Commando Training Centre Royal Marines (CTCRM) Medical Centre

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

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Summary

About this inspection

We carried out this announced comprehensive inspection of Commando Training Centre Royal Marines Medical Centre on 23 May 2024.

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

Are services safe? – requires improvement.

Are services effective? – requires improvement

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 Defence delivered healthcare under the Health and Social Care Act 2008, which also means that Defence delivered healthcare 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 Defence delivered healthcare. DMSR is committed to improving patient and staff safety and will take appropriate action against 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:

The medical centre had positive lines of communication with the units they supported and the welfare team to ensure the wellbeing of service personnel. Proactive partnership arrangements had been forged with other agencies (social services, and local authorities) in order to safeguard vulnerable personnel. Command staff we spoke with confirmed that the medical team were involved in all case conferences and that the confidentiality of patient information was upheld as far as possible unless this posed a risk to someone.

A person-centred culture was embedded to ensure patients received quality and compassionate care to meet their individual needs.

The practice worked collaboratively with internal units and departments and the local NHS to enhance the safety, welfare and wellbeing of recruits.

Multidisciplinary team meetings were held regularly and care plans for complex patients were drawn up jointly with other professionals to ensure the best care was provided.

Processes were in place to identify patients who were considered vulnerable and coding was applied on the patient record. Staff had completed safeguarding training appropriate to their role.

Patients were able to access an appointment and urgent appointments were available the same day.

Arrangements were in place for managing medicines, including obtaining, prescribing, recording, handling and disposal in the medical centre. Some aspects required strengthening.

Quality improvement activity was embedded both within the medical centre, PCRF and Hunter Troop, including various approaches to monitor outputs and outcomes used to drive improvements in patient care.

There was a system in place to manage patients with long term conditions. However, this required strengthening.

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

There was an extensive database in Hunter Company tracking outcomes of recruits who had undergone rehabilitation over the last 10 years. The database had the ability to show trends in injury profile, for example, the week of injury, location of injury and the activity associated with injury. It was able to demonstrate the likelihood of successfully completing Phase 1 training based on the week the injury was obtained. Relevant objective markers were used to progress recruits through phases of rehabilitation relative to their training requirements.

All programmes had been collated into a booklet which was an excellent resource for recruits undertaking rehabilitation. The latest version provided clear aims, explanation and criteria for progression. Programmes linked to stages of training and applied specificity by using a clear coding system. These programmes ran alongside patient individual programmes. Targeted rehabilitation and reconditioning was applied to match the Phase (1 and 2) module of recruit training as patients progressed through Pre-Alpha (assessment), Alpha (rehabilitation) and Bravo (reconditioning) groups.

The medical centre followed the most recent guidance and swiftly incorporated any changes to clinical best practice around the treatment of heat illness. This was led by the civilian medical officer (CMP) and included development of the enhanced treatment room and training updates around the management of heat illness. Work in this area included trials of equipment which monitored vital signs while troops were exercising.

The Chief Inspector recommends to the medical centre:

Ensure all staff complete training in recognising the deteriorating patient/sepsis relevant to their role.

Review the capacity and capability of the nursing team to determine whether the nursing hours and skill mix are sufficient to meet the primary health care needs of the patient population. This should also consider staff wellbeing.

Review the access to emergency medicines and equipment within the bedding down facility (BDF).

A review of the mandatory training programme should be undertaken to ensure staff have completed the DPHC required training to deliver effective care and treatment.

Ensure any temporary staff registered at the medical centre are managed appropriately in accordance with Defence Primary Healthcare policy.

Review systems and processes for medicines management to ensure they are safe, in line with DPHC policy and being followed. This should include a review of systems and processes for the management of Patient Group Directions and Patient Specific Directions and vaccine storage. The arrangement for administering medicines within the BDF also requires review.

Ensure the doctors bag/crash kit is kept securely.

The recall of patients diagnosed with a long-term condition should be reviewed to ensure the process is effective and patients are recalled in line with DPHC policy.

Better utilise the management action plan (MAP) and the issues log on the healthcare governance framework in order to secure improvements with greater efficiency.

Consider how communication across the whole team could be improved.

The Business Continuity Plan should include how vaccines are to be moved or managed during periods of block leave.

Ensure that the building is kept in good repair for the provision of primary health care and follows the guidelines issued by the Department of Health under the Health and Social Care Act 2008 infection and prevention and control of infections guidelines.

Chris Dzikiti

Interim Chief Inspector of Healthcare

Our inspection team

The inspection team was led by a CQC inspector supported by a team of specialist advisors including a primary care doctor, 2 nurses, pharmacist, 2 physiotherapists, an exercise rehabilitation instructor (ERI) and practice manager. Two new specialist advisors also attended in a shadow capacity.

Background to Commando Training Centre Royal Marines Medical Centre

Commando Training Centre Royal Marines (CTCRM) delivers all Phase 1 (initial), Phase 2 (continuation) and career course/specialist training to Royal Marines and officers, including initial training of the Royal Marines Band. All training is conducted under the Office for Standards in Education, Children's Services and Skills (Ofsted) and is continually assured by internal and external agencies.

CTCRM provides the full spectrum of primary and intermediate health care for all entitled service personnel from all 3 services, and occupational care to entitled reservists across the southwest region. CTCRM contains its own 18 bed low dependency Bedding Down Facility (BDF) staffed by registered nurses 24 hours a day, an X-ray department with a reporting radiographer, a physiotherapy department, dispensary and a large complex injury rehabilitation department.

There are no registered dependents and currently a small population of under 18-year-olds. The majority of the patient population are aged between 16 and 55. There is a high turnover of the patient population, which on the day of the inspection was approximately 2,000.

The Primary Care Rehabilitation Facility (PCRF) comprises both clinical rooms in the medical centre and the larger ‘Hunter gym’ which is approximately a 3 minute walk away. The Hunter gym hosts rehabilitation for Hunter Company; injured Royal Marines temporarily join this unit to undergo a programme of rehabilitation before rejoining training and preparing for front line combat duties.

