Mount Pleasant Medical Centre

Mount Pleasant Complex, Falkland Islands, BFPO 655

Defence Medical Services inspection report

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information given to us by the practice and patient feedback about the service.

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

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About this inspection

We carried out this assurance audit on 21 March 2024.

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

Are services safe? – requires improvement

Are services effective? – good

Are services caring? – good

Are services responsive to people's needs? – good

Are services well-led? – good

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

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

At this inspection we found:

The medical centre was well-led and the leadership team demonstrated they had the vision, capability and commitment to provide a patient-focused service.

The medical centre provided a seamless tri-service approach to care and was responsive to the needs, at times differing needs, of the 3 services, and also to the large cohort of civilian patients.

Overall the arrangements for managing medicines minimised risks to patient safety. A process was in place to monitor patients prescribed high risk medicines.

Patients were able to access an appointment and urgent appointments were available the same day.
There was an effective programme in place to manage patients with long-term conditions. Patients received effective care reflected in the timeliness of access to appointments, reviews, and screening/vaccination data. The care provided for children and families was accessible and effective.

Staff training processes were comprehensive, complete and up-to-date.

The medical centre worked collaboratively with internal and external stakeholders. In particular, the strong relationship with King Edward Memorial Hospital (KEMH) meant patients had timely access to services such as diagnostics and secondary care.

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

On induction, all staff completed an individual competency proforma. From this an individual training package was created for the individual to further develop, enhance their skillset and address any training deficiencies.

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

Headquarters should review staffing requirements to ensure that there are sufficient staff with the right skills to deliver both primary care and PHEC (Pre-Hospital Emergency Care). Currently the medical centre is manned to meet the requirements of daytime primary care services, yet staff are delivering OOH (out of hours) care with little or no rest time.

Challenges around timely access to accurate patient records occur as DMICP 'Deployed' is a system with reduced functionality and some outage periods. Headquarters should review the functionality of DMICP 'Deploy' and deliver solutions to improve access to up to date records.

Provide clear lines of senior accountability to the medical centre team to ensure clear ownership of and optimal management of risks.

The Chief Inspector recommends to the practice:

Formalise safeguarding arrangements for contracted staff working on the island. In addition, formalise liaison with the social work, health visiting team and the school.

In line with recent DPHC policy, ensure there is a risk assessment in place for the emergency trolley and the medicines within it. All staff must complete the CardioCheck Plus Test System training.

Stock check all over-labelled medicines. Training should be given to all medics on the process for transferring medicines from the dispensary to locations at the remote radar heads.

Ensure a robust procedure is in place for the safe disposal of clinical waste including an updated standard operating procedure. Consignment notes must be signed for the removal of waste.

Implement a safe system for the management of vulnerable persons, this should include a robust system for adding alerts to patient's notes.

Implement familiarisation training to identify the different alarm sounds and recommend investigating whether the current alarm panel is still fit for purpose.

Where there is any communication between clinicians about a patient, this should be recorded in the patient's notes to ensure other clinicians in future are aware of the rationale for the recommendations and clinical decisions made.

Arrangements should be made for any locum or temporary physiotherapists to have formal line management, supervision and reach back whilst in post.

Expand the audit programme to include the specific nuances of the population group.

Ensure a work service request to install handrails into the disabled toilet is submitted.

Consideration is needed to be given to ensure confidentiality and privacy in the gym area for any patient having a direct access physiotherapy consultation and in improving management and security of any contemporaneous notes.

Develop a practice development plan to continue to formalise the future plans and strategies.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Healthcare

Our inspection team

The inspection team included a CQC inspector and specialist advisors including a primary care doctor, practice nurse, pharmacist and physiotherapist. A member of the Defence Medical Services Regulator supported the inspection in the practice manager specialist advisor role.

Background to Mount Pleasant Medical Centre

Mount Pleasant Medical Centre is located in the Falkland Islands. The medical centre provides primary and occupational healthcare to approximately 1112 service personnel and 1051 civilian patients (912 are contractors). They provide immediate and emergency care to an operational fixed, fast jet and rotary wing airfield on a constant basis, 365 days per year. The services provided include routine nurse, doctor and medic clinics, duty doctor on-call and consultation, adult and child immunisations, well woman clinics, fitness to deploy medical screening and routine occupational medicals.

The Primary Care Rehabilitation Facility (PCRF) provides routine and urgent physiotherapy to service and civilian personnel, along with exercise rehabilitation support and is located in the same building.

The medical centre is open 0800 -1700. Out of Hours/ emergency provision is available between 1700-0800 hours.

In addition to routine primary care services, the medical centre provides a range of other services including immunisations, phlebotomy, sexual health and contraception, smoking cessation, cervical cytology, over 40's health screen and chronic disease management. The dispensary is located in the same building. Maternity services are provided by King Edward Memorial Hospital Stanley as are local laboratory services.

The staff team

Senior Medical Officer (SMO)	1
Civilian Medical Practitioner	Gapped (1 GP Registrar currently working supernumery)
Unit Medical Officers	1
Practice manager	1
Deputy practice manager	1
Nurse	1
Pharmacy Technician	1
Exercise Rehabilitation Instructors (ERI)	1
Physiotherapists	1 (locum)
Administrator (civilian)	1
Combat Medical Technicians* (CMTs)	3 Army 1 Navy 4 RAF
Mount Byron RRH (Not DPHC)	1 (managed remotely)
Mount Alice RRH (Not DPHC)	1 (managed remotely)
Environmental Health (Not DPHC)	1
Ambulance Drivers (Not DPHC)	3

Are services safe?

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

Safety systems and processes

A service personnel support committee (SPSC) meeting was held on a monthly basis. Meeting attendees consisted of the Senior Medical Officer (SMO), padre, SSAFA social worker, officer commanding personnel management squadron and the chief clerk. There were good working relationships between the welfare team, with regular communication outside of scheduled meetings. The welfare of the civilian contractors was managed generally through their line managers but there were no regular or formal arrangements in place. There was some liaison with the social worker and the health visiting team but again nothing had been formalised.

Quarterly local safeguarding partnership Board meetings were held that included the head teacher of the local school, police, the medical centre, welfare, the social worker and their UK line manager. The social worker also visited the medical centre for lunch at least twice a week for an informal catch up and any concerns were raised privately.

A safeguarding adult/child policy was held by the medical centre and was reviewed in February 2024. The appointed leads for safeguarding had completed level three safeguarding training. All staff had completed safeguarding and safety training appropriate to their role and knew how to identify and report concerns. A safeguarding register was held by the medical centre on the clinical operating system (known as DMICP) with access limited to appropriate staff members.

