Yeovilton Medical Centre

RNAS Yeovilton, BA22 8HT

Defence Medical Services inspection

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

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

Published: 10 July 2024

Contents

Summary 3

Are services safe? 7

Are services effective? 14

Are services caring? 19

Are services responsive to people's needs? 21

Are services well-led? 23

Summary

About this inspection

We carried out this announced comprehensive inspection on 6 June 2024.
As a result of this inspection the medical centre is rated as good in accordance with the Care Quality Commission's (CQC) inspection framework.

The key questions are rated as:

Are services safe? – good
Are services effective? – good
Are services caring? – good
Are services responsive? – good
Are services well-led? – outstanding

The Care Quality Commission (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 benefitted from a strong and inclusive leadership style, such that staff felt valued and able to contribute to improved ways of working. An inclusive whole-team approach was supported by all staff who worked collaboratively to provide a consistent and sustainable patient-centred service.

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.

The medical centre, including the Primary Care Rehabilitation Facility (PCRF) had forged close working relationships within military healthcare, with NHS organisations and with the station in planning how services were provided to ensure that they meet patients' needs.

There was a safe system for the management of specimens and referrals.

The medical centre had a system to ensure that staff completed mandated training and held the appropriate professional registrations.

We identified minor deficiencies in the medicines management processes, most were rectified on the day of inspection.

There was an open and transparent approach to safety. An effective system was in place for managing significant events and staff knew how to report and record using this system.

Feedback showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.

Quality improvement activity was embedded in practice and was used to drive improvements in patient care.

We found the following area of notable practice:

The staffing and governance structure consistently combined to provide resilience and promote a safe environment. Of note, leads and deputy roles were spread throughout the team, supported by training and covered all key areas.

The medical centre was trialing the introduction of a formalised mentorship programme. This programme was aimed at junior military staff within the practice, to enhance team cohesion and help support and develop staff to maximise their potential. Leaders at the medical centre met with the medics regularly to check on their wellbeing. This has led to a change of mentor on occasion and when they indicated that they were feeling burnt out or overwhelmed, arrangements were made for them to all have a 4-day weekend. Through support and discussion this mentorship programme had encouraged medics to consider their career plans with some personnel now seeking places to become nurses or doctors. Should the trial of the mentoring programme be successful, the aspiration would be for all staff to be allocated mentors. With the considerable number of staff within the medical centre, the formal mentorship programme provided dedicated time for staff development whilst enhancing team cohesion.

Identifying that there was a significant delay in the process of achieving initial aviation medical signoffs for local winchmen through the existing pathway, the lead aviation medical clinicians, in conjunction with head of Royal Navy aviation medicine reviewed the pathway to enable sign off for simple cases at a local level. This reduced the burden on Occupational Health, improved operational capability and the experience of those individuals involved.

A DMICP (the clinical operating system used) synonym was implemented for better recording of the Anterior Cruciate Ligament (ACL) rehabilitation. Following an influx of injuries from ski injuries and a subsequent ski injury audit. This made the rehabilitation pathway more effective as per best practice guidelines.

Medics were able enhance their muscular skeletal knowledge by being supported and trained by a duty physiotherapist during urgent clinics. Patients also benefited from having prompt access to a physiotherapist. It also reduced the number of inappropriate referrals.

The Chief Inspector recommends to Yeovilton Medical Practice

Review systems and processes for medicines management to ensure they are fully effective including the systems and processes for the destruction of controlled drugs, and the management of Patient Group Directions and Patient Specific Directions.

To ensure equity of access in line with the rest of Defence, consider Direct Access to Physiotherapy (DAP) clinics for permanent staff.

Continue to address the back log in the summarisation of patients' medical notes.

Review the management of the peer review programme within the PCRF.

The Chief Inspector recommends to Defence Primary Healthcare (DPHC)

Review clinical capacity and fill staffing gaps (nurses and physiotherapists) at Yeovilton Medical Centre to ensure that clinicians are not working in excess of the hours stipulated in the Defence Instruction and Notice guidance for service personnel.

Chris Dzikiti

Interim Chief Inspector of Healthcare

Our inspection team

The inspection team was led by a CQC inspector. The team of specialist advisors included a primary care doctor, a practice manager, a physiotherapist, an exercise rehabilitation instructor and a nurse. In addition, two new specialist advisors shadowed this inspection. The pharmacist specialist advisor visited the medical centre on the 12th June.

Background to Yeovilton Medical Centre

Yeovilton Medical Centre provides the full range of primary and intermediate health care for all entitled service personnel from all 3 of the British Armed Forces, entitled foreign military (exchange/NATO) and occupational care to entitled reservists across the Southwest region.

Yeovilton Medical Centre provides a service to the Air Station at Yeovilton. There are approximately 2392 patients, all of whom range between military service personnel, reservists, Military Provost Guard Service and entitled civilians, predominantly aged between 18 and 55. In addition to routine GP services, the practice provides a range of other services including, vaccinations, sexual health, smoking cessation, cervical cytology, over 40's health screening, chronic disease management and aviation medicals. A Primary Care Rehabilitation Facility (PCRF) and a dispensary are located within the building.

In addition to routine GP services, the treatment facility offers physiotherapy and rehabilitation services. Family planning advice is available within the practice and maternity and midwifery services are provided by NHS practices and community teams. Mental health referrals are made to the Department of Community Mental Health (DCMH) Portsmouth.

The medical centre also provides emergency medical cover for 2 airfields during flying hours.

