleaning. Cleaning staff worked to cleaning schedules with non-clinical areas cleaned throughout the day and clinical areas in the evening. The practice manager carried out daily spot checks of the premises, but these were not documented.

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 May 2021.

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. Regimental Aid Post (RAP) staff were largely unavailable to support the delivery of primary healthcare due to unit commitments. The SMO and a locum doctor were the only doctors at the practice whilst the Regimental Medical Officers (RMO) were deployed. The Band 6 nurse was the only permanent nurse, a locum nurse had been recruited for a three-month period. The practice manager was relatively new in post and there was only one administrator.

The arrangements in place to check and monitor the stock levels and expiry dates of emergency medicines were not adequate. We saw medicines, left in a bag used for treating heat injuries, on the floor of the resuscitation room and adrenaline in the emergency trolley that was out of date. We were advised following the inspection that these had been removed.

The practice staff were not fully trained in emergency procedures. On the day of inspection, the training record showed six staff where out-of-date for basic life support and the use of an automated external defibrillator training and that 12 were out-of-date for anaphylaxis training. There had been no training for practice staff in thermal injuries training or sepsis. We saw sepsis guidelines were displayed throughout the practice.

A COVID-19 risk assessment had been completed and measures were 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 (known as FP3 masks) when seeing patients.

Waiting patients could be observed at all times by staff working on the front desk through the use of a CCTV system.

There was a dedicated resuscitation area located at the bottom of a corridor and had curtains to provide privacy. The practice manager and administrator's offices were next to this area where all suspected or COVID-19 positive were assessed. Staff assured us their doors would be closed if a patient was being treated.

There was an induction process in place for locum staff, but it was not comprehensive or bespoke to the practice.

Information to deliver safe care and treatment

A standard operating procedure (SOP) was in place to ensure summarisation of patients' records was undertaken in a safe and timely way. Patients registering at the practice

completed a new patient questionnaire, which was submitted to the nursing team for scrutiny and summarising. This process identified any actions that required follow up.

Peer review of doctors DMICP consultation records was not planned but opportunistic, we saw it had recently been undertaken with the SMO and a locum doctor and a consistent methodology was used. 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. There was no current peer review programme in place for the review of medic consultations due to the lack of staff available.

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

The SMO was the practice lead for medicine management. Dispensing was outsourced to a local pharmacy. Procedures for the safe management and storage of vaccines, medical gases, and emergency equipment were in place. However, on the day of the inspection we found some medicines had expired their use-by date.

Arrangements were established for the safe management of controlled drugs (CD), including destruction of unused CDs. We saw that monthly and quarterly checks were completed.

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

All prescription pads were stored securely.

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. 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.

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

The practice followed the DPHC protocol and local SOP for high risk medicines (HRM). The SMO carried out regular searches to identify patients on HRMs. We reviewed three sets of patients records who were prescribed HRMs and all were subject to a shared care agreement with secondary care. The register of HRMs used at the practice was held on DMCIP and all doctors and relevant clinicians had access to this.

Track record on safety

The practice manager was the designated health and safety lead and a board was displayed near the reception and 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 measures were regularly carried out with a legionella inspection undertaken in February 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 clearly indicate where and how risks were being managed. Risk was discussed as part of the practice governance meeting which was held twice monthly. Insufficient staffing was the main risk this was articulated on the register. Other risks had not been identified and included on the register. For example, the resuscitation area located in an open corridor, the sluice located in an open corridor and the panic alarm system was not audible. There were only two risk assessments in place for the practice so not all risks had been assessed.

There was an integrated alarm system in place throughout the practice. There was no evidence that a register of testing was in place at the time of inspection. The alarm system was activated by a member of the inspection team and there was no response to the alarm by staff. This was likely because the alarm system was not audible throughout the practice.

Lessons learned and improvements made

All staff had access to the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events and incidents. The staff training database showed that three staff were out-of-date with update ASER training.

From interviews with staff and evidence provided, it was clear there was a culture of reporting incidents from those staff able to access the system. Both clinical and non-clinical staff gave examples of incidents reported through the ASER system including the improvements made as a result of the outcome of investigations. An ASER log was maintained on the healthcare governance workbook (, a system that brings together a comprehensive range of governance activities) including any changes made. An ASER trend analysis had been undertaken and it showed dispensing issues from outsourced pharmacy. This issue was raised to regional pharmacist and led to a meeting with the pharmacy to discuss.

