Portsmouth Combined Medical Practice (PMX)

HMS Collingwood Medical Centre, Newgate Lane, Fareham, PO14 1AS

HMS Excellent Medical Centre, Whale Island, Portsmouth, PO2 8ER

HMS Nelson Medical Centre, Queen Street, Portsmouth, PO1 3HH

Southwick Park Medical Centre, Nr Fareham, Hampshire, PO17 6EJ

HMS Sultan Medical Centre, Military Road, Gosport, PO12 3BY

Thorney Island Medical Centre, Baker Barracks, Emsworth, PO10 8DH

Defence Medical Services inspection report

This report describes our judgement of the quality of care at Portsmouth Combined Medical Practice, referred to throughout the report as PMX. It is based on a combination of what we found through information provided about the service, patient feedback and through interviews with staff and others connected with the service. We gathered evidence remotely and carried out an in-depth visit to 3 of the 6 sites. The other 3 sites provided a self-assessment return and we carried out a short visit to view facilities and infrastructure as well as talk to staff. In addition, staff from all sites travelled to Nelson Medical Centre to speak with us.

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?	**Good**	●

Contents

Summary

About this inspection

We carried out this initial announced comprehensive inspection at Portsmouth Combined Medical Practice (PMX) on 17 and 18 September 2024. We had previously inspected the 6 practices individually, however, as they were now fully operational as a combined practice. This inspection was the first for PMX.

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

Are services safe? – good

Are services effective? – good

Are services caring – good

Are services responsive to people's needs? – good

Are services well-led? – good

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

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

At this inspection we found:

- The leadership team had a clear understanding of key issues and the work on combining was ongoing, most notably for the primary care rehabilitation facilities (PCRFs) where combined working practices were yet to be fully developed.
- A system was in place for managing significant events and most staff knew how to report and record using this system. Processes for learning from events were PMX wide and supported by an open door and no blame culture.
- Risks had been identified, assessed and actions recorded when completed. Staffing levels was an ongoing risk although PMX was moving into a stage where the workload was forecasted to be reduced with much of the one off work on combining 6 practices having been completed.

- Effective infection prevention and control processes were in place across all 6 sites.
- Arrangements were in place for managing medicines, including obtaining, prescribing, recording, handling and disposal in the practice. Some minor improvements were highlighted during the inspection process.
- The development of PMX standard operating procedures was ongoing to standardise processes across all 6 sites. PMX polices had been developed and ratified.
- Patient feedback about the service was positive. Data was collated at individual sites to enable localised issues to be pinpointed and across PMX to identify any trends. Staff and patients were able to give feedback (including anonymously).
- The practice had developed an improvement programme which consisted of a comprehensive audit calendar as well as many quality improvement projects.
- The practice had a system to identify the training needs for individual staff. However, there was a need for greater clarity around the status of mandated training courses completed. An effective system ensured that staff held the appropriate professional registrations.
- Effective clinical cover was in place to cover the times when the practice was closed including reach back from ships. This was clearly communicated to staff and patients.
- Staff understood the Mental Capacity Act (2005) and how it applied in the context of the service they provided.
- Information systems and processes were in place to deliver safe treatment and care. There was a backlog of summarising that had been addressed with an action plan.
- The practice had good lines of communication with the units and welfare teams to ensure the wellbeing of patients. Extensive links had been developed both internally and externally to enhance the support provided to patients and staff.
- The building and equipment were sufficient to treat patients and meet their needs. Effective workarounds had been implemented at Sultan where the roof was awaiting repair.
- Formal peer review arrangements were in place or planned for all clinical staff to include effective auditing of notes.
- Staff understood and adhered to the duty of candour principles.

We found the following areas of notable practice:

- Integration into the first formalised combined practice on such a scale had been achieved in the main by the skill and tenacity of PMX staff whilst continuing to carry out their daily duties. Much of the work was pioneering, of note, the governance structure that had been implemented, the induction programme and the referrals management process. PMX had performed successfully under the scrutiny of 2 separate assurance visits in the space of 6 months following on immediately from becoming fully operational.
- Through effective and extensive communication, the leadership team had fostered a culture of being a single practice and this was supported by the innovative use of

OneNote and Sharepoint. In addition, the affiliated staff, including the Commanding Officers, we contacted as part of the inspection reported on how effective communication throughout the combining process ensured that the synergy of the combined practice provided an enhanced level of care to their serving personnel.

- PMX had developed an induction PowerPoint which linked the role specific inductions. This included locum induction, checklists, the health and safety brief, employment checks, multiple links to specific standard operating procedures for week 1 and links to the registration page for military staff. The presentation also included a prompt for a meeting with their line manager and at 3 weeks, asked for feedback and prompts and the issue of a completion certificate. New staff sat in with a colleague for 1:1 instruction on new systems such as DMICP. Bespoke clinics were set up to account for the person's experience until assessed as conversant with working practices. Workplace visits were arranged to support occupational medical care to patients. Nelson had an 'NHS trainee' bespoke booklet that was now also given to each locum. It was planned for this to be used across PMX.
- The PCRF offered a women's health service. This service supported female service personnel from across the region (wider than PMX). The clinician was passionate about the service and other staff reported high praise for the care delivered. There were specific risk assessments and SOPs for the service, examples included consent and chaperoning.
- PMX sites had taken steps to address environmental sustainability. For example, Nelson had implemented environmental sustainability notice boards in the staff and patient areas to encourage recycling along with additional waste bins to segregate waste. There was an active plan to reduce printing where appropriate. PMX was conducting an audit on inhaler use to see if they could reduce the environmental impact without detriment to patient care. Each site engaged with Unit Environmental Health Officers via Unit safety, health, environment and fire meetings and they tried to observe Triad warnings (sent by electricity suppliers to inform of the 3 peak periods of electricity demand, known as triads).

The Chief Inspector recommends to region/DPHC:

- Support PMX in achieving staffing levels to mitigate the associated risks recorded on to the risk register, in particular, the nursing team across PMX and the administration team based at Nelson.

The Chief Inspector recommends to PMX:

- To ensure that mandated training for staff has been completed or planned and that the process for monitoring provides clarity on the status of the training.
- Ensure the DPHC waste log is used at all sites.
- Continue to standardise processes and integration across PMX with a particular focus on the PCRFs and medicines management.

- Review the standard operating procedures and processes around the management of controlled drugs to ensure adherence to DPHC policy.
- Ensure all 6 sites are formally reporting risk and raising ASERs when appropriate.
- Conduct regular checks on panic alarms to ensure they are effectively working.
- Further develop the PCRF induction process.
- Ensure training in learning disability and autism is provided in accordance with the DSMR regulatory instruction issued in April 2024.

Dr Chris Dzikiti

Interim Chief Inspector of Healthcare

Our inspection team

The inspection team was led by a CQC inspector and comprised specialist advisors including a primary care doctor, nurse, physiotherapist, practice manager and a pharmacy technician. In addition, a colleague from DMSR attended and 2 new specialist advisors attended as observers.

Background to Portsmouth Combined Medical Practice (PMX)

As part of the Healthcare Improvement Programme, an initial operating capability document was issued in November 2022 to detail the project of combining 6 sites in the Portsmouth area into one combined practice. The project aimed to improve patient outcomes, increase deployability and improve experience for staff and patients. This would be achieved by sharing resources, data and services to increase healthcare access and delivery options, increase standardisation, enhance best practice, improve efficiency, adaptability and resilience. The scaling of the combined practice resulted in the provision of routine primary care service to a patient population of approximately 10,000 service personnel with a further 2,000-5,000 unregistered patients passing through annually (attending courses, ships when in dock). In addition, the practice provides occupational health to service personnel. PMX reached full operation capability in August 2024 with patient lists and governance structures combined.

Three of the medical centres have a dispensary. All 6 medical centres in the combined practice provide a physiotherapy and rehabilitation service for service personnel. They usually see patients based at their respective sites to minimise travel requirements and provide continuity of clinician along the rehabilitation pathway.

Opening hours varies across the 6 sites but at least 1 site is open from 07:45 until 18:00 hours Monday to Friday. The duty medic can be contacted by a mobile phone and triaged calls initially. A duty doctor is on call to support the medic. Patients are instructed to dial 999 in an emergency and advised on the NHS 111 service for 24/7 medical advice. The closest hospital with an accident and emergency department is Queen Alexandra Hospital Portsmouth and this was within 30 minutes of each of the 6 sites.

The staff team

Position	Numbers
Doctors (18 in total)	1 military Principal Medical Officer (PMO) Lead 1 military Deputy PMO Lead 4 military doctors who are pillar leads (governance, clinical delivery, workforce, infrastructure and organisation) 1 military doctor 1 civilian Senior Medical Officer 10 civilian doctors (1 position gapped)
Nurses (10 in total)	1 Senior Nursing Officer (SNO) 1 military nurses 7 civilian nurses (1 position gapped)
Pharmacy	1 military pharmacy technician 3 civilian pharmacy technicians (2 full-time, 1 part-time)
Primary Care Rehabilitation Facility	3 Band 7 physiotherapists (1 full-time, 2 part-time) 17 physiotherapists (2 positions gapped) 9 exercise rehabilitation instructors (3 positions gapped) 1 administrator
Administration team	1 combined practice Warrant Officer 4 military practice managers 1 civilian practice manager 2 business manager (1 position gapped) 5 military deputy practice managers 12 civil service administrators 14 contracted administrators

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

Portsmouth Combined Medical Practice (PMX) had developed their own safeguarding standard operating procedure (SOP). The SOP had been recently reviewed and referenced vulnerable adults and children. This was accessible electronically to all staff and outlined clearly who to go to for further guidance included links to the Hampshire safeguarding teams. Staff received safeguarding information as part of their induction and refresher training. Staff working at training units also completed a non-clinical 'care of trainees' module.

