

Southwick Park Medical Centre

Southwick Park, Fareham, Hampshire, PO17 6EJ.

Defence Medical Services inspection

This report describes our judgement of the quality of care at Southwick Park 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. We gathered evidence remotely in line with COVID-19 restrictions and guidance and undertook a short visit to the medical centre.

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

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Summary

About this inspection

The inspection announced inspection was carried out remotely and included a short visit by a CQC inspector on 24 November.

The CQC does not have the same statutory powers with regard to improvement action for 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.

Under CQC methodology we would not ordinarily undertake an inspection such as this as the healthcare governance systems supporting Southwick Park are those of the nearby Collingwood practice. Group practice arrangements were largely already in place but not yet formalised. The group model has not yet been declared as 'Full Operating Capability' by Defence Primary Healthcare.

At this inspection we found:

- A person-centred culture was embedded to ensure patients received quality and compassionate care to meet their individual needs.
- The practice had strong lines of communication with the units and welfare team to ensure the wellbeing of military personnel.
- Measures were in place to identify patients who were considered vulnerable, coding was consistently applied to identify patients under the age of 18.
- Systems and processes to keep patients safe were not fully embedded at the medical centre; equipment servicing, and some risk assessments required closer management. Other governance processes were not promoting patient safety as a priority.
- There was a safe system for the management of specimens and referrals.
- Risks to the service were recognised by the leadership team. The main risks were limited resilience to cover for staff absences.
- Staff were aware of the requirements of the duty of candour. Examples we reviewed showed the medical centre complied with these requirements.
- The privacy and dignity of patients was compromised due to the infrastructure.
- Patient feedback about the service was positive. It showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.
- The practice had a clear leadership structure. However, governance arrangements were not fully embedded. Staff at Southwick Park worked well as a cohesive team.

The Chief Inspector recommends that the Medical Centre:

- Improve the infrastructure to ensure sufficient privacy for patients.
- Review the processes for the management of significant events.
- Improve the assessment and management of risks.
- 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.
- Develop a system whereby patient feedback is used to make improvement.
- Review the eConsult model to ensure that patients can access care in a timely way. Consider direct access for physiotherapy services as part of this.'
- Ensure all aspects of medicines management systems are safe including the management of patient safety alerts and the monitoring of Patient Group Directives (PGDs)
- Ensure all equipment in the Primary Care Rehabilitation Facility (PCRF) is fit for purpose.

Notable Practice

- The Primary Care Rehabilitation Facility (PCRF) initiated a quality improvement project that resulted in the addition of a reconditioning platoon ensuring patients were injury free, and also emotionally and physically robust for the fatiguing nature of their course. The results of the most recent audit showed five of the long-term injured patients successfully completed the most physical element of course in the top 10% of the cohort. This quality improvement has now been recognised by South West Region Headquarters and the Southwick Park physiotherapist and Exercise Rehabilitation Instructor (ERI) have been asked to present their work to the National Quality Improvement Symposium as gold standard practice.

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. Recruitment to vacant posts should be progressed in a timely way.
- Improving Access to Psychological Therapies (IAPT) was not available to patients at Southwick Park Medical Centre as funding had not been secured. We have noted that IAPT is made available to patients in some regions, but not all and we have fed this finding back to DMSR (Defence Medical Service Regulator) and DPHC (Defence Primary Healthcare). IAPT services provide evidence-based treatments for people with

anxiety and depression and can be especially helpful for patients whilst they are waiting to be seen by Department of Community Mental Health (DCMH) staff.

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, a physiotherapist, an exercise rehabilitation instructor and a pharmacist.

Background to Southwick Park Medical Centre

Defence Primary Health Care Medical Centre Southwick Park is located in Southwick near Portsmouth. The medical centre provides a routine primary care, occupational health and rehabilitation service to a military service population of approximately 550 who are subject to operational deployment at any time. In addition to routine GP services, the practice provides a range of other services including, immunisations, screening, smoking cessation, cervical cytology, ages 30 and 40 health screening, chronic disease management, aviation and diving medicine medicals.

A primary care rehabilitation facility (PCRF) is located within the medical centre and provides a physiotherapy and rehabilitation service. As there is no dispensary at the practice, medicines are dispensed from Collingwood Medical Centre nearby.