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

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

The staff team

Position	Numbers
Principal Medical Officer (PMO)	One
Deputy Principal Medical Officer (DPMO)	One
Civilian medical practitioners (CMP)	Two (1.4 FTE)
Military Medical Officer (MO)	One
Senior Nursing Officer (SNO)	One
Ward nurses	Seven – (4 Royal Navy and 3 civilian)
Practice manager	One
Deputy practice manager	One
Administrative staff	Three (1 vacancy)
Pharmacy technicians	One
Radiographer	One
Medical Assistants	Thirteen (10 Defence Primary Healthcare and 3 field medics – 2 vacancies)
Physiotherapists	Six

Are services safe?

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

Safety systems and processes

The Principal Medical Officer (PMO) was the lead for safeguarding. Taking account of vulnerable adults and service personnel under the age of 18, the safeguarding policy was comprehensive and included the referral process and contact details for local safeguarding teams. Links to relevant organisational policies and standard operating procedures (SOP) were also included in the policy. The band 7 physiotherapist acted as the rehabilitation lead for safeguarding and provided onsite support within the Parker Hall (rehabilitation gym).

Information and contact details for local child and adult services, including for out-of-hours, was displayed throughout the medical centre. The induction pack for doctors, including locums, provided details of the safeguarding arrangements and links to policies. All staff had completed safeguarding training at a level appropriate to their role. The welfare team provided enhanced support to recruits and considered all recruits vulnerable regardless of their age. The medical centre team had an open and responsive working relationship with the welfare team with formal and informal discussions regarding vulnerable patients taking place frequently. In November 2023 Ofsted undertook a ‘welfare and duty of care inspection’ and rated the medical centre as ‘Good’.

For patients under 18 using the bedding down facility (BDF) an alert was placed on their DMICP record (electronic patient record system). When admitted to the BDF a specific bed space was used to identify them as under 18. Following on from an historical allegation made by a female patient admitted to the BDF, the doctors held a case conference and improvements had been made. Females admitted to the BDF primarily stayed within a designated isolation room with ensuite toilet facilities. Each of these rooms had a hard-wired call alarm to attract prompt attention.

The medical centre considered all new recruits as patients of concern and they were monitored closely with a low threshold for extra support. Service personnel who were posted in from other units were identified at their new patient registration. Recruits presenting with acute mental illness were discussed with all doctors prior to the daily BDF round. There was also an opportunity to discuss all patients of concern at the weekly senior leadership meetings held every Wednesday.

We spoke with the Commanding Officer (CO) of the camp and they were complimentary about the proactive approach taken by the medical team to support personnel who may be vulnerable. The care offered on the BDF to recruits was considered to be an effective safeguard to ensure minors were given the best possible care out of hours.

The Deputy Principal Medical Officer attended a fortnightly carers’ meeting as the medical representative. This meeting was run by the unit with the Adjutant who was the designated

safeguarding lead for the unit. It was also attended by the CO, Regimental Sergeant Major, padres and welfare team. The agenda for this was led by the unit and discussed the management of those service personnel on the Vulnerability Risk Management Information System as well as those who were sick at home.

A central register was held of vulnerable personnel. The PMO met regularly with the PCRF team to discuss any potential safeguarding issues for recruits transferred to Hunter Company for rehabilitation. Case conferences could be called by either the Chain of Command or the medical centre to discuss specific personnel who were considered vulnerable and at risk. A chaperone policy was in place and included the clinical codes to use for the offer/use of a chaperone. Staff (only military) who had the role of chaperone had received chaperone training. The availability of a chaperone was displayed throughout the premises although there was no list of those specifically trained staff for people to refer to.

We noted a temporary member of staff was registered as a patient in the medical centre. There was no alert to indicate that they were a staff member and no guidance in place for clinicians to follow. This was not in line with Defence Primary Healthcare (DPHC) policy.

Although the full range of recruitment records for permanent and locum staff was held centrally, the practice manager demonstrated that relevant safety checks had taken place at the point of recruitment, including a Disclosure and Barring Service (DBS) check to ensure staff were suitable to work with vulnerable adults and young people. DBS checks were renewed in accordance with DPHC policy. The vaccination status for staff members was monitored by the Senior Nursing Officer (SNO). The professional registration status of staff was monitored by the practice manager.

The (SNO) was the lead for infection prevention and control (IPC). There was an audit that was in date and a management action plan (MAP) was in place with actions, responsibilities, and completion dates. On a visual inspection of the medical centre, we saw walls that were in poor repair and this was captured in the MAP. We noted in the enhanced treatment room that pieces of tentage were used as part of the heat injury protocol. These were not IPC compliant (holes mended with masking tape, frayed edges). The training record showed 7 members of staff (4 were clinical staff) that had not completed training in IPC.

Physiotherapists provided acupuncture. We looked at 10 sets of patients notes and saw that they all had been correctly coded. An acupuncture audit had been completed in April 2024 and included confirmation that consent and patient information was in place.

Environmental cleaning was delivered by an external contractor, the cleaning contract was held by the unit and the medical centre has sight of this. A cleaning schedule was in place that the cleaner adhered to. The SNO undertook daily walk arounds to check the standard of cleaning and felt able to raise concerns if required. There were no records of a deep clean within the medical centre; this had been raised with regional headquarters.

A medic were responsible for oversight of clinical waste. The clinical waste policy was reviewed in February 2024. We noted 1 action point had been recorded regarding yellow waste bags. It was not clear if this has been actioned and the audit had not been uploaded

onto SharePoint. Actions from the audit were not held on the issues log or on the MAP so were not visible to all staff to see. Consignment notes were in place and up to date.