There was an appointed lead for PMX and named safeguarding leads for each of the 6 sites; all had completed level 3 safeguarding training. Most staff had completed safeguarding and safety training appropriate to their role and those we spoke with knew how to identify and report concerns. All clinicians had completed a level 3 training course held locally. There was a centralised safeguarding register for the 6 sites that allowed overarching guardianship by the PMX lead. A second unique identification number was added to the patient records to identify the site at which they were based. The register encompassed the 6 main safeguarding groups and each section was reviewed and updated monthly at individual site level. The site level reviews were held in the morning on the same day that the PMX afternoon meeting was held. The safeguarding register was held on an area of SharePoint with limited, controlled access for appropriate staff members. Monthly searches were completed on the electronic patient record system (known as DMICP) and the register updated. The register used service numbers instead of DMICP numbers as DMICP deployed (used in medical centres overseas and on ships) used different patient DMICP numbers than those in the UK.

Vulnerable patients were identified during consultations, through the new patient registration process or through referral from another department, such as the welfare team. All new patients identified as vulnerable were tasked to the safeguarding group (made up of the safeguarding leads, deputies and the nursing team) and the lead for the site where the patient was registered updated the main register. The team applied the correct Read code and added an alert to the patient record so they could be readily identified (Read codes are a comprehensive list of clinical terms used by healthcare professionals to describe the care and treatment given to patients).

There was a risk register of vulnerable patients and a system to highlight them on DMICP. There was an extensive and comprehensive meeting schedule where doctors and other staff, including representatives from the primary care rehabilitation facilities (PCRFs) met. Safeguarding issues and 'patients of interest' were included on the agenda. Each of the 6 sites continued with their own reviews and these were fed into the group to allow for the PMX safeguarding lead to have an overarching view. A note of any discussion was added to the patient record. Registers were reviewed during monthly meetings and we contacted staff from the welfare team who reported that well established and effective communication channels were in place.

Staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or are on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. Consultations for women's health and minor operations always included a chaperone and we saw that these were correctly Read coded in the clinical notes. Staff who had received chaperone training were listed in the healthcare governance workbook (HcG Wb). Posters advising patients about requesting a chaperone were clearly displayed in clinical rooms, the waiting room and in the practice leaflet. Each site maintained a list of trained chaperones that was kept in clinical rooms and at reception. Many of the nursing procedures followed a template which included a section to document the offer of a chaperone. A review of consultations demonstrated that the nurses were offering a chaperone to patients requiring an intimate examination and this was documented in the consultation including if the patient declined.

The full range of recruitment records for permanent staff was held centrally. However, the practice 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. An electronic record identified when each member of staff was required to renew their professional registration. All staff had crown indemnity and professional registrations were recorded on the workforce training log. There were a small number of gaps in this data but these were rectified during the inspection. There was an appointed PMX Workforce Manager and a workforce workbook which was utilised to monitor gaps in staffing. Requests for locum staff were added to a regional 'requests table' on SharePoint and then moved to the 'approvals' spreadsheet when financial approval was in place. Staff were up-to-date with their hepatitis B vaccination and there was a hepatitis B register available to view.

New staff were required to complete the Defence Primary Healthcare (DPHC) mandated induction which included specific elements for the different roles. There was a checklist which recorded progress and completion of induction. All new staff had commenced their induction and all permanent staff had completed an induction. Locum staff were used to cover staff gaps and there was a specific induction pack which included the appropriate recruitment checks.

The Senior Nursing Officer (SNO) for PMX had the lead on infection prevention and control (IPC) and had completed role-specific training. Each of the 6 sites had an IPC link practitioner, and training was 97% compliant. One of the exercise rehabilitation instructors was undergoing training to become a link practitioner for the PCRF. We found that 77% of the staff team were up-to-date with the mandatory IPC training. However, at Nelson, only 51% of staff were in-date. An internal IPC audit had been undertaken in March 2024 and found the practice to be 89% compliant. Minor issues identified were detailed in an action plan, which included target review and completion dates together with delegation to individual staff members. The IPC audit was repeated annually or sooner depending on the result (if the compliance score was low meaning more issues had been identified, the audit would be repeated sooner). There was a PMX IPC register which included sections for each specific site. Any issues identified in the IPC audit were captured in the relevant issues log including reviews and actions. They were moved to the retired issues log when actions had been completed.

All 6 sites had a scheduled deep clean; normally around unit leave periods such as summer and Christmas or following completion of infrastructure works. The IPC audit was shared amongst the team and split over a 12 month period to break it down into sections. An 'action grid' was available on SharePoint for any actions to be taken as the team felt the new audit tool being online did not reflect when actions had been completed. The 'action grid' was reviewed at the monthly nurses' meeting and also governance meetings if appropriate. All sections of the audit had been completed in the last 12 months.

Environmental cleaning was provided by a contractor (2 different companies were used) at each site and contact details were listed on the infrastructure and IT workbook which was managed by an appointed lead (the practice manager at Excellent Medical Centre). Each facility did not have access to the cleaning contract as it was held by the site executive team at each site. However, the SNO and link practitioners had all made a number of attempts to obtain this. The SNO had regular meetings with one of the contractors to raise any issues but reported that the second contractor had not engaged as well.

Some sites had a dedicated medical centre cleaner (the same person was in the medical centre for the duration of their shift). This was apparent in the high standard of cleanliness of those facilities. Some facilities had cleaners rotating through and they covered other buildings. The facilities were clean and met IPC standard. The SNO was working with the cleaning companies to have a dedicated cleaner based permanently in each facility. Some sites documented spot checks and some conducted regular walk rounds with contract cleaning managers. All issues were addressed locally and there were no concerns reported at the time of the inspection. Any issues would be captured on the site specific issues log within the infrastructure and IT workbook.

From discussion with the nursing teams at each site, much work had been completed to improve communication between the facilities and cleaning team/managers and this was evident from the engagement. An example was at Thorney Island where there was insufficient cleaning hours for the facilities that included both the medical and dental centres. This had been highlighted through IPC audits and the practice manager fed back the deficiencies to the on-site team. In response, the on-site manager conducted a monthly walk around to audit the facilities. This was being tracked with a view to increasing the contracted cleaning hours. Five out of the 6 sites closed for block leave. During each block leave period these 5 sites had a deep clean. Nelson remained open and deep cleaning took place in August 2024, spread out over a number of days to ensure delivery of care was maintained.

There were systems for safely managing healthcare waste supported by a policy. Clinical waste and pre-acceptance audits were carried out annually on the same day at each site. Clinical waste was bagged, labelled with the practice code and recorded in the waste log. External storage was in lockable waste skips, held in a secure areas. We reviewed the process at Nelson and noted that the DPHC waste log template was not used and therefore waste collected was not being cross referenced to the log although the evidence was contained within the folder.

There was a comprehensive acupuncture SOP in place developed from the DPHC-wide SOP.

Risks to patients

There were 3 overarching risks on the PMX risk register. These were: the reduction of delivery of high quality patient care, working practices being detrimental to staff wellbeing and an inability to support operational output. These risks had many sub-risks across several domains including staffing levels. There were concerns that had been raised around staff burnout, delays in care as a result; impact of recent civil service recruitment controls and military staff gaps, all of which were compounded by the limitations of the Ministry of Defence locum contract. It had been a turbulent time for PMX with much of the project work regarding the combining of sites congested into the day jobs, most notably for the management team. Although some benefits from combining had been identified, resources appeared to be spread thinly and the staffing establishment had not been sufficient to deliver the outputs of PMX. A period of stability was predicted now that much of the combining work was complete and this was seen as an opportunity to assess staffing levels required.

A consistent theme throughout the inspection was that the combined working had helped the workload of doctors but other staff were often burdened with extra workload and the administrative burden at Nelson Medical Centre was an issue. The senior team and region had a clear awareness of the risks and planned to formulate ways to address them in the immediate future. Across PMX, staff had a ‘green’ and ‘amber’ clinic structure. ‘Green’ was used when staffing was buoyant and ‘amber’ when staffing levels necessitated rationing of appointments or allocating more urgent/soon appointment and less routine slots.

The nursing team currently had gapped and vacant posts. Since combining, the nurses reported that their administrative workload had increased which was taking them away from clinical delivery. Nurses believed this would settle down once all processes were aligned. The SNO was currently reviewing workloads along with tracking timesheets so that the team were proactive rather than re-active. Due to a vacant post, a member of the team had a short-term uplift of hours to reduce frequent extra hours being worked. At the non-dispensing sites, the nursing team reportedly spent approximately 60% of the week on non-clinical work such as medicines management tasks. However, the SNO and pharmacy team were looking at changing practice so the pharmacy technicians could provide support at these sites.

Each facility was equipped to deal with medical emergencies. Emergency kit, including a defibrillator, oxygen with masks and emergency medicines were accessible to staff in a secure area; all staff we spoke with knew of the location at their respective site. Records highlighted that equipment including the emergency trollies were regularly checked. We highlighted that it was DPHC policy to have an emergency medicines risk assessment on or adjacent to each emergency trolley and that the policy for emergency kit was overdue a review. Despite this, we found no risk to patient safety but questioned the need to hold a number of items at Nelson such as a ‘medic crash bag’ (removed on the day), a surgical airway and Magill forceps (used to guide a tracheal tube into the larynx or remove foreign bodies lodged in the airways). However, the emergency trolley at Sultan Medical Centre was kept in a warm, sunny room and the temperature recorded in this room on the day of inspection was on the limit of the recommended parameters. Written procedures (SOPs) were in place to support safe dispensing practice.

Staff had completed basic life support (BLS) training and most were in-date with the refresher update. Those overdue were scheduled into future sessions. Training included instruction on how to use the automated external defibrillator and anaphylaxis (severe allergic reaction). Simulation or 'moulage' training sessions were held to ensure staff were familiar with the equipment and procedures. Simulation training completed by the medics and reception staff were specifically targeted to help them recognise and manage emergencies. Recent examples included an emergency casualty, a casualty incident and the deteriorating patient. A 'divisional day' (organised by the base at Nelson) was attended by medics who ran through simulation training with the wider base team members. Staff spoke positively of this format and a second in-house day was completed for reception and medics.