The medical centre is open on Monday to Friday 07:45 to 18:30. After this, patients are referred to local out of hours services/emergency department.

There is a mix of military and civilian staff. The current establishment and staffing gaps are outlined in the table below:

The staff team

Principal Medical Officer (PMO)	1
Deputy Principle Medical Officer (DPMO)	1
Medical Administration Officer (MAO)	1
Practice Manager	1
Deputy Practice Manager (DPM)	1
Civilian Medical Practitioners	4 (includes 1 locum)
Medical officers	3 x GP Trainees
Nurse	1
Pharmacy technician	2
Exercise rehabilitation instructors (ERI)	2
Physiotherapists	3
Administrators	8
Medics	7 (4 posts currently vacant)

Are services safe?

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

Safety systems and processes

The medical centre worked to the Defence Primary Care Healthcare (DPHC) Tri-Service safeguarding policies. One of the civilian doctors was the lead for safeguarding, they had worked in the medical centre for a considerable time and had developed strong contacts with the Somerset safeguarding team. They attended the monthly online area liaison meeting and was the point of contact if there were any concerns. Additionally, all squadrons were appointed a lead doctor to better improve channels of communication and reduce the risk of safeguarding concerns not being shared appropriately. There was also a weekly PSG (Personnel Support Group) meeting attended by the Principal Medical Officer (PMO) and the Deputy Principal Medical Officer (DPMO), as well as trainee and trained strength carers meeting held with wider welfare, chaplaincy, and the unit executive.

All staff within the medical centre had received up-to-date safeguarding training at a level appropriate to their role. The medical centre's standard operating procedures (SOPs) for safeguarding had been reviewed and included contact details for local safeguarding teams.

Safeguarding concerns were discussed at monthly meetings. Each unit had their own named doctor attached to them for continuity. Vulnerable persons registers, including patients under the age of 18, were maintained and a search of DMICP the clinical operating system used was undertaken monthly. We conducted searches on DMICP and found there were 2 care leavers under 25 years old, 30 carers and 10 personnel aged under 18. In addition, there were 30 personnel coded as vulnerable adults. The medical centre register matched the search. The register also noted when carers were due a flu vaccine and additional health screens. We met with the padre who described the relationship with the medical centre as good. They said staff were helpful and caring and always available when required.

Notices advising patients of the chaperone service were displayed in each clinical room and in the reception area. The medical centre staff were recording on the patients' records whether a chaperone was present or offered/ declined, this included the name and role of the chaperone, this was regularly audited. There was a list of trained chaperones and chaperone training had last been held in October 2023, there was also a PowerPoint presentation available for staff to update their knowledge if required. Staff who acted as chaperones had received a Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

The full range of recruitment records for permanent staff was held centrally. However, the medical centre could demonstrate that relevant safety checks had taken place for the staff,

at the point of recruitment, including a DBS check to ensure staff were suitable to work with vulnerable adults and young people.

The Senior Nursing Officer (SNO) was the lead for infection prevention and control (IPC) and they had completed the IPC link training. Audits were undertaken of the medical centre and the Primary Care Rehabilitation Facility (PCRF) regularly and actions taken as required. The last audit was carried out in February 2024. We noted the outcome of the audit had not yet been shared with the PCRF staff.

Environmental cleaning was provided by an external contractor. A written cleaning schedule was in place and this was signed off to confirm that cleaning tasks had been completed in line with the agreed frequency. Rooms were colour coded to clearly identify the cleaning requirement and there was a signature sheet for each room which correlated to the cleaning schedule. The medical centre had not had a deep clean as this was not included in the cleaning contract. To mitigate this, they initiated monthly cleaning reviews with the contracted cleaning manager and measured standards against the contract cleaning schedule; a copy of this was linked on the healthcare governance (HCG) workbook . It was also displayed in the cleaners cupboard, the IPC board and in the SNO's office. The PMO and SNO conducted quarterly cleaning rounds which were also recorded. There was a cleaning audit scheduled for June 2024.

The management of healthcare waste was in line with policy. Clinical waste was bagged, secured and marked with the medical centre code before being recorded in a waste log and held in the dry store. The waste was then placed in one of 3 waste skips, which on the day, were not secured to the building, during the inspection day a temporary solution was installed and a request for a permanent solution would be submitted. The consignment notes were not being cross referenced to the waste log but this was also rectified during the inspection. The last annual waste audit was undertaken in May 2024 and there were no concerns identified.

One staff member in the PCRF was providing acupuncture to patients. There was an acupuncture SOP and risk assessment in place. This had been reviewed regularly and all staff were aware of. Written consent was gained and scanned onto DMICP.

The lead military exercise rehabilitation instructor (ERI) managed the PCRF servicing requirements. The rehabilitation physical training equipment (PTE) serviceability was just in- date but expired at the end of June 2024. All management actions had taken place and a scheduled visit booked through the service provider. However, an issue with service provider meant that this had not taken place. The PCRF have entered this on their risk register and rescheduled the servicing. Control measures have been put in place to maintain patient safety.

Evidence was seen of 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 medical centre had a system in place to ensure that they are receiving, disseminating and actioning all alerts and information relevant to the practice.

Risks to patients

There was a good balance of well-trained civilian and military staff which afforded continuity of care. There was a good provision of doctors but staffing levels were insufficient within the nursing department to ensure sustainability of the provision of comprehensive clinical care. The SNO was working excess hours on a regular basis being the only military primary care nurse in post, 2 temporary part time locum nurses worked alongside them. A new nurse was due to start in August 2024. Within the PCRF there was a new Officer in Command (OC) and a further 3 physiotherapists posts, 1 of these was vacant and another vacancy was imminent. There were 2 ERIs, one of these was a locum. The department had been dependent of locum staff as well as having long gaps in the OC role.

