Stonehouse Group Medical Practice

RMB Stonehouse, Durnford Street, Plymouth, PL1 3QS

Defence Medical Services inspection report

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

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

Contents

Summary

About this inspection

We carried out this announced comprehensive inspection across three dates: 29,31 March and 1 April 2022.

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

Are services safe? – good

Are services effective? – outstanding

Are services caring? – good

Are services responsive to people's needs? – outstanding

Are services well-led? - outstanding

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

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

At this inspection we found:

- Patients found it easy to make an appointment and urgent and often routine appointments were available the same day.
- Patient feedback about the service was entirely positive. Patients we spoke with provided numerous examples of medical and reception staff going the extra mile to provide exemplary care. Patients told us that care they received in the PCRF and with their mental health was highly accessible and that they were treated with compassion, confidentiality, dignity and respect. Patients felt that they were able to access screening easily and several said that the clinical care they received was the best they had ever experienced thanks to the thorough approach of all medical centre staff.
- A comprehensive and far reaching programme of quality improvement activity (QIA) was in place and this was driving improvement in areas which were relevant and impactful for patients.

- Arrangements were in place for managing medicines including high risk medicines. Any issues we identified on the day of the inspection were addressed within hours of us leaving the site.
- There was an effective and well-designed programme in place to managed patients with long term conditions.
- The medical centre benefitted from a strong, inclusive and particularly open leadership style, such that staff felt valued and able to contribute to improved ways of working. Staff we met on the day routinely told us about improvements they had identified, escalated and delivered.
- The practice had positive lines of communication with the units they supported and the welfare team to ensure the wellbeing of service personnel. Command staff we spoke with confirmed these were more developed than seen elsewhere.
- The medical centre team had identified gaps in mental health support for patients requiring low level support or whilst waiting to attend the DCMH. They had created a bespoke approach to ensure that these patients' needs were not overlooked.

We found the following areas of notable practice:

- All Medical Centre staff were aware of the need to safeguard vulnerable people including those who are not registered with the practice. They used the NHS Safeguarding App to ensure up to date contacts with out of area safeguarding teams. The medical centre's commitment to safeguarding a minor had led them to challenge the outcome from a safeguarding board until the decision was reversed and the minor had been given appropriate support. We noted that reflective sessions took place between relevant clinicians to consider actions taken to support vulnerable patients and to identify learning. Throughout this inspection, we saw numerous examples where staff had not accepted the easy option, rather pursuing the outcome that achieved the best outcome for not only patients but anyone who is vulnerable.
- The SMO had developed a chronic disease management tool which guided clinicians to access the most recent care pathway and guidelines for patients with a long-term condition. This was reviewed annually to incorporate new evidence-based practice. The team followed a chronic disease management protocol which gave guidance around when to run clinical searches to inform the recall of patients. Leads for each chronic condition had been allocated. A standardised set of Read codes was in use and clinical searches had been developed which superseded the Quality and Outcomes Framework (QOF) indicators and so were more relevant to the patient population at Stonehouse. This substantial work ensured the effective management and recall of patients with chronic disease. The SMO sat on the DPHC Clinical Working Group and had shared their approach to chronic disease management with a view to rolling out the good practice across primary care.
- A TRIGPOINT approach had been developed to help cover some gaps in the current mental health care model. It provided mental health 'Step 1' support in a group scenario to individuals who then received follow-up support and an onward referral to DCMH as required. Staff told us that the model had proven useful in ensuring that patients could access meaningful support quickly when they needed it.

- Patients had fed back that waiting times to see a secondary care trauma, orthopaedic and general surgery specialists was 52 weeks. The SMO had therefore successfully engaged and negotiated with the Patient Plus Group (PPG) which aimed to ensure that patients were seen within 18 weeks of a referral (and a two week wait for lower endoscopies). This service has also been extended to patients registered at other military medical centres in the Plymouth area.
- The PCRF had rolled out a number of health initiatives to support the holistic needs of patients and they had worked with patients to find out what provision would be most useful. A health and wellbeing quiz was offered to all new personnel at the Unit which aimed to measure dietary habits, sleep, activity, smoking and alcohol consumption. Analysis of the submissions showed that sleep and diet were the main factors affecting patients and this was discussed with the unit as part of health promotion activity. A staff wellbeing survey was undertaken which resulted in an event to encourage increased activity amongst military personnel, including 'exercise of the week' and lunchtime walking. The SMO had commended the initiative with an award.
- All clinical staff undertook reviews of peer clinical notes. An appropriate notes review template was in use. All staff were encouraged to use DMCIP templates as much as possible to capture all relevant information. PCRF notes were audited on an ongoing basis. Exercise rehabilitation note taking had been identified as an area that could benefit from improvement and this was being actively managed with links into DPHC and the wider ERI healthcare governance and regional teams. Similarly the notes made by trainee doctors had been identified as an area to improve and appropriate action had ensued. We noted that reflective sessions took place between relevant clinicians to consider actions taken to support vulnerable patients and identify learning.

The Chief Inspector recommends to Defence Primary Healthcare (DPHC):

- Electricity generators should be made available to ensure that medicine and vaccine fridge temperatures can be effectively maintained during a power outage.
- Due to the buildings at Stonehouse and Citadel being listed property, air conditioning cannot easily be installed. Standalone air conditioning units should be made available to ensure that staff are not being asked to work in temperatures beyond acceptable parameters.

The Chief Inspector recommends to the medical centre:

- Analyse outputs from the Musculoskeletal Health Questionnaire (MSKHQ) to demonstrate improvements in outcomes for patients in receipt of musculoskeletal care and support.
- In accordance with the ERI Standards of Proficiency to Practice, ERIs should undertake reflective practice in order to ensure that learning influenced future practice.

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 inspection manager and comprised specialist advisors (SpAs) including a primary care doctor, physiotherapist, pharmacist, and an exercise rehabilitation instructor (ERI). The majority of the team were on site on 31 March. However, it was necessary for the physiotherapist and ERI to conduct their interviews remotely on 29 March.

Background to Stonehouse Group Medical Practice

The medical centre provides primary care, occupational health, mental health and rehabilitation service to 1,370 military personnel. This care is provided across three sites : Bickleigh, Stonehouse and Citadel. Since February 2022, DPHC has formally recognised the service as a Group Practice arrangement. Families and dependants of military personnel are not registered at the practice but at NHS practices local to them.