Information about local safeguarding processes were in the detailed ‘Handover Take Over’ notes which were collated by the current nurse in preparation for the next person. There was a 3 day overlap to allow for a thorough handover. Young people and carers were identified on screening paperwork submitted prior to arrival. The medical centre had a search for carers and under 18’s on DMICP. However, this was not always a true reflection on the actual number physically on the island as the number of patients who were coded as carers were carers at their originating units in the UK not on island. The practice had identified this as an area for improvement and were looking at ways to streamline this.

Vulnerable patients (VP) were mainly identified during registration, consultation, via DMICP searches and on a referral from another department such as the welfare team. On review of DMICP, the vulnerable adult / children and carers searches were recently run by the medical centre in March 2024. We reviewed records to ascertain whether an alert had been added to the medical records of patients who were vulnerable. Of the 5 records checked out of a possible 24, only 1 had the allocated safeguarding alert on their medical record. There was no formal register for VPs in place and there were no updates in patient notes regarding internal meetings or discussions.

Notices advising patients of the chaperone service were displayed and information was in the practice leaflet. There were 7 individuals (4 females / 3 males) who were recorded as

being trained chaperones within the practice. All personnel nominated as chaperones were in date with their training along with their Disclosure and Barring Service (DBS) status. Chaperone training was included as part of the practice induction programme and individual training was provided for those personnel not compliant during the induction phase. The training register showed chaperone training was provided to all available staff in January 2024.

Recruitment checks were in place for professional registration, DBS, indemnity and vaccination status. The practice manager checked the professional registers on the arrival of new staff and subsequently on a quarterly basis. The professional registration database was held within the healthcare governance workbook (HcG Wb) and on review all clinicians were in date. All staff were in date with their vaccination statuses, this was a mandated requirement during pre-deployment preparations.

Within the Primary Care Rehabilitation Facility (PCRF) neither of the clinicians were trained to treat paediatric patients. Neither had needed to treat a child since being in post but were aware that at any time a child could be referred to them. They had made good links with the civilian physiotherapists in Port Stanley and felt they could speak to them for advice regarding treating children if needed, although there was no formal memorandum of understanding or terms of reference to reflect this arrangement.

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

An infection prevention and control (IPC) policy was in place. The nurse was the lead for IPC and had completed the required training for the role and, when they could, attended the quarterly Defence Primary Healthcare (DPHC) IPC meetings. However, this was very dependent on internet availability.

The annual IPC audit has been broken down to be completed over a 12 month programme and documented on the audit calendar. The last audit was completed in February 2024 and actions were discussed at governance meetings. It was noted during the inspection that neither the PCRF nor the main station gym (used for a direct access physiotherapy clinic) formed part of the IPC audit as no permanent physiotherapist was in post. The nurse added the PCRF onto the audit template.

The medical centre did not have a designated isolation area for patients with contagious illnesses. However, patients who did need to come into the medical centre were requested to wear a face mask (available at the front door and in clinical rooms) and were allocated an appointment at the end of the clinic. Patients were encouraged where possible to have a telephone consultation first.

The last deep clean of the practice was undertaken in November 2023 and was scheduled to take place again in May 2024 (every 6 months). There were individual cleaning schedules displayed throughout the practice for each area. The nurse conducted a monthly review of the cleaning standards within the medical centre. On completion, they completed a quality review document and sent the competed document to the cleaning

company manager. A copy of quality review document was held within the IPC folder kept in the treatment room. The cleaning manager also conducted a review of the cleaning standard each month. The cleaners signed daily check lists which were located within the cleaner's cupboard and on inspection, the daily checks were up to date.
Healthcare waste was managed via the station waste manager. The disposal of healthcare waste on unit was currently on hold as there was no working incinerator to dispose of healthcare waste as it has been out of action for approximately 3 weeks. Investigations were ongoing to reinstate the previous contact for healthcare disposal with the local abattoir and this had been documented in the issue register.
The medical stores department were responsible for monitoring the storage of clinical waste and when there were enough bags in storage to fill the metal storage container that was used for transferring the waste, an appointment was arranged with the supply squadron for collection. The clinical waste bags were then transferred into a metal container ready for stores to collect. A hazardous waste transfer note was raised stating the amount and description of the clinical waste for collection. However, on review of previous consignment notes, there was no signature from the department or person collecting the waste or any further correspondence relating to the clinical waste being removed from the medical centre. The last annual waste audit was conducted in November 2023 with no issues raised.

The exercise rehabilitation instructor (ERI) was responsible for managing servicing of physical training equipment and all physiotherapy kit was managed by medical stores. The main gym used by the PCRF and all equipment was managed by the station physical training instructors. Servicing dates were synchronised between the gym and the PCRF. All equipment had been serviced and was in good working order.

There were effective processes for the management and action of Medicines and Healthcare products Regulatory Agency (MHRA) and National Patient Safety alerts. Evidence was seen of an in date electronic MHRA Alert register and that the practice had a system in place to ensure that they are receiving, disseminating, and actioning all alerts and information relevant to the practice. The register documented what action (if required) had been taken alerts were discussed in the clinical meeting and there was a link to the MHRA register in the minutes for non-attendees to access and view in the recent (2024) meeting minutes.

Valproate (medicine to treat epilepsy and bipolar disorder) searches were regularly undertaken. There were no patients prescribed this medicine at the time of the inspection. An antimicrobial audit was completed annually.

Risks to patients

The leadership team acknowledged that achieving the correct staffing level and skill mix was a challenge with several issues impacting staffing levels. There were 2 full time doctors working in the medical centre and a GP trainee who was working under supervision. Between them the SMO and Deputy Senior Medical Officer (DSMO) covered the 24hr on-call, when the GP Registrar was on call a doctor was still required to be on call to supervise. This team provided a broad spectrum of care including primary healthcare,

pre-hospital emergency care (PHEC), Out of Hours, chronic disease management, screening of contractors, and airfield cover. This small team faced challenges in providing the necessary level of healthcare with a growing population (both its size and level of medical complexity). An example of this was the lack of paediatric care on the Falkland Islands, with no paediatric service at King Edward Memorial Hospital (KEMH) and British Forces South Atlantic Islands (BFSAI) having approximately 40 children within the population. Doctors were often working late or going into work at the weekends to complete governance tasks and administrative work. This was recognised by the clinicians and wherever possible they tried to ensure an administrative session was planned in for them following a weekend on call. However, with a busy weekday on call there was often no opportunity to properly rest. The impact of the on call was discussed with the doctors and the impact of the lack of sleep noted by the clinicians.