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. All exercise rehabilitation was conducted in an air-conditioned area and exercises was moderated when required.
All staff working in the medical centre had completed basic life support, anaphylaxis and defibrillator training. Information about sepsis was displayed in various areas of the medical centre. All staff had received training in climatic illness and sepsis. Nine members of staff were trained in Immediate Life Support (ILS) and all medics were trained in Battlefield Advanced Trauma Life Support (BATLS).

The medical centre has been involved in large major incident moulage training of possible incidents. The last large training event was in February 2024 and involved the local ambulance and fire service as well as station fire team, air traffic control and other unit staff, this included training on spinal injuries. They have had other smaller training events and were planning to hold another one in the next few weeks. Additionally, they held regular tabletop moulages with the air traffic control team.

Unplanned admissions to hospital were managed well including effective communication and monitoring between the medical centre and the hospital itself. Upon discharge from hospital the patient was given a follow up appointment with a doctor.

All staff knew where the emergency medicines were located. We found all medicines on the emergency trolley were appropriate and in-date and a risk assessment was in place. Ambient temperature monitoring was being completed in accordance with the DPHC SOP for temperature monitoring. Oxygen was held and was accessible with appropriate signage in place. There was a defibrillator kept in the medical centre and staff knew of its location. Waiting patients could be observed at all times by staff working on the front desk. The waiting room within the PCRF had been closed as patients could not be seen whilst waiting, instead patients waited in the main medical centre waiting room to reduce risk. This was recorded on the risk and issues register.

Information to deliver safe care and treatment

An SOP was in place for the management of the summarisation of patients' records. However, the medical centre team were aware that this was not being managed effectively

nor in a timely way mostly due to the shortage of nursing staff. All doctors were currently responsible for summarising medical records and predominantly this was done for new patients registering. All new patients on medication were signposted to the doctor who was the medicines management lead. On the day of the inspection, we found 1250 sets of notes were still requiring summarisation.

Peer review was used to measure and ensure quality of care delivery across most of the staff team at the medical centre. The doctors completed a peer review of each other's clinical records in pairs, this was completed annually. The PMO also worked with one of the Military Aviation Medical Examiner (MAME) leads externally to have review of notes and check the quality of their record keeping.

There was lack of formal peer review process for physiotherapists and ERIs. Joint assessments were undertaken regularly and self-reflection was encouraged, staff also had the option to dial onto regional Multi-Disciplinary Injury Assessment Clinics (MIAC) meetings for complex cases or reach out to senior clinicians in the wider region.

The SNO received comprehensive peer review from the regional nursing advisor. There were monthly nurse meetings with the nurse from Norton Manor, and 3 monthly virtual clinics attended by the SNO and the PMO this was an opportunity to discuss more complex cases. The SNO also attended regional nurse meetings and forums.

Staff confirmed that access to patient records was only occasionally a concern and did not pose a significant risk to continuity of patient care. In the event of a DPHC-wide outage, the medical centre would refer to the Business Continuity Plan (BCP) seeing emergency patients only and routine clinics maybe cancelled. Appointments were printed out at the end of each day for the following day and hard copy forms were held for use in this scenario and documentation would be scanned onto DMICP when available.

The management of referrals was failsafe. Tasks were received into a group task box on DMICP. Three administrative staff could access this and were trained to action and monitor referrals. Staff were able to describe the process in detail. The registers were held in a limited area on SharePoint with DMICP number as the only identifier. Internal referrals such as for the Department of Community Mental Health (DCMH) were also monitored. The PCRF were not included in this process and clinicians from the PCRF monitored their own referrals individually.

An effective process was in place for the management of specimens and this was supported by an SOP. Samples taken were recorded on an online spreadsheet and results were returned via the PathLinks (electronic link between the pathology laboratory and healthcare professionals) inbox. These were reviewed daily by the SNO to confirm receipt and action any urgent results. They were then allocated back to the requesting doctor or the duty doctor for any further action.

Safe and appropriate use of medicines

The lead for medicines management was one of the civilian doctors. The pharmacy technician was aware that the management and working practices of the dispensary were

delegated to them. This was reflected in the Terms of Reference (ToRs). The ToRs were signed electronically and were in-date.

Arrangements were established for the management of controlled drugs (CDs). However, a review of the most recent destruction certificate confirmed that accountable and controlled drugs were not being destroyed in accordance with policy, the destruction should be witnessed by the account holder (the PMO) and an individual external to the practice appointed by the Commanding Officer of the unit. Internal and external quarterly checks were being completed in line with policy. A CD audit had been completed and an action plan written. We saw the annual self-audit had been completed.

The dispensary had a key safe log and key safe for security. The CD keys were kept separate from the dispensary keys but we noted were not sealed and put away into the keypad at the end of the working day, this was noted and the process was changed on the day of the inspection. There were clear processes in place for the access to CDs out of hours (OOH).

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. All staff who administered vaccines had received the immunisation training as well as the mandatory anaphylaxis training.

The medical emergency trolley and medicines were checked daily and monthly or if the trolley had been opened/used. Tags were in place with a list of expiry dates held. We checked all the emergency medicines and kit and these were in-date, including medical gases, which were at sufficient capacity. We highlighted to the medical centre staff during the inspection that the appropriate blood glucose monitoring machine should be used (CardioChek and not Gluco Rx). The medical centre agreed to action this swiftly.
We saw when patients were collecting their medicines that good information was given to them and that they were informed of the patient information leaflet in the medicine's container.