The staff team

Medical team	One Senior Medical Officer (SMO) Three part time Civilian Medical Practitioners (CMP)
Nursing team	One Band 6 Practice Nurses (Part time) One Advanced Nurse Practitioner
Medics	Two Leading Medical Assistants (one gapped) Three Medical Assistants
Practice management	One Practice Manager (also the Chief Petty Officer Medical Assistant)
PCRF	One military Physiotherapist Two Band 6 Physiotherapists Four Exercise Rehabilitation Instructors (ERI) – Unit assets
Administrators	Three Band E1 Medical Administrators (one gapped) One Band E2 administrator

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

The SMO was the safeguarding lead at the medical centre and a CMP was the deputy lead. Both had completed level 3 safeguarding. All clinical and administrative staff were trained to the relevant level for their role.

The practice standard operating procedures (SOP) for both adult and child safeguarding had been reviewed and included contact details for local safeguarding teams. All staff had the NHS safeguarding app on their phones which provided details of out of area contacts. Staff we spoke with all had in depth knowledge of the requirement to safeguard and we noted that team discussion had taken place around what constitutes a vulnerable patient and the need to safeguard 'the hidden child'. This included the need to safeguard all vulnerable people including those who are not registered with the practice. Their commitment to safeguarding a minor had led them to challenge the outcome from a safeguarding board until the decision was reversed and the minor had been given appropriate support. Throughout this inspection, we saw numerous examples where staff had not accepted the easy option, rather pursuing the outcome that achieved the best outcome for patients and their contacts. This included securing perinatal input for a pregnant mother and also organising face to face support for a suicidal patient whose own GP practice were unable to see them in person.

Our review of DMICP (electronic patient records system) demonstrated that alerts were applied to the records of patients deemed to be vulnerable. This included any patients aged under 18. The practice had effective links with welfare services. They had also established links with social services outside the Devon area in order to safeguard vulnerable people. Monthly Unit Healthcare Meetings took place and were attended by medical centre clinicians, welfare officers and the chain of command for the purpose of two-way discussion about vulnerable personnel. We spoke with two welfare officers who confirmed that they could easily secure a telephone conversation with a GP if they were concerned about someone's welfare and that a face to face conversation with the patient would quickly ensue.

Clinical staff had received chaperone training and provided a chaperone service. The chaperone policy was displayed in the patient waiting area and the availability of a chaperone was detailed in the patient information leaflet.

The full range of recruitment records for permanent staff was held centrally. However, the practice could demonstrate that relevant safety checks had taken place at the point of recruitment, including checks to ensure staff, including locum staff, were suitable to work with vulnerable adults and young people. Recent staff to join the team had a current English Disclosure and Barring Service (DBS) check. A process was in place to monitor the professional registration of clinical staff. All staff had indemnity insurance. Vaccination status for staff was also maintained.

The Advanced Nurse Practitioner (ANP) was the designated lead for infection prevention and control (IPC) and had received the appropriate training. Staff confirmed that the regional team provided IPC support as required. The annual IPC audit had been completed and any improvements actioned.

There was a cleaning contract in place. The ANP oversaw the quality of cleaning and had recently engaged with the contractor about some concerns. The medical centre was visually clean on the day of our inspection, although we noted that the cleaners' cupboard at Citadel contained some items that should not (for IPC reasons) be held there. We also noted that there was only one mop in this cupboard – multiple colour-coded mops were required for use in different areas of the practice in order to minimise the risk of cross contamination. Following on from our inspection, we were given evidence that this matter had been raised and mitigated with the contractor. A log of waste consignment notes was maintained by the practice. The nurse undertook an annual waste audit and we saw that actions had been implemented. We noted that the waste bins outside were not secured – we were sent evidence to show that this had been remedied in the days following our inspection.

Arrangements to ensure safety of facilities and equipment were in place. Risk assessments had been undertaken and recommendations actioned covering fire risk, water safety, legionella and electricity. Station staff maintained a log of portable appliance testing (PAT) undertaken.

Risks to patients

From a patient perspective, clinical staffing levels were sufficient as patients interviewed told us they had prompt access to a clinician at all times, including out of hours. Staff appreciated the constraints faced by the regional team but confirmed their view that additional support from a medic and some additional reception cover would mean that all three centres could stay open for longer. The senior nurse had recently joined the team and was trained as an advanced nurse practitioner which brought a useful enhanced skillset to the service. The PCRF team were adequately staffed with an appropriate skill mix. The reception team worked across the three sites and they demonstrated a strong corporate knowledge and were instrumental in managing patient appointments, data tracking and signposting carers to support and advice.

All staff, including locums, completed the DPHC mandated induction which included locum and role specific elements. The practice retained copies of competed induction packs.

The emergency trolleys were accessible at Stonehouse, Bickleigh and Citadel and secure and regular checks were undertaken. We reviewed the medicines on the trolleys and found them to be appropriate and in date. The emergency stock was not recorded in DMICP (the clinical system), but this was actioned in the days following our inspection. There were no expiry dates on blood glucose control solutions at Stonehouse and the solutions at Citadel were out of date. These were replaced shortly after our inspection. Defibrillators were located in the medical centre and also in the gym. Oxygen was held and was accessible. There was no appropriate signage in place but this had been remedied before we left the premises.

All staff had completed basic life support, sepsis, anaphylaxis and defibrillator training. Information about sepsis was displayed in various areas of the practice. Clinical staff had received training in climatic illness, head injury and (following an ASER), rectal thermometer use). There was a named clinical lead for resuscitation and an ILS (Immediate Life Support) instructor on site. During the Covid-19 pandemic, medical officers cascaded training around the safe management of the virus to the staff team. Clinicians and medics had received Lyme disease training due to high incidence in South West England. An ASER raised following a subarachnoid haemorrhage resulted in training for clinicians and medics around headaches. Casualty simulations on cardiac emergency had been undertaken by the team. A tabletop exercise or emergency response was completed annually, including involvement of the unit.

Receptionists working across the group practice had received training in recognising and reacting to emergencies. This training covered the deteriorating patient and sepsis. The sepsis recognition policy and aide memoire for prioritising patients were held at reception for easy reference. In addition , reception staff worked with a telephone consultation protocol which included a RAG rating for condition priority. Patients we spoke with confirmed their opinion that reception staff were highly effective in their role.