The practice manager was responsible for managing safety alerts and the nurse responsible for the medicine alerts. Alerts were received into the group mailbox and forwarded to all staff. We saw safety alerts had been updated onto the register on SharePoint. The nurse told us there were seven medical alerts outstanding as they had not had the time to update into the register. Alerts were not an agenda item at practice meetings and were not discussed.

Are services effective?

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

Effective needs assessment, care and treatment

Clinical staff did not have a forum to keep up to date with current guidance. The SMO attended monthly unit healthcare committee meetings and monthly practice meetings but specific meetings to discuss national clinical guidance, including National Institute for Health and Care Excellence (NICE) and the Scottish Intercollegiate Guidelines Network (SIGN) were not available to them due to time constraints and the shortage of staff. The nurse also attended these meetings and a monthly clinical meeting with their peers. Despite this, staff kept themselves updated and our review of patients' notes showed that NICE best practice guidelines were being followed.

The Defence Primary Healthcare (DPHC) team produced a newsletter that was circulated to clinicians providing further information and a summary of relevant safety updates. The regional nursing advisor sent out weekly updates that included any new guidelines.

Monitoring care and treatment

We found that chronic conditions were managed well. The Standard Operating Procedure (SOPs) outlining the management and monitoring arrangements for long term conditions were in place. Monthly searches were run by the SMO, 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 was provided as appropriate both verbally and written. This check was repeated every three to five years unless identified as at 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 very low numbers of patients on the diabetic register and their care indicated positive control of both cholesterol control and blood pressure. Patients at risk of developing diabetes were identified through the over 40's screening, which included relevant testing (HbA1c). There were low numbers of patients recorded as having high blood pressure. All were recorded as having a blood pressure check in the past nine months. There were low numbers of patients with a diagnosis of asthma and all had an asthma review in the preceding 12 months.

Audiology statistics showed 96% of patients had received an audiometric assessment within the last two years.

Through 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 practice had implemented a programme of quality improvement activity to monitor clinical and non-clinical outcomes to ensure treatment and care was being provided in accordance national and local standards. We noted the audit programme for the nursing team was limited, due to lack of dedicated time to complete them. Audits undertaken in 2020/21 included, antibiotic prescribing, high risk medicines, asthma and eConsult.

Effective staffing

We looked at the induction process for new and existing staff. We noted there was no role specific induction in place for permanent staff. The practice manager confirmed this would be addressed following the inspection.

Although mandated training was monitored, we noted that not all the practice staff team were in-date for all required training. For example, staff were out of date for IPC training, safeguarding, ASER training, basic life support (BLS), anaphylaxis, diversity and inclusion, and mental capacity.

The SMO and nurse had the appropriate skills for their role and were working within their scope of practice. Clinical staff kept up to date with their own continual professional development and revalidation. The nurse attended regional nursing meetings when they were able to. There was no evidence to show medics received any formal clinical supervision due to the lack of staffing and time constraints on the SMO and the nurse.

Internal and external training sessions were available to staff. For example, the practice manager was waiting to undertake the DPHC practice managers course and the Institute of Occupational Safety and Health course.

Staff administering vaccines had received specific training which included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed 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

The practice met with welfare teams and line managers to discuss vulnerable patients. Staff told us that they had forged some good links with other stakeholders, including the local NHS, social services and voluntary organisations.

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.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred or after they were discharged from hospital. Information was shared between services and we saw that a full copy of findings from investigations and any further treatment requirements were sent to the practice to update the patient's records.

Helping patients to live healthier lives

The nurse was the lead for health promotion and had had the appropriate training and experience for the role. We saw information leaflets were available in the treatment rooms.

There were notice boards located in various places around the practice, some example topics covered included, sepsis, smoking, alcohol and safeguarding.

The nurse had the appropriate sexual health training and provided sexual health support and advice. Patients were signposted to local sexual health services for procedures not undertaken at the practice.