The nurse used Patient Group Directions (PGDs) for immunisations and primary care treatments. They were authorised to use the PGDs using the correct policy and documentation were seen but the authorisation was out-of-date for vaccines and no renewal was seen. A PGD audit for the individual had been completed in the last year and it was confirmed that the findings from the audit had been reviewed. However, the PGD audit for the medical centre had not been completed. Patient Specific Directions (PSDs) were used at the medical centre and the majority of these were correctly administered. However, we noted 1 that had not been uploaded into DMICP onto the integrated health record. We discussed this with staff and we were reassured that moving forward PGDs would be uploaded accordingly.

There were clear and thorough processes in place for the requesting and issuing of repeat medication. On discussion with the pharmacy technician and review of DMICP records, it was evident that there was a clear audit trail for the request of repeat medication. The process for handing out prescriptions to patients was discussed and witnessed and was in-line with policy.

We reviewed the records of patients prescribed a high-risk medicines (HRMs) and the consultations were thorough. There was a register in place that supported the safe management these patients. Appropriate HRMs and shared care alerts were raised on patient's DMICP records

Valproate (medicine to treat epilepsy and bipolar disorder) searches were undertaken every month. There were no patients prescribed this medicine at the time of the inspection.

Track record on safety

There was a designated health and safety lead and a board was displayed which was regularly and externally audited. Measures to ensure the safety of facilities and equipment were in place. Electrical and gas safety checks were up-to-date. Water safety checks were regularly carried out. A legionella risk assessment had been completed in September 2023.

A fire risk assessment of the building was undertaken. Firefighting equipment tests were current. Staff were up-to-date with fire safety training and were aware of the evacuation plan.

There were active and retired risk and issues registers. The 4T's had been applied to the risks and all had been given a review date. The active risk register included risks transferred to regional headquarters and all the main risks identified by the management team. There was a range of clinical and non-clinical risk assessments in place including lone working. All the known Control of Substance Hazardous to Health (COSHH) items in use at the medical centre had an appropriate risk assessment in place.

There was a lone working policy which included the PCRF. There was a fixed alarm system in the medical centre this was regularly tested and the findings recorded within the Building Manager's folder.

PCRF staff had embraced opportunities to link into the occupational requirements of their patients. Staff had assessed and experienced the new Royal Navy PES (Physical Employment Standard). To understand the physical demands placed on aircrew of both Merlin and Wildcat aircraft, PCRF staff had undertaken experience flights and observed the dunker (a module to replicate the demands of escaping out of an aircraft underwater).

Lessons learned and improvements made

All staff had access to the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events and incidents. There was a comprehensive ASER log on the HCG workbook which included details of lessons learned, actions taken and correlation with the duty of candour log. 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. Whilst reviewing ASERs

a trend of Caldicott breaches was identified, this led to arranging Caldicott update training for all staff, planned for July 2024.

A system was in place for managing patient safety alerts and the pharmacy technician held responsibility for completing any required action. Recent safety notices were checked and evidenced as correctly being processed during the correct timeframe.

Are services effective?

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

Effective needs assessment, care, and treatment

All doctors were signed up to receive the National Institute for Health and Care Excellence (NICE) and the Scottish Intercollegiate Guidelines Network (SIGN) clinical update emails. The Warrant Officer sent all staff the updates from Navy Command. This was also copied onto the minutes for the monthly clinical meetings. Discussions were recorded and logged.

Earlier this year, the Principal Medical officer (PMO) organised for a Red Whale doctor (Red Whale is a training provider) update course to be held at Yeovilton. This was attended by doctors from all over Defence Primary Healthcare (DPHC).

The range of primary care rehabilitation facility (PCRF) clinical records we reviewed 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 in use to monitor individual patient progress. Quick response or Quick Reference (QR) codes were available for patients to complete outcome measures. The use of the MSK-HQ was clinically coded via the DMICP template.

Patient-related outcome measures were issued on the first contact with a physiotherapist. These were tools used to gather information such as demographics, occupation, pain scores, and impact of injury on daily function. This data could be tracked, measured and repeated on discharge and used to support onward referral. Upon discharge all the relevant data was captured and included the patient's attendance record.

Monthly healthcare governance (HCG) meetings were held every four weeks and attended by the Senior Management Team, who then distribute information through to other departments. A PowerPoint presentation was used for the termly whole practice HCG meeting and individual departments updated topics or issues to be discussed within the meeting.

The PCRF were part of the wider medical centre meeting schedule, this included the practice meeting and HcG meetings. The PCRF staff were part of a multi-disciplinary meeting where they met with the doctors to discuss complex cases. They also had the option to dial into the Regional Rehabilitation Unit (RRU) for clinical support. The PCRF team also had their own meeting schedule where they were able to share evidence-based guidance and continue with their own continuing personal development (CPD).

Monitoring care and treatment

The PMO was the lead for the management of long-term conditions (LTC), they delegated the day to day monitoring to the Deputy Principal Medical Officer (DPMO) and the Senior

Nursing Officer (SNO). The medical centre had worked hard to improve the management of LTCs as they recognised it required better management with recall historically not always being sent. The medical centre now offered specific LTC clinics, for example asthma, they had searches in place on DMICP and a supporting register.

