Drake Medical Centre

Drake Medical Centre, HMNB Devonport, Plymouth, Devon, PL2 2BG

Defence Medical Services inspection

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

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

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Summary

About this inspection

We previously carried out an announced comprehensive inspection at Drake Medical Centre on 28 November 2023. We rated the service as requires improvement overall with a rating of inadequate for the safe key questions and requires improvement for effective and well led. The caring and responsive key questions were rated as good. A copy of the previous report can be found at:

https://www.cqc.org.uk/dms

We carried out this announced focused follow up inspection on 11 February 2025. The report covers our findings in relation to the recommendations made and any additional improvements made since our last inspection. As a result of this inspection the medical centre is rated as good in accordance with the Care Quality Commission's (CQC) inspection framework.

The key questions are rated as:

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

The Care Quality Commission (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 observations and recommendations within this report.

At this inspection we found:

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

Effective safeguarding arrangements were in place. Patients vulnerable due to their mental health were well managed and supported.

The medical centre and Primary Care Rehabilitation Facility (PCRF) had good lines of communication with the units, the welfare team, local NHS, the Regional Rehabilitation Unit (RRU), and the Department of Community Mental Health to ensure the wellbeing of service personnel.

There was an open and transparent approach to safety. An effective system was in place for managing significant events and staff knew how to report and record using this system. As previously found at the last inspection, patient safety was compromised due to the lack of visibility over the clinical records of patients on ships who became the responsibility of the practice when in dock. This is a known and long-term ongoing problem for the Royal Navy. The medical centre was aware of this and had taken steps to partially mitigate the risk. However, the responsibility to find a solution is with Navy Healthcare in Navy Command Headquarters.

There was an effective programme in place to manage patients with long term conditions. Patients received effective care reflected in the timeliness of access to appointments, reviews, and screening/vaccination data.

Our review of records and processes to monitor care showed patients received effective and timely clinical care.

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

The programme of internal audit had been expanded to include clinical audit based on patient population need/or based on national guidance. It was evident that this was driving improvement.

Patients found it easy to make an appointment and urgent appointments were available the same day across all departments including the PCRF.

Risks to the service were recognised by the leadership team. The main risks outside of the medical centre's control had been escalated to Defence Primary Healthcare (DPHC) Headquarters (HQ) and Navy Healthcare in Navy Command HQ.

The Chief Inspector recommends to Drake Medical Centre

Ensure training for all medical centre staff in learning disability and autism is provided in accordance with DMSR regulatory instruction issued in April 2024.

The management of controlled drugs requires an update and review in line with the most recent controlled drug policy.

Review all patients on repeat medicines and ensure they are coded correctly.

Continue to improve the completion rates and follow up of audiometric testing for eligible patients.

Ensure all staff complete thermal injury training as part of the internal programme for staff.

Confirm the arrangements for regular deep cleaning of the premises.

The Chief Inspector recommends to the base:

Find resolution for the medical centre building such that it complies with the Health and Social Care Act 2008 code of practice on the prevention and control of infections and related guidance.

Review the requirements to ensure that staff at Drake Medical Centre are working and patients are seen within an acceptable temperature range.

The Chief Inspector recommends to Navy Healthcare in Navy Command Headquarters:

Urgently find a solution to the practice not being able to see the clinical records of patients they are responsible for.

Chris Dzikiti

Interim Chief Inspector of Healthcare

Our inspection team

The inspection team was led by a CQC inspector. The team included specialist advisors including a primary care doctor, practice manager, pharmacist, physiotherapist, and a nurse.

Background to Drake Medical Centre

Located within HM Naval Base Devonport in Plymouth, Devon, HMS Drake Medical Centre provides primary care, occupational health, and a rehabilitation service to a patient population of up to 6,000 service personnel, along with those who are registered on the ships and submarines in the dockyard. Families are not registered at the medical centre and are signposted to local NHS practices.

HMS Drake is home to the DRAKE Personnel Support Group (which is the parent unit for personnel who are unfit for their primary role) and HASLER Naval Service Recovery Centre, which manages the most complex wounded, injured or sick personnel from across the entire Royal Navy. Patients are aged between 18 and 60 with a small number outside this range.

Family planning is available within the medical centre. They also provide maternity care shared with the named practice midwife at the local maternity centre. They provide post-natal care to patients that remain in the Plymouth area for their maternity leave.

The medical centre provides 24-hour 365 days a year reach-back support for base port units, ships, and submarines. For 2 months of the year, medical cover is provided to military bases in the southwest, so there is no Easter, summer or Christmas shutdown.

The medical centre is open Monday to Friday from 07:45 to 16:00 hours (15:00 on a Friday). The duty Fleet Medical Officer for Devonport and the Drake duty medic can triage patients out of hours and direct to local out of hour providers as required. From 1800 hours weekdays, at weekends and for public holidays, patients are advised to use NHS 111. Patients requiring urgent care out-of-hours can receive emergency care at Derriford Hospital (Plymouth).