The practice is open Monday to Friday 08:00 to 16:30, and from 16:30 to 18:30 for urgent appointments and ad hoc requests only via the duty medical staff mobile number. On a Wednesday there is a reduced service in the afternoon to allow for maximum attendance at meetings and staff training, access to a GP for urgent cases is still available. At weekends and on bank holidays, patients are diverted by a telephone message to NHS 111 services.

The staff team

Principal Medical Officer (PMO)	one (works remotely)
Deputy Principal Medical Officer (DPMO)	one (works at Collingwood four days a week one day a week at Southwick Park.
Civilian Medical Practitioner	one
Practice manager	one (works remotely)

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Nurse	one (civilian)
Exercise Rehabilitation Instructors (ERI)	one (unit assets non DPHC)
Physiotherapists	one (civilian)
Administrator	one
Medical Branch Rating (MBR)	one (unit assets non DPHC)

*In the Royal Navy, a Medical Branch Rating is a sailor 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 medical centre as requires improvement for providing safe services.

Safety systems and processes

- The practice had safety policies including adult and child safeguarding policies which were reviewed, displayed in clinical rooms and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. Policies accessible to all staff (including locums) outlined clearly who to go to for further guidance. The safeguarding policies were reviewed annually.
- The Principal Medical Officer (PMO) was the safeguarding lead for the practice. All staff were up to date with safeguarding training at a level appropriate to their role. There were good links between all the PMOs in the Portsmouth area with monthly meetings held together with a social worker from the Department of Community Mental Health (DCMH). We spoke with the welfare officer for the camp who provided a welfare service to military personnel. They confirmed they had a good relationship with the medical centre and communication between them and outside agencies was good.
- There was a risk register of vulnerable patients and a system to highlight them on the electronic patient record system (referred to as DMICP). A monthly search of DMICP was undertaken to ensure the register of vulnerable patients was current. We reviewed clinical records for vulnerable patients and noted appropriate alerts and coding were used. A clinical meeting was held every week to discuss any vulnerable patients.
- Staff who acted as chaperones were trained for the role and 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.
- Staff checks, including checks of professional registration were conducted.
- The infection prevention and control (IPC) lead for the medical centre was the nurse, they had completed role specific training and was supported by an IPC lead for the region. Audits were carried out monthly and any issues actioned.
- The nurse was the lead for cleaning and the contract was outsourced to an approved company. Systems in place included a process for reporting issues and monitoring the standard of cleaning. Regular checks of compliance were made by the nurse to check on cleaning standards. Deep cleans were regularly undertaken, the last being done in November 2021.
- There were systems for safely managing healthcare waste supported by a policy. Clinical waste and pre-acceptance audits were carried out annually, the most recent in September 2021.
- The practice ensured that facilities and equipment within the medical centre were safe and that equipment was maintained according to manufacturers' instructions. The safety certificates for water, gas and electric and legionella were held by the unit and copies were made available to the practice. We noted that testing for Legionella was

undertaken weekly due to an outbreak in 2019 when the practice had to be closed for six months whilst works were carried out.

Risks to patients

- There was only one permanent member of staff at Southwick Park Medical Centre (the administrator), all other staff were from Collingwood Medical Centre. Staffing levels were insufficient to meet the needs of the patient population across both sites. Staffing gaps, across the group practice, included one doctor, one nurse, one business manager and two medics. Collingwood staff were shared and rotated to work at Southwick Park Medical Centre. The practice management was being undertaken by the practice manager of Collingwood who supported Southwick Park Medical Centre remotely one day a week.
- An induction system was in place for temporary staff and this had role specific elements. All staff had completed a workplace induction, and this has been recorded on the staff database.
- Clinicians adhered to military guidance around sickness periods for personnel. They communicated effectively with Chain of Command so that line managers knew which tasks personnel could safely undertake.
- The practice was equipped to deal with medical emergencies. The staff team was up to date in medical emergency procedures, including basic life support training, use of the automated external defibrillator (AED) and anaphylaxis. Thermal injuries training was undertaken in November 2021 and sepsis training in July 2021. Sepsis guidelines were displayed throughout the practice.
- Arrangements were in place to check and monitor the stock levels and expiry dates of emergency medicines. We saw evidence to show that an appropriately equipped medical emergency kit and trolley were in place and were regularly checked.
- A COVID-19 risk assessment had been completed. Measures introduced to minimise the risk of spreading infection during the COVID-19 pandemic included:
 - signs placed throughout to encourage social distancing;
 - a hand sanitiser dispenser was placed at the main entrance and exit;
 - personal protective equipment (PPE) was provided to staff. This included face masks that protect staff from airborne infection (known as FP3 masks) when seeing patients.