The SMO was assigned for 1 year, the pharmacy technician (PT) was assigned for 2 years, the Royal Navy and Army medics were assigned for 6 months and all other posts were for 4 months. If unexpected sickness absence occurred and due to the remote location there was no cover available, this would fall to the other doctor covering 24hr on call. Though there was an aspirational half day standdown after a weekend of cover, this rarely got used due to capacity requirements.

There were currently no staffing gaps within the medical centre. The next personnel due assignment were 3 Army medics and all replacements had already been informed of their assignment. All duty medical personnel were battlefield advanced trauma life support (BATLS) trained in order to perform the role of duty medic. Shortfalls such as rest and recuperation (R&R) for those on 6-month assignments or staff absence due to sickness were managed within the medical centre by assigned deputies where possible.

There was a Regimental Infantry Battalion (RIC) on site which had 3 medics assigned. They had their own DMICP system and conducted their own urgent care clinics (known as sick parades). Anything outside their scope of practice or that required escalation was referred to the medical centre. They worked independently of the medical centre and the medical centre was not established to assist with any of the RIC exercises.

The PCRF was fully staffed with 1 ERI and 1 physiotherapist. The physiotherapist was a band 6 on a locum contract until June 2024. This post should be a band 7 military post but this post remained vacant.
Staff were aware of where the emergency trolley, kits and medicines were located. Medicines in the emergency trolley had been checked monthly and medicines and medical consumables were in date. The oxygen cylinder was full and in date. The emergency trolley was secured with a serialised tag, a record of when the tag was opened was maintained. A blood glucose monitor was held on the trolley and regularly checked. The control test solutions were in date. The ambient temperature was monitored in accordance with policy for temperature monitoring. The emergency treatment room also had a blood glucose testing meter and a CardioChek Plus Test System in place. In accordance with DPHC direction, the CardioChek Plus Test System is the glucose meter that should be used but staff had yet to receive training in its use.

A comprehensive training programme was in place, including recognising the deteriorating patient, heat illness and moulages and emergencies. All medics were required to complete the heat injury prevention course. All medics were also required to complete BATLs and the integrated emergency care programme (IECP) prior to arriving which covered all aspects of medical emergency training. Sepsis training was last conducted in October 2023. However, due to the staff turnover, it would be best practice for this to be conducted more often. There were sepsis red card protocols in all clinical areas for all the different age groups.

Wet Bulb Globe Temperature checks to indicate the likelihood of heat stress were undertaken. An automated external defibrillator (AED) was kept in the medical centre and all staff knew where it was located.

Waiting patients could be observed at all times by staff working on the front desk. A television was located in the main waiting areas to reduce the possibility of conversations being overheard. Confidentiality posters were also displayed in the waiting area.

A lead was identified for the co-ordination of the Aeromedical Evacuation (AE) service, the medically supervised movement of patients by air to and between medical treatment facilities. A Digital Aeromed Referral Platform (DARP) was used to initiate and monitor AE. We were advised that effective lines of communication were in place with the AE team based in the UK. A total of 37 AEs had taken place between January and February 2024 with no undue delays. Other members of the team were trained to co-ordinate AE in the absence of the lead and guidance/instructions were available to reference. King Edward Memorial Hospital (KEMH) was situated 35 miles from Mount Pleasant complex (MPC) and it took approximately 1 hour to transit to the hospital in an ambulance. KEMH was a GP led facility that equated to a cottage hospital in the UK. It was scaled for 6 doctors but generally ran with only 4, 1 general surgeon, 1 anaesthetist and a team of nurses who ran the accident and emergency department. KEMH had the facility to bed down up to 27 patients and could generate up to 2 high dependency beds. They had an X-Ray department that offered CT scanning, x-ray and ultrasound scans. There was a memorandum of understanding in place with KEMH, but their capabilities were limited and the nearest major trauma units were in either Montevideo in Uruguay or Punto Arenas in Chile.

Information to deliver safe care and treatment

The practice used DMICP ‘deployed’ DMICP(D). This system had reduced functionality compared to the UK patient records system and the medical centre had experienced challenges around access, this was often dependent on the local server and the system slowed down through the day making some tasks impossible. This meant clinicians were sometimes coming into work to do additional work in their own time. The management of DMICP outages and freezes was documented within the business continuity plan and this was last updated in August 2023. In the event of a DMICP issue, the medical centre reverted to the usage of the paper copies and these were then scanned onto the system once DMICP was back up and running. The duty medics printed off the appointment lists each night for the following day. The nurse had a workaround to mitigate any potential

outages, all blood forms were pre-printed and paper medical records were used. Any vaccination appointments were cancelled. Due to outages, the nurse often worked over a weekend to access SharePoint and other MOD sites.

PCRF staff were unable to hold an administrative list on DMICP(D) and therefore had to manage a separate Excel database for patient management. This was password protected but we noted was not held in a limited area. The ERI had been given physiotherapy permissions on DMICP (D) to enable access to doctors' consultations. This was needed particularly if the physiotherapist was unavailable.

A process was in place for the summarisation of patient records. Only patients in continuity posts over 6 months had their notes summarised. These patients were identified during the medical registration process which all personnel were required to complete prior to arrival. These documents were collected by the medical staff in the terminal on their arrival. If an individual was on a continuity post, the medical centre would submit a request for their civilian records.

Arrangements were established for the auditing of clinical record keeping. The doctors peer reviewed each other's records on a regular basis. An audit of all clinicians' notes had been completed and no issues were found. Consultation records completed by medics were reviewed by the doctors. The physiotherapist and ERI reviewed each other's notes every 6 months. We reviewed a wide range of DMICP records and found record keeping was of a very good standard.

One of the medics was responsible for the management of the referral register and tasks were received via the task box on DMICP (D). The referral register consisted of referrals to the KEMH, UK hospitals for personnel in continuity posts and for tracking electrocardiogram reports that were returned to the UK for onward reporting. The referral register was monitored daily and any outstanding referrals were followed up on a weekly basis. All referrals and correspondence to external departments were sent and received via email. Evidence of outstanding referrals were recorded within the register. We noted that if the responsible person was absent for a prolonged period or away, there was no-one delegated or trained to conduct their duties or able to access their task box on DMICP(D).