There were measures are in place to minimise the spread of infectious diseases, including 6 isolation rooms designated to any patient with a suspected infection. There was a separate trolley that held personal protective equipment and a separate clinical waste bin in each room and in the corridor. There was an SOP in place to be used if patients requiring isolation overwhelmed the isolation wards. The SNO would liaise with accommodation for a dedicated floor for patients to use. Patients were assessed as to their suitability before this was used. The medical centre informed the kitchens who sent food. Patients were reviewed by medics in their accommodation at set times throughout the day.

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

Risks to patients

There was a good balance of well-trained civilian and military staff which afforded continuity of care. Staffing levels were insufficient to ensure sustainability of the provision of comprehensive clinical care. The SNO was the only primary care nurse in post, having started in January 2024. Since then, they had made good progress with the delivery of improvements but this was hampered by a lack of capacity to see projects through and upskill staff to support other work. Some resilience could be provided through the BDF nurses but this could not be further developed as the SNO did not have capacity to provide training. The SNO was only able to deliver 2 clinical sessions per week (2 mornings).

The current waiting times for a nurse appointment was 2-3 weeks, which was outside of the usual DPHC delivery levels. In reality, the waiting list could be longer but it was noted that often nurse appointments were split to accommodate more patients and often ran into staff break times.

Within the PCRF numbers were manageable and staffing was appropriate. At the time of the inspection Hunter Company had 110 patients, the timetables were altered if numbers significantly rose. Group size was monitored and the timetabling within phase 1 and phase 2 was adjusted to match caseload requirements in consultation with the training team.

The recruitment of exercise rehabilitation instructors (ERIs) was challenging. Commando Training Centre (CTC) Lympstone is the training pipeline for Royal Marines ERI. On completion of ERI training, all personnel would be assigned to a CTCRM. There had been reduced numbers attending the course which was having an impact on ERI workforce at CTCRM. At the time of the inspection only 4 out of 6 roles were filled.

Training was comprehensive with regular scenario-based moulages focussed on the enhanced treatment facility. More broader training was available and this was factored in

and dependant on need. For example, an audit was undertaken of medics note taking and this was found to be not meeting appropriate standards so a training session was delivered to support this and aid improvement.

The staff from the BDF could be called upon to support the enhanced treatment facility and support the delivery of primary care. However this role had not been incorporated into BDF staffs' terms of reference and competency assessment to undertake specific tasks had not been formalised. We saw a competency-based approach to upskilling, for example, Patient Group Directives were utilised by some staff. The SNO, had the vision to formalise roles and upskill nurses but they confirmed they did not have capacity to formulate and implement the strategy.

Not all the staff team was up to date with Basic Life Support training, anaphylaxis and the use of an automated external defibrillator (AED). Training records showed 5 members of staff were not in date with BLS, including AED and 12 staff members not recorded as having received training in anaphylaxis. The PMO, deputy DPMO and 2 other doctors were trained in Advanced Life Support.

An in-house training programme was run by the civilian medical practitioner and included moulages. This was updated and repeated annually. The programme was determined by the most relevant topic at the time and seasonally based. The medical centre was a leading force in the management of exertional heat injuries (EHI) and had an enhanced treatment room. This had been specifically built due to the number of heat injuries and acute injuries seen due to the arduous nature of the training. The most recent training moulage was heat injury. They also completed moulage training with other units, the unit staff and the local air ambulance.

An AED was located both in the medical centre, the PCRF and the Parker Hall. Both clinical and non-clinical staff we spoke with were aware of the signs and symptoms of the deteriorating patient/sepsis. However, there were no posters or quick reference guides in the reception for staff to refer to. There was a large sepsis display outside the clinical rooms in a corridor. The in-service training record showed sepsis training was undertaken by staff in April 2024 but 15 staff were recorded on the training data base as not having completed it. This included administrative staff who had not received training in sepsis but said they would refer to the duty doctor with any concerns about a patient.

Within the BDF some military nurses had undertaken minor illness/minor injury for patient assessment but they had no formal triage training. There was no clear training pathway for staff, such as patient assessment. Some staff had completed training but this was not standardised for all staff. A patient admitted to the BDF was seen by the duty doctor except for diarrhoea and vomiting (D&V) which was a nurse-led condition. Some nurses had conducted intermediate life support and anaphylaxis training. Moulage training occurred in the medical centre and if possible, the nurses attended but note this was sometimes difficult with shift working to get all staff to attend the necessary training. There was no individual responsible for co-ordinating activities between the BDF staff and the medical centre which would support BDF staff to access training.

There was no crash trolley, oxygen or anaphylaxis kit in the BDF, it was held in the emergency treatment room within the medical centre not within distance to access quickly.

Information to deliver safe care and treatment

Staff confirmed that access to patient records was an issue at times but that this did not pose a significant risk to continuity of patient care. The business continuity plan contained detail around action to take when patient records access was not possible. In the event of a DPHC wide outage, the medical centre would revert to seeing emergency patients only. Hard copy forms were held in the medical centre for use in this scenario and documentation would be scanned onto DMICP when available.

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

The SNO looked at nurses clinical records of patients admitted with diarrhoea and vomiting. There were some gaps in documentation and it was found that clinical notes did not contain sufficient information for a nurse-led admission. Following this, training and support was planned. The SNO found that nurses needed to improve their involvement in training and engaging with the wider medical centre activity but this was difficult with shift working.

Clinicians within the PCRF undertook a yearly notes audit in line with DPHC guidance. There was a formal process in place for the ERI to receive formalised peer review, clinical supervision and mentoring on musculoskeletal assessment skills. We noted that recommendations and action plan resulting from the peer review had no schedule or deadline for completion.

Each morning all doctors attended a ward round together which allowed time for a discussion of all patients currently in hospital elsewhere. They also used this as an opportunity to discuss any patients of concern. They had a policy of discussing all recruits within 24 hours who were presenting with acute mental health symptoms. There was a formal monthly case-based discussion meeting which was minuted and logged. The lead physiotherapist also attended these meetings. Urgent mental health issues could be seen by the Department of Community Mental Health on the same day.