We conducted searches to identify patients with LTCs on the day of the inspection, they were of good quality and the appropriate templates had been used. There was evidence of recalls and were managed correctly.
There were 9 patients on the diabetic register. For 4 patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For 6 patients, the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.

There were 75 patients on the hypertension register. There were 28 patients recorded as having high blood pressure higher than 140/90, or not having their blood pressure taken in the past 12 months. Upon discussion with the doctors, they had recognised the management of hypertensive disease was an area that could be improved and had been impacted by the reduced number of nursing staff. This was going to be addressed.

There were 45 patients with a diagnosis of asthma, 38 were recorded as having had an asthma review in the preceding 12 months. The 7 patients that were overdue were being contacted in an attempt for them to respond.

Patients over the age of 40 were opportunistically invited to a full health check including bloods and identifying risk factors. We searched the clinical system and found that 406 out of 557 (72%) eligible patients had been coded as having a health check. There was a programme in place to slowly catch up on these checks but this was difficult because of the shortage of nursing hours available.

Routine vaccination and audiometric recalls were managed by the medics. Audiology statistics showed 76 % of patients had received an audiometric assessment within the last 2 years.

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 listed in the list of complementary mental health support services, patients with mental health issues could be supported by the padre and unit welfare team. The welfare team were able to offer low level counselling. The medical centre team had recently arranged an ‘Orange Button’ training session in connection the Somerset Armed Forces project manager, delivering mental health and suicide awareness training to those staff on the establishment

(divisional officers and chaplaincy staff) most likely to encounter service personnel in crisis.

We saw that referrals to the Regional Rehabilitation Units and Multi-Disciplinary Injury Assessment Clinics (MIAC) were made promptly with manageable wait times for the patients (approximately 4 weeks).

Within the medical centre there was a comprehensive audit programme in place alongside an annual schedule kept on the HCG workbook. This was overseen by the DPMO and the practice manager. Clinical audit was used to ensure care and treatment followed evidence-based guidelines. For example, chronic disease audits and a most recently a cancer audit. As a result of the cancer audit, a list of actions was identified to be discussed at the clinical meeting, for example, the need for the use of specific clinical coding, having a named doctor and early access to physiotherapy.

Within the PCRF audit was less robust with gaps in audit and integration over the last few years, this was partly down to staffing and the lack of a governance lead. Despite this, there has been some PCRF specific audit work done including a ski injury audit after an influx of anterior cruciate ligament (ACL) injuries. This was then used to create a DMICP template in-line with the best practice guidelines for ACL rehabilitation. The PCRF now had a ‘must/should/extra’ audit register in place to ensure completion, integration, and accountability.

Effective staffing

The medical centre used the DPHC induction programme, with a separate induction for locum staff. There was no role specific induction available for PCRF staff, instead this was done informally. For doctors there was also an aide memoir in place, this provided useful links and information and was kept continually updated. Both the DPHC induction and workplace induction were both recorded on the staff database. There was a full range of tabletop instructions available for all departments, we saw over 60 in total on SharePoint. These linked to the HCG workbook.

Mandatory training was part of the induction pack which listed the training requirements and had a link to the training policy and courses. There was a staff training log which captured internal and external training and compliance was good. Staff were given dedicated time every Thursday to complete training and Continuing Professional Development (CPD). All doctors were General Duties Medical Officers (GDMO) supervisors, all but 1 were appraisers and 2 doctors were GP trainers.

The medics were encouraged to give teaching sessions and evidence of these were seen on the training log. For example, training was delivered in, casualty moulages, ASERs, chaperoning, Caldicott, equipment care and climatic injuries to name just a few. All training presentations links were included within the training log, this gave other members of staff that had not attended these sessions the opportunity to read and engage where needed.

Role-specific training was available for relevant staff. For example, the infection prevention and control (IPC) lead had completed IPC Link Practitioner training. Doctors were MAME

qualified for Aviation medicine and for qualified for diving medicals. The Officer in Command of the PCRF was scheduled to undertake MAME training in the near future.

Staff administering vaccines had received specific training which included an assessment of competence. Staff who administered vaccines could demonstrate how they kept up-to-date with changes to the immunisation programmes, for example, by access to online resources and discussion at nurses' meetings.

Coordinating care and treatment

The 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 stakeholders, including the local NHS midwifery, health visiting service and voluntary organisations.

There were good lines of communication established with the individual units having their own named doctor assigned to them. Aviation medicine dial in calls were held every month.

There was a communication network with the other medical centres who looked after helicopter pilots with the aim to ensure best practice across the board for this specific patient group. The medical centre had a particular affiliation with Culdrose, the other Royal Navy air base.

It was clear that the PCRF were an integral part of the medical centre. There were good streams of communication with staff in the PCRF, meetings were inclusive and governance structures integrated.

The doctors conducted regular handovers to other practices (including NHS) appropriately, this usually took the form of direct discussion with an appropriate clinician. For patients leaving the military, pre-release and final medicals were offered. During the pre-release phase, all patients received a summary of their healthcare record, including immunisations and medication and information on how to obtain a full copy of their records. An individual handover was given for any of patients of concern.

The SNO had good relationships with outside NHS providers including Somerset breast screening services and the bowel screening service. The PCRF had direct links with the local NHS hand therapy service, x-ray at Commando Training Centre Lympstone and women's health services, these were contacted directly through the respective secretaries.

Helping patients to live healthier lives

Health promotion was run from the National Health promotion calendar. The health promotion displays were comprehensive, clear and positioned strategically to target the most relevant cohort of patients. At the time of the inspection there was also a large mental health display inside the front door that had been put together by one of the medics who had a special interest in mental health.

