Imphal Barracks Medical Centre

Imphal Barracks, Fulford Road, York, YO10 4HD

Defence Medical Services inspection report

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

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

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Summary

About this inspection

We carried out an announced comprehensive inspection of Imphal Barracks Medical Centre on 26 November 2024.

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

Are services safe? – 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 the CQC's observations and recommendations.

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

At this inspection we found:

- The practice demonstrated a person-centred approach to accommodate the needs of individuals and the Chain of Command. Patients were involved in decisions about their treatment and care.
- Our review of records and processes to monitor care showed patients received effective and timely clinical care.
- Patient feedback about the service was positive. It demonstrated patients were treated with compassion, dignity and respect.
- Effective safeguarding arrangements were in place. Patients vulnerable due to their mental health and/or social circumstances were well managed and supported.
- Flexible access and services were offered to all patients, including those with a caring responsibility.

- Staff spoke highly of the culture within the team and described an inclusive and supportive leadership management style.
- Governance systems underpinning the safe running of the practice were up-to-date.
- ASER, the organisational-wide system for reporting significant events was effectively used and changes were made as a result of incidents.
- Evidence of appropriate recruitment and completion of mandated training was in place for all staff.
- Medicines and medical products were well managed.
- There was a culture of improving the service through clinical audit. All mandated audits had been completed.
- Appropriate measures were in place to minimise the risk of infection. Infection prevention and control audits were regularly undertaken.

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

- The practice had pro-actively embraced the mandated training to enhance staff knowledge about learning disability and autism. The whole team had completed the training. Formal feedback was sought and it highlighted all staff considered the training beneficial both from a professional perspective and for a personal understanding of the complex issues associated with autism. A member of staff stated on the feedback survey, “I think that this training should be adapted for all work places to give everyone a better understanding on learning disabilities and autism”. The practice manager had since reflected on their leadership approach and recognised that individuals respond differently to situations and not all people process information in the same way. We considered the positive attitude taken to this training and impact it has had for staff a notable piece of work. We highlighted the benefits of sharing it within the ‘White Rose Network’ and the importance of raising it as a quality improvement project so the positive impact is shared widely across Defence Primary Healthcare (DPHC) Services.
- The practice manager with support from the relevant IT team developed a bespoke, simplified and inclusive SharePoint site for the practice. All staff we spoke with indicated the site was easy to navigate and key information could be accessed promptly. This meant time was not wasted searching for documents; time that was re-directed to patient care, and particularly useful given limited staffing levels. The inspection team was shown the SharePoint site and agreed it was exceptionally user-friendly compared to other sites. We highlighted that the approach to developing this SharePoint site would benefit from being shared widely with other DPHC services.
- Based on best practice guidelines and in line with DPHC policy, the practice developed a chronic disease management tool for ease of reference and to ensure a coordinated approach with the management of chronic disease. An overview table outlined each condition including the review period, blood tests required and preliminary checks/observations. A further section provided additional details for each condition, such as the tasks that required completion by the doctor, nurse or medic. Details of the medicines that required monitored were identified based on the North Yorkshire and

York Formulary. This management tool ensured a consistent pathway in how patients were managed.

The Chief Inspector recommends to DPHC:

Ensure staffing levels are adequate at all times to safeguard the health and wellbeing of staff and ensure sustainability of governance requirements for the practice.

Dr Chris Dzikiti

Interim Chief Inspector of Healthcare

Our inspection team

The inspection team was led by a CQC inspector and involved a team of specialist advisors including a primary care doctor, nurse, pharmacist, physiotherapist and practice manager. A newly recruited specialist advisor shadowed the inspection as part of their induction.

Background to Imphal Barracks Medical Centre

Imphal Barracks Medical Centre supports an approximate service personnel population of 905 for 3 units based at Imphal Barracks. Although not included in this number, the practice also provides a service for units based at Queen Elizabeth Barracks, Strensall and minor units located within the area. Families are not registered at the practice.

Imphal Barracks Medical Centre forms part of the 'White Rose Network' (referred to as 'The Network' throughout the report) along with Leconfield, Dishforth and Leeming medical centres.

Routine primary care and occupational health is provided by the practice along with a Primary Care Rehabilitation Facility (PCRF) for physiotherapy and rehabilitation. The practice does not have a dispensary so prescriptions are issued from a local pharmacy.

The practice is open from 08:00 to 16:30 hours Monday, Tuesday and Thursday and from 08:00 to 12:00 hours on Wednesday and Friday. Cover is provided by Leeming Medical Centre until 18:30 hours weekdays. From 18:30 hours midweek, weekends and public holidays patients are directed to NHS 111.

The staff team

Senior Medical Officer	One (civilian)
Ministry of Defence (MOD) GP	One (18.5 hours per week)
Regimental Aid Posts [1]	2 Signal Regiment staff include: Regimental Medical Officer Medical Sergeant General Duties Medical Officer Two Combat Medical Technicians (medics) [2]
Practice nurses	Band 6 (30 hours per week) Band 7 (32 hours per week) – locum covering long term absence Healthcare assistant – post de-established to be replaced with a Band 5 nurse (22.5 per week). Currently advertised.

	Placement student nurse
PCRF	Band 6 physiotherapist Exercise rehabilitation instructor – (full-time split between Imphal Barracks and Leconfield medical centres)
Practice management and administration	Practice manager Office manager Receptionist

[1]A team of clinical staff attached to a unit. When not deployed, the team are based within the medical centre to support force health protection and to maintain their clinical currency.

[2]A medic is a unique role in the forces. Their role is similar to that of a health care assistant in NHS GP practices but with a broader scope of practice.

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

The Senior Medical Officer (SMO) and the MOD GP were the safeguarding leads for the practice. A safeguarding policy was in place and was last reviewed in October 2024. The policy included links to external agencies, such as for the City of York's Safeguarding Children Partnership and to York City Council. All staff were in-date for safeguarding training at a level appropriate to their role.

A DMICP (electronic patient record system) search was established to routinely check for patients under the age of 18. Care leavers were identified when they registered at the practice. The most recent DMICP search to identify vulnerable patients was undertaken in November 2024. A vulnerable patients register was held in a limited area of SharePoint and was monitored by the SMO. Where applicable, clinical coding and alerts were applied to individual DMICP records to ensure vulnerable patients were readily identified. There were no patients under the age of 18 registered at the time of the inspection. The SMO attended quarterly meetings with the North Yorkshire Local Authority safeguarding team.