Information to deliver safe care and treatment

- Internet connectivity at Southwick Park was very slow. If there was a widespread outage staff referred to the business continuity plan and patients were signposted to Collingwood Medical Centre. Packs of paper forms were available to document

consultations which would be later scanned onto DMICP. Paper forms for reporting significant events and safeguarding concerns were also available.

- 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 nurse for scrutiny and summarising. This process identified any actions that required follow up.
- 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

Systems in place for the safe handling of medicines needed strengthening.

- Emergency medicines were easily accessible to staff in a secure area of the medical centre and all staff knew of their location.
- Medication requiring refrigeration was monitored twice a day to ensure it was stored within the correct temperature range.
- All staff who administered vaccines had received the immunisation training as well as the mandatory anaphylaxis training.
- All prescription pads were stored securely.
- Relevant guidance had been followed for the use Patient Group Directions (PGDs), a prescriber instruction for the administration of a medicine without the need to refer to the doctor for an individual prescription. However, we noted no PGD audit had been completed.
- Medics had received training regarding the use of Patient Specific Directions (PSD) which had been signed off by the DPMO and authorised by the PMO. A PSD is a prescriber instruction for a medicine for a named patient.
- 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.
- We saw a process was established for the management of and monitoring of patients prescribed high risk medicines (HRM). The register of HRMs used at the medical centre was held on DMICP and all doctors and relevant clinicians had access to this. We looked at a sample of patient records, we saw that all had been coded or had shared care agreements in place.
- Medicines were dispensed from Collingwood Medical Centre and sent over to Southwick Park. There was no recorded system in place for the transfer of prescriptions between the two medical centres making it difficult to audit what medicines were where. Patients collected prescriptions from the medical centre

reception, but there was no additional signposting for patients if they had any concerns or questions about their medications.

Track record on safety

- The medical centre staff had handheld portable alarms; these were tested monthly.
- The PCRf gym equipment had not been serviced as required in since August 2021 meaning equipment could not be correctly utilised as part of the rehabilitation programme, a business case has been submitted for this to be resolved.
- The practice manager was the lead for health and safety at each of the locations and had completed training relevant for the role. Risk assessments were in place including needle stick injury and lifting and handling. The PCRf had specific risk assessments in place including safe use of needle acupuncture, although these had not been reviewed since 2018.

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 database showed that all staff had completed ASER training.
- Despite several ASERS being raised in the past 10 months, there was little evidence of lessons learnt, sharing with the wider team or how they informed quality improvement. An ASER log was maintained on the Healthcare Governance Workbook (HWG, a system that brings together a comprehensive range of governance activities), all entries were for Collingwood and we were not able to differentiate those relevant to Southwick Park nor see a record of any discussion had or changes made.
- The system in place for managing patient safety alerts required improvement. Whilst these were an agenda item at practice meetings and we saw evidence these were actioned, there was little evidence to see how these were shared or discussed with all staff.

Are services effective?

We rated the medical centre as good for providing effective services.

Effective needs assessment, care and treatment

- Clinical staff had a forum to keep up to date with current medical centre and DPHC guidance. These included weekly clinical meetings between the doctor and the nurse where patients were discussed. These discussions did not always include a review/record that national clinical guidance had been followed, including NICE (National Institute for Health and Care Excellence) and the Scottish Intercollegiate Guidelines Network (SIGN).
- The doctor, physiotherapist and the ERI attended monthly Unit Healthcare Committee meetings and had established good links between the unit and the PCRF.
- Staff were kept abreast of clinical and medicines updates through the DPHC newsletter circulated to individual staff and to the medical centre each month. Participation with regional events and forums also provided an opportunity for clinicians to keep up to date although this had been temporarily halted due to Covid restrictions.