The doctors were qualified in Sports and Underwater Medicine Course (SUMC) and so could offer diving medicals to patients requiring them. If aviation medicals were required, patients could be referred to another site.

Waiting patients could be observed at all times at all three sites by staff working on the front desk either directly or through the use of a CCTV system. This included patients who had received vaccinations.

Information to deliver safe care and treatment

Staff confirmed that access to patient records was only occasionally a concern but did not pose a significant risk to continuity of patient care. The Business continuity plan stated that if there were a prolonged DMICP outage then clinical delivery would move to another site in the group Practice. In the event of a DPHC wide outage, the Practice would revert to seeing emergency patients only. Hard copy forms were held in the Practice for use in this scenario and documentation would be scanned onto DMICP when available.

Summarisation of notes for newly registered patients was undertaken. The clinical notes and new patient forms were reviewed by medics and then tasked to a GP or the ANP for clinical summary. No backlog was identified during this inspection. The SMO had reviewed summarisation of notes to ensure that all notes had been appropriately dealt with over the past 3 years. We looked at patient records and saw how the summarisation process had helped to identify and prompted ongoing review of, for example, patients with high body mass index (BMI) and high blood pressure.

All clinical staff undertook reviews of peer clinical notes. An appropriate notes review template was in use. All staff were encouraged to use DMCIP templates as much as possible to capture all relevant information. PCRF notes were audited on an ongoing basis. Exercise rehabilitation note taking had been identified as an area that could benefit from improvement and this was being actively managed with links into DPHC and the

wider ERI healthcare governance and regional teams. Similarly the notes by trainee doctors had been identified as an area to improve and appropriate action had ensued. We noted that reflective sessions took place between relevant clinicians to consider actions taken to support vulnerable patients and identify learning. Hospital referral letters had also been audited in October 2020 to ensure that appropriate standards had been met.

The process for managing specimens and test results was failsafe and considerable work had been undertaken over the past year to ensure this. Three ASERs were lodged and investigated leading to improvement in the way that test results were managed, particularly in the absence of key staff. An SOP had been adopted to address the risk when a patient could not be contacted either to collect a specimen or to discuss a result : Chain of Command would be contacted and the GP would review and risk assess the case.

There was a failsafe system in place to manage referrals. There was a dedicated referral clerk and a colleague trained to cover absences. The majority of external referrals were made via the NHS electronic referral system (eRS) which was managed by one member of the administration team, with cover in place in the event of absence. Some referrals were actioned by phone and email if the required specialty wasn't available on eRS. A referrals tracker with limited access was maintained and two week wait and urgent referrals were highlighted to be easily visible. The register has recently been expanded to include internal referrals to the regional rehabilitation unit, occupational health team and department of community mental health were also tracked to ensure that appointments were both secured and attended. Staff told us about a referral that had not been actioned by the hospital. Medical staff had raised an ASER and requested timely action.

Safe and appropriate use of medicines

The SMO was the lead for medicines management at the group practice. The medic was responsible for the day to day management of medicines. None of the three sites dispensed medicines to patients – this was delivered through an arrangement with Lloyds pharmacy.

Patient Group Directions (PGD), which allow practice nurses to administer medicines in line with legislation, were in place and had been signed off. Nurse had completed training in using PGDs and administering vaccines and annual competency assessments were carried out. Medicines dispensed under a PGD were recorded in DMICP. A PGD audit had recently been undertaken by the SMO.

Patient Specific Directions (PSD) were also being used and we saw that details of medicines and patients being administered within a PSD had been maintained and staff competency was up to date. A doctor had assessed each patient to ensure that administration of medicine within a PSD was appropriate.

A process was in place for the management of information about changes to a patient's medicines received from other services. Incoming correspondence, such as from out-of-hours services, hospital discharge letters and out-patient clinics was scanned and then tasked to doctors. This system had been audited.

All blank prescriptions were stored safely. There was a logbook for receiving new blank prescriptions. When doctors took blank prescriptions they recorded the serial numbers.

A process for the safe processing of repeat prescriptions was in place. Where appropriate, medication reviews were taking place and were Read coded. Prescriptions were authorised by doctors.

Uncollected prescriptions were checked monthly and a note was made on the patient's record and the medicine destroyed including the prescription serial number. The prescriber was alerted if the medicine was high risk.

The medical centre was holding only one controlled drug and this was being held on behalf of one of the units. We asked that this medicine be stored separately from the medical centre's own stock in line with best practice guidelines and were advised that this had been implemented shortly following our inspection.

The temperature checks of the medicine fridges and the ambient temperature of the dispensary were held electronically. A standard operating procedure (SOP) was in place and we saw that recently recorded temperatures had remained within appropriate parameters at Stonehouse and Bickleigh but that temperatures in the vaccine fridge at Citadel had been recorded as above eight degrees on six occasions, but no action had been taken. Following our inspection, corrective action was taken.

We noted that the ambient temperature at Citadel was hard to control as air conditioning units could not be fitted inside a listed building. Staff told us about plans for a new building in the future, but in the interim, a standalone unit could provide a solution. Electricity generators were not available on any of the three sites and recently medicines had to be brought from Bickleigh to Stonehouse due to power outage.

The practice followed the DPHC protocol and local SOP for high risk medicines (HRMs). Regular searches to identify patients on HRMs requiring a shared care agreement were undertaken. At the time of our inspection only one patient was being prescribed this type of medicine and we saw that national guidance had been followed. Patients receiving medicines from the NHS specialist pharmacy list of drugs were monitored and audit work had been undertaken.

An audit on antimicrobial prescribing was undertaken in June 2020 which showed that prescribing of an appropriate duration was not always correct and compliance was 77% overall. This was discussed in the clinical meeting in July 2020 where all staff were reminded to use the National Institute for Health and Care Excellence (NICE) and Public Health England (PHE) guidance. Re-audit was undertaken in November 2021 and showed an improvement in compliance to 80% overall. This was discussed in the clinical meeting in November 2021and a re-audit was planned.