The SNO was the sexual health lead and was able to offer advice and support but was not specialist trained. The medical centre had good access to the sexual health team based in the southwest region and were able to contact them when required. A female nurse attended from Norton Manor Medical Centre on a regular basis to provide women's health such as smears and to fit intrauterine devices (coils). The medical centre had direct access to the local sexual health services, SWISH (Somerset Wide Integrated Sexual Health). Referrals could be made by the clinicians or patients could self-refer. The medical centre including the PCRF were engaged with the unit health fairs on the station, providing medical information and blood pressure checks to all those who attended. This was a good opportunity to network with other departments on base including welfare and the dental centre.

All eligible female patients were on the national cervical screening database and were recalled by the nurse. The latest data confirmed a 97% 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.

Vaccination statistics were identified as follows:

- 89% of patients were in-date for vaccination against diphtheria.
- 89% of patients were in-date for vaccination against polio.
- 93% of patients were in-date for vaccination against hepatitis B.
- 80% of patients were in-date for vaccination against hepatitis A.
- 89% of patients were in-date for vaccination against tetanus.
- 94% of patients were in-date for vaccination against MMR.
- 82% of patients were in-date for vaccination against meningitis.

Consent to care and treatment

Staff had a good understanding of the Mental Capacity Act (2005) and how it would apply to the patient population, all staff had received training in mental health this was delivered by the GP registrar in November 2023.

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. A review of patient notes evidenced that verbal consent was recorded and coded appropriately on DMICP. Clinicians advised us that implied consent was accepted for basic procedures such as the taking of blood pressure. Written consent was taken for more intimate examinations and this was regularly audited.

Are services caring?

We rated the medical centre as good providing caring services.

Kindness, respect, and compassion

In advance of the inspection, patient feedback cards were sent to the medical centre. A total of 20 patients responded and feedback was positive. The last patient survey, undertaken by the medical centre (February 2024) showed 99% (of applicable patients) said their care was good or excellent when asked if they were treated with kindness and compassion. We spoke with 5 patients on the day and they were highly complementary of the care they had received.

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 the padre who said staff at the medical centre were always available when needed and were kind and compassionate.

Through discussion with the team, we learnt how medical centre staff routinely went the extra mile to ensure that the mental health and holistic needs of patients were met in a timely, respectful and compassionate way. We saw several examples.

One patient had required enhanced support regarding housing and financial support even to help getting to appointments. The medical team continued to support this patient even though they had moved to another base. Further examples were of 2 more patients who were receiving palliative cancer care. The Deputy Principal Medical Officer (DPMO) and Petty Officer Medical Assistant (POMA) had visited them at home even though the journeys were up to 2 hours away.

Involvement in decisions about care and treatment

The clinicians and staff at the medical centre recognised that the personnel receiving care and treatment could be making health care decisions that could have a major impact on their military career. Staff demonstrated how they gauged the level of understanding of patients, gave clear explanations of diagnoses and treatment, and encouraged and empowered patients to make decisions based on evidence-based guidance and clinical facts.

Patients identified with a caring responsibility were captured on a DMICP register. It included what had been discussed at the monthly practice/clinical meeting and any actions identified. There was a practice leaflet which included information for carers. Alerts were made on individual patient’s notes to ensure that longer appointments were given if needed. There were 30 carers registered. Searches were conducted to ensure that the flu vaccine was offered appropriately. There was a carers poster on display in the waiting area.

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

Patient feedback showed that they were confident that the medical centre would keep information about them confidential. All stated that they felt that their dignity and privacy were upheld by medical centre staff. Consultations took place in clinic rooms with the door closed. Patients were offered a private room if they wanted to discuss something in private or appeared distressed.

The physiotherapist assessment and treatment areas within the Primary Care Rehabilitation Facility (PCRF) was in separate clinical rooms, the rehabilitation gym was open plan with curtains so conversations could be overheard. This had been mitigated by having music playing. Staff also have the option to use a private office for confidential conversations. Hydrotherapy slots were arranged specifically for rehabilitation patients so that they did not have to work through their programme in-front of their peers.

All staff had completed the latest training with regards to Handling and Protecting Information within Defence and Medical Centres, which incorporated Caldicott Principles.

Are services responsive to people’s needs?

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

Responding to and meeting people’s needs

The medical centre considered the occupational needs of the patient population when planning clinics. For example, there was a duty doctor available every day, throughout the day, and urgent clinics were available twice a day (morning and afternoon) to accommodate those patients who needed to be seen sooner. The Primary Care Rehabilitation Facility (PCRF) had introduced a duty physiotherapist initiative that allowed new patients to be seen early alongside a medic. This provided both a responsive service and one in which the medics were able to see more urgent cases and develop their skillset.

Clinics specific to deployment were held in liaison with the Chain of Command. Telephone appointments and eConsult were routinely available and there was a home visit log on the healthcare governance workbook.

The PCRF had made changes to some aspects of service delivery based on patient feedback and to be more responsive to patient need. For example, they introduced wrap around Individual Programme (IP) classes. This was because patients were struggling to get into the PCRF for supervised rehabilitation sessions, so the PCRF made this service available early hours and at the end of the day.

Diversity and inclusion in house training was regularly delivered. There was good communication with the station leads and nominated leads within the medical centre. An Equality Access Audit as defined in the Equality Act 2010 was completed in May 2024. Any points identified were discussed and put onto the issues register.