The staff team

Principal Medical Officer (PMO) Medical Officers MOD GP’s	One One Deputy Principal Medical Officer Six (five full time equivalent) (FTE)
Practice manager	One
Warrant Officer	One
Nurses	Four (two military, one civilian and one locum)
Exercise Rehabilitation Instructors (ERI)	Two (civilian)
Physiotherapists	Nine (four and a half FTE)
Occupational Therapist	One
Administrators Primary Care Rehabilitation Administrator Medical Administrative Officer	Eight (six and a half FTE) (one vacant) One One
Pharmacy Technician	Two (one military)

*A medic is a unique role in the forces and 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 requires improvement for providing safe services.

At the last inspection, we rated the medical centre as inadequate for providing safe services. This was because of gaps found in the processes around the monitoring of vulnerable patients, high-risk medicines, summarising and the monitoring of doctor's notes. At this inspection, the medical centre was able to provide clear evidence to show that they had addressed these issues.

Safety systems and processes

The Principal Medical Officer (PMO) was the overall safeguarding lead supported by a civilian medical practitioner (CMP) and Deputy Principal Medical Officer (DPMO) who were the respective leads for children and adult safeguarding. Safeguarding was included as part of the induction and the induction pack contained details of the local teams. Staff had completed safeguarding training at a level appropriate to their role. There was a link to both the safeguarding children and young people policy and vulnerable adults standard operating procedures (SOPs) within the healthcare governance (HCG) workbook and these had been updated in October 2024. Safeguarding was a standard agenda item at the weekly doctor's meeting and the PMO or DPMO attended the weekly 'carer forum' which included a separate meeting to Personnel Support Group and HASLER Naval Service Recovery Centre (NSRC, the most seriously ill, complex and long-term injured patients). An up-to-date vulnerable patient register was in place and patients on the register had an alert added to their records on DMICP (the electronic clinical operating system).

Notices advising patients of the chaperone service were displayed in each room, in the practice leaflet and in the reception area. A list of staff who were available to chaperone was displayed. Staff assured us they knew their roles and responsibilities and were competent in fulfilling this role. Staff who acted as chaperones had received a Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

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

There was a dedicated lead for infection prevention and control (IPC) and they had had completed the IPC link practitioner training.

Measures were taken to minimise the spread of infectious diseases. Staff received updates that kept them informed of any trends or new training requirements. Personal protective equipment and hand gel was readily available throughout. Regular IPC audits had been undertaken including hand hygiene and equipment hygiene, the findings and actions were discussed at the practice meetings.

Staff within the Primary Care Rehabilitation Facility (PCRF) provided acupuncture to patients. There was an acupuncture SOP and risk assessment in place that had been reviewed regularly and all staff were aware of. Written consent was gained and scanned onto DMICP. Training was regularly undertaken with the last being in September 2024. An acupuncture audit was completed annually.

Gym equipment in the PCRF treatment area was maintained, serviced and monitored. Checks on equipment were completed daily.

An IPC policy was in place. The Senior Nursing Officer (SNO) was the lead for IPC supported by a deputy from the nursing team, both had completed training for the role. The most recent IPC audit was completed in November 2024. At the previous inspection we saw a 10-point action plan of minor non-compliance had been developed (October 2023). Points included a sink that was not plug-free and coved edges coming away from the wall. None of the non-compliance areas presented a serious risk to patient safety but they did prevent the building from being effectively cleaned. The general environment, equipment and environmental sluice action plans were included in the main plan. There was no sluice so bodily fluids had to be discarded in the toilet. This issue had been transferred to the risk register. High-level curtains (covering large windows) were in some treatment rooms and funding had been given to get these cleaned, following the inspection we received assurances that this had been actioned and a date set for completion. Timeframes and individual responsibility had been assigned against each action but many of the issues required external input and budgetary approval.

A contract and schedule was in place for environmental cleaning. The cleaning contract was centrally managed by the MOD and the medical centre did not have sight of this. There was no allocated deep clean, and no known last deep clean date. According to the contractor the cleaners undertook a deep clean of a different area each month on a rolling basis, though this was not evidenced nor monitored.

There were cleaning monitoring arrangements in place, there was a monthly walk around with practice staff, a representative from the contractor and the cleaning supervisor. This was used as an opportunity to escalate any cleaning issues and there were no examples of recent issues. Following the last inspection staff had escalated the need for enhanced cleaning in some high-risk areas and as a result twice a day cleaning was now taking place in clinical rooms and patient toilets.

The pharmacy technician was the lead for clinical waste, the contract was managed by the Contract Monitoring Team for the base. Supported by a waste disposal policy, the management of clinical waste included a waste log. Consignment notes were uploaded electronically and could be accessed via a portal. The clinical waste was secured external to the building, we noted the external waste bin was broken and did not lock. Following the inspection, we received confirmation that a replacement had been ordered.

Risks to patients

There was a good balance of well-trained civilian and military staff which afforded continuity of care. Since the last inspection there had been some improvement in staffing with a collective team effort between the medical centre and the regional headquarters.