Communication with the Department of Community Mental Health (DCMH) and the PCRF was done via DMICP (D) using tasks and verbal communication within the medical centre. For external communications with specialists, this was done by PANDO and uploaded onto DMICP and by email to specific specialists. Though PANDO communications were routinely uploaded to the patient records, this was not the same for emailed communication with specialists other than a conclusion or summary of the records or summary of actions. (PANDO is a tool for secure collaboration and teamwork which allows clinicians to access Subject Matter Expert SME advice and share clinical decision making in order to provide the most appropriate care for patients).

A process was established for the management of samples. Specimens were requested by the doctor or nurse (for cytology and sexual health screening) and a request form was printed prior to the appointment to account for any IT/ DMICP outages. All samples were documented on DMICP and in the specimen register. Routine samples were processed at

KEMH. However, if the test was unable to be processed at KEMH, then the sample was sent and processed in the UK. There was no access to Path Links. Results were sent via email to the group mailbox and on receipt the medics printed the results and tasked the requesting doctor to review along with completing the specimen register to record the results had been returned. The nurse checked the specimen register for any outstanding results and contacted the laboratory if any are missing. A 100% check of the specimen register was completed every week. Cytology samples were sent via special recorded delivery and processed at the laboratory in Wolverhampton, results took approximately 2-3 weeks to be returned. Cytology results were received via the group mailbox and the nurse actioned them.

Safe and appropriate use of medicines

The Senior Medical Officer (SMO) was the lead for medicines management. The pharmacy technician (PT) was responsible for the day-to-day management of the dispensary and this was reflected in their terms of reference.
Patient Group Directions (PGD), which authorise practice nurses to administer medicines in line with legislation, had been signed off. We checked the PGD medicines and all were in date. A check of DMICP confirmed that the PGD template was being used. The nurse was in date for PGD training. To ensure PGD's were in date, the nurse had the expiry dates noted on the white board in the treatment room. The nurse recently undertook a satellite clinic on board a ship located nearby in Mere Harbour as it was deploying at short notice. Notes for the personnel were scrutinised first, prescriptions raised and signed by the doctor and the vaccinations were administered on the ship.

The PT had access to the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events and incidents. All incidents reported were logged through the ASER system.

An electronic near miss log was in place. Two near misses were recorded between July and December 2023 which evidenced the use of the log in practice. Through discussion of the two near misses, the PT understood the importance of using a near miss log in the dispensary and sharing the learning with the wider team.

There were clear processes in places for the transfer of care from secondary to primary care. We discussed the process with the PT and were assured that notification of changes to medicines by other services were scanned onto the patient's record and the nominated doctor tasked to action or review the patient. If notifications or changes were urgent, the patient was reviewed by a doctor.

An effective process was in place for requesting and issuing repeat medicines. From discussion with the PT and a review of patient records, it was evident that the repeat prescription standard operating procedure was being followed correctly. The PT showed good awareness of their responsibilities, including when requests should be tasked to a doctor. Repeat prescriptions were only issued if the patient's review date was in-date and there were available repeat counts on the patients prescribing record.

A check of dispensed repeat prescriptions showed that all repeat prescriptions were dispensed within 8 weeks. This indicated patients were informed when prescriptions were ready for collection. Uncollected medicines were returned to stock.
From discussion with clinicians and a review of patient records, we were assured that patients' medicines were appropriately reviewed, including treatment and clinical medicine reviews.
It was evident well defined processes were in place for the ordering and receipt of vaccines. All vaccines were in date and were routinely rotated in the fridge. The temperature of the fridges was monitored twice a day and the external thermometers were in-date.
We checked a range of prescription only medicines, vaccines and medical consumables and all items were in date. Evidence of effective stock management was seen with the medicines with the shortest time expiry placed at the front of the shelf. Expired medicines were destroyed using the appropriate pharmaceutical clinical bins.

Controlled and accountable medicines were kept in the controlled drug (CD) cupboard in the dispensary. A check of physical stock and documentation in the CD register (BMed 12) showed accounting of controlled and accountable medicines was accurate.
There was a local working practice in place to advise on accessing the dispensary and CD cupboard if required out of hours. The practice had a key press that held the CD/accountable drugs keys was a log controlling the access of the dispensary and CD keys. The CD keys were kept separate from the dispensary keys.

There was a CD destruction certificate in place and it was in date. A review of the most recent destruction certificate (March 2024) confirmed that accountable and controlled drugs were being destroyed in accordance with policy.

The practice had very few patients prescribed high risk medicines (HRMs). Given the transient nature of the patient population it was evident that the HRM register was in place as a tool to support safe management. We noted there were patients that were listed on the HRM register that had left the island. However, due to the transiting nature of the population, it was considered safer to have these patients listed on the register in preparation for their return. Searches were run by the PT and any new patients were highlighted to a doctor. We reviewed 3 patients on the HRM register and we noted they did not have the correct clinical code added, this was actioned after the inspection. From the five notes reviewed, it was evident that appropriate and timely blood monitoring had been undertaken for patients prescribed HRMs and that those that needed a review had been booked in with a clinician to discuss the results and or further actions.

All staff knew where the emergency medicines were located. The medical centre had 2 emergency trollies, and both were secured with a serialised tag. All medicines held on the emergency trolley were checked and were in date. We noted the emergency trolley held several medicines from the primary care optional drug list that were not documented on the emergency drugs risk assessment in accordance with policy.

The system used for the transfer of medicines to Mount Alice showed some stock discrepancies had occurred with the over-labelled medicines. The quantity requested in December 2023 did not reflect the quantity booked out of the dispensary or the quantity documented at Mount Alice.

The oxygen cylinder was full and in date. The medical gas store was clean and the empty cylinders were segregated in the gas store. No smoking signs were present on the gas store. Appropriate Hazchem signage was displayed on the doors holding the gases. Expiry date checks were being completed monthly and there was evidence that time expiry reports were being run monthly for all medicines held on the emergency trolley DMICP(D) list.

Valproate (medicine to treat epilepsy and bipolar disorder) searches were regularly undertaken. There were no patients prescribed this medicine at the time of the inspection. An antimicrobial audit was completed annually.

Track record on safety

The practice manager was the designated lead for risk management. A register of up-to-date risk assessments covering all aspects of patient/staff safety was in place, including lifting/handling, lone working, COVID-19 and Control of Substances Hazardous to Health (COSHH). COSHH products were stored appropriately. The ERI carried out the risk assessments for the PCRF.