The Principal Medical Officer (PMO) was the Royal Navy lead for the transgender community. The medical centre team were actively supported some patients undergoing gender reassignment. A policy was in place to guide staff in exploring the care pathway for patients transitioning gender.

Timely access to care and treatment

Details of how patients could access the doctor when the medical centre was closed were available through the station helpline and was outlined in the practice information leaflet. Shoulder cover was provided by the duty doctor until 18:30 hours, then patients were directed to the NHS 111 service.

All doctors consultations were for a minimum of 15 minutes with at least 30 minutes for mental health and occupational health. All acute illness and injury could be seen on the day. Routine appointments to see a doctor were available within a few days and

occupational health appointments within a week. An appointment with the nurse could be facilitated within a few days.

Within the PCRF appointments were available promptly although direct access referrals into physiotherapy was not offered. A new patient appointment was available within 2 days with the follow up appointment available within the following week. Urgent physiotherapy appointments were available within 1-2 days. Patients could see the exercise rehabilitation instructor (ERI) within 2 days and a follow up within the following few days. Rehabilitation classes could be facilitated within a day and hydrotherapy within 2 days.

Home visits were rare but had been offered as an exception if required on a case by case basis. The latest patient survey carried out during the month of February showed that 94% of patients that responded (48) said they could access healthcare easily.

The Deputy Principal Medical Officer has established links with the station DASOR lead (Aviation significant events reporting tool) to ensure that all events within medial relevance were shared for review and comment. This followed a COSHH incident where individuals came into close contact with a material which had the potential to cause harm. The Medical Centre found out by chance, which led to the PMO contacting the unit to ensure that all personnel exposed received appropriate health checks and follow ups.

Listening and learning from concerns and complaints

The medical centre had implemented a process to manage complaints in accordance with the Defence Primary Healthcare complaints policy and procedure, 6 written complaints had been recorded within the past 2 years and these were seen to have been managed appropriately with good communications with the patients and full duty of candour applied.

Information was available to help patients understand the complaints system, including in the patient information leaflet and in the waiting room.

Are services well-led?

We rated the medical centre as outstanding 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 to its own mission statement which was

‘Cohesive, compassionately led team, delivering safe and effective patient centred clinical care, to meet the operational requirements of the UKs maritime, littoral and land aviation war fighting capability.

The Primary Care Rehabilitation Facility (PCRF) vision and mission statement was:

> ‘To sustain and improve the training and operational effectiveness of injured service personnel by provision of high-quality targeted rehabilitation, accelerating their return to optimal physical capability, whilst influencing their psychological and social health and wellbeing.’

The new Officer in Command (OC) in the PCRF, had set some fresh objectives, which were laid out as part of a PCRF development plan. One of the main new objectives was to provide regular holistic health and wellbeing classes to complement the current patient treatment regimes. There was clear engagement and support from the medical centre to support PCRF priorities.

The management team had developed a practice development plan (PDP) to enhance the service they provided to their patients; some actions on the PDP had already been completed. Examples included obtaining an iPad for the waiting room so patients could use this to provide feedback and replacement of notice boards so they were infection, prevention and control compliant.

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. They were doing this by using laptops and large screens to share information, for example, not printing minutes of previous meetings or agendas but having them on screens. Quick Reference (QR) codes were available throughout the medical centre and the PCRF to facilitate information sharing.

Leadership, capacity, and capability

During the inspection we spoke with the Executive Officer for the station and the Commanding Officer of the Commando Helicopter Force. Both described a medical centre that was well run, responsive and always available to support patients. Communication between the medical centre and the station was described as excellent.

At the time of this inspection, a number of positions in the established team were not filled. This had minimally impacted service delivery due to the hard work and resilience of the team and the upskilling of medics to provide effective and safe patient care. The management team had a wealth of experience and worked well together, they provided direction, decision making and structure. There was a comprehensive meeting structure that underpinned the governance structure and promoted an inclusive leadership approach. Staff we spoke with consistently praised the leadership and this was echoed in the feedback from affiliated staff and patients. It was apparent from walking round the medical centre and discussions with staff that there was a high level of respect and support across all levels/ roles and professions within the team.

Joint working was evident within the PCRF with them having regular engagement with the Regional Rehabilitation Unit (RRU).

All staff had Terms of Reference (ToRs) which included their primary role and all other secondary lead roles. There was a log of all ToRs on the healthcare governance (HCG) workbook which included review dates.

The last internal assurance visit was completed in November 2022 and the medical centre was rated as 'substantial assurance'. The RRU undertook an advisory visit of the PCRF in January 2023, the issues identified were swiftly actioned. The medical centre staff said they felt well supported by the regional team including Regional Clinical Director (RCD) who was approachable and supportive.

The team were committed to delivering the best care through a culture of constant learning and improvement. The medical practice was an approved training practice and had a well-established training ethos. It supported learners in a variety of trade groups including doctors and medics which ensured teaching and learning was always a high priority.

Culture

It was clear from patient feedback, interviews with staff and quality improvement activity that the needs of patients were central to the ethos of the medical centre. Staff felt that their contributions to the development of the service were valued. All staff attended the practice meetings where they could put forward suggestions or raise concerns.

We interviewed a cross section of staff, and all told us that it was a happy place to work and that they could rely on their work team to discuss and mitigate any concerns they faced. They spoke about colleagues who were supportive, compassionate, and caring. All the management team empowered the junior staff within their roles. This created good relationships between the senior and junior staff and made them feel valued whilst

promoting trust and mutual respect. The junior staff we talked with confirmed they felt comfortable in their roles and felt part of the medical centre development.