Monitoring care and treatment

- We found that chronic conditions were managed well. The SOPs outlining the management and monitoring arrangements for long-term conditions were in place. Monthly searches were run by the nurse, patients were recalled by letter or email and followed up by a telephone call if needed.
- All patients over the age of 40 are invited to a full health check including bloods and identifying risk factors. Verbal and written lifestyle and health advice were provided as appropriate. This check was repeated every 3-5 years unless identified as at risk when patients were recalled annually for blood testing. All chronic disease patients 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 blood pressure check in the past 12 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 64% of patients had received an audiometric assessment within the last two years. This number was reduced due to the impact of the pandemic and in line with DPHC policy.
- We looked at a range of patient records and were assured that the care of patients with a mental illness and/or depressive symptoms was being effectively and safely managed. Patients presenting with a mild to moderate anxiety or low mood were

assessed in accordance with the pathway and treated initially at the practice (step 1) or referred to the DCMH team if their clinical need was assessed as greater than what step 1 could provide. Clinicians did not have access to iTalk (Hampshire NHS talking therapy service) which was the service available to local GPs. Instead and in the interim, doctors were using other providers including the Warrior Programme accessible through Army Welfare services for self-help coping strategies.

- Staff confirmed that in the region where Southwick Park sits, Improving Access to Psychological Therapies (IAPT) was not available to patients as funding had not been secured. IAPT services provide evidence-based treatments for people with anxiety and depression and can be especially helpful for patients whilst they are waiting to be seen by DCMH staff. We have noted that IAPT is made available to patients in some regions, but not all and we have fed this finding back to DMSR (Defence Medical Service Regulator) and DPHC (Department of Primary Healthcare)
- An integrated audit programme was in place and included work to identify improvements at both sites. However, it was not always clear which practice populations had been included. Audits were discussed as part of the practice meetings and minuted, teaching sessions were scheduled if continual professional development was thought useful. The audit calendar included a variety of set audits for both clinical and administrative areas.
- The nurse undertook audits of long-term conditions. Most recently they undertook an audit of asthma patients as the overuse of short acting bronchodilators (SABA) was widely recognised as a marker of poor asthma control. The audit showed the need for better patient education and the introduction of thorough asthma management plans.
- Audits carried out by the PCRf were extensive and took account of the population, for example musculoskeletal injuries, a Did Not attend (DNA) audit and an injury surveillance audit. Actions were taken as a result of audit, for example a quality improvement project was implemented with the addition of a reconditioning platoon ensuring patients were not only injury free but both emotionally and physical robust for the physically fatiguing nature of the course. The results of the most recent audit showed five of the long-term injured patients successfully completed the most physical element of course in the top 10% of the cohort. This quality improvement has now been recognised by South West Region Headquarters and the Southwick Park physiotherapist and ERI have been asked to present their work to the National Quality Improvement Symposium as gold standard practice.

Effective staffing

- Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date. Peer review of notes was formally completed by the PCRf staff and informally done by the doctors and nurses at clinical meetings. A review of the medic's clinical notes was not formally done but carried out by one of the doctors on an ad hoc basis due to time constraints.

- Collingwood Medical Centre had a training calendar in place. We saw compliance was good across the Southwick Park Medical Centre team. Compliance was monitored and required training was discussed at the practice meetings. Time was available to staff every Wednesday afternoon to complete mandatory training.
- The PCRf staff had trained medics in the urgent care management of muscular skeletal injuries and urgent care management.

Coordinating care and treatment

Staff worked well together and with other care professionals to deliver effective care and treatment.

- Staff told us that they had forged some strong links with other stakeholders. The PCRf staff fostered close working relationships, meeting with the doctor and nurse when required to ensure individual patients were discussed and care planned appropriately to support good recovery. There were good examples seen of regular meetings arranged between the medical centre staff, the rehabilitation staff and the chain of command. The PCRf had good links to the Regional Rehabilitation Unit and held multi-disciplinary meetings together every two weeks
- The physiotherapist, ERI, and medic met regularly together to discuss and review any patient that had been downgraded due to a muscular skeletal injury and that were due a review by the doctor. This enabled the doctor to have up-to-date information pertinent to the patient's functional capability to ensure they were properly protected long term.
- 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 medical centre 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 in this field. We saw information leaflets were available in the treatment rooms. Patients were signposted to local sexual health services for procedures not undertaken at the medical centre.
- There were notice boards located in the medical centre, some example topics covered were, sepsis, men's health and safeguarding.

- The PCRf staff attended new joiners' sessions to educate and inform new patients about the role of the PCRf and the services they offered.
- Within the PCRf, as part of the overall assessment the health and wellbeing of the individual was given equal priority. This included diet and lifestyle. Patients could be signposted to services they may benefit from, for example mindfulness and yoga classes.
- Across both medical centres the number of women aged 25 to 49 and 50 to 64 whose notes recorded that a cervical smear had been performed in the last three to five years was 95%. The NHS target was 80%.
- There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using public health information posters and they ensured a female sample taker was always available. Regular searches were undertaken to identify patients who required screening for bowel, breast and abdominal aortic aneurysm in line with national programmes.
- An effective process was in place to recall patients for their vaccinations. As a result of the COVID-19 pandemic and in accordance with DPHC guidance routine immunisations were ceased and remained so at the time of inspection. Only operationally essential vaccinations were administered. This had an effect on the vaccination statistics, and figures should be considered with this in mind.