The Regional Clinical Director (RCD) had been very responsive and supportive in securing a 0.6 full time equivalent doctor and remote clinical support to assist with the backlog in summarising. The medical centre had also been shielded from military trawls, meaning staff could remain in post and not be deployed. The medical centre had regional priority for civil service recruitment into any vacant posts. Within the PCRF there were 2 exercise rehabilitation instructors (ERIs) in post. The facility was under resourced in relation to patient need with each ERI having 100 plus patients on their caseloads.

Locums were requested but if sufficient time was not given to organise security clearances, often the locum would move onto another contract. Equally due to Plymouth being a considerable distance from anywhere, locums often required accommodation which could also be difficult.

Whilst the past year had seen improvement, staffing was still insufficient for the complexities of the population at risk and to fully mitigate the IT limitations, there was specific issues around the interface between Defence Medical Information Capability Programme (DMICP) fixed (used in firm base medical centres) and DMICP deployed (used for example on ships and submarines). The medical centre provided 365 days a year, 24-hour reach-back support for base port units, ships and submarines. For 2 months of the year, medical cover was provided to naval bases in the southwest so there was no summer or Christmas shutdown. Moving forward the medical centre were due to lose 60% of the senior leadership team in the coming year and concerns were raised about how the medical centre could continue to improve.

The medical centre was housed within a building that was over 200 years old, with it originally being barracks accommodation. There were ongoing problems with heating and a lack of air conditioning in the summer months. Issues with the building were frequent and ongoing, most recently there was a leak in the ceiling in the first-floor conference room. Long term discussions on a new build were evident but no plans had yet to be made.

All staff had received updated training in emergency procedures, including basic life support (BLS), automated external defibrillator (AED) and anaphylaxis. Both clinical and non-clinical staff were familiar with the signs and symptoms of sepsis and had received training. The reception staff had completed triage training and had flow charts at the desk for suspected signs of sepsis. There was some ad hoc simulation training to supplement training but this was not regularly planned. Not all staff had completed heat (hot) injury training.

All staff undertaking vaccinations received training annually. Information and medicines were in all clinical areas for management of anaphylaxis.

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

All staff knew where the emergency medicines were located. We found all medicines on the emergency trolleys were appropriate and in-date, we saw risk assessments for some optional medicines, for example Amiodarone (a medicine used for irregular heart rhythms) were absent. Following the inspection, we were given assurances that these were now in place.

Emergency medicines were easily accessible to staff in a secure area of the medical centre and all staff knew of their location. The medical store containing nitrous oxide and oxygen cylinders was cluttered and full of debris and the Hazchem signage was faded. Appropriate signage was required on treatment room doors, and to the entrance to the medical centre. This was rectified on the day.

Within the PCRF all staff had received hydrotherapy evacuation training, with the last being in October 2024. Emergency scenario training was also completed within the hydrotherapy pool. The swimming pool was supervised by pool lifeguards and covered by video monitoring. Emergency pull cord testing was completed weekly and this was recorded. All staff had prompt access to the medical emergency kit, oxygen, emergency medicines and AED, 1 was situated in the gym and 1 was in the lifeguard's office.

The layout of the waiting rooms in both the medical centre and the PCRF allowed patients to be observed whilst waiting for their appointment.

Within the medical centre each staff member was issued an individual panic alarm as there was no working alarm system installed in the building. There was a statement of need (SON) submitted and this sat with the operations manager and regional headquarters held the risk.

Information to deliver safe care and treatment.

At the previous inspection we found a substantial backlog in patients records requiring summarising (1695 overdue), at this inspection we found this had been addressed and 94% percent of theses had been completed.

There was a thorough process in place for the summarising of patients notes. The team was using the new DPHC referrals database, 2 members of the administrative staff shared the workload of managing the referrals. Administrative staff were tasked by clinicians when a referral was completed, then the administrative team actioned it appropriately. Urgent referrals were managed in the same way and reviewed frequently.

At the last inspection we found there were no formal arrangements in place for the auditing of doctor's record keeping. This had improved and doctor's clinical records were audited by the Senior Medical Officer from another practice. Clinicians used peer review to measure and ensure quality of care delivery. There was a process in place for the peer review and audit of nursing records. Nurses audited each other's records using a standardised template. These were then collated by the SNO and fed back at the nurses meeting and used as clinical supervision. The minutes from the most recent nurses meeting reflected this. Medics records were peer reviewed by nurses, using the same audit template. Within the PCRF we saw evidence of clinical supervision led by band 7 physiotherapist every month. The PMO supported the OC PCRF with their clinical supervision. Notes audits were completed and any actions discussed with the team.

There was regular communication and discussion in place with both the Department of Mental Health (DCMH) and the PCRF. A representation from DCMH attended the carers meetings. There was a monthly PRIMO' clinic in place attended by physiotherapist, the

ERI and the Medical Officer, patients were reviewed with the aim to optimise their care provision.

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

An effective process was in place for the management of specimens. Due to previous issues with high numbers of patients' specimens not being processed by the NHS laboratory, the nurses had worked closely with them to improve the situation and reduce errors. As a result, the medical centre had moved away from using handwritten request forms, to printing electronic requests and using printed stickers to label bottles. This has significantly reduced the amount of rejected samples and related significant events reported through the electronic organisational-wide system (referred to as ASER). All samples taken were recorded on an electronic register and checked by a member of the nursing department each day to ensure all results were returned.