We were given an example of how a serious safeguarding concern was managed. The welfare team were actively involved with supporting the patient and the SMO attended the multi-agency risk assessment conferences (referred to as MARAC). When the patient requested a consultation, the practice insisted it was a face-to-face appointment so a welfare check could be facilitated.

The chaperone policy was reviewed in October 2024. Clinical staff had received chaperone training and a register of available chaperones was displayed in all clinical rooms. Our review of patient records showed the offer and use of a chaperone was recorded.

Although the full range of recruitment records for permanent staff was held centrally, the practice manager demonstrated that relevant safety checks had taken place at the point of recruitment, including a Disclosure and Barring Service (DBS) check to ensure staff were suitable to work with vulnerable adults and young people. DBS checks were renewed in accordance with Defence Primary Healthcare (DPHC) policy. Staff vaccination checks were monitored and retained by the nursing team. Vaccination data was not available for a member of staff and the nurse was following this up.

The infection prevention and control (IPC) standard operating procedure was reviewed in August 2024. The Band 6 nurse was the lead for IPC and had completed the link practitioner training in May 2024. All staff were up-to-date with mandated IPC training. The lead attended quarterly IPC meetings for link practitioners. The IPC audit was carried out in sections over a 12 month period; the general management element of the audit was completed in November 2024. Handwash posters were displayed in all clinical rooms.

IPC compliant sinks and taps were in each clinical room except for the room used by the General Duties Medical Officer (GDMO). This room had a portable sink, which was identified on the risk register and was cleaned in accordance with the manufacturer's

instructions. The room was not in use at the time of the inspection as the GDMO was deployed. A designated isolation area with a separate entrance/exit was available if a patient had, or was suspected of having, an infectious disease.

Clinical rooms were cleaned twice a day and non-clinical areas once a day. The environmental cleaning team had a colour coded chart in the cleaners' cupboards and relevant matching coloured buckets. We highlighted that this chart would be beneficial for new cleaning staff if it was available on the door of each room. The practice manager provided evidence shortly after the inspection to confirm this had been actioned. A deep clean was carried out twice a year; last completed in June 2024 and next scheduled for December 2024. Practice staff described how they had a good rapport with the cleaning team and cleaning supervisor; any issues with cleaning were addressed quickly. The IPC lead had a meeting with the cleaning supervisor in November 2024.

Records showed the medics checked all clinical rooms each week. Staff were responsible for cleaning their desks and maintained a log. Disposable privacy curtains were changed every 6 months or more frequently if needed. Minutes confirmed IPC was a standing agenda item at the practice meetings.

A lead was identified for the management of clinical waste. A clinical waste log was in place and up-to-date. The most recent pre-acceptance audit was completed in June 2024, Clinical waste was stored securely outside of the building, including pharmaceutical waste. Sharps boxes were labelled, dated and disposed of appropriately.

Clinical waste was electronically signed for on a Personal Electronic Device (PED) held by the driver collecting the waste, which confirmed the number of clinical waste bags removed. Information from the PED automatically populated the 'Greenzone Portal'. The waste management company then forwarded an invoice with the amount of waste products disposed of, which could be checked against the figures on the portal.

Risks to patients

Practice meeting minutes from October 2024 identified staffing levels as the top risk for the practice. We asked a range of staff if there were sufficient staff to ensure a safe, timely and effective service for patients. Staff highlighted that the number of patients registered at the practice was not a true reflection as the practice supported personnel who were 'sick at home' and others who were out-of-area. At the time of the inspection, staff reported that the number of doctors and Primary Care Rehabilitation Facility (PCRF) staff was sufficient to meet patients' needs and undertake governance activity.

The nursing team was under pressure as the healthcare assistant (HCA) post had been vacant since June 2023 despite attempts to recruit a locum HCA. The HCA post had since been de-established. Instead, an advertisement had been posted for a part-time Band 5 nurse (22.5 hours per week). The Band 6 nurse was appointed in January 2024 and had only 2 weeks working with the Band 7 nurse as part of their induction. The Band 7 nurse had been absent from the service since January 2024. A locum nurse had been appointed to cover their post. Due to unforeseen circumstances, the locum nurse had been working from home and their contract was due to end at the end of November 2024.The Band 6 nurse had to manage their time smartly with some governance tasks taking a lower

priority, such as clinical audit. As there was no dispensary at the practice, the nurse had the additional responsibility of managing medicines.

Staff reported there was a reliance on the Regimental Aid Post (RAP) team to enhance clinical capacity. The Regimental Medical Officer had not been regularly available to the practice throughout the year. If no medics were available to facilitate the emergency clinic each morning (referred to as sick parade) then the nurse had to pick this work up. Relying on the RAP team was not a sustainable solution as the RAP's primary commitment was to the unit and RAP staff could be recalled by the unit at any stage, including at short notice. The team valued being part of The Network as they could lean into other practices for support, particularly if they were short of staff.

The seal on the medical emergency trolley was checked daily and a full check of the kit and emergency medicines was undertaken monthly or if the trolley had been opened/used. All medicines and emergency equipment were in-date. Medical gas cylinders were stored alongside the emergency trolley and appropriate signage in place. Gas cylinders were full when we checked. A risk assessment was in place for items not held on trolley. The small PCRF gym close to the medical centre had access to the automated external defibrillator (AED) in the medical centre. There was also an AED in the unit gym and another was held in the guard room.

The SMO was the lead for medical emergencies and a deputy lead was also identified. The staff team was up-to-date with basic life support training, anaphylaxis and the use of an AED. Scenario-based or moulage training was periodically held. A scenario based on a collapsed patient at reception was facilitated in November 2024. The majority of staff had completed thermal injury training. A training session on recognising the deteriorating patient/sepsis was held in November 2024. Both clinical and non-clinical staff were familiar with the signs and symptoms of sepsis. Sepsis information was in displayed in the practice. The practice was considering including spinal injury training on the training plan for next year.

Information to deliver safe care and treatment

Staff reported minimal concerns with IT outages although highlighted that DMICP was not always consistent. There was an unplanned DMICP outage the week before this inspection. Consequently, the practice followed the business continuity plan and all routine clinics were cancelled and only patients with an emergency need were seen. Consultations were recorded on FMED 5s (medical summary forms) and then transferred to DMICP once it was accessible. Cancelled clinics were re-arranged. The outage also impacted vaccination clinics leading to a back log. This meant personnel at high readiness to deploy were also affected. Although not an organisational requirement, we discussed with the practice manager whether it would be useful for audit purposes to maintain a log of DMICP outages/issues.