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

Pathology specimens were taken to the Royal Devon and Exeter Hospital. Samples were taken at least once a day and occasionally twice if required. The unit provided the transport and there was no report of logistical issues. There was a log of samples sent and received. Results were received within 1-2 days. All doctors checked for results and this was also part of the duty doctors daily routine as a failsafe. Recruits were brought in for a

face-to-face review to discuss results. For other patients this was done on a case-by-case basis and some patients had a planned review.

There was a close working relationship with the microbiology department as there had been issues with Panton -Valentine Leukocidin (PVL) a soft tissue disease, and influenza outbreaks. This had resulted in an annual visit to the camp by one of the consultants. Due to some regional variation in microbe sensitivity to antibiotics, microbiologists often made different recommendations on first line antibiotic treatment to ensure recruits received the most up to date treatment.

The civilian doctor frequently delivered lectures on EHI to all instructors during instructor development weeks. This had resulted in improved safety training by improved identification of potential EHI prior to injury.

An effective system was in place for managing both internal and external referrals, although there was scope to make it more efficient. Urgent 2-week-wait referrals were well managed and a SOP supported the process. All referral letters were written by the doctors and then tasked to the administrative group to make the referral. The work was done by a senior administrator who was the only administrator to hold an access card to the electronic referral system (eRS). They submitted all referrals and information was passed to the reception team for them to upload onto the tracker and follow up. As only 1 person had an eRS card, referrals would either have to wait or for urgent referrals administrative staff would submit the referrals by phone. However, we were advised following the inspection that 2 further cards had been ordered and were now in place at the medical centre.

Safe and appropriate use of medicines

The PMO was the lead for medicines management and the pharmacy technician was the deputy lead, both had terms of reference (ToRs) in place.

All receipt and supply of prescriptions (Fmed 296) was correctly recorded and accounted for. Prescriptions were held securely in the dispensary and monitored by the pharmacy technician.

Arrangements were established for the safe management of controlled drugs (CD), including destruction of unused CDs. Emergency medicines were easily accessible to staff in a secure area of the medical centre and all staff knew of their location. Stocks were in line with DPHC SOPs. Medication requiring refrigeration was monitored twice a day to ensure it was stored within the correct temperature range.

Excess vaccines were held in fridges hindering adequate airflow as fridges should only be filled to a maximum of 75% capacity and should and not be touching the sides of the fridge. Vaccines were not monitored during periods of block leave, meaning in the event of a power loss costly vaccines would be wasted.

Patient Group Directions (PGDs) had been signed off to allow appropriately trained staff to administer medicines in line with legislation. The nurses on the BDF used PGDs if they were confident and capable. There was concern that nurses were only producing prescriptions for enhanced PGDs not routine PGDs. Medics were issuing medication in accordance with their medics issuing protocols (referred to as MIPs) these were recorded in the patients notes and logged in a register.

Patient Specific Directions (PSDs) were used in paper format. We checked 8 and found some had no clinical code applied and no consultation notes added. The prescriber signing had also not put a consultation and clinical code in patients records. Training was required for medics and prescribers to compete these correctly.

Within the BDF there were differing processes for the administration of medicines. There was no formal governance approach or risk assessment in place to govern whether patients could self-medicate or if they were to be administered medicines by the nurses.

The medical centre was looking into setting up a contract with a late-night pharmacy to help with out of hours outsourcing of prescriptions. We discussed with staff obtaining a government credit card (epc) as recruits don't aways have money for the prescription charge.

We saw a doctors bag/crash kit that held amongst other things, a defibrillator and a pain-relieving gas (Entonox) was not kept securely but instead left next to unlocked door, this needed to be moved to a more secure area/room.

The pharmacy technician had protected time to carry out stock checks, expiry checks and other administrative tasks although staff still directed patients to collect prescriptions during this time causing interruptions to much needed administrative time.

Requests for repeat prescriptions were managed in person or electronically in line with policy. A process was in place to update DMICP if changes to a patient's medication was made by secondary care or an out-of-hours service.

A process was established for the management of and monitoring of patients prescribed high risk medicines (HRM). The register of HRMs used at the medical centre was held on DMCIP and all doctors and relevant clinicians had access to this. We looked at a sample of patient records and saw that all had been coded or had shared care agreements in place. HRMs were monitored rather than audited. The last review was in May 2024. The outcome of these were discussed at the monthly doctors meeting.

Arrangements were in place for the monitoring/auditing of antibiotic prescribing in line with local and national guidance. The last audit was in April 2024 which showed a number of patients prescribed antibiotics outside the current guidelines. Usually, this audit was repeated annually but they were planning to repeat this in 6 months.

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.

Track record on safety

The practice manager was the designated health and safety lead. Electrical safety checks were up to date. Water safety checks were regularly carried out and records were made available to us. A legionella risk assessment was carried out for each practice. A fire risk assessment of each practice was undertaken annually. Firefighting equipment tests were current. Staff were up to date with fire safety training and were aware of the evacuation plan.

Both the practice manager and the PMO managed risk together. Considering the '4 T's process' (transfer, tolerate, treat, terminate), the risk register was comprehensive, regularly reviewed and included detail of action the medical centre had taken to address each risk. Minutes demonstrated that risks were discussed at the heads of departments (HODs) meetings but not whole practice meetings meaning that not all staff were aware of the risks and informed of changes. There were active and retired risk registers on the healthcare governance workbook. The issues log was also held on the HCG workbook and it could be better utilised to include audit findings and areas for improvement including issues with infrastructure and the building. This should be visible to all staff to capture and task all action points across the medical centre.

There were risk assessments in place for all rooms which included both clinical and non-clinical risks. The Control of Substances Hazardous to Health (COSHH) risk assessments were reviewed and all COSHH items had been captured.

The PCRF facility was well provisioned to meet the specific needs of the patient population. Some 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. Wet-bulb globe temperature (WBGT – a heat stress index) readings were taken daily and activity managed accordingly.