Measures to ensure the safety of facilities and equipment were in place. Water safety checks and a legionella risk assessment were regularly carried out. A fire risk assessment of the building was undertaken every 5 years and was in date. Firefighting equipment tests were current. Staff were up-to-date with fire safety training and were aware of the evacuation plan.

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

There was a business resilience plan (BRP) in place that had been reviewed in August 2023. The BRP provided a means of ensuring the continuation of the medical centre's functions in the event of a peacetime disaster affecting the infrastructure and/or its personnel. Examples of a disaster could be fire, flood, total IT failure or terrorist attack.

A risk register and issues log was in place for the practice. Risks were appropriately managed in accordance with the 'four T's process' (transfer, tolerate, treat, terminate). The register was reviewed each month and updated accordingly at the management meetings. Alarms were present in each clinical room. The panic alarm was activated in the treatment room during the inspection. Despite there being evidence within the HcG Wb that the alarms were conducted monthly no-one responded for approximately 3 minutes as all staff thought the alarm was relating to the fire alarm system and left the medical centre to muster at the fire assembly point.

Lessons learned and improvements made

The practice manager was the lead for the management of significant events. All but 2 staff had access to the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events and incidents (this was being actioned by the regional team). A comprehensive ASER register was maintained, we saw there were 3 ASERs recorded and all were being managed within the stated guidelines. We noted the tracker in the HcG Wb required updating to account for the ASERs on the live system and to account for those that had been recently discussed during the HcG meeting. ASERs were a standing agenda during the HcG meeting which was attended by all members of staff. We saw an ASER that demonstrated the duty of candour had been applied relating to a medical risk assessment that had been sent to the incorrect individual.

An effective process was in place for the management and action of Medicines and Healthcare products Regulatory Agency (MHRA) and National Patient Safety alerts. The electronic MHRA alert register was current and a system was in place to ensure the practice received, disseminated, and actioned all alerts and information relevant to the practice. Practice meeting minutes showed alerts were discussed.

Are services effective?

We rated the practice as good for providing effective services.

Effective needs assessment, care and treatment

Processes were in place to support staff to keep up-to-date with clinical developments including National Institute for Health and Care Excellence (NICE) guidance, clinical pathways, legislation and standards. New or updated guidance was reviewed at the monthly clinical meetings attended by all clinical staff and the pharmacy technician. During the last meeting ovarian cancer, hearing loss in adults, thyroid disease, pneumonia and familial breast cancer were discussed. In addition, staff were kept informed of clinical and medicines updates through the Defence Primary Healthcare (DPHC) newsletter circulated each month. Clinicians regularly referred to 'NICE Clinical Knowledge Summaries' and updates to these were also discussed at the meetings.

The primary care rehabilitation facility (PCRF) had the necessary equipment and space needed to deliver an effective service. New patients were assessed by the physiotherapist and the exercise rehabilitation instructor (ERI) at their first appointment so that joint treatment planning could be done. The physiotherapist referred to the Department of Defence Rehabilitation to ensure best practice guidance was being followed.

Patients with a mental health need were supported by the medical centre with initial interventions which included sign posting to mental health resources and support, the padre service, third sector support, welfare support, a welfare psychologist based in Port Stanley and routine prescriptions. For enhanced mental support, clinicians could make remote referrals to the Department of Community Mental Health (DCMH) in the UK.

Monitoring care and treatment

The Deputy Senior Medical Officer (DSMO) was the lead for chronic disease. A standard operating procedure (SOP) was in place for each chronic disease to ensure consistency of management. The nurse monitored patients with long-term conditions (LTC). At the time of the inspection, the medical centre did not have an LTC register, instead monthly DMICP searches were undertaken and patients recalled as necessary. The nurse had completed online updates to ensure their knowledge was current.

Where chronic disease reviews had been undertaken, they were of good quality and the appropriate templates had been used. There were 72 patients recorded as having high blood pressure. Records showed 50 patients had their blood pressure taken in the past 12 months. Of the 50 patients, 28 patients had a blood pressure reading of 150/90 or less. There were 22 patients with a diagnosis of asthma. All patients were offered an asthma review in the last 12 months, 17 had been reviewed, others declined but were regularly recalled. A consistent asthma review template was used. There were 47 patients on the diabetic register. For 40 patients, the last measured total cholesterol was 5mmol/l or less

which is an indicator of positive cholesterol control. For 46 patients, the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control. Our review of a range of patient records showed patients with chronic conditions were recalled and monitored in a timely way appropriate to their needs.

Audiology statistics showed 98% of patients had received an audiometric assessment within the last 2 years. Our review of patient records showed Joint Medical Employment Standards (referred to as JMES) were appropriately managed.
The audit programme was overseen by the DSMO. The nurse was the deputy audit lead. There was an audit calendar held on SharePoint with the year split into quarters. The nurse had completed an IPC audit, yellow fever, consent and cytology audits. The audits reviewed were clear, followed a structure and identified some opportunities for good practice and or improvement.

On review of the audit plan, 28 audits scheduled between January and March 2024 had not been completed. Whilst clinical audits had previously been completed there was little evidence of clinical actions undertaken or responsiveness to specific nuances of the population group within the audit/reaudit cycle. For example, managing chronic disease was highlighted by the medical centre as an area of concern to the CQC team. There was a hypertension audit documented from June 2020 that highlighted required improvements in targeted outcomes. A reaudit in March 2023 showed a 100% increase in number of new hypertensive patients and a deterioration in targeted outcomes. A reaudit due in March 2024 was postponed due to capacity.

The range of PCRF clinical records we looked showed evidence of multi-disciplinary discussion. The Musculoskeletal Health Questionnaire (MSK-HQ) was the standardised outcome measure for patients to report their symptoms and quality of life. Rehab Guru (software for rehabilitation exercise therapy) was difficult to use because of Wi-Fi connectivity on island. Exercise programmes were produced, monitored and adjusted on DMICP and then printed off and given to the patient. The team within the PCRF took a holistic view of patients' needs including, mood, sleep and lifestyle. The team planned to put together an audit schedule as there had been no audit or service evaluation within the PCRF in the past 12 months. We saw that referrals to the Regional Rehabilitation Units were made promptly with manageable wait times for the patients.

Effective staffing

The DPHC induction programme was used by the medical centre. However, the medical centre felt that the induction needed to be streamlined and profession specific. They had recently updated the locum induction and intended to implement further changes to the others in the near future. Additional to this a dispensary induction was in place for every doctor that joined the medical centre and a comprehensive SOP supported this induction activity.