Track record on safety

There was a risk register, retired risk register, issues log and retired issues log on the healthcare governance workbook. All risks included detail of the 4T's (treat, tolerate, transfer or terminate) and had a review date. We saw that some risks had been transferred

to Regional Headquarters and DPHC HQ. There were a range of both clinical and non-clinical risks including lone working. The risk assessment for Control of Substances Hazardous to Health (COSHH) was developed during the inspection. Both practice level and individual staff COVID-19 risk assessments were in place.

The practice was working to a COVID-19 risk assessment. The number of people accessing the building had been reduced, social distancing measures were in place, face coverings were mandated and the number of chairs in the waiting room had been reduced. There was a protective screen at reception and hand sanitiser was available for staff and patients.

Patients could access PCRF facilities at all three sites and these were well provisioned to meet the specific needs of the patient population. A range of physical training, rehabilitation and medical equipment had been procured and was managed within servicing agreements. A faults register was in place and any work needed had been undertaken. Risk assessments for each of the PCRFs were generic and there was scope to individualise these. Wet-bulb globe temperature (WBGT – a heat stress index) readings were taken in hot weather and activity managed accordingly.

Staff had personal alarms and weekly tests were carried out in the main medical centre buildings, although not in PCRFs.

Lessons learned and improvements made

Significant events and incidents were reported through the electronic organisational-wide system (referred to as ASER) in line with the DPHC ASER policy. A local ASER SOP was in place. All staff had an ASER login. Our interviews with staff across the whole team and our review of the ASERs raised and investigated to date, indicated that there was a particularly positive culture whereby staff were encouraged to report concerns. ASERs were routinely discussed at the practice meetings and identified in the minutes. It was clear from our discussions with staff that lessons learned were shared with the team. We noted that ASERs had also been raised by contracted staff and cleaning staff.

The medical centre had a system in place to distribute Medicines and Healthcare products Regulatory Agency (MHRA). Discussion took place at clinical meetings and was recorded in minutes. The SMO circulated any alerts that required priority action to other clinicians. The CAS (Central Alerting System) alert log was held on health governance workbook including detail of action taken. Alerts were also discussed at the practice meeting as a standing agenda item.

Are services effective?

We rated the practice as outstanding for providing effective services.

Effective needs assessment, care and treatment

Processes were in place to support clinical staff to keep up to date with developments in clinical care including NICE guidance, clinical pathways, current legislation, standards and other practice guidance. For example; a new chronic Kidney disease assessment and management SOP had been produced; the chronic disease management tool had been updated to reflect chronic kidney disease in all chronic diseases and new section was added to the chronic disease management tool and protocols to include gout and its management.

we saw that recent updated guidelines around chronic kidney disease had been discussed, added to the practice development plan and a new 'gout in chronic disease' management tool had been developed. This has led to improved outcomes for those with gout. Changes in NICE guidance around the management of miscarriage and ectopic pregnancy had been adopted and the SOP updated. Strongyloidies (caused in warm temperate regions by a pathogenic parasitic roundworm) had been discussed in the practice meeting and discussion with any potentially impacted patients had taken place.

Practice meetings were held every two weeks in order to discuss practice issues. Clinical meetings were held monthly where NICE and Scottish Intercollegiate Guidelines Network) SIGN updates were discussed. Records of these meetings were seen with evidence clearly visible of all updates contained within meeting minutes. Clinical meeting records were maintained on the healthcare governance workbook.

PCRF staff were familiar with Department of Defence Rehabilitation Guidance and provided examples of treatment provided based on evidence-based guidelines and care pathways. ERIs used Rehab Guru (software for rehabilitation exercise therapy) but our review of notes showed that not all physiotherapists were recording their use of this software.

Monitoring care and treatment

The SMO held the lead role for chronic disease management and was supported by the nursing team who ensured that patients with chronic disease were appropriately monitored. Leads for each chronic condition had been allocated. The SMO had developed a chronic disease management tool which guided clinicians to access the most recent care pathway and guidelines for patients with a long term condition. This was reviewed annually to incorporate new evidence-based practice. The team followed a chronic disease management protocol which gave guidance around when to run clinical searches to inform the recall of patients. A standardised set of clinical codes was in use and clinical searches had been developed which superseded the Quality and Outcomes Framework (QOF) indicators and so was more relevant to the patient population at Stonehouse. This

substantial work ensured the effective management and recall of patients with chronic disease. The SMO sat on the DPHC Clinical Working Group and had shared their approach to chronic disease management with a view to rolling out the good practice across primary care.

There were 20 patients recorded as having high blood pressure. All patients had a record for their blood pressure taken in the past nine months. 15 patients had a blood pressure reading of 150/90 or less. Staff audited compliance of hypertension management against NICE standards regularly. In August 2021, a third cycle of the audit provided evidence that patients were receiving the support required to manage their condition well.

There were five patients on the diabetic register. The medical centre audited compliance of diabetes management against NICE standards regularly. We reviewed audit work undertaken in August 2021 (a third cycle) which demonstrated that patients were receiving appropriate support to actively manage their condition.

The practice used several approaches to identify and monitor those at risk of developing diabetes: the over 40s health check which included a check for glucose; recall of patients with impaired fasting glucose and gestational diabetes for an annual review of HbA1c; an annual diabetes case finding audit was undertaken to ensure those who may have diabetes were not missed.

There were 13 patients with a diagnosis of asthma. 12 patients had an asthma review in the preceding 12 months which included an assessment of asthma control using the three RCP (Royal College of Physicians) questions. An asthma SOP was followed by clinicians and a consistent asthma review template was in use.

Sixty-seven percent of patients' audiometric assessments were in date (within the last two years). During COVID-19 routine audiometry had ceased in line the April 2020 DPHC directive. The practice had resumed audiometry as restrictions relaxed and were working to reduce the backlog, initially prioritising patients who had hearing loss, had not yet had their first three audios in service and those who not had an audio since before 2018.

The SMO had undertaken an audit of patients with a diagnosis of depression in November 2021 and found that all patients had received a review within the required parameters, but that these reviews had not always been Read coded correctly. This issue was subsequently discussed at the clinical meeting as a trigger for improvement.