Lessons learned and improvements made

From interviews with staff and evidence provided, it was clear there was a culture of reporting incidents. Both clinical and non-clinical staff gave examples of incidents reported through the ASER system including the improvements made as a result of the outcome of investigations. The medical centre worked to the DPHC policy for reporting and managing significant events, incidents and near-misses, which were recorded on the ASER system. The staff database showed all staff had completed ASER training to access the system.

All ASERs were put onto the governance log which recorded investigations and outcomes. They were discussed every 2 weeks with the doctors, nurses and HODs. ASERs were on the agenda for the 3 monthly whole practice meeting which occurred 3 times a year.

Medicines and Healthcare equipment Regulatory Agency (referred to as MHRA) alerts were emailed to clinical staff by the pharmacy technician. Alerts were a standing agenda item on the week 2 assurance meeting that the senior leadership team attend. We saw

minutes that alerts were discussed. Not all staff were aware of these as they were not discussed at whole practice meetings.

Are services effective?

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

Effective needs assessment, care and treatment

Arrangements were in place to ensure staff had a forum to keep up to date with developments in clinical care and guidance included weekly clinical and monthly healthcare governance (HCG) meetings. The monthly clinical meeting incorporated an agenda item to discuss national clinical guidance, including National Institute for Health and Care Excellence (NICE) and the Scottish Intercollegiate Guidelines Network (SIGN). A recent example of discussion was of the change on guidance of asthma inhalers.

Each morning all doctors attended a visit of the Bedding Down Facility (BDF) which allowed time for a discussion of all patients. They also used this as an opportunity to discuss any patients of concern. They had a policy of discussing all recruits presenting with acute mental health symptoms within 24 hours and alongside this there was a formal monthly case-based discussion meeting which was minuted and logged.

The Senior Nursing Officer (SNO) had conducted notes audits for nurse-led conditions. They were looking to develop new templates for use, which would then inform peer review audits involving all staff.

There was an extensive database in Hunter Company tracking outcomes of recruits who had undergone rehabilitation over the last 10 years. The database had the ability to show trends in injury profile, for example, the week of injury, location of injury and the activity associated with injury. Staff could demonstrate the likelihood that patients would successfully complete phase 1 training based on the week the injury was obtained. Relevant objective markers were used to progress recruits through phases of rehabilitation relative to their training requirements.

Monitoring care and treatment

The Deputy Principal Medical Officer (DPMO) delegated responsibility of monitoring long term conditions (LTCs) to the SNO. They managed the chronic disease register and highlighted what patients should be called in for, routine checks and monitoring. There was concern that the SNO did not have capacity to fulfil this role fully. The majority of patients were recruits and the level of chronic disease was low. Moving forward it was planned that this would be managed by one of the ward nurses to free up some capacity for the SNO. The individual consultations for the small amount of LTCs were of a safe standard although there were some gaps and delays in the recall process. This was due mainly to the SNO’s lack of time to deliver in this area. The LTC register was detailed and was beginning to capture shortfalls.

During the inspection we conducted searches to identify patients with an LTC.

There were 2 patients on the diabetic register. One did not have diabetes but should have been coded as having pre-diabetes. The second was correctly coded with numerous entries that they were overdue routine review but this had not been actioned by clinicians.

There were 15 patients on the hypertension register and 10 had not had their blood pressure recorded in the past 12 months.

There were 4 patients with a diagnosis of asthma. All patients had received an asthma review in the preceding 12 months.

On arrival, patients over 40 were offered the over 40s health screening. Searches were run to capture over 40's and a check of their records was completed to ensure they have been offered the service. The clinical searches showed there were 196 eligible patients, and 137 (70%) of these had received a health check.

Audiology statistics showed 63% of patients had received an audiometric assessment within the last 2 years. The nursing team and medics had a recall process in place, completed the appropriate templates and applied the correct clinical codes.

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

An audit calendar was in place. The medical centre was engaged with the DPHC regional headquarters healthcare governance (HCG) audit programme and this was tracked in the HCG workbook. There was an audit programme with an annual schedule on the governance log. This was overseen by the SNO and the Principal Medical Officer (PMO) and discussed monthly at the meetings attended by doctors and heads of departments (HODs). There was an ongoing plan and many quality improvement programmes in place.

The Primary Care Rehabilitation Facility (PCRF) was conducting audits relevant to rehabilitation and clinical delivery. Elements of best practice from best practice guidelines (BPGs) were incorporated into the management of recruits. However, we noted that BPGs were better suited to trained staff and not recruits in training. The PCRF had developed their own guidelines relevant to their patient population. The PCRF had not audited against their own guidelines but the overall return to training rates was 69% of personnel who were downgraded since 2016. General trend data suggested that 9% of personnel who returned

to training would present again to Hunter Company at some point in their training with the same injury.

All programmes had been collated into a booklet which was an excellent resource for recruits under rehabilitation. The latest version provided clear aims, explanation and criteria for progression. Programmes linked to stages of training and applied specificity by using a clear coding system. These programmes ran alongside patient individual programmes (IP). Targeted rehabilitation and reconditioning was applied to match the phase (1 and 2) module of recruit training as patients progressed through Pre-Alpha (assessment), Alpha (rehabilitation) and Bravo (reconditioning) groups.

The medical centre followed the most recent guidance and swiftly incorporated any changes to clinical best practice around the treatment of heat illness. This was led by the civilian medical officer (CMP) and included development of the enhanced treatment room and training updates around the management of heat illness. Work in this area included trials of equipment which monitored vital signs while troops were exercising.

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

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

The medical centre had also developed a rapid pathway for cardiology assessments for Royal Marine recruits in training via a private service which was funded by the unit with an average a 12 week wait.

Effective staffing

There was an induction pack for all new staff that included role specific sections. All staff new to DPHC completed the online induction. Staff were also required to complete a separate health and safety induction. On arrival, locum staff completed the DPHC mandated locum induction programme which has been amended accordingly to include cadres specific elements and information relevant to the unit.