On induction, all staff completed an individual competency proforma. From this, an individual training package was created for the individual to further develop, enhance their skillset and address any training deficiencies.

Due to the frequent staff changes on and off island, all personnel were responsible for ensuring their individual and job specific handover notes were updated prior to the arrival of the new incumbent to ensure all corporate knowledge was captured to enable a smooth handover and transition into the new role. The medical centre had a portfolio management spreadsheet in place which contained links to all SOPs for the various areas within the medical centre. All staff were able to access this spreadsheet and were responsible for the upkeep of their specific areas whilst they were in post. However, there had been no full or formal handover between this incoming and outgoing physiotherapist and ERI only a small amount of patient information was left as written notes and they both started in post on the same day. Both staff said the medical centre induction was comprehensive but lacked detail for the PCRF specifically.

The medical centre had a comprehensive trade training programme in place to ensure all staff remained competent when dealing with emergency situations. Due to the austere conditions and remote location, trade training was adapted to ensure all staff received regular and relevant training. Training provided on a weekly basis over the past few months included:

- Skills practice (Intravenous infusions training).
- Extraction.
- Major incident which involved 17 real life casualties and all available medical personnel deployed to the scene and were actively involved with the management of the casualties.
- Major incident training.
- Ejection injuries.
- Skills Practice (equipment care).
- There was a forecasted training programme in place so that all personnel were aware of future training opportunities which also provided the staff with the opportunity to research and present topics.

Clinicians had the appropriate qualifications to meet the needs of the patient population. For example, both doctors were qualified Military Aviation Medical Examiners.
All staff were assigned mentors on arrival whilst they transition to life at Mount Pleasant Complex. All military members of staff received an appraisal on completion of their detachment which also included a mid-term report. The medical centre at the Falklands was administered by the DPHC overseas team. There was little to no peer support within the region available. However, there have been informal linkages created with other overseas clinicians to share learning especially around challenges unique to overseas practices. The nurse had no formal peer review but did participate in case discussions with the multidisciplinary team, actively networked with the clinical team in the Falklands and also with nurses who had previously been posted to the island. The overseas team did organise meetings for the overseas nurses, however participation was reliant on connectivity.

The locum physiotherapist had no formal line management, no appraisal and no professional support other than ad hoc contacts with people they knew in the UK. They

were able to reach back to the regional rehabilitation unit if needed for remote support but no formal arrangements for supervision or peer support were in place. The ERI had communication with overseas Regional Trade Service Advisor.

Coordinating care and treatment

The medical centre staff met with welfare teams and line managers to discuss vulnerable patients. Staff told us that they had forged some good links with other including the local hospital, health visiting service, and the midwife. There were good lines of communication established with the individual units. There were good streams of communication with staff in the PCRF and multidisciplinary meetings were inclusive.

Helping patients to live healthier lives

Clinical records we reviewed showed that supporting patients with healthy lifestyle options was routine to consultations where appropriate.

Measures used to share health promotion information widely included through the mess, through the British Forces Broadcasting Services (BFBS), a monthly newsletter and via the Facebook page.

Health and lifestyle information was available throughout the patient areas of the building. Displays included ovarian cancer, mental health and chronic diseases.

The nurse was trained in sexual health having completed the Faculty of Sexual Health training. All eligible female patients were on the national cervical screening database and were recalled by the nurse. The latest data confirmed an 88% uptake, the NHS target was 80%. Regular searches were undertaken to identify patients who required screening for bowel, breast, and abdominal aortic aneurysm in line with national programmes. Alerts were added to their DMICP record which allowed for opportunistic discussion with a health professional. DMICP searches had been created for all national screening.

The nurse worked closely with the health visitor based at the local hospital for the recall of children. Immunisations were given as per the UK schedule including chicken pox due to the remote location. The health visitor was responsible for re-calling the children and ran regular health development check clinics at the medical centre, the nurse supported the health visitor and updated DMICP records as the health visitor vaccinated.

Vaccination statistics for children:

- The percentage of children aged 1 who had completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (i.e., 3 doses of DTaP/IPV/Hib/Hepatitis B) was 100%.
- The percentage of children aged 2 who had received their booster immunisation for Pneumococcal infection was 100%.

- The percentage of children aged 2 who had received their immunisation for Hemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e., received Hib/MenC booster) was 100%.
- The percentage of children aged 2 who had received immunisation for measles, mumps and rubella (one dose of MMR) was 100%.
- The percentage of children aged 5 who had received immunisation for measles, mumps and rubella (two doses of MMR) was 100 %.

Vaccination statistics for service personnel:

- 100% of patients were in-date for vaccination against diphtheria.
- 100% of patients were in-date for vaccination against polio.
- 100% of patients were in-date for vaccination against hepatitis B.
- 98% of patients were in-date for vaccination against hepatitis A.
- 100% of patients were in-date for vaccination against tetanus.
- 100% of patients were in-date for vaccination against mumps, measles, rubella.
- 95% of patients were in-date for vaccination against meningitis.

Consent to care and treatment

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. Implied consent was used. The clinical records we looked at showed consent was obtained from patients where required.

Clinicians understood the Mental Capacity Act (2005) and how it would apply to the patient population group. Clinicians were aware of both Gillick competence (young people under 16 with capacity to make a decision) and Fraser guidelines (advice/treatment focused on a young person’s sexual health).

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

We saw the most recent patient satisfaction survey showed that 90% of all respondents indicated staff treated them with kindness, respect and compassion. We spoke with 3 patients they all complimented the care they received and praised the staff.

Patients could access the welfare team and various support networks for assistance and guidance. Information regarding these services was available in the waiting areas and the clinical staff were fully aware of these services to signpost patients if required. We spoke with 3 members of the welfare service, who said staff at the medical centre were always available when needed and were kind and compassionate. An example given was patients sometimes experienced difficulties returning 24 hour blood pressure monitoring equipment due to the location of the medical centre being timely to get to, so often the nurse would collect these from the patients to save them a journey.

Involvement in decisions about care and treatment

Our review of clinical records and patient feedback about the practice indicated patients were actively involved in the planning of their treatment and care.

Staff explained that they rarely saw patients who spoke English as a second language but they could access a translation service if they needed it.

Privacy and dignity

There were confidentiality signs displayed in the waiting area informing patients that if they wanted to speak to a member of staff in confidence they could ask at reception. This was also documented within the practice leaflet. There was a television in the main waiting area which helps minimise conversations being overheard.