Patients with mental health needs were supported in a number of ways:

- patients with concerns were able to self refer themselves into the local DCMH and this included patients with perinatal and postnatal worries;
- supportive management and prevention strategies as well as psychological intervention were offered to patients who could benefit from them;
- patients were able to access Headspace, an app which offers advice and guidance on mental wellbeing, tips on sleeping better and different exercises to improve mood. It also has articles to listen to including how to reduce worrying, improve focus and manage anxiety.

The PCRF had rolled out a number of health initiatives to support the holistic needs of patients and they had worked with patients to find out what provision would be most useful. A health and wellbeing quiz was offered to all new personnel at the Unit which aimed to measure dietary habits, sleep, activity, smoking and alcohol consumption. Analysis of the submissions showed that sleep and diet were the main factors affecting patients and this was discussed with the unit as part of health promotion activity. A staff wellbeing survey was undertaken which resulted in an event to encourage increased activity amongst personnel, including 'exercise of the week' and lunchtime walking. The SMO had commended the initiative with an award.

A TRIGPOINT approach had been developed to help cover some gaps in the current mental health care model. It provided mental health 'Step 1' support in a group scenario to individuals who then received follow-up support and an onward referral to DCMH as required. Staff told us that the model had proven useful in ensuring that patients could access meaningful support quickly when they needed it.

Thirty-four registered patients responded to the DMSR patient satisfaction survey which complemented this inspection. The survey included a question about whether the patient felt that their healthcare professional had recognised and/or understood their mental health needs. Of the 34 respondents, 22 stated that they had had a mental health need. Of these, 91% said that the healthcare professional had understood their mental health needs. Two patients stated that their needs were not well understood.

An extensive and comprehensive quality improvement programme was in place which had been designed for optimal relevance to the patient population. We saw that some 160 audits were in place spanning clinical, administrative and managerial topics. More than one cycle had been undertaken in many instances and there was evidence of positive direction of travel over several years. Required changes were actioned through the Practice Development Plan.

Effective staffing

All staff, including locums, completed the DPHC mandated induction which included locum and role specific elements. Copies of competed induction packs were retained and doctors were signposted to 'Desk Top Instructions' for additional guidance. The PCRF had a standardised induction process for all new staff, including a tick list of all essential activity and mandatory training.

Performance appraisals were conducted by line managers for all staff and uploaded to HR systems. All doctors were in date for appraisal and all doctors and nurses had completed timely revalidation. Peer/notes review for PCRF staff had been undertaken. The peer reviews had been uploaded to the audit calendar on the healthcare governance workbook. ERIs were not currently line managed by PCRF staff as they worked for the Units, although updated terms of reference had recently been introduced to ensure that appropriate and consistent standards were being followed.

Mandatory training was recorded on the staff database. All staff had protected time for the completion of mandatory training and attendance at group training. Regular clinical supervision and reflection took place for doctors and nurses. Physiotherapy staff received

regular appraisals, attended regular multi-disciplinary team meetings and more recently, recording of peer review and clinical supervision had been implemented. A programme of peer review and clinical supervision had been instigated for ERIs (who reported to Chain of Command) but this was not yet fully mature. There was scope for ERIs to undertake reflective practice in order to ensure that learning influenced future practice.

Coordinating care and treatment

The medical centre team had forged effective links with all units on the three bases including welfare staff and we were told that a mutually supportive communication stream was in place. We interviewed a welfare officer as part of our inspection. They confirmed that regular meetings took place with the aim of supporting personnel and that conversations were two way such that each party could raise concerns about vulnerable personnel.

We also spoke with three Commanding Officers who represented the units registered with the medical centre and they were complimentary about the proactive approach taken by the medical team to not only support personnel who may be vulnerable, but also to identify and support anyone who finds themselves in a vulnerable situation. A theme ran through the conversations held : of medical centre staff striving to go beyond their daily responsibilities to maximise positive impact for the military community and the wider population.

The SMO had identified that patients were waiting 52 weeks to be seen for trauma, orthopaedic and general surgery referrals into secondary care and was successful in negotiating with the Patient Plus Group (PPG) which aims to ensure that patients are seen within 18 weeks of a referral (and a two week wait for lower endoscopies). This service has also been extended to patients registered at other military medical centres in the Plymouth area. The SMO had some concerns about the quality of care being received by patients and so met with the secondary care provider to discuss these.

Patients were referred to the multi-disciplinary injury assessment clinic when required and staff commented that the wait to be seen was currently around two months due to staffing issues at the local Regional Rehabilitation Unit (RRU). We noted that multi-disciplinary discussion took place for any patients awaiting assessment and that this involved physiotherapists, ERIs, doctors and nurses. 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.

The team had established useful links with local NHS services. GPs attended local NHS GP education and appraiser meetings as relevant to their areas of interest and nurses liaised with NHS providers for clinics such as diabetes education and retinopathy. The health promotion work done by the team was based on NHS resources. The team established timely and effective links with the NHS COVID-19 vaccine service, resulting in rapid access to vaccines for patients and staff. The team held case conferences with NHS midwives at Green Ark who supported any pregnant patients.

The SMO took part in the Naval Service Medical Board of Survey (NSMBOS) to ensure that patients were well represented during the determination of their employment medical category.

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 of the patient's health needs was provided. For patients with complex needs moving to another medical centre, a summary letter was given to the receiving medical officer. Patients were also made aware of the Veterans Health Service and, if appropriate, the Veterans Mental Health Transition, Intervention and Liaison Service (TILS). The practice had forged impactful links with local charities supporting the welfare of veterans and also carers.

The medical centre was working with the Deanery on the early stages of developing a career pathway for civilian GPs who had an interest in working in the military setting: Supporting NHS GP Registrars to understand the role of primary care in the military.

Helping patients to live healthier lives

The health promotion lead within the practice kept the information uptodate on the notice boards in line with national priorities when appropriate. We saw a number of health promotion boards in the waiting area and corridors and these included information around sexual health, hydration, smoking cessation, being a carer and the symptoms of sepsis. Booklets from the Oxford Cognitive Therapy Centre were also available for patients to take away and these tackled themes such as recovery from PTSD and coping with suicidal feelings.

The SMO was qualified and held a Diploma of the Faculty of Family Planning and also held the lead for sexual health. There were established links with both the local provider Sexual Health in Plymouth (Derriford Hospital) and the military sexual health consultant. Free condoms and chlamydia kits were available at the practice. Information about sexual health, contraception and pregnancy was displayed in the patient waiting area. Staff had arranged for any testing kits to be posted out to patients in blank envelopes to ensure privacy.