Doctors actioned their own request results by midday, after this time the duty doctor would view the global results and action all outstanding. This ensured a failsafe in the event of any doctor's absence, and meant results were promptly actioned.

Safe and appropriate use of medicines

There was a dedicated lead for medicines management and the day-to-day tasks were delegated to the pharmacy technician. This was reflected in up-to-date terms of reference (ToRs).

Arrangements were established for the management of controlled drugs (CDs), including destruction of unused CDs. However, a review and update of daily practice in line with the most recent controlled drug policy should be undertaken. We found quarterly checks were not in line with policy. Quarterly checks should be completed by the PMO and an external representative. We checked a selection of CDs and all were correct with no errors found. Destruction must be completed by the account holder (PMO) and an external individual.

The CD keys were kept separate from the dispensary keys. Keys were not stored as per policy that required them to be in a sealed pack, this was corrected on the day of inspection.

The medical emergency trolleys and medicines were checked weekly these were recorded. We checked all the emergency medicines and kit and these were in-date.

The pharmacy technician was registered to access the Medicines and Healthcare products Regulatory Agency and the Central Alerting System website for alerts. These were actioned by the pharmacy technician and information was shared. Upon review of the management and practice meeting minutes we saw alerts were commented on but

provided no detailed information. More accurate meeting minutes would provide further assurance that the information was being shared with the wider team.

Medication requiring refrigeration was monitored twice a day to ensure it was stored within the correct temperature range. Fridges were locked in the treatment rooms and the ambient temperature in these rooms was monitored.

Patient Group Directions (PGDs) had been signed off to allow appropriately trained staff to administer medicines in line with legislation. The PGDs were current and signed off by the authoriser. Medicines that had been supplied or administered under PGDs were in-date. A spreadsheet had been developed that was maintained by the SNO that informed all staff of what vaccination PGDs they were in-date for. Patient Specific Directions were used and were found to be completed correctly with all the required information.

There were clear and thorough processes in place for the requesting and issuing of repeat medication. Through discussion and review of DMICP records, it was evident that there was a clear audit trail for the request of repeat medication. Upon review of DMICP records, we found 654 patients were eligible for repeat medication but only 222 had been reviewed. Upon further review we saw some of the patients were on legacy repeat medicines that could be removed and some were not coded correctly.

Valproate (medicine to treat epilepsy and bipolar disorder) searches were regularly undertaken, evidence of this was seen at the time of the inspection.

At the previous inspection we found the management of high-risk medicines required improvement. At this inspection we found a good process was established for the management and monitoring of patients prescribed high risk medicines (HRM). The register of HRMs was held on DMICP and all doctors and relevant clinicians had access to this. We looked at a sample of patient records and saw that all had been coded, monitored within recommended timescales and had shared care agreements in place.

An audit on antimicrobial prescribing was undertaken annually which showed that prescribing was appropriate.

Track record on safety

Measures to ensure the safety of facilities and equipment were in place. The base conducted inspections and held the details on a spreadsheet, health and safety audits were completed and sent back to the health and safety team. Electrical safety checks were up to date. Water safety checks were regularly carried out. A legionella risk assessment had been completed in February 2025.

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

Portable appliance testing (PAT) had been completed.

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

Lessons learned and improvements made

All staff worked to the DPHC policy for reporting and managing significant events (SE), incidents and near-misses, which were recorded on the electronic organisational wide system (referred to as ASER). They were discussed at the healthcare governance meeting every week. All staff we spoke with knew how to raise an SE or incident. We saw evidence of a significant event that was raised in regard to missed letters and hospital appointments due to NHS systems, a good resolution was found and failsafe put into place to prevent errors occurring again. Of note we saw little significant event reporting by PCRF staff with the last one being raised in June 2024.

Are services effective?

We rated the practice as good for providing effective services.

At the last inspection, we rated the medical centre as requires improvement for providing effective services. This was because of minimal clinical audits undertaken. At this inspection we found that this had improved.

Effective needs assessment, care, and treatment

All doctors were signed up to receive the National Institute for Health and Care Excellence (NICE) and the Scottish Intercollegiate Guidelines Network (SIGN) clinical update emails. These were discussed at clinical meetings and other informal forums provided a good opportunity for peer support, including opportunistic sharing of relevant patient information.

Nurse's meetings were held monthly and included reviewing Defence Primary Healthcare (DPHC) newsletters, staffing updates, significant events, Patient Group Directives (PGD's) and any other topics of interest. These were minuted so could be referred to following the meeting. We noted there were some gaps in the minutes especially around the sharing of evidence-based guidance.

Our review of Primary Care Rehabilitation Facility (PCRF) patient records confirmed the physiotherapist used the Musculoskeletal Health Questionnaire (MSK-HQ). The MSK-HQ is the 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.

The PCRF used patient recorded outcome measures to assess patients, the Visual Analogue Scale (VAS), the StartBack screening tool and the Oswestry Disability Index (ODI) (a questionnaire used for assessing functional status and quality of life). The physiotherapists referred to the defence rehabilitation intranet site to ensure best practice guidance was being followed. Staff used online tools to aid and display data collection. This allowed for analysis of outcomes and change in practice.