Vaccination statistics were identified as follows:

- 98% of patients were in-date for vaccination against polio.
- 60% of patients were in-date for vaccination against hepatitis B.
- 60% of patients were in-date for vaccination against hepatitis A.
- 98% of patients were in-date for vaccination against tetanus.
- 100% of patients were in-date for vaccination against MMR.
- 100% of patients were in-date for vaccination against meningitis.
- 98% 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 had a good understanding of the Mental Capacity Act (2005) and how it would apply to the population group.
- 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 requires improvement for providing caring services.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- An information network known as HIVE was available to patients. This provided a range of information to patients who had relocated to the base and surrounding area.
- We saw several examples where staff went above and beyond to provide holistic patient care. These included the PCRf staff visiting the accommodation block to assess patient safety post operatively. We also saw an example where a patient was given detailed and specific help and education for good vegan nutrition following a bone stress injury. There was also good liaison with the wider camp regarding mess contracts to ensure nutritional support whilst on camp.

Involvement in decisions about care and treatment

- 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.
- We were advised patients usually identified themselves as a carer through the new patient registration form or when the Unit Welfare Officer shared this information with the medical centre. Alerts were added to all registered carers and they were offered flexibility with appointments.
- Staff explained that they occasionally saw patients who spoke English as a second language. They could access a translation service if they needed it.

Privacy and dignity

- Confidentiality was compromised due to infrastructure, curtains and screens were used but conversations could still be overheard. Conversations can be heard in reception despite a TV providing background noise. There was mitigation in place for privacy at reception including the offer of using a separate room for patients wishing to speak in private. The ageing infrastructure allowed sounds to travel between consulting rooms and corridors meaning the whole clinical space was not confidential. Staff did all they could to mitigate this with radios and not working in rooms next to each other, at the same time, if possible.
- The medical centre could not always facilitate patients who wished to see a clinician of a specific gender so patients could be directed to Collingwood Medical Centre if needed.

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 was committed to meeting the principles of the Equality Act 2010, including safeguarding people with protected characteristics.
- An equality access audit had been reviewed in October 2021. The practice trained staff in equality and diversity and there was a 'diversity and inclusion' lead within the medical centre.
- All clinicians worked together to make sure clinics ran smoothly and to time and would often help out others. This allowed clinicians to know they could spend more time with those patients should they need it.

Timely access to care and treatment

- Details of how patients could access a 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.
- In response to restrictions associated with COVID-19, a remote triage model, eConsult was in place. This model had put the doctors under considerable strain with numbers of these consultations reaching 774 in September 2021 across both sites. This was further impacted as patients were unable to make a direct access appointment to see a physiotherapist, instead, patients had to arrange an eConsult. Due to the number of referrals and the lack of doctors this could sometimes take up to six days for a patient to be triaged. The PCRf also had no administrative support so had to lose patient consultation time to support this. In November this year, staff had recorded how much of their time had been taken with administrative tasks in one week, this totalled 16 hours. There has been no administrative support since January 2020. This had been raised as a business case to the regional office several times.
- Patients with an urgent need were seen on the same day by the duty doctor. All patients were triaged by medics who referred on to a nurse, doctor or physiotherapist as required (a military medic delivers healthcare similar to a healthcare assistant in the NHS but has a greater scope of duties). Routine doctors' appointments were available by booking in advance.
- Appointments to see a nurse were available the same day.
- We spoke with five patients who had recently received care from the medical centre. They all told us they were confident that they would be seen quickly if they had an urgent concern but that to secure a routine appointment took longer. They all said they were very happy with the standard of care they received.

Listening and learning from concerns and complaints

- Complaints were managed in accordance with the DPHC complaints policy and procedure. Written and verbal complaints were recorded and discussed at the medical centre meetings. A complaints audit had not been undertaken as there was only one complaint recorded.

Are services well-led?

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

Vision and strategy

The completion of the integration of Collingwood and Southwick Park was key to the vision and strategy for the service. It was considered from several perspective including the size, needs of the patient population, resources, the units supported and the needs of organisation.