Several members of staff had completed additional training that included 'Battlefield Advances Trauma Life Support', referred to as BATLS, and Immediate Life Support. The PMO at Sultan and Deputy Principal Medical Officers (DPMOs) at Nelson and Collingwood were Advanced Life Support instructors. Nurses from the Institute of Naval Medicine Thermal Injury Clinic had delivered a training session on recognition of thermal injuries to the nursing team and thermal injuries was also included in the medics continued professional development. Spinal injuries training was normally delivered to personnel afloat.

Clinicians knew how to identify and manage patients with severe infections including sepsis. Sepsis training had been delivered for all staff across PMX in September 2024. A support template with prompts to help identify potential sepsis was built into templates on DMICP. Posters were displayed to guide patients and staff in recognising the signs of sepsis.

The areas used by the PCRF were air conditioned and staff used wet globe bulb testing to ensure that environmental conditions were safe for physical activity. PCRF staff had completed BLS training as part of their mandated training and some of the staff had also participated in recent simulation training to practice the response to a medical emergency.

Information to deliver safe care and treatment

Staff at each of the 6 sites described how they would utilise the business continuity plan during DMICP outages. A hard copy of the following day's clinics was printed so they knew which patients were scheduled to attend. Only urgent patients would be seen during the outage and paper records would be produced using the 'DMICP down' packs. Paper records would be scanned onto the DMICP health record when available. Thursday outages were planned each week and Nelson provided out-of-hours cover for any ships in dock at Portsmouth.

The practice was able to demonstrate a process of peer review/audit of clinical records was in place, in which clinicians cross checked each other's record keeping, including elements of following evidence-based practice, quality of clinical record and use of templates. The Senior Medical Officer at Thorney Island Medical Centre led on this work and each clinician got feedback on the overall themes identified. Nurses told us that they discussed records at their monthly meetings. The formal peer review for PMX nurses was scheduled to take place in quarter 4.

Notes audits had recently been undertaken by some PCRF staff and the process was being embedded as part of the PMX audit programme. An audit of patient notes was carried out as part of the inspection. The general standard of notes was high with 1 exception where no assessment had been recorded for a new patient. We discussed how the process could be developed to ensure the same process and standards are applied to future audits and utilisation of PMX PCRF wide synonyms to support effective documentation.

Nursing staff found that clinical searches were not easy to build due to multiple Read codes and due to the work completed for combining. Information held varied which prolonged providing regional returns. Staff reported that they experienced issues with the reliability of information which made the administration cumbersome and not robust.

Practice nurses and medics completed the summarising of patient notes. The SNO led a 'tiger team' of nurses and medics to address the backlog in the summarising of patient notes. Approximately 5,000 sets of notes had recently been summarised and the team used population manager to monitor the status of outstanding work. All new patient notes were summarised as part of the registration process but there was a backlog of patient notes that were overdue a 5 year review. Since the working group had been established, the backlog in summarising had reduced from 6,000 in May 2024 to 2,000 in September 2024. The summarising process was used to educate and inform staff about the importance of consistent Read coding.

Each site had a designated referral department and the department at Collingwood provided an oversight of the referral activity within PMX. Collingwood Medical Centre had introduced a system to monitor referrals: routine (weekly), urgent (4 days) and 2 week wait (2 days). They also monitored the electronic referral system, known as eRS daily for each of the sites within PMX to ensure all there were no outstanding actions or responses from the hospitals. On review of the referral database, a percentage check was undertaken on outstanding routine, urgent and 2 week wait appointment. Every referral contained an auditable record of when it was last hastened and a comment to state what the latest action was. All hastening action had been conducted in accordance with the above timeframe for hastening appointments. All PMX sites could access the Collingwood Hospital referral instructions which included processes for the electronic referral system, naming referrals, hospital points of contact (POCs), protocols and processes. There was also a wide range of information for clinicians and patients, such as displaying hospital waiting lists for all specialities, handouts that included hospital POCs for patients and details about each of the hospitals.

Tasks were sent on DMICP to the group task box which could be accessed by all referral staff. Leave was coordinated between the team so that the department always maintained a presence. Referral departments at other sites within PMX were able to assist and were granted permission to access the group task box if no staff were available. The central referral register captured internal and external referrals (internal referrals included occupational health and the Department of Community Mental Health). The referral department at Collingwood had excellent communication and strong links with the local hospitals. The latest referral templates had been uploaded onto DMICP for all the sites within PMX. There was no requirement for the doctors to maintain an oversight of referral activity as this was effectively managed by the PMX referral team. The referral team

tasked the referring doctor with any requested actions from the hospitals and continued to monitor until completion.

There was an effective system in place to ensure specimen samples were taken safely, appropriately recorded on DMICP and results reviewed and actioned by a clinician within 7 days. This was supported by an SOP. All specimen samples leaving the various sites were recorded on a central PMX electronic register and stored in a SharePoint folder with limited access. The results were received electronically into the Nelson electronic inbox. The nursing team then moved the results to the inbox of the requesting clinician and the report was not filed until seen by a doctor. Following a recent audit, urgent results, results flagged by the laboratory, or results where the nurse had concerns, were now sent to the duty doctor pathology links inbox. Each clinician in work was responsible for checking, actioning, filing and archiving their own bloods each day. A nurse or medic checked the global list twice a day and changed ownership as appropriate. The duty doctor at each site actioned the results of those clinicians who were not in work for the next 3 days or if the results were abnormal and the requesting clinician not in work that day. If the requesting clinician was away for more than 3 days, the duty doctor would review their bloods fully. The aim of these actions was to keep the global inbox to a daily minimum whilst ensuring tasks were not missed during times of unexpected, prolonged absence. Histology results were returned within 2 weeks. This timeframe was the result of a historic negotiation and PMX received their results much quicker than the local NHS GP surgeries. Histology was logged and tracked on the same register as all samples sent to the laboratory to ensure the result was received back.

Safe and appropriate use of medicines

A lead and deputy were identified for medicines management with the day-to-day duties delegated to the pharmacy technician. There was an additional lead for high risk medicines (HRM). There were extensive terms of reference in place for each role and we saw that these had been sent to the individuals who held lead roles. For completeness, we highlighted that they should be signed by those who held the role.

Safe procedures were in place for managing and storing medicines, including vaccines, emergency medicines and equipment. We found all items were within their expiry date and appropriately stored. We highlighted a number of considerations for the storage and transport of medical gases at Collingwood Medical Centre. These were actioned on the day where possible but a risk assessment had not been undertaken for the duty car used to transport the ‘medics plus kit’ that included medical gas. We were told that there was no signage on the car to inform that medical gases were transported in the vehicle.

Dispensing was carried out at 3 of the 6 sites (Nelson, Collingwood and Sultan) by a pharmacy technician. Medication requiring refrigeration was monitored daily to ensure it was stored within the correct temperature range. The vaccine fridge at Nelson was full so there was a plan to redistribute stock across PMX. Access to the fridges at Nelson and Sultan was not controlled as they were situated in empty rooms that were not locked. There was some lone working in the dispensary at Nelson on Friday afternoons but duty staff were in the building. There was an ongoing issue with the ‘dispensary queue’ that had approximately 300 prescriptions across the 6 sites with a similarly high number of items

owing. Staff at Nelson Medical Centre were working to remove outsourced prescriptions and we noted that the other sites needed to support this by clearing stock from the queue. An SOP for insourced medicines was being worked on. Patients were followed up 3 times to collect their medicine. We considered this could be reduced by a sending a standard reply to eConsult requests to inform that it should be ready in 3 days as a first reminder. We saw that medicines for mental health and antibiotics that remained uncollected within a week were reported to the doctors.

Arrangements for the safety of controlled drugs (CDs), including destruction of unused items required strengthening. Although these arrangements were supported by an SOP, we highlighted that the version being used had not been updated. Monitoring, storage and access arrangements were not unsafe but were not in accordance with DPHC policy. For example, the account holder with a witness should carry out CD destructions. Identification was checked but not recorded appropriately for schedule 2 medicines. There was no logbook for accessing CD (or dispensary) keys. Each site should review access policy and have a signed list of who the PMO authorises to gain access. A line should be left blank after the record of return for a CD to allow for completion (record of destruction) once destroyed. We discussed the need to review this policy and conduct a review in a pharmacy meeting so each site followed the same processes.

There were processes for the management and monitoring of patients prescribed HRMs. Regular searches were run to identify those patients on a HRM who were then added to a register by the pharmacy technicians. There was an HRM working group that consisted of a doctor and a nurse who checked that all requirements were in place. Oversight was maintained and formally checked through a quarterly audit. The patient records we reviewed showed that monitoring was completed within the recommended frequency and shared care agreements (SCAs) were in place with secondary care providers. SCAs are important to provide clear responsibilities between clinicians involved in the patient's care. The Chief Petty Officer (CPO) and pharmacy technician attended the HRM meetings but the other technicians had little involvement. We discussed the option of supporting all technicians to attend with the CPO for experience or to discuss HRMs in the pharmacy meeting to increase awareness across PMX of patients on HRMs.

Staff had access to the British National Formulary and prescribing formulary. We saw that the prescribers were working to both local and national guidelines for prescribing. The practice generally used NHS Health England and the National Institute for Clinical Excellence antibiotic prescribing. The last antibiotic audit was conducted in June 2024. This also reviewed prescribing of antibiotics by the dental centres and results generally provided assurance.