The practice used civil service ‘in-year awards’ to financially reward hard work. For example, within the last year:

- 1 Hebert Lott Award (this award if for innovation, useful research suggestions or interventions)
- 1 Kings Garden Party successful recommendation
- 6 in year financial awards
- 1 vouchers award scheme
- 1 Commanding Officer’s award
- PMOs monthly award

One of the medics organised a Macmillan Coffee Morning within the medical in September 2024 to raise awareness of cancer, raising £400 for the charity.

Staff members were highly complementary about the leadership in the practice. They felt respected, supported and valued.

Processes were established to ensure compliance with the requirements of the duty of candour, including giving those affected reasonable support, information, and a verbal and written apology. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. We were provided with examples of when duty of candour had been applied.

Governance arrangements

The leadership team had established responsibilities, roles and systems of accountability to support good governance and management. Key roles were supported by a named secondary person to provide resilience. A range of meetings with defined topics for discussion were held to ensure a communication flow within the team. The medical centre had a designated meeting matrix in place which included the following:

- Full practice meetings.
- Clinical and development meetings
- Healthcare governance meetings
- PCRF meetings
- Welfare meetings
- In-house training held (protected time allocated weekly)
- Southwest virtual Multi-Disciplinary Injury Assessment Clinics (MIAC)
- Muscular skeletal multi-disciplinary team

The medical centre had worked hard to maintain the healthcare governance workbook, it was extensive, well referenced and integral to the effective running of the service.

Managing risks, issues and performance

There was a current and retired risk register on the healthcare governance workbook along with current and retired issues. The register articulated the main risks identified by the medical centre team. The registers were regularly reviewed. There were a range of risk assessments in place including both clinical and non-clinical risks.

Staff who were not performing would be supported initially to identify any underlying cause and implement support structures. If performance did not improve then formal performance management processes, military or civilian, would be followed.

There was a business continuity plan (BCP) in place that had been reviewed in April 2024. The BCP 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. The medical centre had also developed a medical response document which clarified their role within the unit major incident plan and this was last reviewed in February 2024.

Appropriate and accurate information

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

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

The Governance Assurance Performance and Quality (GPAQ) dashboard was used to monitor and analyse patient feedback. There were QR codes for the survey available in reception along with paper feedback forms and a newly installed iPad for immediate feedback. Continued work was ongoing to establish an active patient participation group but attendance had been minimal.

The medical centre conducted a staff survey in March 2024 where the responses were largely positive. There were some minor issues around communication, and as a result the leadership team now minute their weekly 'clear lower deck meetings', that are then distributed out to the whole team.

The management team had tried to use all reward and recognition processes to thank staff for hard work and also utilised 'Whitespace' activity to enhance teamwork. Several events had been organised to boost staff morale often in conjunction with increasing understanding of how departments across the station functioned. As well as regular social

events such as pottery painting and BBQs, there had been visits to the dunker (used for helicopter training) and air traffic control tower and helicopter experiences.

The medical centre was trialing the introduction of a formal mentorship programme. This programme was aimed at junior military staff within the practice, to enhance team cohesion and help support and develop staff to maximise their potential. Leaders at the medical centre met with the medics regularly to check on their wellbeing. This has led to a change of mentor on occasion and when they indicated that they were feeling burnt out or overwhelmed arrangements were made for them to all have a 4-day weekend. Through support and discussion, this mentorship programme had encouraged medics to consider their career plans with some personnel now seeking places to become nurses or doctors. Should the trial of the mentoring programme be successful, the aspiration would be for all staff to be allocated mentors. With the considerable number of staff within Yeovilton Medical Centre, the formal mentorship programme provided dedicated time to staff development whilst enhancing team cohesion.

To increase the communication between the medical centre and patients, a monthly newsletter has been introduced, this was written by one of the medics. This was shared to all units and the wider station.

Continuous improvement and innovation

A quality improvement programme was in place. The audit register clearly demonstrated that the practice 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. Quality improvement projects (QIP) carried out by the practice were held on the DPHC HCG workbook and 10 QIPs had been logged since March this year. Some examples were:

- Identifying that there was a significant delay in the process of achieving initial aviation medical signoffs for local winchmen through the existing pathway, the lead aviation medical clinicians, in conjunction with head of Royal Navy aviation medicine reviewed the pathway to enable sign off for simple cases at a local level. This reduced the burden on Occupational Health, improved operational capability and the experience of those individuals involved.
- Medics were able enhance their muscular skeletal knowledge by being supported and trained by a duty physiotherapist during urgent clinics. Patients also benefited by having prompt access to a physiotherapist. It also reduced the number of inappropriate referrals.
- The enhancement of the induction programme for doctors to include a ‘live’ aide memoir has benefited new clinicians coming to the medical centre.

Within the PCRF the QR codes introduced gave access to information databases to facilitate processing of relevant information. The benefits were centralisation of various daily practices within the PCRF including administrative processes and paperwork

The PCRF worked collaboratively with professionals supporting Rotary Wing flying stations. They aimed to share initiatives on injury prevention and management projects, such as the Aircrew Conditioning Programme, and invigorate joint learning and problem solving.

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A DMICP (the clinical operating system used) synonym was implemented for better recording of the Anterior Cruciate Ligament (ACL) rehabilitation. Following an influx of injuries from ski injuries and a subsequent ski injury audit. This made the rehabilitation pathway more effective as per best practice guidelines.

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