The PCRF had the necessary equipment and space needed to deliver an effective service. Patients were assessed by physiotherapist in the PCRF and referred to exercise rehabilitation instructor (ERI) in main gym.

Patients with mental health needs were managed and supported in line with standard practice. The Department of Community Mental Health (DCMH) had provided doctors with guidance in Step 1 of the mental health intervention programme. Standardised clinical codes were applied and patients were regularly reviewed. The Chain of Command was involved if appropriate and the DCMH was available for additional advice and guidance. If referred to the DCMH, the patient had an initial assessment within 3 weeks or within 24 hours if urgent. Self-help booklets were held available in the consultation rooms and there was an electronic leaflet for patients. Patients could also be signposted to SSAFA (Armed Forces Charity), Padre and to the welfare team. Our review of records for patients with a

mental health need showed they were appropriately supported and managed. Consistent clinical coding was used.

Monitoring care and treatment

As per the last inspection there remained specific issues around the interface between Defence Medical Information Capability Programme (DMICP) fixed (used in firm base medical centres) and DMICP deployed (used for example on ships and submarines). Maintaining accountable oversight for patients who were deployed, particularly those with a chronic condition, was challenging when patients moved between two versions of the clinical recording system. As a result, not all patients who received care at the medical centre were registered and therefore it was challenging to search for and identify these patients. This was a known long-term issue for the Royal Navy that sat at headquarter level and Navy Command Headquarters level.

The Senior Nursing Officer (SNO) was the lead for chronic disease management. New chronic disease templates were used and diseases coded appropriately in patient's notes. There was no chronic disease register, instead this was monitored by using the built-in searches on the clinical system (DMICP). Patients were notified via text and they were invited to book in with nurse. Following the initial appointment a follow up was made with the appropriate clinician for review including advice and guidance.

We reviewed the delivery of care for known patients, registered at the medical centre, with a chronic condition including asthma, diabetes and high blood pressure. Our review of a range of patient records showed these patients were recalled and monitored in a timely way appropriate to their needs. Methods of identifying patients at risk to developing diabetes included opportunistic screening and a search for those with a raised blood sugar level (HbA1c test). Any patients found to be at risk were offered annual blood tests, checkups and health promotion advice.

Audiometry assessments were in date for 60% of the patient population. A review of patient records indicated appropriate Hearing Conservation Programme recalls were in place and patients were being managed in line with DPHC policy. Patients were not actively recalled due to reduced staffing, instead staff tried to capture this opportunistically. We recognise the responsibility of the Chain of Command to identify which patients required an assessment, but the medical team need sufficient staff to deliver this promptly to prevent risk of further damage to hearing.

Over 40 health checks were completed opportunistically or by direct patient request. Staff were not able to actively recall patients for the checks due to staffing constraints but every effort was made to review these patients when possible.

The Principal Medical Officer (PMO) was the lead for quality improvement activity, including clinical audit. Clinical audit was used to evaluate the quality of care and improve patient outcomes. At the last inspection clinical audit was minimal due to staffing constraints. DPHC audits had been completed but clinical audits were needed to help improve patient safety. At this inspection we saw that a range of clinical audit had been undertaken, we reviewed these and they were of good quality. These included a firearms audit, hormone replacement therapy and a pneumococcal audit.

Various audits had been undertaken by the PCRF team. Examples included adherence to lower back pain best practice guidelines (BPGs), this instigated a more streamlined data collection process, education on BPGs and a change in definition. Also, a restorative practice class, was due to start February 2025, this was identified as a requirement following back pain service evaluation. It specifically targeted patients that needed a low-level basic intervention in the first instance and who could not tolerate anything more in their early stages of rehabilitation.

An acupuncture audit was completed in July 2024, and changes were made as a result including better reflected treatment details, education and improved documentation of needle placement.

Effective staffing

Staff had received an appropriate induction and appraisal. New members of staff were required to complete the DPHC mandated induction. The induction package was recorded on the staff training database managed by the practice manager.

Mandatory training was recorded on the healthcare governance workbook which captured internal and external training. At the time of the inspection the log showed key training had been completed but there were some gaps in other training, for example diversity and inclusion. We discussed this with the practice manager who explained some staff were new and had not yet completed their training, this was ongoing. Protected time was allocated for mandatory training as well as continuing personal development (CPD). Staff were encouraged to apply for courses and were supported to do so, we spoke with one of the administrative staff who was about to begin an NVQ in business administration supported by senior leaders.

The PCRF had their own administrative officer that enabled them to effectively organise diary management and data collection.

Clinicians had specialist training that met the specific needs of the population, for example 2 doctors were aviation medicine trained, 3 were trained to provide occupational health for diving, 2 had a special interest in women’s health and 1 led the monitoring of firearms applications.

The doctors all completed regular appraisal and revalidation. The nurses had completed their revalidation. All clinicians were aware of the CPD requirements and used clinical meetings, mandatory training, and practice meetings to support with meeting this requirement.