Patient Group Directions (PGDs) had been developed to allow nurses to administer medicines in line with legislation. The PGDs were current and signed, with 1 exception that was actioned during the inspection. We discussed the progression towards having a single PMX PGD managed centrally to remove confusion around who could sign and to provide oversight and availability for all across all 6 sites. PGD training sheets, non-medical prescriber authorisation and yellow fever training were all held in the dispensary. We highlighted that these should be held by the Senior Nursing Officer (pharmacy technicians cannot clinically monitor nurses) and the paperwork transferred to a central location.

Patient Specific Directions (PSDs) were used by the medics at some sites and we found all records since March 2024 had a clinical check recorded. Collingwood Medical Centre were using an old form that did not include Read codes. We showed staff the current form that included Read codes and were told this would be shared with all staff who used PSDs. PGDs are a written instruction allowing non-prescribing clinicians to administer certain medicines to a group of patients. PSDs are a written instruction that must be signed in advance of a medicine being administered to a named patient after the prescriber has assessed the patient on an individual basis.

PMX's arrangements for the access, storage and monitoring of prescription stationary required strengthening to make it a fully effective traceability system. Blank prescription pads and prescription paper were stored securely and a tracking system was followed. However, although first and last serial numbers of prescriptions were recorded when issued, there was no running total. Nelson Medical Centre staff had been monitoring prescriptions left in printers and planned to write this up as an audit and report the findings to relevant staff.

Requests for repeat prescriptions at each site were safely managed and no telephone requests were accepted. However, the process for repeat prescriptions across PMX could be standardised to support cross site working. Nelson and Collingwood medical centres were using eConsult with some paper slips handed in (medics could support with this). At Sultan Medical Centre, the pharmacy technician handled all repeat requests.

A process was in place to update DMICP if changes to a patient's medication was made by secondary care. Prescriptions were signed before medicines were dispensed and handed out to patients. There was a good recall system for patients requiring a medication review. Pharmacy technicians were unaware they could take items off repeat if not issued within 16 months so now planned to look across PMX to support tidying up medical records when summarising and ad hoc when dispensing.

We also saw that a regular search was carried out for patients prescribed Valproate (medicine to treat epilepsy and bipolar disorder).

Track record on safety

PMX had a good safety record. The PMO for PMX was the risk lead and the practice manager at Nelson Medical Centre the risk manager.

There was a risk register on the HcG Wb along with a retired risk register and issues log. There was a range of both clinical and non-clinical risk assessments in place at PMX which included lone working. The risk assessments were included on the SHEF (safety, health, environment and fire) workbook held on SharePoint. The risk register template was in line with the DPHC guidance note and although the '4Ts' (tolerate, terminate, treat and transfer) had not been formally applied (this was rectified during the inspection), it was evident in the approach taken to risk management.

As part of the inspection, we requested the dates of safety certificates for each of the 6 sites. These included certificates for water, gas (where applicable), fire risk assessment, electrical safety, portable appliance testing and legionella. A return submitted by each site

highlighted some gaps most notably at Southwick Park Medical Centre. However, evidence sent after the inspection showed that the SHEF team had ensured that all safety certificates were in-date.

Data sheets and risk assessments were held for hazardous substances held across PMX. A couple of items were not included initially but these were added during the inspection (controlled drug disposal kit and cytology sample kits). Equipment checks, including the testing of portable electrical appliances were in-date.

At each of the 6 sites, patients could be observed when seated or standing in the waiting areas. This was possible through a mix of being in the direct eyeline of reception (Excellent, Collingwood and Southwick Park) or by use of CCTV (Nelson, Thorney Island and Sultan). Panic alarm systems were in place and were effective at each site. Alarm system checks were documented at Nelson Medical Centre and they were last checked on in September 2024. However, there was no documentation to support panic alarm checks at other facilities although there were plans to add these checks to one of the workbooks.

Equipment was safe and maintained according to manufacturers' instructions. The PCRF had a named lead for equipment care across PMX.

Lessons learned and improvements made

The practice shared learning and made improvements when things went wrong.

There was a system and policy for recording and acting on significant events (referred to as ASERs) and incidents. This was supported by an SOP which had last been reviewed in April 2023. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so. Access to the investigation stage was held by PMOs, DPMOs, practice managers, SNO and the lead physiotherapist.

The ASER lead for PMX was the Nelson Medical Centre practice manager who managed activity via a workbook, which included both active and archived ASERs. The log included lessons learned, date of meeting, where ASER was discussed and a link to the duty of candour log where appropriate. The root cause analysis was conducted by the ASER lead together with the subject matter expert even though clinical ASERs were reviewed in the monthly ASER working group. The minutes included the reference number, a short narrative and details of why the ASER was discussed.

There was evidence that the practice learned and shared lessons and took action to improve safety in the practice. There was an ASER log on the HcG Wb which included themes emerging from ASERs and whether duty of candour was applied. All staff had completed ASER training and all had a login to the ASER system (except 3 staff that were waiting for their passwords to be generated). However, a culture of reporting was yet to be embedded across all 6 sites. A pre-inspection report produced by the Defence Medical Services Regulator indicated that no ASERs had been raised at Southwick Park Medical Centre. Although we were shown that staff at Southwick Park had raised ASERs through Collingwood (as they were combined prior to PMX formation), when asked to log onto the ASER system, staff had forgotten their logins and how to access the system. The same

report highlighted a significant difference in the number of ASERs reported when broken down to site level.

We reviewed examples of where the ASER process had resulted in improvement. For example, access to a pharmacy to request a repeat prescription was highlighted as a limiting factor so a 'drop box' for repeat medication requests was implemented with a text message service that informed patients when medication was ready to collect. A second example was of an ultrasound result tasked to a clinician who was out-of-office. The individual passed the task to the absent clinician despite the out-of-office response being in place. It was concluded that this was human error/oversight and some re-training was completed.

The ASER lead had completed a trend analysis for the period January 2024 to June 2024 which showed improved engagement and understanding of the ASER process and more emphasis on purple ASERs (positive events).

There was a near miss log that included issues such as doctor spelling, mistake in dose and prescriptions that had been printed but not issued. These records appeared to be for reporting into region which suggested a potential duplication with there also being an intervention template that was used to record and report on the same issues.

The pharmacy technicians were responsible for managing medicine and safety alerts. Alerts were sent from Regional Headquarters and the pharmacy technicians together with the practice managers were also registered to receive alerts direct from the Medicines and Healthcare products Regulatory Agency (MHRA) website. We saw that alerts including those from the Central Alerting System (CAS) and Field Safety Notices were discussed at clinical meetings as well as at heads of department meetings. Minutes provided evidence of assessment of impact and completion of appropriate action. Once acknowledged and received, an email was sent by a pharmacy technician to inform all prescribers of the alert.

However, without a structure that named a responsible individual among the 4 technicians, arrangements were more of a collective responsibility. Alerts were not being processed effectively across all 6 sites. For example, some sites were marking the alert as 'not applicable' without any detail on why, such as stating that none of the medicine or equipment named in the alert was held. Although we saw that email alerts were received, the most recent 2 MHRA alerts had not been acknowledged and reviewed at the 3 sites visited by the pharmacy specialist advisors. We discussed the potential solution to have one of the pharmacy technicians responsible and this could be done on rotation between them. There was a CAS alert register held on SharePoint that included a link to the alert. Any urgent alert was emailed to appropriate staff for immediate action.

PCRF staff had an understanding of the ASER process and there were some good examples of learning points. For example, the training and referral process changed following an ASER raised after a medic had missed a deep vein thrombosis after surgery. The reporting of ASERs across the 6 PCRFs did show an inconsistency with some reporting a culture of dealing with incidents as opposed to reporting them. There was opportunity to improve PCRF PMX-wide understanding, utility and general culture around ASERs to standardise practice across all 6 sites.

Are services effective?

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

Effective needs assessment, care and treatment

Clinicians were aware of relevant and current evidence-based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. We saw that meeting agendas did include clinical guidelines, for example, the weekly clinical meetings and the monthly pillars meeting. Minutes of the meetings were saved in a PMX wide OneNote, these included links to give quick access to the guideline discussed. We saw that some new guidelines fed into Defence Primary Healthcare (DPHC) or local standard operating procedures (SOPs) once issued. These were then audited retrospectively. PMX had produced more audits as the clinical leads now had capacity to focus on their area instead of all doing all areas. The results of audit were fed back in the clinical meeting. Our review of patients' notes showed that NICE best practice guidelines were being followed. The peer review notes audit also included a check that evidence-based guidance was being followed. Nurses had monthly meetings and specific trade training and clinical updates were included in both, shared via SharePoint and through updates sent from the clinical delivery pillar. External speakers had also attended to speak on subjects that included diabetes, HARK (a validated screening tool for domestic violence and abuse) and respiratory syncytial virus (a respiratory virus).

Multidisciplinary team (MDT) meetings were undertaken each week. A virtual clinical was set up at each site independently to produce a list of patients of interest (who usually attended that site) to be discussed with the wider clinical team. Each virtual clinic was labelled per site. The MDT discussion provided collaborative care and learning points. For example, occupational medicine questions were discussed and support provided. For patients with complex needs, case conferences with the Chain of Command and Recovery Cell were arranged ad-hoc when required.

In support of medical centres, the DPHC team produced a newsletter that was circulated to clinicians providing further information and a summary of relevant safety updates.

Monitoring care and treatment

The Defence Medical Services have responsibility to deliver the same quality of care as patients expect in the NHS. Because the numbers of patients with long-term conditions (LTCs) are often significantly lower at DPHC practices, we did not use NHS data as a comparator.

A doctor and a member of the nursing team were nominated to lead on the management of each LTC. They were managed via a cross practice approach and the pathways used were consistent across PMX. The LTC leads were responsible for patients across PMX, however, it had been acknowledged that some of the chronic disease groups were significantly larger and the Senior Nursing Officer (SNO) was reviewing the workload of the

nursing team by grouping some conditions together to enable more than 1 nurse to work on them. Examples included hypertension and asthma. GOV.UK.Notify was used for recalling patients via text or email. Administration teams were tasked by the nursing team to send a message to the patient. A total of 20 sets of patient's notes were reviewed, all were Read coded appropriately and aligned to the chronic disease register with a clear action plan in place. Only 1 patient was out-of-date for a recall but there was evidence of recall previously and of an upcoming appointment.