The locum nurse was working from home to address the summarisation backlog. At the time of the inspection, 75% of patients records had been summarised.

Arrangements were in place for the auditing of consultation records for each clinician. The doctors reviewed each other's clinical records annually. In the absence of the other nurses at the practice, the Band 6 nurse linked in with the nurse at Leconfield Medical Centre who

carried out a records audit in November 2024. Records maintained by the medics were audited by the nurse in July 2024. The physiotherapist reviewed the exercise rehabilitation instructor (ERI) records every 6 months. The ERI audited the physiotherapist notes template and SMO cross checked.

The Band 6 nurse described the start-to-end process for the management of samples. An electronic specimen register was maintained. The SMO checked the register daily and responded to the results. For normal results, the SMO tasked the receptionist to send a text to the patient stating the results were normal. Abnormal results were either addressed directly by the SMO or tasked to the doctor who requested the test. Patients were advised to contact the practice if they had not received their results within 10 days. Although a solid system was in place, we highlighted that the process was predominantly dependent on the SMO so would benefit from other clinicians having knowledge and experience of the process.

An effective system was in place for managing both internal and external referrals including urgent and 2-week-wait referrals. Overseen by the office manager, the practice was using the new DPHC centralised process for referral management. This provided a variety of functions to support the monitoring of referrals, including an alert to prompt follow-up and the ability to transfer details of the referral if the patient moved to another practice. Most external referrals were made via the NHS e-Referral Service and some referrals were made by email, such as those to radiology and cardiology. The office manager reviewed the referrals each week, updated the register accordingly and followed up on outstanding referrals and/or outcome letters. There were long waits for some specialities such as ear, nose and throat and dermatology; both with wait times of approximately 52 weeks. Depending on the urgency, the SMO had the facility to apply for funding to use private healthcare services.

The physiotherapist monitored their own referrals and the ERI covered in their absence. External referrals could be made for a scan or for an orthopaedic opinion without referral to the Regional Rehabilitation Unit (RRU). Often this option was taken as referring via the RRU had previously caused delays due to waiting times. The physiotherapist received an acknowledgement from the Multidisciplinary Injury Assessment Clinic (referred to as MIAC) once the referral was accepted. The physiotherapist checked the referrals each week. PCRF referrals made to Clifton Park Hospital and Nuffield Health York Hospital were tracked by the office manager.

Safe and appropriate use of medicines

The SMO was the lead for medicines management. The Band 6 nurse was the deputy lead and they managed pharmacy supplies with support from a pharmacy technician within The Network. As there was there no dispensary at the practice, all dispensing was outsourced to a local community pharmacy. Medicines management was reflected in the terms of reference for both the SMO and nurse. The nurse described receiving good support from the regional pharmacist, who also monitored medicine use by the practice.

Military prescriptions (Fmed 573 and Fmed 296) were managed and stored securely. The SMO controlled the logging and issuing of prescriptions. NHS FP10 prescriptions for controlled drugs (medicines with a potential for misuse) were stored in the controlled drugs (CD) cabinet and were issued by the SMO; they were signed out of the CD book. A

running total was maintained, along with all other safety requirements. CD prescriptions were always checked by another prescriber. Fmed 296 and NHS prescriptions were photocopied and retained in CD cabinet for records.

The CD keys were kept in a safe, which only the SMO had access to. The BMed 12 (CD register) was held in the outer section of CD cabinet. The annual CD audit was last completed in December 2023. No CDs were held or destroyed at the practice. Although it had not happened, we discussed that it would be more appropriate if patients returning CDs were redirected to the local community pharmacy to have the medicines destroyed.

There was restricted access to the code for the medicine fridges. The Band 6 nurse was responsible for ordering vaccines and, in their absence, the pharmacy technician at Dishforth Medical Centre. Vaccines were recorded on DMICP and our check of vaccines showed all were in-date. Fridge temperatures were correctly monitored and were in range. Thermometers were in-date and correctly deployed with fridge thermometer probes in eyedropper bottles of water. Dataloggers were also in the fridges. Although we noted the stock was untidy, it was stored away from fridge walls allowing air to circulate. Stock was rotated appropriately with longer expiry dates to rear of fridge.

Although not a regular occurrence, approved insulated boxes to maintain medicines at a stable temperature were used if vaccines needed to be transported to another medical centre.

The Band 6 nurse was a non-medical prescriber, which was captured on the Nursing and Midwifery Council register. Their speciality was primary health care so they prescribed within their scope of practice. A letter of authorisation from DPHC Headquarters was in place to permit the nurse to prescribe. Patient Group Directions (PGD) to administer medicines in line with legislation were also used by the nurse and the university placement nurse. PGD training was current and PGDs had been signed off by the SMO. PGD audits were undertaken with the Band 6 nurse auditing the placement nurse and a nurse within The Network auditing PGDs for the Band 6 nurse. We reviewed a range of DMICP consultations undertaken by the Band 6 nurse and all followed the DMICP PGD protocol. Patient Specific Directions were not used as prescriptions were issued for medics to administer vaccines.

Repeat prescriptions were requested by eConsult, email or a quick response (referred to as QR) code. Adverse effects of medicines were discussed with patients during their consultation. Information leaflets were issued by the dispensing community pharmacy.

The Band 6 nurse reviewed the medicines prescribed to patients with a with a chronic disease and used the chronic disease management tool and template on DMICP to capture the review. Occasionally and if appropriate, a telephone review was undertaken by a doctor.

Patients prescribed a high risk medicine (HRM) were reviewed by the SMO or one of the other doctors. A HRM register was in use and maintained by SMO. A process was in place to monitor when blood tests were due. Patients were booked in for a review and prescriptions issued once the blood tests were reviewed. Our review of patient records showed HRMs were managed in line with requirements for HRM monitoring.

Correspondence related to the prescribing of medicines from internal departments and secondary care were scanned to the patient’s records for the SMO to review. This was confirmed by our review of DMICP records.

Routine DMICP searches for patients prescribed Valproate (medicine to treat epilepsy and bipolar disorder) were undertaken with the most recent conducted in November 2024. No patients were prescribed this medicine at the time of the inspection.