Coordinating care and treatment

The medical centre had effective relationships with the units and with internal defence services including the DCMH, Regional Occupational Health Team and Regional Rehabilitation Unit. Relationships were established with NHS services. For example, there were good links with the local NHS hospital in Plymouth. There was a local acute GP

admission service and patients were sent to the local Medical Assessment Unit for advice, urgent care and investigations. Some examples of other effective co-ordinated working included:

- Engagement with NHS Derriford Hospital Plymouth regarding sample labelling and processing, resulting in improved processes.
- Engagement with NHS screening services to streamline screening invitations (of patients deployed) and sending direct results onto Path Links (NHS clinical pathology network).
- Engagement with the Chain of Command regarding management of deployed patients
- Engagement with HMS DRAKE Base Executive to re-establish stamped joining routine in order to better track patients joining/leaving the medical centre.

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 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 SNO was the lead for health promotion. The medical centre followed the NHS health promotion programme so health topics were refreshed regularly. There was a wide variety of thoughtful health promotion materials displayed in the waiting room including weight management and dermatology. The nursing team and one of the doctors had recently attended a women's health day at the Joint Hospital Group Southwest, where they provided a health promotion stand.

Within the PCRF one of the physiotherapists was involved with woman's health study days. Injury prevention sessions and back injury guidance sessions were provided by one of the ERIs to the units.

There was no specific sexual health lead, however 2 nurses were sexual health trained (known as STIF) and a doctor was the named lead for women's health. Patients could self-refer to local NHS sexual health services.

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 96% of the eligible population. The NHS target was 80%.

Monthly searches were undertaken for patient's due bowel, breast, AAA and cervical screening. Data showed

AAA – 1 eligible patient who had been screened.

Bowel – 157 eligible, 84% had been screened.

Breast – 18 eligible, 100% had been screened.

There had previously been identified an issue with bowel screening, in that patients on board ships had not been readily identifiable to the NHS screening service. As a result, the medical centre had asked ships medics to keep their own list of patients due screening as a failsafe. If patients were at sea, test kits arrived these went to the medical centre and patients are unable to access them. This process had been improved so that when a test kit was received at the medical centre it was recorded and coded on DMICP and patients were notified by text message.

Newly registered patients' due vaccines were captured as part of the new joiners notes summarising. Patients were not recalled for vaccines but were captured opportunistically and as part of pre-deployment checks. The nurses were working through diary dates on DMICP to ensure vaccine data displayed on patients 'MyHealth' app was accurate these enabled patients to take responsibility for their own vaccine readiness. Statistics were as follows:

- 89% of patients were in-date for vaccination against diphtheria.
- 89% of patients were in-date for vaccination against polio.
- 91% of patients were in-date for vaccination against hepatitis B.
- 93% of patients were in-date for vaccination against hepatitis A.
- 89% of patients were in-date for vaccination against tetanus.
- 98% of patients were in-date for vaccination against MMR.
- 98% of patients were in-date for vaccination against meningitis.

Consent to care and treatment

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. A review of patient notes evidenced that verbal consent was recorded and coded appropriately on DMICP. Clinicians advised us that implied consent was accepted for basic procedures. Verbal consent was taken was taken for more intimate examinations and recorded on the patients' health record. A chaperone and consent audit was completed in November 2024.

Within the PCRF we saw consent was captured appropriately and was saved onto DMICP. This included hydrotherapy and acupuncture.

Staff had a good awareness of the Mental Capacity Act but had no specific training around this instead awareness came through various safeguarding training packages.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect, and compassion

In advance of the inspection, patient feedback cards were sent to the medical centre, feedback was from patients that had been seen by the Primary Care Rehabilitation Facility (PCRF), the dispensary and the medical and administrative staff. A total of 30 patients from responded and feedback was positive including comments about the good level of care received and the kindness shown to them by the reception staff.

The last patient survey showed 18 patients had provided responses through the DPHC Patient Experience Questionnaire between October and January 2025. The responses were positive with 100% confirming they are satisfied with their healthcare. Patient feedback was used positively and as a tool for improvement.

Patients could access the welfare team and various support networks for assistance and guidance. We spoke to a member of the welfare team who described the medical centre team as kind and responsive. Information regarding these services was available in the waiting areas and the clinical staff were fully aware of these services to signpost patients if required.

The medical centre provided medical care for the HASLER Naval Service Recovery Centre (NSRC) and one doctor was assigned to this cohort of patients. A named doctor was assigned to each patient to provide a high level of personalised care. This included handing out a contact mobile number for ease of access.

Involvement in decisions about care and treatment

Carers were identified when the patient registered at the medical centre. There were also posters around the base asking carers to identify themselves. There was a carers register with appropriate alerts; monthly searches were undertaken to ensure any new carers were recognised. They were offered flu vaccines and health checks when appropriate. There was information for carers included in the practice leaflet and on the notice board.

Supported by a standard operating procedure, a translation service was available for patients who did not have English as a first language. International ships brought their own interpreters.