A total of 324 patients were recorded as having high blood pressure and 312 had a record of their blood pressure having been recorded in the last 12 months. A total of 200 patients had a follow-up blood pressure reading of 150/90 or less (an indicator for mild hypertension).

There were 60 patients on the diabetic register and 37 had a total cholesterol of 5mmol/or less, an indicator of positive cholesterol control. For 56 patients, the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.

Patients identified as having hypertension were offered a blood test, and opportunistic testing was done if patients were concerned about excessive weight gain or loss. There were 324 patients recorded as having high blood pressure. A total of 312 patients had a record for their blood pressure taken in the past nine months and all had a blood pressure reading of 150/90 or less.

There were 111 patients on the asthma register and 103 had been reviewed in the last 12 months. The 8 remaining patients had reviews pending. A consistent template had been implemented and included the appropriate Read codes. An audit to review the appropriate monitoring of patients diagnosed with asthma had been undertaken in August 2024 but the results were being written up at the time of inspection.

We looked at a range of patient records and were assured that the care of patients with a mental illness and/or depressive symptoms was being effectively and safely managed. Patients presenting with a mild to moderate anxiety or low mood were assessed in accordance with the pathway and treated initially at the practice (step 1) or referred to the Department of Community Mental Health (DCMH) team if their clinical need was assessed as greater than what step 1 could provide. The single point of access referral pathway was included on OneNote. DCMH Portsmouth was based in HMNB Portsmouth (with a central route via Aldershot) and facilitated easy access with PMX clinicians able to contact the psychiatrist easily for advice. The PMO met periodically with the DCMH clinical lead.

Information from the force protection dashboard, which uses statistics and data collected from military primary health care facilities, was also used to gauge performance. Service personnel may encounter damaging noise sources throughout their career. It is therefore important that they undertake an audiometric hearing assessment on a regular basis (every 2 years). Audiometric assessments were in date for 63% of patients. Audiometric assessments were dependant on the patients being on base as well as medic availability to run clinics. These reasons were why the uptake was lower than planned.

One of the doctors was the overall audit lead and PMX had implemented a calendar that included mandatory DPHC audits and audits completed to reflect the local needs, local population and PMX clinical practices. These were identified by individual clinicians or by

working groups. The calendar included a sheet that detailed the learning points and recommendations for each audit. Findings were also presented at clinical meetings. A named lead was allocated to each audit. Antibiotic prescribing audits had been repeated and showed good adherence to local area formulary guidance. Audit work was established and repeated to demonstrate quality improvement in clinical outcome as well as monitoring the effectiveness of administrative processes. Following the work in combining the 6 practices into PMX, staff had focussed on getting standard operating procedures (SOPs) aligned and embedded. Due to this work having only recently been completed, some of the audits only had one cycle. However, we saw good examples of where second cycle audit was driving improvement and the calendar showed that repeat cycles were planned throughout. Audits included:

- controlled drugs
- hyperlipidaemia
- chronic kidney disease
- patient group directives
- infection, prevention and control
- safe prescribing
- pre-acceptance healthcare waste.

‘Mortality and morbidity’ meetings were held periodically to review any new patients with a cancer diagnosis or any deaths. Cases were reviewed to see if lessons could be learnt and shared to improve knowledge skills and care delivery.

There was an opportunity for the PMX Primary Care Rehabilitation Facilities (PCRFs) to align service evaluation processes to increase standardisation. Different questionnaires were used to seek out feedback from patients and audits were not synchronized to take place concurrently. There were some audits to monitor treatment against best practice guidelines but these were localised rather than PMX-wide.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up-to-date.

There were separate induction programmes available on SharePoint for permanent and locum staff. It was a requirement for all staff to complete an induction checklist. They were then issued with an induction certificate and the training recorded on the mandatory training spreadsheet. All new staff were also required to complete a regional face-to-face induction day. Feedback on the induction programme was encouraged through a dedicated form.

PMX had developed an induction PowerPoint which linked the role specific inductions. This included locum induction, checklists, the health and safety brief, employment checks, multiple links to specific SOPs for week 1 and links to the registration page for military staff. The presentation also included a prompt for a meeting with their line manager and at 3 weeks, asked for feedback and prompts and the issue of a completion certificate. New staff sat in with a colleague for 1:1 instruction on new systems such as DMICP. Bespoke clinics were set up to account for the person's experience until assessed to be familiar with working practices. Workplace visits were arranged to support occupational medical care to patients. The locum doctor reported that the induction programme was very useful and felt very well supported. Nelson had an 'NHS trainee' bespoke booklet that was also given to each locum. It was planned for this to be used across PMX.

A detailed PMX PCRF induction package had recently been created. This document contained pertinent clinical, administration, regional and occupational information for all personnel. However, the use of it remained limited throughout the PCRF, with some using local, legacy documents.

PMX had processes to provide staff with ongoing support. These included one-to-one meetings, appraisals, mentoring, clinical supervision and support for revalidation. The nursing team felt supported with both training and continued professional development (CPD). In service training formed part of the monthly nurses' meeting, all staff were up-to-date with appraisals, staff were encouraged to use the CPD funding and access local NHS courses. The SNO was working to establish a PMX peer review programme that planned to start with patient group direction audits. We were also told that informal group supervision was carried out at the nurses' meeting and the SNO was looking at how this could be formally documented.

PMX had appointed a training lead who monitored online training records and sent a quarterly email to staff reminding them about any overdue training courses. Group training was arranged to address any areas of concern. Compliance with mandatory training was now a priority now that PMX development work was mostly completed. However, the compliance rates were not accurate due to staff not updating the spreadsheet with all completed training. We saw evidence that more training had been completed than stated in the online training records.

Medics on placement undertook internal development and assurance work. The SNO was the named mentor and the nursing team were mentor trained.

Internal and external training sessions were available to staff. For example, patients had access to doctors across PMX trained in aviation medicine, underwater medicine, minor surgery and sexual health services that included coils and implants. However, the practice managers had submitted to attend but had not yet completed the joint practice manager's course, health and safety (referred to as IOSH) training (including the health and safety lead for PMX). Nursing staff had access to the CPD fund and to the local Integrated Care Board free training courses. Chronic Disease specialists were limited so the SNO was looking at alternative courses for the nursing team to access which would give a broad overview of subject areas and then individual nurses could decide if they would like to specialise. All Band 6 nurses were infection prevention and control trained, however, they reported that it was difficult to access some external training due to funding.

PMX had recognised the administration volume and impact on PCRF clinical time and had introduced a single administration support found amongst existing staff. This consisted of 2 individuals that supported the PCRF administration lists. The administration post was to be reviewed under future workforce reviews as it was insufficient for the demands of the large PCRF so clinicians had to use clinical-facing time to undertake administrative duties, reducing capacity across the combined practice. The Band 7 role had changed following the merger and creation of the combined practice, notably regarding the leadership responsibility. However, the job description and terms of reference had not been changed. To enable the Band 7s to effectively supervise, lead and manage services across PMX, their job descriptions would need to be adjusted accordingly.

There was a PMX-wide acupuncture special interest group which discussed policy and offered specific continued professional development to maintain currency.

Coordinating care and treatment

Staff worked together and with other care professionals to deliver effective care and treatment. The practice met with welfare teams and line managers to discuss vulnerable patients. As part of the inspection, we sought feedback from the Commanding Officers at Nelson and Collingwood, chaplains and members of the welfare team. Responses were all positive and spoke of well-established relationships being in place. There was a monthly phone call with the medic in the local Personnel Support Group (PSG). The PSG looks after those patients ‘sick at home’ and many downgraded personnel who are on the recovery pathway. Checks include completion of medical reviews and that the patients are being correctly tracked/cared for.

PMX had forged good links with the Local Health and Wellbeing Boards and PMX representatives attended a number of different local stakeholder meetings. Due to the staggered borders there were multiple local health authorities, PMX aimed to send a representative to each one. PMX staff were invited to local CPD events where they had updates from local secondary care consultants and on updated local care pathways. The improved links had increased patient safety and care pathways (the Ministry of Defence system does not link to NHS systems electronically). The improved links ensured that every time a local NHS form was updated, a copy was sent to PMX to be added to DMICP. PMX now had access to the local protocols and pathways which has improved patient access to local NHS services. The combining had also simplified links with the local NHS as there was now only 1 practice and not 6 to maintain links with. The nursing team described strong links with local NHS services particularly for sexual health and diabetes. The link nurses attended training and CPD which had strengthened the referral pathway for patients.

On leaving the military, patients without any specific needs had their discharge medicals generated and given to the patient to hand to their next NHS GP. For those with ongoing clinical or welfare concerns, a letter was written with the relevant information and passed to the new GP (if known) or to the patient to pass to their next GP.

Each PCRF reported attending local multidisciplinary team (MDT) meetings with doctors and other clinical staff. Staff also reported being able to call others within the PMX PCRFs to discuss clinical matters. PCRF staff reported the significant value of the Regional

Rehabilitation Unit (RRU) MDT meeting dial-ins. This offered PCRF clinicians an opportunity to discuss complex patients, highlight patients of concern and discuss referral requirements early with RRU staff.

Helping patients to live healthier lives

The practice identified patients who may need extra support and signposted them to relevant services. For example, patients at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.