The North Yorkshire guidance for prescribing antibiotics was out-of-date so the practice was following the Royal College of General Practitioners prescribing guidance at the time of the inspection.

Track record on safety

The practice manager was the risk manager for the practice and the office manager assisted. One of the medics was the lead for health and safety (referred to as SHEF) and the practice manager was the deputy lead. The office manager was the lead for fire safety and the receptionist deputised. The practice manager was the lead for equipment and one of the medics was the deputy lead.

A risk register was in place, which reflected the DPHC '4 T's process' (transfer, tolerate, treat, terminate) to illustrate at what level each risk was being managed. A wide range of regularly reviewed clinical and non-clinical risk assessments were in place including for the PCRF. These were signed off by the SHEF lead.

Risk assessments for substances hazardous to health (COSHH) were reviewed annually or if there was a change to the products used. The COSHH data sheets were held in a locked cupboard with the products. Although the data sheets contained a section titled 'Description of first aid measures', this information was not readily accessible if someone was exposed to a product, such as through inhalation or ingestion. After the inspection, we sent the practice manager a 'quick reference template' for exposure to COSHH products that was identified as 'notable practice' from a previous inspection. The practice manager promptly provided evidence to confirm it had been completed specifically for the COSHH products used at the practice and was now accessible to staff. Cleaning staff were responsible for monitoring the COSHH products they used.

Processes were in place for the regular monitoring of utilities. The gas safety certificate was issued in August 2023 and the electrical certificate in February 2023. The legionella risk assessment was carried out in January 2024. In addition, taps in the building were run for 5 minutes on Mondays and Fridays.

The 5-yearly fire risk assessment for the premises was completed in April 2021. Weekly and monthly checks of the fire alarm system and firefighting equipment were up-to-date. A fire evacuation drill was held annually with the most recent taking place in July 2024. A fire exit was available for staff based on the first floor. A separate fire monitoring folder was in place for the PCRF gym.

An equipment inspection (referred to as a LEA) was scheduled the week after this inspection and the practice manager provided us with a copy of the report. The 1 area of non-conformance identified was outside the control of the practice and was being addressed by the medical and dental servicing section (a military capability referred to as MDSS). We highlighted that the practice was using outdated pre and post user check forms (referred to as 373's) and this was promptly addressed by the practice manager. The ERI managed the equipment for the PCRF, which was last serviced in July 2024.

The practice manager and SHEF lead carried out a full formal check of the building every 6 months and any concerns identified were actioned. Minutes demonstrated that SHEF, risk and equipment were standing agenda items at the practice meetings.

Unit physical training instructors (PTI) carried out wet globe bulb testing for the barracks to indicate the potential for heat stress. Previously, PTIs logged the temperatures on SharePoint but during the year moved to paper records. The PCRF staff were working with the PTIs to re-introduce electronic records so all staff could access the information. PTIs informed PCRF staff if temperatures were too high. There was ventilation in the small PCRF gym, including a temperature probe.

Staff carried handheld personal alarms to summon assistance in the event of an emergency. We activated a few of these off throughout the day to establish if they could be heard in all areas. Staff responded promptly including the ERI based at the top of the stairs. The practice manager was further away on the upper floor so did not hear the alarms. The practice manager confirmed promptly after the inspection that the limitations with the alarm system had been added to the risk register. In addition and for their personnel safety, the practice manager confirmed high decibel alarms had been purchased for the 2 staff based on the first floor. We highlighted the importance of checking personal alarms periodically to ensure they were in working order.

The lone working risk assessment for the practice was reviewed in November 2024. A specific risk assessment was in place for lone working in the PCRF gym. Actions included the member of staff informing the practice manager they were in the gym and using their mobile phone to seek support if needed.

Lessons learned and improvements made

The practice worked to the DPHC policy for reporting and managing significant events, incidents and near-misses, which were recorded on ASER system. The staff database showed all staff had completed ASER training to access the system.

An ASER register was established and any new incidents/events were discussed at practice meetings. Minutes showed action was taken and changes made if appropriate. All staff interviewed described a recent ASER that was discussed at the meeting.

A safe process was in place for managing notices from the Medicines and Healthcare products Regulatory Agency (MHRA). Notices were up-to-date and logged on SharePoint along with who had checked the MHRA site. Minutes showed that MHRA notices and alerts received through the Central Alerting System were a standing agenda item for discussion at practice meetings.

Are services effective?

We rated the practice as good for providing effective services.

Effective needs assessment, care and treatment

The doctors, Band 6 nurse and physiotherapist attended the monthly optimal care meeting. A variety of topics were discussed at this meeting, including vulnerable/concerning patients and maternity patients. ‘Sick at home’ patients were also discussed as an arrangement was in place to support patients from other units who were on long term sick and waiting medical discharge dates. The practice provided ‘bridging care’ for this cohort of patients until such time as they left the service.

In addition, the optimal care meeting provided a forum to discuss developments in clinical care including National Institute for Health and Care Excellence guidance, the Scottish Intercollegiate Guidelines Network, clinical pathways, current legislation, standards and other best practice (BCP) practice guidance. Furthermore, clinicians provided feedback on clinical courses attended and audits completed. Updates were issued to the team via regional Defence Primary Health care (DPHC) quarterly updates. ‘Hot topics’ were discussed at informal lunchtime meetings and other informal forums provided a good opportunity for peer support, including opportunistic sharing of relevant patient information. In addition, the doctors referred to ‘Red Whale’, a learning resource for primary care clinicians.

Our review of Primary Care Rehabilitation Facility (PCRF) patient records confirmed the physiotherapist used the Musculoskeletal Health Questionnaire (MSK-HQ) and Functional Activity Assessment (FAA). Both the MSK-HQ and FAA are standardised outcome measure for patients to report their symptoms and quality of life. The MSK-HQ was used at the initial appointment and on discharge of the patient. The use of the MSK-HQ was clinically coded via the DMICP template. Patients accessed rehabilitation exercise programmes through Rehab Guru (software for rehabilitation exercise therapy). The exercise list provided was also documented in the patient’s record.

Both the physiotherapist and exercise rehabilitation instructor (ERI) were aware of the rehabilitation BCP guidance on the Defence Learning Environment. The PCRF was well equipped with sufficient space and equipment to meet the needs of patients.

A monthly case review was held between the physiotherapist and ERI. If the ERI was concerned about a patient they arranged a discussion with physiotherapist and a joint appointment if appropriate.