Consultations took place in clinic rooms with the doors closed. Privacy curtains were used when patients were being examined.

The assessment and treatment area within the Primary Care Rehabilitation Facility (PCRF) was in a separate clinical room which was open plan with curtains so conversations could be overheard. This had been mitigated by having music playing. The exercise rehabilitation instructor (ERI) and physiotherapist undertook joint assessments of new patients in this room so only 1 patient was in at a time for such appointments. There was also a small separate private gym area within the PCRF. Staff also had the option to use a

private office for confidential conversations. The ERI worked from the main station gym in afternoons so allowing more privacy for the physiotherapist if required.

Are services responsive to people's needs?

We rated the practice as good for providing responsive services.

Responding to and meeting people's needs

The medical centre offered a 24 hour 7 day a week service for patients. Anyone requiring an urgent appointment was triaged on the day by the duty medics and referred to the doctor if required. Out of hours, the medical centre was staffed by 2 duty medics and an on-call duty medical officer. Telephone appointments were available for those patients working at the remote locations this included calls with the nurse for health screening and smoking cessation support for patients.

The medical centre was responsive to the patient population needs when planning clinics. For example, the uptake of the annual flu vaccines was low due to location and opening times of medical centre so drop in clinics were planned to run in another area closer to patient's living areas for ease of access and at different times of the day to cover those patients' working shifts. This was widely advertised throughout the camp.

The deputy practice manager was the designated lead for equality and diversity. The medical centre had a diversity and inclusion board situated outside the nurse's office which displayed information and other useful links.

The medical centre identified the needs of patients with protected characteristics under the Equality Act 2010. For example, an alert was noted on the patient's medical records to identify any gender reassignment, this would include details of how the patient would like to be addressed. A unisex toilet was available in the medical centre as well as specific male and female toilets.

An Equality Access Audit as defined in the Equality Act 2010 was completed in March 2024 by the current practice manager. Since the previous audit in November 2023, the toilet situated next to the gymnasium had been assigned as a designated toilet for patients with mobility issues. However, the audit stated that there were no grab rails fitted in the appropriate positions or that the toilet was accessible from right and left sides. The practice manager stated that a work service request to install handrails into the disabled toilet needed to be submitted.

Timely access to care and treatment

Doctors offered face-to-face consultations and telephone appointments. Patients requiring emergency care were offered an appointment on the same day. Routine appointments could be accommodated within 1 day. Appointments with the nurse were usually available on the day or if not the next day.

Patients had the option to make a direct referral to physiotherapy. An urgent appointment with physiotherapist could be facilitated on the day the request was made and a routine appointment within 2 days. A new patient appointment with the exercise rehabilitation instructor was available within 2 days.

Following a patient giving feedback a direct access clinic into physiotherapy was initiated in the gym on the camp. The patient said the medical centre was a long way to go for an initial appointment and wanted somewhere closer to be seen. Whilst this was effective in meeting this patient's needs further consideration needed to be given to ensuring confidentiality and privacy in the gym area and in improving management and security of patient's notes.

Listening and learning from concerns and complaints

The practice manager was the lead for complaints. Complaints were managed in accordance with Defence Primary Healthcare policy and local procedure. The complaints procedure was outlined in the practice leaflet and displayed in the patient waiting area. Two complaints had been received in the last 12 months. We discussed these with staff and it was clear they had been appropriately addressed and to the satisfaction of the complainants. Complaints were discussed at the practice meetings.

Are services well-led?

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

Vision and strategy

Staff we spoke with were clear that their remit was to support patients to benefit from the best possible healthcare outcomes which, in turn, supported operational capability. The medical centre worked to the Defence Primary Healthcare (DPHC) mission statement which was:

‘DPHC is to provide safe, effective healthcare to meet the needs of our patients and the chain of command to support force generation and sustain the physical and moral components of fighting power’.

The medical centre also worked with the British Forces South Atlantic Islands (BFSAI's) mission statement:

> ‘To deter any military action against the South Atlantic Overseas Territories’ by ensuring the practice outputs meets the needs of the population at risk and that personnel maintain their operational effectiveness whilst employed in the Falkland Isles’.

There was clear engagement and support from the medical centre to support the Primary Care Rehabilitation Facility (PCRF). However both staff within the PCRF had only been in post for approximately 6 weeks and no vision or plans for the department had yet been made. The lack of a comprehensive handover and lack of continuity had left the PCRF lacking in development planning. The PCRF staff were engaged and committed and were hoping to improve this moving forward.

There was no evidence that the medical centre held a practice development plan to continue to keep driving the practice forward. This was acknowledged by the practice manager who said they would use the findings of this report as a tool to steer the development of an improvement plan.

The medical centre actively promoted the need to recycle and there were many recycling bins around the building. They were also trying to reduce paper wastage within the medical centre where possible.

Leadership, capacity and capability

The medical centre was a cohesive and joined up practice. All members of staff we spoke with were genuinely engaged and supportive of the practice vision. The practice management team were clear, transparent and accountable and they recognised their limitations and were working within these. This was demonstrated within the attitudes to learning and training using skills need assessments when new staff arrived and exit interviews used for reflection and further planning.

Staff were clear that their remit was to support patients to benefit from the best possible healthcare outcomes which, in turn, supported operational capability. Nevertheless, the medical centre leadership team were concerned with the delivery of a full primary care service and the additional requirement to lead the Pre-hospital emergency care (PHEC) service extended beyond the reasonable capacity of key individuals. The 2 doctors were providing primary care to military personnel, their families and children and contractors during office hours and were then providing out of hours and PHEC cover in addition.

We found that the leadership team worked well together and demonstrated high levels of experience, capability and resourcefulness to provide a person-centred, responsive and sustainable service for the patient population. The Primary Care Rehabilitation facility (PCRF) team felt integrated into medical centre and both felt that the doctors ran a truly 'open door' system.

There was a role and responsibility list in place which detailed the designated leads and nominated deputies for each of the key positions within the medical centre. The Senior Medical officer (SMO) was the clinical lead for the medical centre and the Deputy Senior Medical Officer (DSMO) deputised in their absence.

The following positions within the medical centre offered continuity:

- SMO (1 year)
- Pharmacy technician (2 years)
- Army and Navy medics (6 months)
- RAF medics and the and the exercise rehabilitation instructor (ERI) (4 months)

All other positions within the medical centre were for a 4 month duration. The physiotherapy role was covered by a locum, who might be replaced by a military physiotherapist on a 2 year continuity tour. The SMO and practice management posts were the key leadership and managerial positions within the practice and both roles had allocated deputies to provide continuity if required. Only personnel assigned to the Falkland Isles for a 6 month or greater deployment were entitled to 2 week rest and recuperation leave. This leave was staggered between personnel to ensure practice outputs were maintained in their absence. DPHC regional headquarters were supportive with request for locums or initiating trawls to cover key positions.