It was not clear how many of the staff team were in-date for mandatory training. There were gaps in the training log with some staff having none of the mandatory courses recorded as completed. For example;

- 5 staff recorded as having not completed basic life support including Automated External Defibrillator (AED) - 2 administrators,1 nurse, 1 medic, also 1 medic recorded as completed but with no date recorded).
- 12 staff no anaphylaxis training recorded (nurses, medics, and doctors)

It was unclear as to whether staff had not completed training or simply had not recorded their completed training. The training log in place was missing information and relied on staff to remember to do the training, and then record as completed. There was limited overview from the management team.

There was almost no requirement for aircrew medicals. In the event this was required, service personnel would be directed to Yeovilton. Three of the full-time doctors were up to date for underwater medicine/ diving medicals.

Two of the doctors had a diploma in Immediate Medical Care in line with the provision of prehospital emergency care for acute incidents. The nurses in the bedding down facility (BDF) were secondary care nurses. There was insufficient primary care provision to provide the service required as well as ensuring safe governance and adequate nurse management.

Performance appraisals were conducted by line managers for all staff. All doctors were in date for appraisal and all doctors and nurses had completed timely revalidation. Regular clinical supervision and reflection took place for doctors and nurses. Physiotherapy staff received regular appraisals and attended regular multi-disciplinary team meetings. The SNO provided clinical support to the medics.

A new clinical mentorship programme was introduced in 2024 whereby Exercise Rehabilitation Instructors (ERIs) compiled their continuing professional development CPD) and this was recorded on the DPHC CPD log. ERI rehabilitation and reconditioning lessons were observed and peer reviewed. Reconditioning group lesson delivery was linked to Ofsted and records were kept. ERIs were seen to using the ERI scope of practice and Standards of Proficiency to Practice.

The medical centre was General Practice Education Committee (GPEC) accredited. However, they did not have a GP trainer within the medical centre. They were certified to have a GP trainee within the practice for a short 3-month individual placement.

The SNO networked with other practices in close proximity and across the region and actively invited other nurses into the medical centre. They had active engagement with governance and assurance leads in the regional headquarters team who they felt were supportive. Clinical supervision took place regularly both internally and externally. The regional nurse also offered a scheduled drop in clinical supervision monthly.

The SNO was the supervisor for both BDF nurses working within the treatment room to achieve competency prior to moving to a primary healthcare position. In addition to this they supervised a placement nurse in the medical centre undergoing the primary healthcare qualification. Although only a single occurrence, the placement nurse did supervise a ward nurse for a period of time whilst the SNO was on leave. This was due to:

- Lack of sufficient staff to supervise.
- Lack of clear working parameters.
- A robust competency framework.

This was not a critical safety aspect as all the nurses understood the concept of scope of practice. However, this is an area of concern that needed to be rectified.

Coordinating care and treatment

A 'Leaving the Military' standard operating procedure (SOP) was in place. For patients leaving, pre-release and final medicals were offered. They were also provided with a comprehensive veterans pack and other information. Patients were also made aware of the Veterans Health Service and, if appropriate, the Veterans Mental Health Transition, Intervention and Liaison Service (TILS).

There was a longstanding link with the local microbiology team following outbreaks of Panton -Valentine Leukocidin (PVL), Adenovirus and Influenza. Additionally, there was a clear pathway to the ear nose and throat team in Plymouth for acute acoustic trauma events to ensure rapid management. They had also developed a rapid pathway for cardiology assessments via a private service which was funded by the unit with a 12-week average wait. They have also agreed a private service to obtain MRIs within 4 weeks for suspected bone stress injuries. Again, this was funded by the unit. The local safeguarding team held a monthly open forum online which the doctors could attend. The medical centre had close association with the Royal Marine Charity which was located on camp.

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

Helping patients to live healthier lives

There was a dedicated lead for health promotion. A health promotion calendar was established with a specific topic identified each month. A wide range of health promotion/lifestyle information leaflets was available in the waiting area for patients. Leaflets included information about alcohol use, nutrition and testicular cancer. Information about women's health, alcohol and sexual health was displayed. Clinics were offered to patients for smoking cessation and vaping.

One of the civilian doctors was the sexual health lead alongside the SNO. The SNO was sexual health trained. All recruits were offered a sexual health screen on entry. Full screening was available in the medical centre or quick reference (QR) codes were

available to order chlamydia kits if they wished to be tested anonymously. For treatment, they were encouraged to use a local service and recruits were issued a chit for release from training with no details and appointments made so to maintain their confidentiality.

A system was in place that identified and monitored patients eligible for national screening programmes. Bowel, breast, cervical and abdominal aortic aneurysm screening (AAA) was led by the NHS. Patients received letters directly from the NHS. The SNO tracked the patients to confirm they had been offered screening; monthly for cytology, 3 monthly for bowel and breast and 6 monthly for AAA.

The percentage of women that had a cervical smear in the last 3-5 years was 94%. The NHS target was 80%.

For service personnel, the vaccination statistics were:

- 87% of patients were in-date for vaccination against diphtheria
- 87% of patients were in-date for vaccination against polio
- 87% of patients were in-date for vaccination against tetanus
- 90% of patients were in-date for vaccination against hepatitis B
- 96% of patients were in-date for vaccination against hepatitis A
- 99% of patients were in-date for vaccination against measles, mumps and rubella
- 99% of patients were in-date for vaccination against meningitis

Consent to care and treatment

Implied, verbal and written consent was taken depending on the procedure. DMICP templates captured consent. All the patient records we looked at indicated consent had been appropriately taken. Clinicians understood the Mental Capacity Act (2005) and how it would apply to the patient population. Record keeping audits incorporated a review of consent.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

In advance of the inspection, patients were invited to give feedback using comments cards. A total of 31 patients responded and feedback was positive. We also observed staff being courteous and respectful to patients in person and on the telephone. The overriding theme was that staff were friendly, professional and caring. We spoke with 2 patients on the day and they felt well cared for.

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.