Step 1 of the DPHC mental health pathway was delivered at the practice. Patients who needed intervention beyond step 1 were referred to the Department of Community Mental Health (DCMH) and the patient added to the unit Vulnerability Risk Management register if appropriate. Regional triage for access to a DCMH was undertaken at Faslane. The practice had access to out-of-hours contact details for the DCMH. Our review of clinical records showed patients with a mental health need were well managed and appropriate clinical coding was used.

Monitoring care and treatment

The Senior Medical Officer (SMO) was the lead for chronic conditions and the Band 6 nurse was the deputy lead. The birthday month was used to recall patients for a review. The nurse was responsible for taking bloods and any other tests required prior to a review by the doctor.

Based on best practice guidelines and in line with DPHC policy, the practice developed a chronic disease management tool for ease of reference and to ensure a coordinated approach with the management of chronic disease. An overview table clearly outlined each condition including the review period, blood tests required and preliminary checks/observations. A further section provided more details for each condition, such as the tasks that required completion by the doctor, nurse or medic. Details of the medicines that required monitored were listed based on the North Yorkshire and York Formulary. This management tool ensured a consistent pathway in how patients were managed.

Our review of the data provided indicated the small number of patients with a diagnosis of diabetes were well managed. Patients from the age of 40 were invited for well-person checks. Those identified with pre-diabetes were offered an annual follow-up and were referred to the NHS pre-diabetes service. Patients with gestational diabetes were monitored postnatally. The practice was trialling the use of cholesterol monitors for over eligible patients over the age of 40.

Similarly, data showed that patients with asthma had been appropriately reviewed in the last 12 months. The DMICP asthma monitoring template was consistently used by clinicians when annual reviews were undertaken. Thirty-two patients were diagnosed as having high blood pressure and data indicated all had their blood pressure checked in the past 12 months. Our review of clinical records for these chronic diseases showed patients were well managed and appropriate clinical coding was used.

Audiometry assessments were in-date for 84% of the patient population. Our review of patient records demonstrated Joint Medical Employment Standards (referred to as JMES) were appropriately managed.

The MOD GP was the lead for quality improvement activity, including clinical audit, and the SMO was the deputy lead. Clinical audit was used to evaluate the quality of care and improve patient outcomes. An integrated audit programme was established for the medical centre and PCRF and managed by the GP. They ensured adherence to the audit programme by sending out monthly reminders to the team. A wide range of audits had been undertaken. The 3 audits (high blood pressure, diabetes and family planning consent) we reviewed were of good quality.

Various audits had been undertaken by the PCRF team. Examples included direct access to physiotherapy (DAP), key performance indicators and attendance at group classes. Although the DAP audit showed peaks and troughs in referral rates, we were advised DAP worked well. The next DAP audit was due in December 2024. An audit of the patient pathway to improve downgrades for the field hospital showed an improvement of 32% over 6 months. The aim was to convert this audit into a quality improvement project. The ERI completed an audit on injury rates following an increase in referrals. It involved exploring the mechanism of injury, injury area and acute/sub-acute/chronic injury, and how to reduce the number of injuries.

The outcome of completed audits were discussed at the optimal care meeting or the practice meeting depending on the nature of the audit. PCRF audits based on patient pathways and BPG were limited and the physiotherapist said they would include these in the audit programme.

Effective staffing

Staff new to the practice, including the PCRF, completed an induction programme and a role specific induction. There was no specific induction for locum staff and the practice promptly addressed this after the inspection providing evidence to confirm it was now in place. Although PCRF staff reported that they had completed an induction on the use of gym equipment, we did not see documentation to confirm this.

New staff described a thorough and supportive induction. For example, the Band 6 nurse had protected time in the afternoon to complete the structured online training package and spent 2 weeks working with the Band 7 nurse supporting the morning clinics. The practice manager provided guidance on how to use the governance systems. The nurse also spent a day shadowing the nurse at Leconfield Medical Centre and a day with the Regional Nurse Advisor. In addition, the pharmacist from Dishforth Medical Centre provided the nurse with an overview of medicines management, including high risk medicines.

The Medical Sergeant confirmed medics had no involvement with patients until the induction was signed off as completed and they had shadowed the emergency morning clinic.

The practice manager monitored mandatory training and we confirmed all staff were up-to-date with training, including the General Duties Medical Officer who kept up-to-date even though they were overseas. In service training (IST) was facilitated on Wednesday afternoons and included a range of topics, such as sepsis, domestic violence and head injury training. Minutes showed mandated and IST training was a standing agenda item at practice meetings.

Staff had access to training specific to their lead and secondary roles for example, the Band 6 Nurse had completed the link practitioner infection prevention and control (IPC) training, smoking cessation, immunisation, cytology and yellow fever. They had also completed the non-medical prescriber (NMP) accredited course. Furthermore, they attended NMP forums for updates to maintain their knowledge and skills since qualifying

The clinical work of medics was monitored by the Medical Sargeant. They periodically observed the clinic facilitated by medics, including a check to ensure correct clinical coding was used. The Medical Sargeant also checked in with the SMO to confirm they were happy with the clinical work of the medics.

The Band 6 nurse participated in the quarterly nurses forum arranged by Regional Nurse Advisor and held at Catterick, which provided a good opportunity to discuss clinical updates. They also joined the monthly dial-in meeting for IPC with other IPC nurses in the region.

Clinical staff had protected time for continuing professional development (CPD) and all were up-to-date with their CPD and revalidation.

Coordinating care and treatment

The practice team had effective relationships with the units. The SMO regularly attended the Commander's Monthly Case Review (CMCR) meetings to discuss patients. The Medical Sergeant also participated in the CMCR and provided occupational health statistics, such as those for audiology and vaccinations, and an update on patients who failed to attend their appointments. The PCRF team previously attended the CMCR but due to a change in personal for the unit, the PCRF provided occupational health statistics for the meeting and met with the Officer in Command to discuss individual patients.

DMICP searches were undertaken prior to the monthly meeting to identify new vulnerable patients. Vulnerable patients were also identified via the unit Vulnerable Risk Management system. In addition, the SMO was pro-actively involved with the welfare services. For vulnerable patients moving to another area, a DMICP task was sent to the receiving practice. If required, the SMO discussed the patient's needs with a clinician at the new practice.

The practice also had good links with internal defence services including the DCMH, Regional Occupational Health Team and Regional Rehabilitation Unit.