Culture

It was clear from patient feedback and interviews with staff that the needs of patients were central to the ethos of the practice. The team provided a seamless tri-service approach to care and were responsive to the needs, at times differing needs, of the 3 services, and also to the large cohort of civilian patients.

The medical centre adopted a no blame culture along with an open-door policy in place. The staff felt valued and described a good working and friendly ethos throughout the team.

All staff were encouraged to attend group physical training sessions on a Tuesday and Thursday afternoon. In the evenings, the team regularly got together to undertake group activities such as cinema nights or bowling. In April there is a medical centre charity walk arranged to support the Head Up charity.

All staff were invited to attend the practice and healthcare governance meetings to further their development and actively participate in delivering optimal healthcare for their patients.

All staff had access to the ASER system and were able to demonstrate they could access the system. Staff were encouraged to try to resolve issues and felt they could raise concerns at all levels. A whistleblowing policy was in place and this was read by all staff during their induction.

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.

Governance arrangements

A portfolio management spreadsheet contained a link to all of the terms of reference (TORs) held within the medical centre, these had all been reviewed in July 2023. All personnel were issued their TORs on arrival as part of the induction process. This was evidenced on review of the completed induction packs and individual folders held by personnel. There was a list of the key roles and responsibilities for all leads and deputies throughout the medical centre in the clinical and administration rooms.

- A range of formal and informal meetings were held to ensure effective communication and information sharing across the staff team. The monthly meeting schedule included management, healthcare governance (HcG) ASER/audit and clinical multidisciplinary meetings. The medical centre holds the following monthly meetings:
- Practice and Healthcare Governance meeting - attended by all staff
- Clinical Meeting / Welfare – attended by all clinical staff
- Remote Radar Heads (RRH) – attended by the deputy practice manager, aeromedical evacuation liaison officer, Mount Bryon and Mount Alice medics, Junior Non Commissioned Officer (JNCO) Aeromed and the Unit Medical officer (UMO).
- Junior’s meeting (JNCO and below)
- Service Personnel Support Committee (SPSC) - attended by the SMO, Padre, SSAFA social worker, officer commanding personnel management squadron and the chief clerk
- The DPHC RHQ Oversea holds a BFSAI quarterly governance meeting which is attended by the Regional Clinical Director (RCD), HcG Lead and the BFSAI PM.

The practice manager was responsible for ensuring the healthcare governance (HcG) workbook was up-to-date. The workbook was an overarching system used to bring together a range of governance activities, including the risk register, medicine alerts, audit, health and safety and quality improvement. The workbook was clear and comprehensive and all staff had access to it.

The medical centre felt well supported by the DPHC overseas team and were aware of the different leads and who to contact if they had any issues. The regional pharmacist conducted an assurance visit in February 2024 and the last internal healthcare governance assurance visit (HGAV) was in July 2023. We noted that health assurance framework (HAF) had not been updated by the headquarters overseas team to reflect that the HGAV had been conducted. The DPHC headquarters overseas team held a quarterly governance meeting which was attended by the Regional Clinical Director (RCD), healthcare governance lead and the practice manager.

Managing risks, issues and performance

Risks to the service were well recognised, logged on the risk register, kept under scrutiny by the practice manager and discussed at the HcG meetings. The risk register was held on the HcG workbook contained 27 individual risks. The live and retired risk registers adopted the 4T approach and contained clinical and non-clinical risks. Several of these risks stated that they had been escalated or transferred, however there was no evidence that they had been accepted onto either the BFSAI or regional headquarters (RHQ) risk register. To ensure all risks were effectively managed at the correct level it was imperative that the risk manager confirmed that all risks were sitting at the appropriate level, acknowledged and updates were regularly hastened.

The business continuity plan (BCP) was reviewed in August 2023, all staff were required to read it as part of their induction. The medical element of the unit disaster plan was also read as part of the induction process and was recently utilised in the medical centre's response to the mass casualty incident in January 2024. Any changes to these policies were shared via the monthly HcG or practice meetings.

Processes were in place to monitor national and local safety alerts, incidents, and complaints. This information was used to improve performance.
The leadership team was familiar with the policy and processes for managing staff performance. Although not a concern that was indicated, were familiar with the range of processes to manage performance including welfare support, re-training, appraisal and disciplinary processes.

Appropriate and accurate information

The DPHC electronic health assurance framework (referred to as eHAF) was used in to monitor performance. It is an internal quality assurance governance tool to assure standards of health care delivery within defence healthcare. Risk management was a standing agenda item in the HcG monthly meeting. The practice manager reviewed the

management action plan (MAP) on a monthly basis. On review of the MAP there were no outstanding actions for the medical centre. However, a review of the HAF online (January 2023) revealed that there were 18 KLOEs that were graded as limited assurance. No action plan was in place to address these.

Arrangements were in place which were 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

The practice had been utilising their patient feedback to produce actions that were documented on the 'You Said, We Did' board. These included:

- A patient said that the layout of the medical centre was confusing, and they were unsure where to go. As a result directional signage was put in to make navigating easier.
- A patient said the medical centre was too far away from the main complex and there was lack of transport available. As a result a direct access physiotherapy /ERI advice clinic was now offered within the main gymnasium every Monday.
- There was a training request made to include the emergency response agencies (fire, police and the port). Multiple multidisciplinary training sessions were now in place.

The medical centre produced a monthly newsletter for the patients. It included information such as health promotion tips, vaccination updates and charity events.

Continuous improvement and innovation

The medical centre staff continually sought to improve the service for patients. There had been 3 entries on the quality improvement project (QIP) register since July 2023 and was a standing agenda item at HcG meetings. They included:

Implementation of a training needs analysis for each member of staff. Designed to identify and improve the clinical skills and confidence of medics undertaking duties. This had been incorporated into the induction programme and an individual training plan was created by for each individual.

Due to the poor connectivity, a single document had been created with all the useful main links for both facility management and to clinical information.

A review was undertaken of current procedures for implementing chronic disease management and consideration of how these could be made more sustainable in a high-

turnover workforce. A significant proportion of the registered population with multi-morbidity underwent an in-depth clinical review as part of this QIP.