Health screening was proactively encouraged by the medical centre. Regular searches were undertaken for bowel (one patient identified), breast (one patient identified) and abdominal aortic aneurysm screening (no patients identified) in line with national programmes. Ninety-seven percent of women who were eligible for a cervical smear had received one in the last five years which exceeded the NHS target of 80%.

Immunisations were regularly reviewed and administered to patients when they were required. Vaccination rates were high:

- 94% of patients were recorded as being up to date with vaccination against diphtheria.
- 94% of patients were recorded as being up to date with vaccination against polio.
- 99% of patients were recorded as being up to date with vaccination against hepatitis B.

- 96% of patients were recorded as being up to date with vaccination against hepatitis A.
- 94% of patients were recorded as being up to date with vaccination against tetanus.
- 99% of patients were recorded as being up to date with vaccination against MMR.
- 93% of patients were recorded as being up to date with vaccination against meningitis.

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 patient population. Mental capacity training was incorporated into the safeguarding training.

Consent was appropriately recorded in the clinical records we looked at for physiotherapists, nurses, mental health staff and doctors. The offer and use of a chaperone was recorded in patient records.

An audit of occupational health referrals was undertaken in August 2020 and established that patients had consented to occupational staff accessing their clinical records.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

We interviewed 12 patients as part of the inspection and feedback indicated staff treated patients with kindness, respect and compassion at all times. All 12 patients explained how medical staff centre routinely went the extra mile to ensure that the physical, mental health and holistic needs of patients were met in a timely, respectful and compassionate way. This included supporting patients with conversations with their line managers, extended appointments, out-of-hours support, ensuring that appropriate secondary care referrals were obtained and support with gender transition. Seven patients specifically mentioned how the caring approach of reception staff had been instrumental in them securing timely appointments and in remembering to attend them.

We reviewed the records for a number of patients who were experiencing poor mental health and noted that this was a significant proportion of the clinicians' workload. Clinicians were responding to patients with kindness and compassion, ensuring that patients had the space and time to talk when they needed to.

We interviewed the majority of staff working across the medical centre at the time of the inspection. All staff told us that Stonehouse Group Medical Practice was a happy place to work and that they could rely on their work team to discuss and mitigate any concerns they faced. They spoke about colleagues who were supportive, compassionate and caring.

Thirty-four registered patients responded to the DMSR patient satisfaction survey which complemented this inspection. All patients who responded to a question about how well clinicians listened to them, said that their experience was very good or good. Similarly, all respondents stated that they felt that they had been treated with appropriate care and concern.

Involvement in decisions about care and treatment

All 12 patients we spoke with said they were involved with decision making and planning their care. Several patients indicated that clinicians had provided exemplary information to help support their decision making.

Of the 34 patients who responded to the DMSR patient satisfaction survey, 27 stated that they had been fully involved in decisions about their care and treatment. Two patients stated that they had not been involved in decision making and five patients reported that this did not apply to their situation.

The PCRF used light duties chits and used downgrade maintenance physical therapy and reconditioning physical therapy prescriptions appropriately.

Patients with a caring responsibility were identified through the new patient registration process and a clinical code assigned to their records. There was a reminder for carers in the practice information leaflet and information in the waiting area. DMICP searches were undertaken to monitor carers. The centre receptionist had championed the needs of carers and created a specific area in the waiting room with detailed information around how to access support. They had also run a coffee morning to engage with carers.

An interpretation service was available for patients who did not have English as a first language.

Privacy and dignity

All patients we spoke with stated that they were confident that the practice would keep information about them confidential. All stated that they felt that their dignity and privacy were upheld by medical centre staff. Consultations took place in clinic rooms with the door closed (including all physiotherapy assessments). Rehabilitation sessions took place in curtained cubicles and privacy challenges were mitigated as far as possible with screens and notices. Patient identity checks were completed prior to any information being disclosed. There were privacy curtains in all clinical rooms. There was a notice on reception advising patients they could speak with a member of staff in private if required. All staff had completed the Defence Information Management Passport training which incorporated the Caldicott principles. The radio was playing in the waiting area to help mask any conversations taking place with reception staff.

Patients were able to see clinicians of either gender according to their preference. All patients who responded to the patient survey stated that they were able to see a clinician who suited their needs.

Are services responsive to people's needs?

We rated the practice as outstanding for providing responsive services.

Responding to and meeting people's needs

- The Bickleigh medical facility was a purpose built clinical facility and was well provisioned to meet the specific needs of the patient population, including access for patients using a wheelchair. The other two buildings (Citadel and Stonehouse) were contained within old listed properties which brought challenges around temperature control and accessibility. Nevertheless, the team had mitigated any risks as far as possible and any risks had been escalated appropriately. Any patient with access requirements could be supported to attend the Bickleigh site. There was scope to ensure that reception staff at the Citadel site could access an area which was thermally regulated during hot weather. The team could meet in large groups for meetings and training using rooms close to the Stonehouse Medical Centre or at the Bickleigh site. Patients we spoke with did not report any concerns with accessing the facilities. An Equality Access Audit for all three buildings and PCRF had been carried out and barriers had been noted.
- 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 and during non-office hours in order to ensure that personnel could deploy at short notice. Patients and unit staff we spoke with confirmed how valuable this rapid response was to supporting operational capability.
- A policy was in place to guide staff in exploring the care pathway for patients transitioning gender. Medical centre staff had received training to support the appropriate and effective care of people who were transitioning gender. We discussed care provided to an individual who was in transition and saw that best practice care and support was being provided. We also spoke with the patient concerned and they told us that they found the service they received to be thorough and highly accessible.
- During the past 24 months and in response to the COVID-19 pandemic the practice took on additional roles: setting up and running a regional bedding down facility for COVID19 patients and setting up and running the region-wide hot hub facility for COVID19 patients. These initiatives ensured that patients testing positive for COVID-19 were supported either remotely or in a ward setting depending on their risk factors and symptoms. During this same time period, the team also took on responsibility for the patient population registered with Drake Medical Centre as their staff were deployed to assist the NHS COVID response.
- Patient feedback was driving improvement. Feedback had been acted upon to purchase new rehabilitation equipment and to improve the dispensing arrangement with Lloyds Pharmacy.