Relationships were established with NHS services. For example, maternity care was provided in conjunction with the community midwife. As service personnel mostly returned to their home for maternity care with NHS services, the practice provided post-natal care for the patient as a temporary resident. In the rare event of a mother returning to the unit with their baby, then the child was registered at a local NHS practice. The nurses had good links into the diabetes centre at York Hospital for advice, including pre-diabetes education.

DPHC guidance was followed for patients leaving the military including, pre-release and final medicals. During the pre-release phase, patients received a summary of their healthcare record and given information about registering with NHS primary care. They also were provided with information about additional services, such as Op COURAGE, a free NHS service in England that provided mental health support for veterans and their families. Furthermore, patients were advised about the Armed Forces Covenant, which is a guarantee that those who have served in the armed forces are treated with fairness and respect.

Helping patients to live healthier lives

The nurse was the lead for health promotion and the SMO deputised. The receptionist assisted. The practice followed the NHS health promotion programme so health topics were refreshed regularly. The receptionist maintained and refreshed the waiting area monitor screen system, which provided a range of educational information and videos for patients to listen to while they were waiting. Practice and PCRF staff participated in the unit-led health promotion fairs.

The main health promotion topic displayed at the time of the inspection was 'Movember' to raise awareness of men's health. Resources for mental health wellbeing were available, including a range of QR codes for issues, such as suicide, stress and bereavement. Information was accessible via QR codes in relation to musculoskeletal conditions

including hip pain, groin strain and low back pain. Guidance regarding post-natal physical activity and rehabilitation was also displayed. Information was provided detailing the recent policy for purchasing sports bras. Strength and conditioning information was displayed outside the ERI's treatment room.

The SMO was the lead for sexual and reproductive health and the MOD GP deputised. Contraceptive implants and intrauterine devices (coils) were fitted at the practice. In addition, a clinic in York provided sexual health services and accepted both GP and self-referrals. Condoms were available at the practice.

The SMO was the lead for cervical cytology and the nurse deputised. Monthly searches were carried out to identify patients eligible for the national screening programmes. Cervical screening was managed using the new NHS CIS2 portal. Patients were sent 3 invitations for cytology screening. If there was no response then the nurse followed up with the patient to encourage the patient to engage with the screening programme. Outcome letters received from the NHS were forwarded to patients and scanned to the patient's DMICP record.

The number of women who had a cervical smear in the last 3-5 years was 116 which represented 94% of the eligible population. The NHS target was 80%. There were very low numbers of patients eligible for bowel and breast screening and no patients met the criteria for abdominal aortic aneurysm screening.

The nurse monitored the vaccination status of service personnel and this information was shared with the Chain of Command at the CMCR meetings. Three regiments were on high readiness to deploy so maintaining currency with vaccinations was essential. Medics were responsible for vaccination recall. The nurse reviewed the vaccination status for new patients registering at the practice. Service personnel were encouraged to use the 'MyHealth' app to manage and track the status of their audiology and vaccinations.

At the time of the inspection, the vaccination statistics for eligible service personnel at the was identified as:

- 93% of patients were in-date for vaccination against diphtheria.
- 93% of patients were in-date for vaccination against polio.
- 84% of patients were in-date for vaccination against hepatitis B.
- 75% of patients were in-date for vaccination against hepatitis A.
- 93% of patients were in-date for vaccination against tetanus.
- 99% of patients were in-date for vaccination against measles, mumps and rubella.
- 89% of patients were in-date for vaccination against meningitis.

Consent to care and treatment

Implied and verbal consent was mostly taken depending on the intervention. Written consent was secured for more invasive procedures, such as implants and coils. New patients attending the PCRF completed a consent form prior to their appointment. All the patient records we looked at indicated consent had been appropriately taken. Consent was considered as part of the consultation audits and a separate consent audit was undertaken in October 2024.

Clinicians understood the Mental Capacity Act (2005) and how it would apply to the patient population. Staff completed annual training and mental capacity was also discussed at the optimal care meeting. The 5 statutory principles of The Act was displayed.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

As part of the inspection, we received feedback about the service from 49 patients. In addition, we considered the 39 responses from the practice's patient survey. All feedback suggested staff were friendly, understanding and compassionate.

The practice used a 'question of the week' to seek additional feedback. At the time of the inspection, the question was 'Do you feel you are treated with kindness and compassion?' The previous week's question asked if patients would recommend the practice to family and friends and the response was 100% positive.

Staff provided various of examples of when the practice had shown compassionate care patients, including immediately responding to a patient who arrived with severe abdominal pain when the practice was closed at lunchtime. The severity of the patient's condition was promptly identified and managed immediately.

Involvement in decisions about care and treatment

Feedback indicated patients were involved with planning their care and this was confirmed by our review of patient records. Many patients highlighted that they felt understood as clinicians listened to them and things were explained in a way that they understood.

A translation service was available for patients who did not have English as a first language and information was displayed for patients about how to access the service. It was last used 8 months ago when German clinical records required translating.

Patients with a caring responsibility were identified through the new patient registration process or opportunistically. Monthly DMICP searches were undertaken for carers and the 16 carers identified had a clinical code and alert applied to their record. Carers were given an information leaflet, offered the flu vaccination and an annual heath check. Information about services to support carers was displayed in the waiting area.

Privacy and dignity

Patient consultations took place in clinic rooms with the door closed. If headphone sets were used for telephone consultations then the patient's ID was checked prior to any information being disclosed. Privacy curtains were available in all clinical rooms for intimate examinations. Window blinds were also used. Measures were in place at reception for patients to talk to the receptionist discreetly.

If a patient had a preference to see a clinician of a specific gender and this could not be accommodated then they could be offered a chaperone of their preferred gender.

Alternatively, patients could be seen at another practice or Primary Care Rehabilitation Facility within The Network

Are services responsive to people's needs?

We rated the practice as good for providing responsive services.

Responding to and meeting people's needs

The practice followed the Defence Primary Healthcare (DPHC) 'Total Triage' standard operating procedure. This was facilitated either by telephone or through patients presenting themselves at the practice between 08:30 and 10:00 hours each morning. The aim of total triage was to remove pressure from reception staff by experienced clinical staff swiftly identifying which care pathway the patient should take. In addition, the specific needs of patients were identified when scheduling appointments through the use of DMICP alerts, such as those for vulnerable patients and carers. This meant these patients were promptly identified and prioritised for an appointment. Extended appointment times could also be facilitated. eConsult was managed daily by the medics or nurse with patients given an appointment with a clinician. Appointments were scheduled to accommodate patients' occupational needs.