Involvement in decisions about care and treatment

Feedback indicated patients were involved with planning their care, confirmed by our review of patient records. Supported by a standard operating procedure, a translation service was available for patients who did not have English as a first language. Staff said they had not needed to use this service.

Patients with caring responsibilities and cared for patients were identified through the new patient registration form and at new patient medicals. Patients identified as having a caring responsibility had an alert on their notes and were captured on a DMICP register.

The mix of male and female staff allowed the medical centre to facilitate patients who wished to see a clinician of a specific gender. If requests could not be met by the medical centre, they would be accommodated by signposting patients to an alternative Defence medical centre in the region.

The Primary Care Rehabilitation facility (PCRF) used light duties chits and used downgrade maintenance physical therapy and reconditioning physical therapy prescriptions appropriately.

Privacy and dignity

Patient consultations took place in clinic rooms with the door closed. Privacy curtains were available in all clinical rooms for intimate examinations. The PCRF consisted of a number of curtained cubicles with plinths to treat patients and there was access to a separate treatment room if more privacy was needed. Radios were used in the cubicle area to help mitigate potential privacy and confidentiality issues.

The staff team had completed Information Management training which incorporated the Caldicott principles. These principles were displayed at the practice.

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

Are services responsive to people's needs?

We rated the practice as good for providing responsive services.

Responding to and meeting people's needs

The medical centre used an appointment system where patients could be seen in person or have a consultation by telephone. Where possible all patients were seen face to face. There was little request for telephone consultations and they had very few eConsults. All doctors consultations were a minimum of 15 minutes with at least 30 minutes for mental health and occupational health.

One of the civilian doctors and 2 medics routinely attended the 30-mile speed march tests providing medical cover and also any incidents on the Tarzan assault course.

The medical centre had a diversity and inclusion lead role. There was a dedicated noticeboard situated in the staff room. Due to changes with policy and females now able to join the Royal Marines, the unit were starting a women's network, for all women within the unit military and civilian. They also provided briefings for women in arduous training.

Staff were aware of the new Defence Primary Healthcare (DPHC) transgender standard operating procedure. To date the medical centre had not had any patients undergoing gender reassignment but would readily support such patients if required. There had been an occasion when they had offered extra support to patients for religious reasons. For example, supporting dietary requirements during Ramadan. They had also looked at how to support vegan patients to get sufficient calorie intake while doing arduous training.

The nursing team tried to accommodate the specific needs of patients, for example appointments suitable for patients different working hours. However, this was very limited due to the lack of appointments available.

An access audit as defined in the Equality Act 2010 had been completed for the premises in March 2024. Issue identified in the audit had been actioned. These included submitting a statement of need for replacement front doors as the ones in place were heavy and not easily opened.

Timely access to care and treatment

The medical centre was open Monday to Friday 07:00-16:30 hours. The medical centre was staffed 24 hours a day 7 days a week by a duty medic and ward nurse, with a doctor and medic on call for emergencies. Urgent care clinics (fresh case) were held twice a day, during the week and once a day in the morning at weekends. All patients were triaged by medics who referred on to a nurse or doctor as required.

The patient information leaflet, answerphone message and patient information board outside of the medical centre provided details about opening times and access to medical care out-of-hours.

Direct Access Physio (DAP) clinics were not available for recruits: they would be seen promptly by one of the doctors and referred on if PCRF input was required on the same day. There was a DAP clinic for permanent staff which meant they could self-refer. Rapid access to PCRF support was available with patients being seen well within the key performance indicators (same day for acute referrals). Routine physiotherapy appointments were available within 1 day and follow up appointments within 5 days. To see an exercise rehabilitation instructor, a new patient appointment was available the same day and follow up appointments could also be accommodated within 1 day.

The PCRF was co-located in the medical centre and had sufficient space for assessing and treating patients but limited space for rehabilitation. Recruits would usually transfer to Hunter Company if downgraded which allowed for access to appropriate space and equipment. Permanent staff who required rehabilitation and access to further equipment were able to use Parker Hall outside of recruit training times. This limited the times that permanent staff could undertake rehabilitation and had been raised as an issue by the PCRF.

Listening and learning from concerns and complaints

The practice manager was the lead for complaints. Complaints were managed in accordance with the DPHC complaints policy and the practice policy. Both verbal and written complaints were recorded on the complaints log. The complaint log showed 2 complaints were received in the past year. We discussed the complaints received this year and were satisfied they were effectively managed in accordance with policy.

All complaints were discussed at clinical and heads of departments meetings on a monthly basis. Any outcomes were recorded. A recent example was given that a patient felt that they did not have enough information about his Navy medical board occupational service process. As a result, the medical centre developed a check list with information about what is expected of the patient. Patients were made aware of the complaints process through the practice information leaflet and information displayed in the waiting room.

Are services well-led?

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

Vision and strategy

The practice worked to the Defence Primary Healthcare (DPHC) mission statement outlined as:

“To provide safe, effective healthcare to meet the needs of our patients and the chain of command in order to support force generation and sustain the physical and moral components of fighting power.”

The mission statement specific to the Commando Training Centre Royal Marines Medical Centre was defined as:

”Providing first class primary healthcare and rapid access to secondary care and rehabilitation in support of Royal Marines training”.

The Primary Care Rehabilitation Facility (PCRF) had their own mission statement: “Following injury or illness our aim is to facilitate rapid restoration of form and function to futureproof recruits against reoccurrence in order to return them to mainstream training in the optimal time transmits through the service”

Parker Hall had a recruit charter that upheld the values of excellence, integrity, self-discipline and humility.

Leadership, capacity and capability

The medical centre benefitted from the expertise of an experienced team. All staff we spoke to seemed happy with the leadership in the medical centre. There was a good balance of civilian and military staff which afforded continuity of care. However, staffing levels were not sufficient to meet the needs of the patient population. It was a busy practice especially with the extended roles managing the prehospital emergency care (PHEC) cases both in the medical centre and externally on the training areas. The team stated that there was insufficient nursing provision to provide the basic monitoring and recall of patients with a long-term condition (LTC), optional health checks and daily nurse clinics (currently only 2 mornings). There were only 3 civilian administrative staff and also only 1 pharmacy technician. There was 1 receptionist although there was meant to be 2 in post. Due to the current civil service recruitment ban this post would remain vacant indefinitely.