Timely access to care and treatment

- During the COVID-19 pandemic and associated restrictions, the medical centre continued to deliver a comprehensive healthcare service which was extended to include the Drake Medical Centre patient population (as Drake Staff were mostly deployed on MACA (requests for military aid to civil authorities) response.
- The medical centre was providing very responsive care for its patient population. Urgent and routine appointments with either a doctor or a nurse or physiotherapist could be accommodated on the same day if required. The patients we spoke with during the inspection confirmed they received an appointment promptly and at their preferred time. In the patient survey, 100% of respondents stated that their experience of making an appointment was very or fairly good.
- Patients requiring occupational medicals could access one very quickly. If there was an urgent need for a quicker medical turnaround, these could be turned around on the same day. Appropriately qualified doctors were available to provide diving medicals.
- Arrangements were in place in order that patients could access a clinician at all times when the practice was closed and in an emergency. General out of hours (OOH) shoulder cover was provided either by Drake Medical Centre or via the duty mobile. After 18:00 cover was provided by NHS 111 or the Devon Doctors NHS OOH service. An out of hours "watch bill" was in place and required medics and doctors to be on call for emergencies that sit outside the NHS OOH contract.
- Where there was clinical need, home visits were triaged by the duty doctor and accommodated if appropriate. We noted an example where a bereaved patient had been visited and supported at home. Telephone consultations were available and doctors, nurses and physiotherapists used them.
- Patients had fed back that waiting times to see a secondary care trauma, orthopaedic or general surgery specialist was 52 weeks. The SMO had therefore successfully negotiated with the Patient Plus Group (PPG) which aimed to ensure that patients were seen within 18 weeks of a referral (and a two week wait for lower endoscopies). This service has also been extended to patients registered at other military medical centres in the Plymouth area.
- Daily walk-in gym clinics were available in the PCRF and were arranged at different times to meet the shifts and working patterns of the patient population. Direct Access Physio (DAP) clinics were also accessible for patients (although currently paused at Citadel). Patients we spoke with reported using the direct access clinic and that they had found it beneficial to them.
- Rapid access to PCRF support was available with patients being seen well within the key performance indicators (within one day for acute referrals and within five days for routine referrals). Non-attendance of appointments was not an issue at the time of our inspection. A routine physiotherapy appointment was available within five days, a follow-up appointment within five days and an urgent appointment facilitated on the next day. For the ERI, a new patient appointment was available within five days and follow up appointment could be accommodated within three days. Access to rehabilitation classes was via referral to a rehabilitation troop and could be accommodated quickly.

Listening and learning from concerns and complaints

- The practice manager was the lead for complaints. Two complaints had been received in the last 12 months. A comprehensive log was in place with RAG ratings to annotate timely progression through the complaints process. No trends had been noted, but learning had been discussed at a practice meeting.
- Patients were made aware of the complaints process through the practice information leaflet and a poster in the waiting room. Patients we interviewed were aware of how to complain but said they had no reason to make a complaint about the service.

Are services well-led?

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

Leadership, capacity and capability

- The staff team at Stonehouse Group Medical Practice worked with tenacity to deliver the best possible care for their registered patients, coupled with the dual aim of prompting improved care delivery DPHC-wide. All staff we spoke with described a driven and able leadership team with an SMO at the helm who demonstrated an open leadership style designed to deliver results. Considerable improvement work had been undertaken in recent years to ensure that consistently high standards were being delivered across Stonehouse, Citadel and Bickleigh facilities. Staff owned detailed terms of reference for their main role and separate terms of reference for any key lead roles that they undertook. Staff were also guided by desk top instructions to ensure that they understood their daily responsibilities.
- Throughout this inspection we met with patients and unit staff who described a medical centre team that frequently went the extra mile to ensure that patients' needs were met as quickly as possible in order to ensure their health and wellbeing, alongside their role in facilitating operational capability.
- The medical centre team had the capacity and skills to provide care that extended well beyond the baseline at times. During the COVID-19 pandemic, the team had set up and delivered care in a bedding down facility; provided support to other patients testing positive in the area and provided care to the patients registered with Drake Medical Centre. The bespoke tool for long term condition management was delivering the best possible support for patients with a chronic disease. Staff were committed to safeguarding all vulnerable individuals whether registered patients or not and this commitment had led the team to take out of area action and to challenge decision making by other agencies.
- The team had well established links with the regional team who provided input when required.

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 Group Practice worked to DPHC's mission statement 'Provide and commission safe and effective healthcare which meets the needs of the patient and the chain of command in order to contribute to Fighting Power'.
- However the team had also created their own vision statement:

  'Stonehouse Group Medical Practice is a place where staff want to come into work every day and patients want to come for their care. It is an accessible, high-quality health care service offering a timely, prompt, genuinely caring service

that understands the role the patient plays in defence, delivered by a progressive, cohesive team that supports staff and patients alike to maximise their career opportunities.' The staff team chose to headline this vision statement as **"Healthcare: done properly, done best."**

- The medical centre had forged close links with all the units it supported and tailored the service to their specific needs to support deployments such as force protection clinics. Duty doctors, nurses and medics were routinely on hand to facilitate urgent access to care.
- The team strove to deliver a preventative approach which involved proactive health promotion support, lifestyle advice and prompt barrier-less access to mental health provision. Care was delivered to patients through an integrated multi-disciplinary approach. With the patient truly at the centre of this shared care approach, the benefits and positive outcomes for patients were not accidental.

Culture

- Staff we spoke with described a strong team ethic with patients' individual requirements held at the centre of all decision making. We observed staff going the extra mile to provide a comprehensive service to their patients, often accommodating short notice requests to meet occupational health requirements for personnel about to be deployed, providing accessible bereavement care, ensuring that carers could access the support they might need.
- The practice team operated an open and honest meeting culture where all staff were encouraged to attend and offer suggestions or raise concerns. Leaders operated an open door policy for staff to use and everyone we spoke with confirmed that this was the reality in practice. We noted that staff we interviewed were confident and empowered to discuss issues and concerns they had identified and escalated. We saw numerous examples of improvements identified and delivered by staff of all ranks. A recent staff survey noted that 100% of staff felt able to challenge a colleague about a concern and 95% felt they had a voice and were listened to.
- Staff were aware of the whistleblowing policy and were also aware of the Freedom to Speak Up (FTSU) process within the region. Staff spoke about how this was frequently re-enforced at practice meetings.
- Processes were established to ensure compliance with the requirements of the duty of candour, including giving those affected reasonable support, information and a verbal and written apology. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. We were given examples of when duty of candour had been applied appropriately.