We were given numerous examples of when the practice had 'gone to extra mile' to respond to individual patient need. For example, if a patient required a test following a consultation with a doctor then the clinical team ensured the test was carried out at the same time rather than the patient returning another day. This arrangement was particularly supportive for patients travelling a distance to the practice. The practice also accommodated service personnel who were out-of-area due to holiday, sick or maternity leave. We heard of occasions when staff delivered prescriptions to the pharmacy to save patients based a distance away having to undertake the journey twice.

The 2 Signal Regiment provided diversity and inclusion advice and the practice manager was the deputy diversity and inclusion lead. The equality and diversity policy was displayed and staff we spoke with were aware of the protected characteristics under the Equality Act 2010.

In line with the legislation, an access audit for both the medical centre and Primary Care Rehabilitation Facility (PCRF) had been completed in May 2024. There were some areas of non-compliance for the PCRF gym. We noted these had not been added to the issues or risk register and this was addressed promptly after the inspection. A hearing loop was not required as no patients, staff or contractors used hearing aids at the time of the inspection. A wheelchair was available at the front door should a patient need to use it.

Clinicians had experience of providing support for patients in the early stages of gender transition and followed the MOD policy in relation to the management of transgender personnel in the military. Regular reviews were provided for those transitioning, including signposting to other services.

The practice had pro-actively progressed the mandated training to enhance staff knowledge about learning disability and autism. All staff had completed the training, including the General Duties Medical Officer who was overseas. Staff provided feedback on the training and the survey results highlighted all staff considered this training beneficial for their role within DPHC. Survey comments indicated staff considered it was worthwhile

both from a professional perspective and also from a personal understanding of the complex issues associated with autism. A member of staff stated on the survey, "I think that this training should be adapted for all work places to give everyone a better understanding on learning disabilities and autism".

The practice manager had since reflected on their leadership approach and now recognised that individuals respond differently to situations and not all staff process information in the same way. We considered the positive attitude taken to this training and impact it has had for staff a notable piece of work. We discussed with the practice manager the benefits of sharing it within the network. Furthermore, we discussed the value of raising it as a quality improvement project so the positive impact/outcome of the training is shared widely across DPHC Services.

The practice responded to feedback from patients and the Chain of Command. For example, the PCRF increased level 1 and 2 physical therapy by an hour twice a week to improve the readiness to deploy. This was in response to feedback from the 2 Signal Regiment.

Timely access to care and treatment

From patient feedback we confirmed patients were satisfied with timely access to a clinician. One of the medics described how an assessment was carried out as part of the morning total triage clinic. If the medics were concerned and unable to manage the patient's issue then they referred to the duty doctor who had dedicated appointments for patients with an urgent need.

Routine appointments with a doctor could be facilitated within a day. It was a 1 day wait for an urgent appointment with the nurse and 2 days for a routine appointment. A routine physiotherapy new patient appointment was accommodated within 4 working days and a follow-up appointment within 3 working days. An urgent physiotherapy appointment was available on the same day. New patient and follow up appointments with the exercise rehabilitation instructor were available within a day. There was availability at the rehabilitation classes held on Tuesdays and Thursdays.

The Direct Access Physiotherapy (DAP) pathway was available for patients to use and some patients were identified through total triage as meeting the criteria for DAP. When on leave, the physiotherapist at Leconfield PCRF followed up on referrals and any patients with an urgent need. Catterick was the main Regional Rehabilitation Unit referral point. The waiting time for the Multidisciplinary Injury Assessment Clinic was 20 days.

Although home visits could be facilitated if clinically appropriate, there had not been a situation whereby a home visit was required. Family planning, minor surgery, dermoscopy (examination of the skin using a skin surface microscope) and diving/aircrew medicals could be sourced within The Network.

Listening and learning from concerns and complaints

The practice manager was the lead for complaints, which were managed in accordance with the DPHC complaints policy and the practice standard operating procedure. A

structured complaints log including actions and learning was maintained. Complaints about clinical care were referred to the Senior Medical Officer. Four complaints relevant to the medical centre were received in the last 12 months and all had been appropriately managed to the satisfaction of the complainant. There had been no complaints about the PCRF. Minutes showed that complaints and compliments were a standing agenda item at practice meetings.

Patients were made aware of the complaints process through the practice information leaflet and information displayed in the waiting area.

Are services well-led?

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

Vision and strategy

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

> "….to provide safe effective healthcare to meet the needs of our patients and the Chain of Command in order to support force generation and sustain the physical and moral components of fighting power."

In addition, the practice, including the Primary Care Rehabilitation Facility (PCRF), had developed its own mission statement:

> "Imphal [Barracks] Medical Centre will provide a psychologically safe environment with the welfare and development of staff at its core, and in doing so safeguard the delivery of professional, accessible, high quality patient focussed care the community we support".

Our findings throughout the inspection clearly demonstrated that the practice was successfully meeting the principles of both mission statements. In relation to future and strategic planning, a practice development plan was in place. Information gained through patient and Chain of Command feedback was central to future planning.

The practice was part of the White Rose Network consisting of 4 practices. This arrangement was supportive as resources were shared to ensure continuity of care, such as for medicals and other clinical interventions. As staffing was identified as a main risk, the practice could lean into The Network during periods of staff shortages.

To address environmental sustainability, recycling was encouraged and the use of QR codes and electronic information rather than printed information. Recycle bins were available and a notice was displayed reminding staff to switch off electronic items at the end of the day. The use of prescribed inhalers was being reviewed to move towards the use of 'greener' products.

Leadership, capacity and capability

The leadership team was highly skilled and experienced. The Senior Medical Officer (SMO) was an ex Lieutenant Colonel and the physiotherapist had worked at the practice for many years. The practice manager had 31 years military experience, 6 years of defence healthcare experience, including 4 years at Imphal Barracks Medical Centre and 2 years practice managing the dental service. It was evident from our discussions with staff that the leadership team worked collaboratively. They adopted a 'bottom-up' approach by encouraging the wider staff team to contribute ideas, suggestions in decision making to improve and develop the service. Leadership continuity was achieved as all leaders were DPHC civilian staff so movement of the workforce was minimal.