The bedding down facility (BDF) had no individual manager. The senior nursing officer (SNO) oversaw the BDF as well as being responsible for the line management of the

nursing staff. They also had many areas of responsibility within primary care such as infection, prevention and control, the management of LTCs and health promotion.

The medical centre had forged close links with the unit and tailored the service to their specific needs, such as daily ‘fresh cases’ clinics. Duty doctors, the SNO 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 and, lifestyle advice. The leadership team described good and effective support from Regional Headquarters.

Culture

It was clear from patient feedback and interviews with staff that the needs of patients were central to the ethos of the medical centre. Staff understood the specific needs of the patient population and tailored the service to meet those needs.

Staff told us they were supported, respected and valued by the leadership team. They said that everyone in the team had an equal voice, regardless of rank or grade. Staff undertook a 360 feedback survey which was anonymous. They said they would go to their line managers if they had any concerns.

Both formal and informal opportunities were in place so staff could contribute their views and ideas about how to develop the practice. There was a log of staff wellbeing events including meals out as a team, attending sports events and a trip to an escape room.

Staff said they felt confident and empowered to discuss issues and concerns they had identified and escalated. Staff were aware of the whistleblowing policy and were also aware of the Freedom to Speak Up (FTSU) process within the region. Staff were encouraged to raise concerns. There was information regarding the FTSU in all the staff rooms and toilets.

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

There was a clear staff reporting structure in place. Staff were aware of their roles and responsibilities. Staff with lead roles had protected time to carry out their additional duties. Terms of reference) were established for those with secondary roles.

The last internal assurance review (IAR) took place in April 2023 they were given limited assurance and it was stipulated on the IAR that a re-inspection should be undertaken no later than March 2024; this had not yet taken place. They medical centre was also inspected by Ofsted in November 2023 and were rated as good.

Staff had multiple additional roles to fulfil, such as deputising roles. 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, standard operating procedures, quality improvement activity and complaints. A meeting's matrix was used to deliver a robust schedule of meetings which included healthcare governance meetings, practice meetings and multi-disciplinary meetings. We noted that practice meetings were only held every 3 months for the whole staff team making it difficult to keep all staff fully updated in all areas, for example risks, ASERs, safety alerts and the issues log. The PCRF was operating as a fully integrated part of the medical centre team.

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. There was scope to better utilise the management action plan on the healthcare governance framework or a spreadsheet visible to all staff to capture and task all action points across the medical centre.

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 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 risks to the service. However, we noted there was no reference to block leave and the management and or moving of vaccines.

Appropriate and accurate information

The DPHC electronic health assurance framework (referred to as HAF) was used in to monitor performance. The HAF is an internal quality assurance governance tool to assure standards of health care delivery within defence healthcare.

There were arrangements at the practice in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

Various options were available to prompt patients to provide feedback on the service and the practice acted on feedback received, including the DPHC online survey.

PCRF patient feedback questionnaires were accessible via QR codes across the medical centre and the PCRF. Responses and trends have yet to mature into any changes. An early indicator for increased rehabilitation time was reported by Officer Commanding PCRF, with considerations to increasing daily sessions within Hunter Company.

Continuous improvement and innovation

A quality improvement programme (QIP) was in place. The audit register clearly demonstrated that the medical centre actively engaged with audit activity. Quality improvement activity, including individual audits, were discussed at the clinical and/or practice meetings, confirmed by a review of meeting minutes.

Within the PCRF all programmes had been collated into a booklet which was an excellent resource for recruits under rehabilitation. The latest version provided clear aims, explanation and criteria for progression. Programmes linked to stages of training and applied specificity by using a clear coding system. These programmes ran alongside patient individual programmes (IP). Targeted rehabilitation and reconditioning was applied to match the phase (1 and 2) and module of recruit training as patients progressed through Pre-Alpha (assessment), Alpha (rehabilitation) and Bravo (reconditioning) groups.

There was an extensive database in Hunter Company tracking outcomes of recruits who had undergone rehabilitation over the last 10 years. The database had the ability to show trends in injury profile for example the week of injury, location of injury and the activity associated with injury. It was able to demonstrate the likelihood of successfully completing phase 1 training based on the week the injury was obtained. Relevant objective markers were used to progress recruits through phases of rehabilitation relative to their training requirements.

From feedback the medics that have a sleeping duty in the medical centre either overnight or for the weekend, staff managed to source funding to freshen up the staff room including painting the walls, getting soft furnishings and making the area more comfortable for all staff to use.

One of the doctors was the lead for the national AccuRx SMS messaging service within DPHC. They identified the benefit of messaging systems to provide patients with information and other information related to their condition. Unfortunately, DPHC have halted the trial but the medical centre was hopeful this would restart in the future.

Because Defence do not use the same IT systems as the NHS there was risk of recruits being seen at hospitals out of region and the medical team not being able to see discharge summaries, with many NHS Trusts no longer posting them (or if they do there was a delay). To help with this in the local region, the medical centre was in the process of having a Data Protection User agreement signed by DPHC headquarters so that they would have access to ‘Epic Link’. This would enable them to log on to the Royal Devon and Exeter Hospital systems (soon to be broadened to Plymouth and Torbay) so that they could see results, appointments and discharge summaries. This was still awaiting DPHC

headquarters authorisation. In the meantime, until this was achieved, one of the civilian doctors was the designated liaison and sat in on meetings to enable better communication. To solve the same issue out of region, credit card sized recruit/trainee cards had been made to make the receiving hospital aware who the patients were and to provide contact details (email addresses) so they can provide discharge information and to request advice (particularly microbiology).