Governance arrangements

- Stonehouse Group Medical Practice operated across three integrated sites which offered increased flexibility for patients registered with them. Work was ongoing to avoid duplication of effort for reporting and governance purposes e.g. a joint eHAF

(electronic health assurance framework) has been developed. Two memorandums of understanding were in place; one with the Chain of Command for the use of deployable medical staff in the Group Practice and another with Drake Medical Centre for support and shoulder cover to the Stonehouse Group Practice.

- 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, SOPs, QIA and complaints.
- Communication across the three sites was strong and an appropriate meeting structure and healthcare governance approach was in place. This included regular clinical, practice, healthcare governance and unit healthcare committee meetings, chronic disease, safeguarding, PCRF meetings and audit discussion. The PCRF was operating as a fully integrated part of the medical centre team.
- A comprehensive quality improvement programme was in place and covered an extensive range of administrative, clinical and managerial topics. The programme was ongoing and involved an ongoing cycle of audit work. Much of this work was leading to demonstrably improved outcomes for patients.

Managing risks, issues and performance

- There was a current and retired risk register on the HGW along with current and retired issues. The register articulated the main risks identified by the practice team. All risks included detail of the four T's: 'treat, tolerate, transfer or terminate' and had a review date. We saw that some risks had been transferred to Regional and DPHC Headquarters. The registers were regularly reviewed. There were a range of risk assessments in place including both clinical and non-clinical risks. The assessments included lone working, sharps safety and health and safety; COSHH risk assessments were developed during the inspection. There were processes were in place to monitor national and local safety alerts, 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 all the main risks to the service and included all three sites. The practice had a major incident plan which supported all units and had been agreed by unit commanders.
- Staff who were not performing would be supported initially to identify any underlying cause and implement support structures. If performance did not improve then formal performance management processes, military or civilian, would be followed.

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 group practice had developed an eCAF to combine all three sites. The medical centre had received an HGAV recently and this had resulted in a small number of suggested actions that had mostly already been implemented.

- Systems were in place that took account of data security standards to ensure the integrity and confidentiality of patient identifiable data, records and data management.

Engagement with patients, the public, staff and external partners

- There were various options in place to encourage patients to provide feedback on the service and contribute to the development of the service. These included a patient experience survey and a suggestions box was available in the waiting room.
- Changes had been made as a result of patient feedback and include:
- Work to investigate access issues to medicines through the local pharmacy due to unclear opening times. Chain of Command commented on a noticeable improvement for personnel.
- New chairs for the waiting area have been ordered
- New rehabilitation equipment has been acquired for the PCRF
- Updated the Patient Satisfaction Questionnaire to include reception
- The practice team stated that they felt well supported and had excellent communication streams with all Units they supported. Welfare staff told us that their relationship with the MC team was positive and trusted. Communication channels with local NHS services, including NHS GP practices, local sexual health services and secondary care providers had been established and meant that patients could access the care that they needed locally.

Continuous improvement and innovation

- As part of the response to the COVID-19 pandemic the practice took on additional roles:
    - Setting up and running a regional bedding down facility for COVID19 patients
    - Setting up and running the region-wide hot hub facility for COVID19 patients

  These initiatives required staff to undertake a number of risk assessments for the ongoing delivery of primary care, for resuscitation, cleaning, infection prevention and control, ward and bed management and referral management.

- The Group Practice is a pilot site for ‘Defence Digital Transformation’ which seeks to test out various IT developments including “total triage”, formal texting, staff rosters.
- The SMO had developed a chronic disease management tool which guided clinicians to access the most recent care pathway and guidelines for patients with a long term condition. This was reviewed annually to incorporate new evidence-based practice. The team followed a chronic disease management protocol which gave guidance around when to run clinical searches to inform the recall of patients. Leads for each chronic condition had been allocated. A standardised set of Read codes was in use and clinical searches had been developed which superseded the Quality and

Outcomes Framework (QOF) indicators and so were more relevant to the patient population at Stonehouse. This substantial work ensured the effective management and recall of patients with chronic disease. The SMO sat on the DPHC Clinical Working Group and had shared their approach to chronic disease management with a view to rolling out the good practice across primary care.

- A TRIGPOINT approach had been developed to help cover some gaps in the current mental health care model. It provided mental health 'Step 1' support in a group scenario to individuals who then received follow-up support and an onward referral to DCMH as required. Staff told us that the model had proven useful in ensuring that patients could access meaningful support quickly when they needed it.
- Patients had fed back that waiting times to see a secondary care trauma, orthopaedic or general surgery specialist was 52 weeks. The SMO had therefore successfully engaged and negotiated with the Patient Plus Group (PPG) which aimed to ensure that patients were seen within 18 weeks of a referral (and a two week wait for lower endoscopies). This service has also been extended to patients registered at other military medical centres in the Plymouth area.
- Staff used the NHS Safeguarding App to ensure up to date contacts with out of area safeguarding teams. The medical centre's commitment to safeguarding a minor had led them to challenge the outcome from a safeguarding board until the decision was reversed and the minor had been given appropriate support. We noted that reflective sessions took place between relevant clinicians to consider actions taken to support vulnerable patients and to identify learning. Throughout this inspection, we saw numerous examples where staff had not accepted the easy option, rather pursuing the outcome that achieved the best outcome for not only patients but anyone who is vulnerable.
- The PCRF had rolled out a number of health initiatives to support the holistic needs of patients and they had worked with patients to find out what provision would be most useful. A health and wellbeing quiz was offered to all new personnel at the Unit which aimed to measure dietary habits, sleep, activity, smoking and alcohol consumption. Analysis of the submissions showed that sleep and diet were the main factors affecting patients and this was discussed with the unit as part of health promotion activity. A staff wellbeing survey was undertaken which resulted in an event to encourage increased activity amongst military personnel, including 'exercise of the week' and lunchtime walking. The SMO had commended the initiative with an award.