Whilst not overtly expressed by staff, we identified a general sense that relationships with the Regional Headquarters (RHQ) could be improved. An anonymous staff survey highlighted that 67% of the team indicated they were not well supported by the regional team.

Culture

From patient feedback, interviews with staff, a review of patient records and outcomes/outputs for patients, we confirmed holistic and person-centred care was key to the principles of the practice. Staff understood the specific needs of the patient population and organised the service to meet those needs.

Staff spoke highly of the inclusive nature of the team. The leadership team spent time with individual staff to ensure they were supported. Positive morale was evident throughout the inspection and the Regimental Aid Post (RAP) team was clearly integrated within the practice. Staff reported that the whole team worked well together and individuals told us they were valued and respected by leaders. There was an open-door policy with everyone having an equal voice, regardless of rank or grade.

The physiotherapist previously nominated the practice manager for an ‘in-year’ reward for their line management. The SMO had nominated the team for the ‘thank you’ scheme. The team participated together in social activities outside of work. ‘White space’ time had been deferred due to multiple inspections recently.

The Defence Medical Service’s policy regarding ‘freedom to speak up’ was displayed for staff to access. Staff we spoke with understood whistleblowing and said they would have no hesitation using the policy if they had concerns.

Processes were established to ensure compliance with the requirements of the duty of candour (DoC), including giving those affected reasonable support, information and a verbal and written apology. Displayed for staff to access, DoC is a set of specific legal requirements that services must follow when things go wrong with care and treatment. A DoC register was maintained and included 2 recent entries. One involved a previous locum who was not aware of the process. We highlighted that this issue would benefit from inclusion in the locum induction. We noted the DoC register included the service number and date of birth for personal. The practice manager rectified this promptly after the inspection by switching to using of DMICP numbers only.

Governance arrangements

The SMO was the lead for healthcare governance (HCG) and the practice manager assisted. Both clinical and non-clinical governance systems we reviewed were used effectively to support the smooth operational management of the service.

A clear reporting structure was established and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. Terms of reference for staff were up-to-date. It was positive to see that the RAP staff held lead or deputy roles as this arrangement is not only inclusive but supportive in terms of learning and development. As RAP staff were subject to deployment, a DPHC staff either held the lead

or deputy role to ensure continuity. There were some gaps for deputy lead roles due to staff absences and a vacant post.

Formal and informal communication channels were established including regular structured meetings, such as the practice meeting and optimal care meeting. Practice meetings minutes demonstrated the DPHC standardised approach was followed. Meetings were well attended and the practice meeting minutes we reviewed were comprehensive. The practice was also represented at The Network meetings.

A programme of quality improvement activity was established to monitor the outcomes and outputs of clinical and administrative practice. Audits were presented and discussed with staff at the HCG meeting.

Failure to attend appointments was monitored and clearly displayed in reception for patients to see. In October 2024, a total of 20 appointments were missed for all clinicians. This meant there was over 10 hours of clinical time wasted. This information was shared with the Commander's Monthly Case Review meetings.

Managing risks, issues and performance

Risks identified for the service were logged on the risk register and kept under scrutiny through review at practice meetings. As staffing levels was a key risk, any forecasted gaps in the workforce were discussed and either a locum sourced or support through The Network requested. Risk assessments were in-date for the medical centre and PCRF. Significant events and incidents were discussed at practice meetings, including any improvements identified.

Reviewed in July 2024, the business continuity plan (BCP) for Imphal Barracks Medical Centre was displayed for staff to access. The BCP was last exercised in September 2024 when the practice was notified of a power outage the day prior.

Processes were in place to monitor national and local safety alerts, incidents, and complaints. This information was used to improve performance.

The leadership team was familiar with the policy and processes for managing staff performance, including underperformance and the options to support the process in a positive way. Staff appraisals were up-to-date.

Appropriate and accurate information

Accessible to all staff, the practice used the HCG workbook to manage and monitor governance activity. In addition, the Health Assessment Framework (HAF), an internal system, was used by the practice as a development tool and to monitor performance. The HAF was reviewed at practice meetings and a practice management action plan was in place to monitor and update action points.

The practice manager with support from the relevant IT team developed a bespoke, simplified and inclusive SharePoint site for the practice. All staff we spoke with indicated the site was easy to navigate and key information could be accessed promptly. This meant time was not being wasted searching for documents, time that was re-directed to clinical

care; particularly important given limited staffing levels. The inspection team was shown the SharePoint site and agreed it was extremely user-friendly compared to other sites. The approach to developing this SharePoint would benefit from being shared widely with other DPHC services.

An internal assurance review was undertaken in December 2023. Substantial assurance was identified for all domains except well-led which was rated as limited assurance. All recommendations had since been actioned.

Arrangements at the practice were in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. The Caldicott Principles, guidelines for the management of patient identifiable information, were displayed. Caldicott checks were carried out each month to ensure records were not being accessed inappropriately. Any concerns identified were addressed at the practice meeting. The staff team had completed Defence Information Management Passport training which incorporated the Caldicott principles.

Engagement with patients, the public, staff and external partners

Various options were available to prompt patients to provide feedback on the service. Complaints, suggestions and compliment forms were available for patients to complete and submit in both the medical centre and PCRF. An electronic tablet was available by reception for patients to undertake an anonymous DPHC patient questionnaire. It was identified that patients often partially completed the questionnaire due to the length of time it took. Because of this, the practice had developed its own shorter survey. Patients were also invited to respond to the ‘question of the week’. A notice board at reception provided patients with action the practice had taken in response to feedback.

Staff were encouraged to provide feedback at the practice meetings and via the open-door policy. A QR code was displayed for staff to access the survey to provide feedback on the service.

The practice worked closely with the Chain of Command, welfare support services and other defence services to ensure a collective approach with meeting the needs of the service personnel population.

Continuous improvement and innovation

The practice team was committed to continually improving the service and this was evident through quality improvement activity. Despite inconsistent staffing levels, the practice was delivering effective care for patients while maintaining the governance of the practice.

Although there was evidence of innovative practice being raised as quality improvement projects (QIP), we identified additional good practice initiatives which had not been raised as a QIP, such as the autism and learning disability training and the simplified structure of the practice SharePoint. Raising ‘purple’ (good practice) ASERs and QIPs and uploading

them to the DPHC Healthcare Governance webpage showcases positive performance and also enables the sharing of good practice with other DPHC facilities.