All eligible female patients are on the national cervical screening database and are recalled by the nurse. The latest data confirmed a 95% uptake. Regular searches were undertaken to identify patients who required screening for bowel, breast and abdominal aortic aneurysm in line with national programmes. At the time of the inspection, there was one patient identified that met the criteria for each of these. 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:

- Ninety two percent of patients were in-date for vaccination against polio.
- Ninety two percent of patients were in-date for vaccination against hepatitis B.
- Ninety two percent of patients were in-date for vaccination against hepatitis A.
- Ninety two percent of patients were in-date for vaccination against tetanus.
- Ninety eight percent of patients were in-date for vaccination against MMR.
- Ninety eight percent of patients were recorded as being up to date with vaccination against diphtheria.

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. However, their training required updating.

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

An information network known as HIVE was available to patients on the camp. This provided a range of information to patients who had relocated to the base and surrounding area. HIVE provided information about facilities available on the station and locally including civilian healthcare facilities.

We spoke with 13 patients prior to the inspection. They all described their care as good and each one said the staff were kind and respectful.

Patients were offered a private room if they wanted to discuss something in private or appeared distressed.

Involvement in decisions about care and treatment

The clinicians and 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.
The e-referral service had been implemented and was used to support patient choice as appropriate. (e-referral is a national electronic referral service which gives patients the choice of date and time for their first outpatient appointment in a hospital).

Patients identified with a caring responsibility were captured on a DMICP register, it included what had been discussed at the monthly practice/clinical meeting and any actions identified. The practice has a practice leaflet which included information for carers.

Staff explained that they occasionally saw patients who spoke English as a second language. They could access a translation service if they needed it. Staff told us about a recent instance where ‘The Big Word’ was used to provide a translation service during consultation.

Privacy and dignity

Patients who provided feedback about the service said their privacy and dignity was met at the practice.

All consultations were conducted in clinic rooms with the door closed. All clinical rooms had a separate screened area for intimate examinations.

The waiting room had a television on so that conversations from reception could not be overheard.

The practice only had male doctors and a female nurse; patients were offered a chaperone routinely. Patients had access to a clinician of their preferred gender at Nelson Medical Centre if required

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 understood the needs of its patient population and tailored services in response to those needs. Appointments slots were organised to meet the needs of specific population groups. For example, the practice saw any patient with any urgent needs each morning. Telephone consultations and eConsult appointments were alternative options for patients who required an appointment.

The practice was constantly ready to respond at very short notice to the occupational needs of patients who needed to deploy. Additional clinics were arranged at short notice in order to ensure that personnel could deploy at short notice. Patients and unit staff we spoke with confirmed how valuable this response was to support operational capability.

An Equality Access Audit as defined in the Equality Act 2010 was completed for the premises in January 2021 and no significant concerns were identified. There was no hearing loop but the practice stated that they had no patients on their register with hearing impairment.

The lead for diversity and inclusion (D&I) was a member of the unit staff and the practice had good links with them to utilise when needed. There was an information board in the practice providing information for staff and patients. On the day of inspection there were five members of the practice team out of date for mandatory training in D&I.

Timely access to care and treatment

Details of how patients could access the doctor when the medical centre was closed were available through the base helpline. Details of the NHS 111 out of hours service was in the medical centre leaflet.

Urgent doctor and nurse appointments were available on the day. Routine doctor appointments were available within two working days. Routine appointments to see a nurse were available within a few days, these were sometimes fitted in around vaccination clinics or in the nurse's administrative time due to the lack of staff.

Outside of routine clinic hours, cover was provided by the doctors from HMS Nelson up until 18:30 hours. From then patients were diverted to the NHS 111 service and/or eConsult (a message could be left for the practice to follow up on the following working day if not urgent).

We spoke with 13 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 the Defence Primary Healthcare (DPHC) complaints policy and procedure. The process included the recording of both written and verbal complaints.

There had been one complaint received within the past 12 months. This had been dealt with appropriately.

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 requires improvement for providing well led services.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care. Their mission statement was;

> ” The Medical Centre will provide a comprehensive and professional service encompassing primary medical care, force protection (medical), medical examinations including occupational, aviation and underwater medicine. Provision will be flexible and responsive, tailored to the needs of the individual, Unit and Air Defence Group.”

Staff were aware of and understood the vision, values and strategy and their role in achieving them.