The SNO had the temporary lead for health promotion whilst PMX recruited a health promotion lead. The health promotion strategy had been formulated into a calendar for the next 12 months and was underpinned by national priorities and DPHC initiatives to improve the population's health. Promotions were refreshed in line with seasonal and/or topical demand. Information leaflets and booklets were on display at each of the 6 sites

For complex needs and services not offered within PMX, the doctors referred patients to the local sexual health clinic. Patients could also self-refer. The local service was deemed satisfactory but access could sometimes be slow for patients. The PMO fitted uterine coils and contraceptive implants. A civilian doctor and a long-term locum doctor also fitted coils

PMX staff attended unit open days and staffed stalls to provide health promotion information to personnel. Examples of health promotion activity that PMX had supported recently included:

- 'Let's Get Active for Women', held at HMS Temeraire in January 2024, for all women in the Portsmouth area. PMX had a stand on cervical screening, contraceptive choices and menopause.
- Collingwood Health fair in April 2024 where PMX had a wellbeing and health check stall.
- Sultan Unit Health fair in May 2024.
- Smoking cessation promotion board and leaflets in September 2024.
- Sexual Health advice in September 2024.

Mental health information was available for patients that took into account wellbeing and mindfulness. It provided details about where patients could access for further information.

The PCRF offered a women's health service. This service supported female service personnel from across the region (wider than PMX). The clinician was passionate about the service and other staff reported high praise for the care delivered. There were specific risk assessments and SOPs for the service, examples included consent and chaperoning.

A total of 2,356 patients were eligible for the over 40s health check. A total of 269 patients had completed a health check in the last 12 months but this did not include those that had been covered as part of annual chronic disease reviews. There were 501 patients overdue or due in the next 30 days. PMX had focussed resources on those patients over 45 who

had not had a blood pressure reading in the last 5 years. This cohort of patients was 92% completed for health checks. The nursing team planned to continue to catch up and focus on the over 40s.

A monthly search was undertaken for all patients aged 50 to 64 years who were entitled to breast screening. The practice also engaged with all national screening programmes and had a mechanism to ensure that eligible patients were referred into the bowel cancer or abdominal aortic aneurysm (AAA) screening programs. Data provided by the practice showed screening was up-to-date.

The number of eligible women whose notes recorded that a cervical smear had been performed in the last three to five years was 976 out of 1038. This represented an achievement of 94%. The NHS target was 80%. Invite letters were sent out and followed up if not responded to.

It is important that that military personnel have sufficient immunity against the risk of contracting certain diseases. The World Health Organisation sets a target of 95% for vaccination against diphtheria, tetanus, pertussis and polio and measles, mumps and rubella. PMX had a large transient population (trainees, on ship personnel) which impacted on the vaccination uptake data. Nelson and Thorney Island routinely added 'surge' clinics due to deploying personnel as a number were held at readiness and these took priority over routine vaccines. A number of personnel, most notably at Excellent, were in land-based roles and would not normally deploy. Vaccinations were not routinely administered at sea which impacted the status of vaccinations completed. The team were aware of some of the deficiencies and would pro-actively make attempts to recall patients. The data below from September 2024 provides vaccination data for patients using this PMX (regional and national comparisons were not available).

- 68% of patients were recorded as being up-to-date with vaccination against diphtheria.
- 68% of patients were recorded as being up-to-date with vaccination against polio.
- 87% of patients were recorded as being up-to-date with vaccination against Hepatitis B.
- 91% of patients were recorded as being up-to-date with vaccination against Hepatitis A.
- 68% of patients were recorded as being up to date with vaccination against Tetanus.
- 88% of patients were recorded as in date for vaccination against MMR
- 98% of patients (under 25) were recorded as in date for vaccination against meningitis.

The unit executive team and individuals were responsible for ensuring personnel kept up-to-date with vaccinations. The 'MyNavy' app allowed individuals to access their medical information that included vaccines. PMX worked collaboratively with Chain of Command to ensure all personnel requiring additional immunisations in line with operational requirements were identified and vaccinated within an appropriate timeframe. Updates were reported at the PMX wide force protection group that met every 6 weeks and was attended by a lead from each of the 6 sites. The focus in the last quarter had been for patients with an unknown vaccination status. It was planned to target diphtheria, tetanus

and polio in the next quarter. PMX was responsive to the vaccination needs of ships and delivered short notice vaccination clinics to cover these patients.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance. When providing care and treatment for young patients and when appropriate, staff carried out assessments of capacity to consent in line with relevant guidance. Clinical staff were aware of the protocols and were supported by DMICP templates. We saw that consent was obtained and recorded appropriately. Monitoring was undertaken as part of the peer review process. Written consent was recorded for minor operations undertaken at 2 sites by 2 doctors. The DPHC mandated form (directed in the DPHC minor operations SOP) was used and filed in the patient DMICP record once signed by the patient. However, there was potential to standardise the process by having a single register across PMX to record all minor operations on.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (MCA) 2005. Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Clinicians demonstrated a good awareness and understanding of Gillick competence (used to assess a child's capability to make and understand their decisions and consent to their treatment) and Fraser guidelines (used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment) were discussed in clinical meetings as PMX had a small number of patients under 18 years of age.

Are services caring?

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

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

PMX had taken account of patients' personal, cultural, social and religious preferences and to accommodate their personal and operational needs. For example, minor surgery patients were often prioritised to ensure procedures were completed before ships sail. Nurses at Thorney Island agreed to do spirometry tests at short notice to help a patient get timely care to meet their needs. When ships docked, PMX accommodated a surge of urgent requests before the ship sailed. The Big Word translation service was available and staff were familiar with how it could be used.

The practice gave patients timely support and information. We were given a number of examples of when staff had gone the extra mile. One example from the nursing team was for a patient with palliative care needs who required intravenous medication. The team at PMX worked with local NHS GPs and pharmacies to set up medication and delivery of equipment and medication, which included the setting up of a device by local services. A second example was when the nursing team attended one of the medical centres to complete wound care over the weekends rather than pass a patient onto secondary or out-of-hours care as they had reason to believe that the patient would not attend.

The practice had an information network available to all members of the service provided through the 'Hive' or welfare service. This was further supported by Padre staff and via the Unit Health Committee meetings. PMX staff had been proactive to provide compassionate care by improving the care pathway for patients returning from overseas for health reasons. They had requested and had reinstated the contract for transferring patients requiring inpatient mental health care.

We gained feedback from 10 patients as part of the inspection who made positive comments about the way they were treated by all staff at the practice. The practice ran their own surveys in June 2024 and September 2024 and received a combined total of 73 responses. When asked if they would recommend the practice to friends and family, 72 said yes, and 1 did not comment.

Involvement in decisions about care and treatment

The clinicians and staff at the practice recognised that the personnel they provided care and treatment for could be making decisions about treatment 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 sound guidance and clinical facts.

Results from the practice's Patient Experience Survey; 65 out of 73 patients who responded said they felt they were given clear information regarding their treatment and care (8 did not respond).

Patient notices were displayed in the patient waiting areas which informed patients how to access a number of organisations. Information was prominently displayed and accessible. Quick response or 'QR' codes were used to allow patients to easily take information away with them. Mental health support services were promoted.

The practice maintained a centralised register of patients who were also carers and provided extra support as required, such as liaison with welfare and with the Chain of Command. Carers were identified as part of the new patient registration process and recalled for seasonal vaccination against influenza. Carers and cared for patients were Read coded and given more time during consultations. There was an open-door policy for support to be provided and staff knew of services that carers could be signposted to. The regular schedule included a dedicated multi-agency meeting which facilitated the identification of carers who may not be known to PMX. If not seen in person, carers were contacted once registered to establish any specific needs and then annually to confirm that there had been no changes in circumstances. Each unit had a 'unit carers' meeting attended by welfare, station executives, chaplaincy, a PMX representative and the police.

Privacy and dignity

The practice respected patients' privacy and dignity.

Privacy screening was provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. All clinical room doors were closed during consultations.

We requested a self-declaration from each of the 6 sites which included a summary of how the layout of the reception area promoted privacy and confidentiality. We also visited all 6 sites, although 3 were short visits, to view the facilities. Confidentiality was promoted in a number of ways dependant on the layout at reception and siting of the waiting area. Arrangements across the 6 sites included the waiting areas being set away from the reception desk, demarcation lines on the floor to denote a suitable gap that should be maintained when waiting to be seen and background noise provided by a television. Notices that were conspicuous from the reception desk advised patients that a private room would be offered should they wish to discuss sensitive issues and QR codes were utilised in signposting patients to further services.

The practice could facilitate patients who wished to see a clinician of a specific gender. The staffing team at PMX included both male and both doctors, nurses and physiotherapists. Therefore any request for a same gender clinician could be met internally although it could involve travelling to a site away from where the patient resided.

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 practice organised and delivered services to meet patients' needs and preferences. Despite combining into one practice, there were local site differences and specific patient needs. PMX accommodated these by being flexible with the processes employed to engage patients. Some sites were used for phase 1 and phase 2 training and the students had limited access to smart phones or computers, and patients could not self-certify. Therefore, 'fresh cases' clinics had been retained at these locations (these allowed patients to walk in and be seen on the day). At other sites, the patient population was more diverse. At these sites eConsult (patients could use eConsult to communicate their symptoms by email and a response would normally be sent out the same or next day) and telephone triage was used to book patients into clinics and there was less reliance on sick-parades.

Excellent had zonal painting to support neuro divergent patients. Across PMX there was a requirement to see patients who were aircrew or aircraft controllers, as a result there were a number of doctors trained as Military Aviation Medical Examiners. At Nelson, Excellent and Collingwood, there was a greater need for diver medical trained doctors. Different length appointments were allocated for Army and Navy occupational medicine reviews due to the different time burden or assessments.

As a base port, Nelson remained open all year to support the operational demand/output. Other sites closed when the base is closed or on compulsory leave.

The nursing team worked core working hours with some specialist clinics for triage and women's' health. A mix of face-to-face and telephone consultations were available with longer appointments where required. No routine evening or weekend clinics were scheduled, however, in the event a ship was activated to deploy, the team would respond to the demand in a timely manner. Southwick Park ran weekend reservist clinics once a month and it was planned to also run reservist clinics at Nelson in the future.