Privacy and dignity

Consultations took place in clinic rooms with the door closed. Patients were offered a private room if they wanted to discuss something in private or appeared distressed. Telephone conversations were undertaken in private to maximise patient confidentiality.

The reception areas both in the medical centre and the PCRF were large and well laid out and at a distance from the reception meaning that conversations between patients and reception would unlikely be overheard.

Are services responsive to people’s needs?

We rated the practice as good for providing responsive services.

Responding to and meeting people’s needs

An Equality Access Audit as defined in the Equality Act 2010 was completed within the past year. Any points identified were discussed and put onto the issues register.

Issued by the Defence Medical Services Regulator in April 2024, we asked about the Regulatory Instruction, ‘Training for staff in learning disability and autism’ and how it was being implemented. Not all staff were aware of this training and it had not been completed, with the exception of the Principal Medical Officer (PMO) and the Warrant Officer who had completed this training.

One of the doctors was the lead in caring for transgender patients. Clinicians had experience of providing support for patients in the early stages of gender transition and followed the standard operating procedure (SOP) in relation to the management of transgender personnel in the military.

There was a Royal Navy Temporary Memorandum (RNTM) in place that reflected the updated arrangements for primary medical care support during the out of hours (OOH) and block leave periods, which was available to all HMNB Devonport and Plymouth area units. HMS Drake medical centre co-ordinated and delivered the OOH care support in the Plymouth area. The RNTM applied to all Devonport based ships, submarines and lodger Units (whether alongside or deployed on operations), as well as any visiting ships or submarines. It also supported:

HMS Drake

HMS Raleigh

RMB Stonehouse,

RMB Bickleigh,

BRNC Dartmouth and

Commando training centre (CTC) Lympstone.

The OOH period was between 18:00 hours to 08:00 Monday to Thursday, 18:00 Friday – 08:00 Mon (covering weekends) and all public holidays.

Timely access to care and treatment

The medical centre had a flexible approach to the management of appointments to meet patients' needs. A recent survey showed that 95% of patients found it easy to access healthcare.

There was a daily walk-in clinic, referred to as 'fresh cases', available for urgent appointments, led by medics with support and guidance provided by a nurse/doctor. A walk-in triage service was available throughout the day. Telephone consults were available with doctors. Carers/ vulnerable patients received same day access to appointments. Telephone and appointments by eConsult were also available.

A duty nurse was available every day for urgent appointments if required. A doctor held a duty phone for ship reach back support. The doctor who looked after HASLER patients conducted home visits. Nurses held vaccination clinics were held on ships in dock and this was well attended.

At the previous inspection we discussed why direct access to physiotherapy or 'DAP' was not considered as this gave patients a choice of not having to be referred for rehabilitation by a doctor. Following the inspection various models of accessibility to physiotherapy were discussed. The PCRF trialled DAP for 3 months and audited their findings, the audit showed an increase in inappropriate referrals to clinic and that the uptake was low. Patients currently were seen in fresh cases and could then be referred directly to the PCRF with minimal wait times. Access to physiotherapy was compliant with the DAP policy and met the SOP definition. Key performance indicators were adhered to (2 working days for triage and 10 working days for appointment), whilst also meeting the needs of the patient and the Chain of Command by ensuring the patient was seen at the right time by the correct clinician. This allows early intervention and appropriate occupational consideration to be made alongside PCRF treatment.

Routine appointments with a doctor or nurse could be facilitated within 3 working days. A routine physiotherapy new patient appointment was accommodated within 5 working days and a follow-up appointment within 1 working day. An urgent physiotherapy appointment was available on the same day. New patient appointments with the exercise rehabilitation instructor were available within a day and a follow up appointment within 25 days. There was always availability at the rehabilitation classes. The waiting time for the Multidisciplinary Injury Assessment Clinic was 10 days.

Listening and learning from concerns and complaints

The practice manager was the lead who handled all complaints. Complaints were managed in accordance with Defence Primary Healthcare policy complaints policy and local procedure. The complaints procedure was displayed in the practice leaflet, on daily orders and on a noticeboard in reception.

Are services well-led?

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

At the last inspection, we rated the practice as requires improvement for providing well-led services. This was primarily due to gaps in clinical audit, the summarising of patients notes, improvement needed in the management of high-risk medicines and the management of vulnerable patients. At this inspection we found all areas had been improved.

Vision and strategy

Staff we spoke with were clear that their remit was to support patients to benefit from the best possible healthcare outcomes which, in turn, supported operational capability.

The medical centre worked to the Defence Primary Healthcare (DPHC) mission statement which was:

‘Provide and commission safe and effective healthcare which meets the needs of the patient and the chain of command in order to contribute to Fighting Power.’

It was evident the medical centre was meeting its mission as we found the service was highly responsive to the needs of individual patients and the occupational needs of units. Integration was promoted, evident through the close working relationship between medical centre staff and the Primary Care Rehabilitation Facility (PCRF) team.

To address environmental sustainability, the medical centre aimed to reduce the use of paper by communicating via email and the use of links rather than producing paper booklets. Staff were vigilant with switching off lights, closing windows and the use of heating. Recycling bins were positioned around the building. The band 7 physiotherapist was part of the ‘defence green network’.