From our review of clinical care, including access to patient records and interviews with both patients and staff, we found practice staff were committed to delivering effective patient care. This focus showed patients were at the centre of practice delivery

Leadership, capacity and capability

The civilian Senior Medical officer (SMO) and the civilian practice manager were the leaders for the practice and provided consistent leadership. They clearly understood the practice priorities and demonstrated they had capability to drive service change for the benefit of patients. Other leaders attached to the unit were stretched in terms of their leadership capacity due to unit commitments needing to be prioritised.

Culture

Staff were consistent in their view that the practice was patient-centred in its focus.

A responsive and patient-centred focus was clearly evident with this ethos embedded in practice. Staff continually looked at ways to improve the service for patients.

All staff described an approachable and supportive leadership team that was committed to ensuring cohesion, equality and inclusion. It was clear from discussions with staff that their contributions to the development of the service were valued. All staff attended the practice meetings where they could put forward suggestions or raise concerns.

We heard from staff that the culture was inclusive with an open-door policy and everyone having an equal voice, regardless of rank or grade. All were familiar with the whistleblowing policy and said they would feel comfortable raising any concerns.

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 provided with examples of when duty of candour had been applied.

Governance arrangements

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, Standards Operating Procedures (SOPs), and Quality Improvement Activity (QIA) and complaints. The practice manager had identified improvements were needed with the flow of information and governance structures. These issues were being addressed as a priority. Work had started on the newly introduced Healthcare Governance workbook to ensure it was developed and structured in line with DPHC expectations.

There was a staffing structure in place and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. Due to staff vacancies all staff but notably the SMO and the Band 6 nurse, had been allocated numerous secondary duties, which they had limited time to fulfil. Administrative staff also had a number of secondary roles meaning often tasks were not completed on time.

A QIA programme had been established for 2021/22. Although there were gaps in the annual programme of QIA, clinical audit in key areas had been maintained by the SMO including antibiotic prescribing and long-term conditions. However, we found some key findings, such as found in the eConsult audit, had not been followed up with a repeat cycle.

A schedule of regular practice meetings was in place, within this meeting some governance issues were discussed. All staff attended the meetings and minutes were maintained.

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.

Managing risks, issues and performance

The leadership team was mindful of risks to the service. The main risks identified were staffing levels/recruitment. During the inspection the SMO referred frequently to a lack of resilience in the service, given the size of the service including the number of units and the requirement for them to rapidly deploy.

Strategies were in place to ensure enough clinical cover was in place. For example, the SMO coordinated their annual leave around the availability of the Regimental Medical Officer (RMO).

A system was in place to monitor performance target indicators. The system took account of medicals, vaccinations, cytology, summarising and non-attendance. Risk to the service were recognised but not always logged on the risk register.

Processes were in place to monitor national and local safety alerts and incidents, but these were underdeveloped and needed further work to ensure patient safety.

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

There was a limited range of risk assessments in place for the practice, there was no evidence that the practice had reviewed the risk register to include all identified risks.

All staff were in date for ‘defence information passport’ and ‘data security awareness’ training. When a member of staff left smart cards were returned to the guard room and they were removed from having access.

There was a business resilience plan and a major incident plan that were reviewed regularly and tested through simulation. All staff were informed of BCP updates. The practice also had an active practice development plan laid out for upcoming year.

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

Appropriate and accurate information

The eCAF (Common Assurance Framework) commonly used in DPHC 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 eCAF 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 systems in place to encourage patients to provide feedback on the service and contribute to the development of the service. Patient experience surveys regarding appointment times and the availability of appointments, were completed by patients for three weeks prior to our inspection; we received 33 responses, and all were positive about access to care.

Patient experience surveys were also uploaded directly to Governance Assurance Performance and Quality (GPAQ). The most recent request to feedback via this route had no responses for the month of January. However, we did speak with 13 patients all of who spoke highly of the care they received from the team at the practice and of the kindness of staff.

Good and effective links were established with internal and external organisations including the Welfare Officer, Regional Rehabilitation Unit (RRU), Defence Primary Healthcare (DCMH) and local health services.

Continuous improvement and innovation

We identified that the practice had worked hard to continue to provide a good service over the last year despite many challenges, with staff clearly motivated to develop the service.