The leadership philosophy was

- Integrity
- Communication
- Effort
- Everyone has a role and is respected
- Integrated workforce – one team

Throughout the inspection it was clear staff were committed to providing and continually developing a service that embraced the vision and values of the service.

Leadership, capacity and capability

- The leaders at the medical centre had been working hard to address areas they had identified as requiring improvement as well as building resilience and continuity within the team. The practice management was limited although a long-term plan was in place for both Collingwood and Southwick Park to become a 'Group' practice. This has yet to be achieved due to limited assurance in governance provision across both sites.
- There was consistent evidence throughout the inspection that both sites were working as one practice with a combined DMICP and one set of meetings, policies, training etc. The PMO and practice manager retained overall responsibility for both sites. There was evidence of cross site working and the team worked well together however there appeared to be a discrepancy between staffing across the two sites. The clinicians felt strongly that were not sufficient doctors available for patients to receive appropriate, responsive care exacerbated by gapped posts and increases in workload and demand. The eConsult demands exceeded the capacity of the practice with patients waiting two weeks for routine appointments. There was significant and consistent evidence that the staff felt under pressure and reported struggling to keep up with the workload.
- Staff felt that they could raise concerns if they had them. A practice-wide meeting had been established where all staff could get together to share and learn from key messages. Staff spoke highly of internal communication.

Culture

- Staff were consistent in their view that the medical centre 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.
- Both civilian and military staff described an approachable and supportive 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.
- The PCRf had engaged well with the unit, providing support to the training population with care, compassion and professionalism. This committed approach to patient focus was reflected with effective work with the Unit Healthcare Committee and the introduction of a rehabilitation troop.
- 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

- There was a clear staffing structure in place and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. Terms of reference (ToRs) were in place to support job roles, including staff who had lead roles for specific areas.
- The medical centre worked to the health governance workbook (HGW), a system that brings together a comprehensive range of governance activities, including significant events tracker, lessons learnt log, training register, policies, meetings, quality improvement and audit. Staff had access to the workbook which provided links to meeting minutes, policies and other information. A programme of clinical and internal audit was in place.
- A schedule of regular practice meetings was in place, within this meeting clinical and 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 medical centre had a business continuity plan and major incident plan in place that was located on SharePoint (an electronic database of documents). This was also displayed on a board for ease of access. All staff were required to read and sign they had understood all action plans in the event of an incident as part of the induction process.
- A 'group practice' risk register and issues log were established. Risks were discussed at both the practice and healthcare governance meetings. We found some systems to manage risk were not fully failsafe. These had been identified by the leadership team and were included as development areas in the group practice. For example, the management of risk assessments and equipment. 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.

Appropriate and accurate information

- An internal Health Governance Assurance Visit (HGAV) took place in October 2021 and a management action plan was developed as a result. The HGAV assessment outlined significant concerns (categorised as limited assurance in five of the eight domains). Actions identified had been completed or were in progress. The PCRf HGAV took place in April 2021 and demonstrated good levels of governance with minimal recommendations made.
- There were arrangements at the medical centre in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

- There were systems in place to encourage patients to provide feedback on the service and contribute to the development of the service. However, these were limited and we saw no evidence to show these were used to inform quality improvements.
- The PCRf staff prompted patients to complete a survey after their consultation. Results were analysed monthly, and staff informed at the PCRf meetings. Results of the survey were also discussed at the wider practice meetings. We saw evidence of high patient satisfaction with the service provided by the PCRf staff.
- Good and effective links were established with internal and external organisations including the Welfare Officer, Regional Rehabilitation Unit (RRU), DCMH and local health services.

Continuous improvement and innovation

There were extensive examples of quality improvement activity for the PCRf. There was a QIP list in the healthcare governance workbook. An example of some of these were;

- Rehabilitation Platoon, daily reviews of patients.
- Health promotion to the new soldiers arriving for phase 2 training as part of a medical brief.
- The civilian physiotherapist arranged in-service training for the Southwick Park medical team as well as for the region, including the doctors and consultants from Portsmouth Regional Rehabilitation Unit and Collingwood medical practice to have theory and a practical demonstration of the new Army Role Fitness Test. This was to improve the occupational knowledge of the medical team regarding the service populations physical training requirements and to improve patient care through accurately reflected gradings and protection.
- Teaching for the medics in respect of muscular skeletal injuries and urgent care management.