Leadership, capacity, and capability

The senior leadership team had worked at the medical centre for several years so were very experienced and in tune with the patient population’s clinical and operational needs and also governance processes. However, it was a concern that 60% of this team were leaving the medical centre in the coming months. The team were currently reviewing the handovers required and looking at resilience planning, using standard operating procedures (SOPs) to assist and guide them through this process.

The civilian doctors and other civilian staff at the medical centre provided continuity for the service; some had worked there for many years. The leadership team described effective support from Regional Clinal Director (RCD) including support with staff vacancies.

The medical centre was an approved training practice and had a good training ethos that considered the population it provided care for. They received full re-accreditation in

October 2024, the feedback for the accreditation visit was entirely positive describing a culture of learning where rank was not seen as a barrier and everyone was treated with respect and as an asset.

Culture

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

We interviewed a cross section of staff, and all told us that it was a happy place to work and that they could rely on their work team to discuss and mitigate any concerns they faced. To promote and sustain positive team morale, regular social and team building events were held.

Staff said they would feel comfortable raising any concerns and were familiar with the whistleblowing policy, they had access to the whistleblowing local working practice as well as online and telephone civil service and MOD bullying and harassment helplines.

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

Governance arrangements

Communication was strong across all departments. There was a healthcare governance workbook in place for monitoring governance activity. There was an integrated governance approach for the medical centre and PCRF, for example there was:

- Integrated audit programme
- Joint meetings/forums for the whole practice
- Integrated systems (health governance workbook)

Within the PCRF there were lots of part time staff that allowed for a variety of experiences and skill sets, communication was good and this was managed well considering there was no day when all the staff were in together.

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

There was a range of SOPs in place for all key processes and these were kept under review. A thorough rotation of a range of meetings was in place to ensure effective communication and information sharing across the staff team. Other meetings included,

PCRF meetings, audits, quality improvement, risk/issues, healthcare governance, clinical, administrative and the practice meeting.

Managing risks, issues and performance

A comprehensive register was maintained of risks staff had identified. The concerns in relation to insufficient staffing resources was clearly articulated as a transferred risk to region on the register, which the regional team had access to.

Processes were in place to monitor national and local safety alerts, incidents, and complaints. The PMO was familiar with applying policy and processes for managing performance and ensuring staff were supported in a sensitive way taking account of their wellbeing. Appraisals were up to date for all staff.

A business resilience plan was in place and had been reviewed, it detailed the action to be taken in the event of loss of any services.

Appropriate and accurate information

The Health Assessment Framework (HAF) was the internal system used by the medical centre as a development tool and to monitor performance. Staff contributed to the HAF and, where their role required, had dedicated management time for this activity.

Recommendations made to the medical centre identified from the previous CQC inspection had been actioned. The recommendations made to the base remained the same and recommendations made to Defence Primary Healthcare had been addressed in part. Actions outside the control of the medical centre had been added to issues log and escalated to region or the unit for support/action.

Arrangements at the medical centre were in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. National quality and operational information was used to ensure and improve performance.

Engagement with patients, the public, staff and external partners

Despite inconsistent staffing levels, the medical centre prioritised engagement with patients in order to improve the patient experience. Options were available to prompt patients to provide feedback on the service including QR codes on the back of each chair in the waiting room and an iPad in the waiting area that patients could use to give direct feedback. Some examples of changes made following patient feedback were.

- Gym times were changed allowing increased access to the rehabilitation gym
- Extra capacity was made for ‘fresh cases’ to reduce waits and increase access

The medical centre worked closely with the Chain of Command, Regional Rehabilitation Unit, the PCRF, Department of Community Mental health and welfare support services to ensure a collective approach to ensuring the health needs of the regiment and with supporting vulnerable patients.

Continuous improvement and innovation

The team was committed to continually improving the service. There was evidence of this, such as:

Engagement with NHS screening services to streamline screening invitations (of patients deployed) and sending direct results onto Path Links (NHS clinical pathology network).

Engagement with HMS DRAKE Base Executive to re-stablish stamped joining routine in order to better track patients joining/leaving the medical centre.

A gym induction presentation was introduced and given to new rehabilitation attendees to lay out expectations of rehabilitation.

Further engagement with the Chain of Command with regard to patients undergoing rehabilitation had increased gym attendance from 500 visits per week to 1200.

Two new rehabilitation classes had been introduced, ‘mastering movement and restorative practice’

Integrated goal setting with RRU.

A medics’ learning hub was held on SharePoint site containing patient information leaflets for medics to use and refer to.

Improved system in place for mail received into the medical centre following a significant event being raised.

One of the band 6 physiotherapists is the women’s health lead. They were actively involved in supporting and educating other clinicians on best practice guidelines. Sessions had been directed to patients via education days and attendance at bumps and babies’ sessions on base. A specific session was delivered during a health promotion day laid on for the joint hospital group, promoting health for healthcare professionals.

In addition, audit, quality improvement activity clearly demonstrated that the medical centre continually sought to improve the service for patients. Despite inconsistent staffing levels, they were delivering effective care for patients while maintaining good governance.