Access audits as defined in the Equality Act 2010 had been completed at each site in 2024. No issues had been identified. We visited each of the 6 sites and found modern or modernised facilities that were fit for purpose. PMX were unaware of the requirement for staff training in learning disability and autism. During the inspection, the link to the Defence Primary Healthcare (DPHC) online courses was added to the PMX training timetable for October 2024.

Doctors and nurses from the practice did not routinely provide home visits. However, there was a standard operating procedure, last reviewed in May 2024, that detailed when a home visit would be provided. A register of any home visit was kept and showed that there had been only 1 was carried out in the past 3 years.

Patients could refer themselves directly by using the Direct Access to Physio (DAP) service. This had been implemented and patients could self-refer using e-consult. In line with DPHC policy, DAP was not offered to phase 1 and phase 2 trainees until they were reviewed by a doctor before being referred. This was to add an extra layer of clinical oversight for newly-joined service personnel.

PMX had an appointed lead for diversity and inclusion and there was a point of contact for each site. All staff were required to complete training as part of their mandatory requirements. The practice did have some transgender patients. Their stage of transition was supported and wishes for their name/gender was reflected on DMICP. The practice had unisex toilets and protected characteristics were identified on the patient registration form.

Timely access to care and treatment

The practice accommodated patients with an emergency need on the day they presented at the practice. Phase 1 and phase 2 trainees were offered a same day appointment if clinically required and had daily fresh case parades available.

Outside of routine clinic hours, cover was provided via a duty telephone and any calls were triaged by a medic who had access to a duty doctor should they be required. Patients could use eConsult (a message could be left for the practice to follow up on the following working day if not urgent). A nearby accident and emergency department was at the Queen Alexandra Hospital, Portsmouth.

Results from the practice's patient surveys from June 2024 and September 2024 (73 responses were received in total) showed that patient satisfaction levels with access to urgent care and treatment were high;68 of 73 of patients said they were able to access healthcare advice easily.

The practice leaflet provided comprehensive details for out-of-hours services and there was information displayed at the main entrance to each building.

Across the PMX PCRFs, wait times were within or under the key performance indicators. This was despite the reports of reducing staffing. However, clinicians reported the lack of staffing limited their ability to follow up the patients as often as they would prefer. The PCRF staff reported being able to share caseload and distribute new patients depending on wait times at individual sites within the combined practice.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

The practice manager of each site was the first point of contact for complaints in their facility. The Group Warrant Officer (GWO) was the designated responsible person who

handled all complaints across PMX and the Principal Medical Officer (PMO) had overall responsibility. PMX had implemented a process to manage complaints in accordance with the DPHC complaints policy and procedure. This included annual auditing of complaints. All complaints were acknowledged with a letter. The GWO then managed the complaint or delegated this whilst retaining oversight. Complaints were passed to the PMO for final consideration, review and decision. If the PMO was involved or named in the complaint, it would be passed to another PMO for review. In the event that all PMX Senior Officers were named in the complaint, it would be passed to another military medical centre via Regional Headquarters.

There had been a combined total of 22 formal and informal complaints recorded in 2024. These were well managed using a comprehensive spreadsheet that tracked each complaint through to completion with dates added at each stage. The form included consideration to raising as a significant event and a section to summarise any lessons learnt. We reviewed 1 complaint in detail and found it was handled appropriately. The details including outcomes from complaints were standing agenda items at healthcare governance and practice meetings. Information was available at each site to help patients understand the complaints system and also in the PMX patient information leaflet. The complaints process was displayed on notice boards in the waiting rooms. Forms were also available for patients.

PMX recorded both verbal and written compliments and had recorded a combined total of 31 during 2024. As with complaints, these were recorded on a comprehensive spreadsheet and uploaded to region. These were categorised and the main themes were staff assistance and clinical care.

Are services well-led?

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

Leadership, capacity and capability

The development of Portsmouth Combined Practice (PMX) has enhanced this area by ensuring cross cover for key roles when posts are gapped or personnel are deployed. It has also facilitated greater resilience and peer support. Full operating capability had only recently been achieved (8 August 2024) so combining work was still ongoing, in particular with administrative tasks, the nursing team and the Primary Care Rehabilitation Facilities (PCRFs). Workload had shifted between sites and this had resulted in a burdening workload in some areas, in particular, the administration team at Nelson Medical Centre had taken on much of the work from all 6 sites. When speaking with staff at the other 5 sites, the shift in work had reportedly made their workload manageable rather than create additional capacity.

The leaders at PMX had developed key roles for a wide range of staff members, in doing so, this provided resilience and opportunities for staff development. Many of the lead roles were deputised to provide further resilience. The practice managers had a close and supportive relationship which was evident during the group interview sessions when they guided each other to locate documents and demonstrated good knowledge of the processes embedded in PMX. They all commented on how positive PMX had been in developing peer support. Staff spoke positively about strong leadership and the effective care provided highlighted. However, there were a combined 12 gapped posts in the established staffing levels across PMX. The problem with gapped posts was compounded by recent civil service recruitment controls and limitations in the Ministry of Defence locum contract. Staff levels had been added to the risk register and detailed concerns around capacity and potential burnout of staff which would lead to delays in patient care. There was one civilian practice manager and 2 civilian business managers within PMX to provide continuity. Of note, when asked, it was reported that staff had to burden the extra workload of combining alongside their day-to-day duties. With no external assistance and each of the sites carrying workforce gaps, their achievements had been commendable.

Staff felt that they could raise concerns if they had them. PMX-wide meetings offered an opportunity where all staff could get together to share and learn from key messages. Staff spoke highly of internal communication.

PMX felt well supported by the host unit and the Regional Clinical Director had previously been Principal Medical Officer (PMO) at Nelson Medical Centre so had a good understanding of the challenges and was said to be very supportive of the PMX team. The practice managers also reported good support from the Regional Headquarters (RHQ) team and reached out when required.

Leaders in both PMX and region were knowledgeable about issues and priorities relating to the quality of services. The nursing team felt patient care was at the centre of core processes and felt safe in their environment but stated that day to day business could be missed when the team are busy.

Terms of reference that reflected the key responsibilities given to individuals were either in place or being completed by a dedicated working group assigned to the task.

PCRF staff consistently reported feeling much of the planning and focus for the PMX combined practice merger was aimed at medical aspects, not PCRF. The PCRF felt they were left behind compared to the medical processes. This reflected with delays in the integration and embedding of combined practice processes. However, the senior leadership were aware of this and work on further integration had started with a recent PMX PCRF objective setting project.

Vision and strategy

PMX promoted both the Defence Primary Healthcare (DPHC) mission and vision statement and their own PMX vison statement:

‘A single practice across 6 sites in which motivated, professional, fulfilled staff deliver high quality, safe, cost-effective, occupationally focused primary healthcare to optimise operational effectiveness’.

Although the practice leaflet was a combined PMX document, it still displayed the mission statement for each practice (Collingwood and Southwick Park was combined) together with the DPHC mission statement:

‘Provide and commission safe and effective healthcare which meets the needs of the patient and the chain of command to contribute to fighting power’.

PMX also had a set of aims to measure the success of the transformation into a combined practice. These were; ‘increased deployability, better clinical outcomes, improved experience for our people and greater value for money’. It was apparent throughout the inspection that these aims were fundamental in the combining process and underpinned the development and execution of the project. The aims had been clearly articulated to staff and were repeated at every practice meeting.

Staff were aware of and felt fully engaged in the vision, values and strategy and their role in achieving them. Key responsibilities had been and continued to be assigned throughout the team and all staff spoke positively about the inclusive culture.

PMX planned its services to meet the needs of the practice population and liaised with unit personnel to promote their vision and values. The treatment and care were tailored for the unit where any specific medical requirements were identified. There were strong links with the station executives and good communication from PMX when advising of any service changes.

The management team believed PMX needed more time to embed before the development of future plans into a long-term strategy. However, short-term objectives were being set as the combined practice evolved. The management team have placed emphasis on stakeholder engagement; especially with unit Commanding Officers and Warrant Officers. They have ensured that support to Phase 1 and 2 training has been unaffected by the changes. In addition, short-term goals included summarising of clinical

notes, development of the triage process together with the establishment of a triage hub and the formation of a patient participation group,

PMX sites had taken steps to address environmental sustainability. For example, Nelson had implemented environmental sustainability notice boards in the staff and patient areas to encourage recycling along with additional waste bins to segregate waste. There was an active plan to reduce printing where appropriate. PMX was conducting an audit on inhaler use to see if they could reduce the environmental impact without detriment to patient care. Each site engaged with Unit Environmental Health Officers via Unit safety, health, environment and fire meetings and they tried to observe Triad warnings (sent by electricity suppliers to inform of the 3 peak periods of electricity demand, known as triads).

Culture

The PMX leaders had engaged staff throughout the combining process and had established a structure aimed at engagement with all staff and achievement of a high level of morale in the workforce. Examples included the cross-site/cadre pillar structure, cadre specific meetings, including one for civilian medical practitioners. This supported the empowerment of staff and helped integrate all across role/location. Speaking with staff, morale had reportedly dipped during the combining process, it was hard work and some felt close to burnout. More recently, some staff were starting to feel the benefits and the leadership team were aware of the areas that required further work, most notably, the administration team at Nelson.

PMX held a staff party for all staff (a barbecue in Collingwood, with a disco). All staff we discussed this with spoke of it very highly of their appreciation of the social opportunity and said it was very beneficial to meet colleagues from other sites

Openness, honesty and transparency were demonstrated when responding to incidents and complaints. PMX was aware of and had systems to ensure compliance with the requirements of the duty of candour. There was information displayed to advise staff on the freedom to speak up process and this included signposting to ‘Speak Out’ a confidential helpline to support those who felt bullied, harassed or discriminated against. The management team had an open door policy and the meeting structure was inclusive in providing all staff the opportunity to offer their opinion.

Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They spoke of how the culture was one where both suggestions and concerns would be both listened to and acted on. The exception was Southwick Park where staff were not familiar with processes so were entering ASERs onto the system through colleagues at Collingwood.

Processes were in place to provide staff with professional development. This included appraisal and peer review. All staff received annual appraisals and were supported to meet the requirements of professional revalidation where necessary. Staff were encouraged to complete courses aimed at their professional development, of note, strong links had been developed with locally run NHS courses.

Generally, staff morale seemed high across the PMX PCRF teams. However, there was an underlying feeling of differences between PMX eastern and western sites. The culture within the PCRFs was emerging and developing at the time of inspection. Most staff reported the combined practice as an opportunity to improve practice, working patterns and continued professional development.

Governance arrangements

The core management structure consisted of the PMO, Deputy PMO and Group Warrant Officer who retained an overarching view over 4 key areas that were termed as ‘pillars’. The four pillars were governance, clinical delivery, workforce and infrastructure and organisation. The PMO was also the lead of the governance pillar and all pillars included the PCRF. Working groups fed into the pillar, meeting before the pillar meeting. Health assurance framework (HAF) review boards were undertaken during which the progress and task assignments were checked. The HAF review board sometimes split into departments to address specific actions and tasks. The leadership team had defined responsibilities, roles and systems of accountability to support good governance and management. The practice had built in more resilience with leads and deputies in most areas. The healthcare governance workbook was the overarching system used to bring together a range of governance activities, including the risk register, ASER tracker, training register, quality improvement projects (QIP) and complaints. PMX leaders had introduced and implemented a suite of policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

The last independent assurance review had taken place in July 2024 and PMX were awarded ‘substantial assurance’. Most issues related to infrastructure and were beyond the control of PMX. There had historically been issues with recurrent legionella, flooring had been replaced and was ongoing. This took 2 years from reporting to the work being undertaken due to asbestos being found. Sultan had the most significant challenges with infrastructure, in particular in the gymnasium, but risks had been mitigated and workarounds implemented whilst waiting for planned work to be completed.

A comprehensive meeting schedule was established and this included a 6 week rolling meeting schedule that consisted of safeguarding, mandatory training/continued professional development (twice every 6 weeks), practice based small group learning (twice every 6 weeks) and whole practice meetings. A series of working groups had been set up. These included working groups for each pillar as well as ones for significant events, audit, risk, staff wellbeing and terms of reference. In addition to the weekly clinical meetings, regular meets were held by the heads of department, the nursing department and the healthcare governance team. Representatives from PMX also attended Unit Health Committee meetings. Discussion at each meeting was recorded and made available to those unable to attend. Information was readily available on how the combined practice concept was progressing and all staff were updated weekly during the ‘clear lower decks’ meeting which were held at all individual sites each week.

The practice had a system to monitor all patients on high risk medicines (HRMs). Shared care protocols were in place for patients taking high risk drugs. Regular clinical searches

were carried out to monitor patients on HRMs. The governance arrangements for controlled drugs required a review to ensure that all sites were working to DPHC policy.

Joint working with the welfare team, pastoral support and Chain of Command was in place with a view to safeguarding vulnerable personnel and ensuring co-ordinated person-centred care for these individuals.

A comprehensive and established audit programme was in place. Repeat cycles of the same audit had been completed or planned in many instances to monitor improvement and drive better outcomes.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

Practice leaders had established a governance structure that provided oversight of risk and the quality of service across the 6 sites.

PMX maintained a risk register and we saw that these were reviewed regularly and acted on. Completed actions were clearly recorded. The PMX PMO was the risk lead and the Nelson practice manager was the risk manager. The risks were separated into 3 areas, patient care, staff and force generation. Some elements within each risk had been transferred; when risks were resolved they were moved to a retired risk register. Although it was evident on the approach to manage some risks, the 4Ts had not been formally applied. This was rectified during the inspection.

Although there had been no performance issues with staff, leaders were aware of policies to be followed and where to access support if advice was needed. Staff would initially follow a supportive route considering welfare concerns, training needs, coaching and mentoring and ensuring appropriate objectives were in place. The annual appraisal process would be used alongside these processes. If concerns remained, the practice would consider more formal mandated performance management processes detailed in the PMX standard operating procedure.

There was a business resilience plan (BRP) which had last been reviewed in August 2024 and included agreed workforce loss (for each department and for military/civilian staff), loss of IT systems, loss of telephone system and failure or interruption to the supply chain. Each risk had been assessed comprehensively and the BRP contained a ‘recovery log sheet, and a list of key personnel together with their contact details (internal, regional and external).

Appropriate and accurate information

A number of different meetings were held regularly and extended to the whole team. A practice wide meeting was held monthly and provided a forum for effective discussion and shared learning. Minutes from meetings we reviewed demonstrated that key agenda items

had been discussed including safeguarding, National Institute for Health and Care Excellence guidance and Central Alerting System alerts.

The eHAF (electronic 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. The HAF was integrated for all 6 sites and used by PMX to collate information in an effective way that facilitated sharing both internally and externally to RHQ and DPHC.

There were robust arrangements at PMX in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. Caldicott reports were reviewed weekly. PMX staff were not permitted to register as patients at PMX and a Caldicott report would be generated if their records were accessed by a colleague to ensure data safety. There was good compliance across PMX with mandated information governance training

Engagement with patients, the public, staff and external partners

The practice involved patients, staff and external partners to support high-quality sustainable services. When combining, PMX senior leaders met with all base Commanding Officers to canvas their opinions. This allowed for nuances to be accommodated in order to meet the specific needs of the patients at each site, for example, walk in ‘sick parade’ or ‘fresh cases’ were more heavily used at sites with phase 1 and phase 2 trainees, whilst eConsult triage was used at those sites with a more diverse population.

The leaders actively sought feedback from staff. There has been a couple of iterations of staff feedback that had not delivered the output nor effect they were seeking. They recently used the NHS Culture of Care Barometer for the PMX Staff Survey which took place between 18 May and 16 June 2024 and included 36 questions regarding well-being in the workplace. 103 staff members across the PMX took part in the survey. The results were broadly positive. The Staff Wellbeing working group was now analysing the results with a view to formulating an action plan.

There were various options in place to encourage patients to provide feedback on the service and contribute to its development. A patient experience survey was undertaken throughout the year and the results shared with patients.

Patients could leave feedback anonymously via a suggestion box positioned in the waiting rooms. A notice board in the waiting areas at each site provided a summary of the complaint process and duty of candour principles. All 6 sites had a ‘you said, we did’ board to feedback to patients about changes made based on their feedback. Examples included the provision of additional sexual health items such as femidoms, sanitary products and nappies for parents with new babies attending appointments. These items were in place at Nelson.

The management team utilised all staff rewards available to them to recognise hard work and achievement. They had conducted a staff morale survey which was planned to be repeated. There was a PMX staff wellbeing working group each month. There were also departmental meetings which fed into the management team from the Heads of Departments. Furthermore, an anonymous electronic form was available, which staff could complete to raise concerns or suggestions. Good and effective links with internal and external organisations were established, including with the welfare team, Chain of Command and local NHS services and the Integrated Care Board. A staff survey was undertaken and we saw how feedback and comments was used to influence and shape decision making at a senior level. PMX had implemented a team awards system, which was in-house and based on colleague nominations. The awards applied to all, from the cleaner to the PMO and were awarded 3 times per year. Those nominated had their citations read at the PMX practice meeting and the senior leaders decided the winner. Winners received a framed certificate and small monetary prize sourced from Naval funds.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation. There was a monthly PMX continuous improvement working group which had identified a number of QIPs by PCRF, staff some which related to the PMX project. However, not all had been written up due to capacity of staff with PMX being the focus. The practice had completed a number of QIPs which were recorded on the HcG Wb. Good examples of quality improvement included:

A ‘low carb’ group had been set up at Collingwood and Southwick Park for patients with diabetes. In the first group of 10 patients (2 dropped out), 7 had seen a reduction in their HbA1C, improvement in symptoms and in 2 cases, the Type 2 diabetes had been reversed. A second group was being planned across PMX.

Use of QR codes to promote feedback from staff and patients. These codes improved confidentiality when signposting to further services such as travel healthcare needs. In addition, an email was sent to the nurses’ group email box to enable the nurse to complete background preparation prior to seeing the patient (if required). This had saved appointment time and streamlined travel health.

During the inspection we highlighted further areas of good practice that were not QIPs but worthy of mentioning:

OneNote was used extensively to enhance communications. The software was effectively used to keep documents organised and included the comprehensive set of SOPs, guides and induction programme. In addition, we commended PMX on their SharePoint site, in particular the landing page that provided clear navigation to documents held within that included a platform for staff to raise concerns or report issues.

The benefits that stemmed from the innovative and effective combining of 6 practices could clearly be seen in resilience and improved wellbeing for staff, better access to services for patients, standardisation of clinical structure, leadership and collaborative followship.

The civilian medical practitioners (CMPs) held their own bespoke meeting and were represented at pilar meetings and conferences to ensure that the CMP view was represented. The CMPs had helped shape PMX sites and processes and had undertaken joint clinics to support one another. We spoke with CMPs as a group who spoke positively around the cohesion and now felt like they had a voice within PMX.

The PCRF teams showed some positive examples of QIP although these had not been formally recorded. Examples included the use of synonyms (short cuts used to standardise consultations), a project to improve PCRF specific patient feedback, in service training for late stage upper limb rehabilitation and supporting the development of Navy fitness training processes.

The work that PMX staff had been doing for the past 2 years with the combining of 6 practices was a significant quality improvement project in itself. Although it was acknowledging that the practice was now moving into the ‘test and adjust’ phase, it was consistently reported as an overall success during the inspection. The project had empowered personnel to be a lead and to take the lead, providing them with protected time to do this had been key. Efforts had been championed through awards and innovations rolled out across PMX.