Stonehouse Combined Practice

RMB Stonehouse, Durnford Street, Plymouth, PL1 3QS

Defence Medical Services inspection report

This report describes our judgement of the quality of care at Stonehouse Combined Practice. 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	**Outstanding**	
Are services safe?	**Good**	
Are services effective	**Outstanding**	
Are service caring?	**Outstanding**	
Are services responsive to people's needs?	**Outstanding**	
Are services well-led?	**Outstanding**	

Contents

Summary

About this inspection

We carried out an announced comprehensive inspection of Stonehouse Combined Practice (SCP) on 21 January 2025. We visited both Stonehouse and Bickleigh medical centres. As a result of this inspection, SCP is rated as outstanding in accordance with the Care Quality Commission's (CQC) inspection framework.

The key questions are rated as:

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

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

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

At this inspection we found:

The medical centre benefitted from strong and inclusive leadership, such that staff felt valued and able to contribute to improved ways of working.

Patients were truly respected and valued as individuals and were empowered in their decision making regarding their care. Feedback from patients who used the service was continually positive about the way staff treated them. Patients thought staff went the extra mile to support them.

Staff were highly motivated and inspired to offer care that was kind and promoted patients' dignity. Relationships between patients and staff were strong, caring and supportive. These relationships were highly valued by all staff and promoted by the senior management team.

SCP provided care in a way that kept patients safe and protected them from avoidable harm.

Flexible access and services were offered to all patients, including those with a caring responsibility.

A comprehensive programme of quality improvement activity was in place and this was driving improvement in areas which were relevant and impactful for patients.

There was an effective and well-designed programme in place to manage patients with long term conditions.

Patients found it easy to make an appointment and urgent and often routine appointments were available the same day.

SCP had forged close working relationships within military healthcare, with NHS organisations and with the local community in planning how services were provided to ensure that they meet patients' needs.

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

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

A system was in place for managing significant events and all staff knew how to report and record using this system. Processes for learning from events were supported by an open door and no blame culture.

The practice had suitable health and safety arrangements in place to ensure a safe service could be delivered.

Risks to the service were recognised by the leadership team. The main risks outside of the practice's control had been escalated and workarounds implemented. A range of risk assessments were in place.

We found the following areas of notable practice

The leadership, governance and culture was used to drive and improve the delivery of high-quality person-centred care. Leaders had an inspiring shared approach and strived to deliver and motivate staff to succeed. There were high levels of staff satisfaction. Staff were proud to work for SCP and spoke highly of its culture. There was strong collaboration and support across all staff and a common focus on improving the quality of care and people's experiences. Of note:

The team ran an ongoing cycle of clinical searches as a safety netting exercise to ensure that patients' needs could be identified, and rapid prevention measures actioned.

Training had been delivered to physiotherapists on vestibular rehabilitation with the aim of providing optimal support for patients managing traumatic brain injury. Following this training it was determined the 3 physiotherapists would undertake assessment of the next patient who was referred. The practice will also be updating the head injury protocol and the OC PCRF will deliver training sessions on this topic.

The practice had worked with the units and their exercise rehabilitation instructors to ensure they were fully competent in the primary care rehabilitation setting.

A specific Step 1 therapy programme was developed between the SCP and UK Commando Forces' mental health nurse. This service, called TRIGPOINT, was a 6 hour session for Step 1 intervention run from the welfare offices by the mental health nurse with support from the practice if required. Administative staff booked the appointments for patients to attend this course. Pre and post course improvement scores were measured to monitor effectiveness. Patient feedback has been positive. Patients who needed intervention beyond step 1 were referred for a Department of Community Mental Health (DCMH).

SCP had engaged with 'Harbour', Plymouth's substance misuse charity. They were in the process of facilitating them to attend each of the sites every month to provide a drop-in service for patients for support and to raise awareness, they had also engaged with welfare and the Chain of Command to support this. This would also strengthen practice delivery of the DPHC Standard Operating Procedure (SOP) on gambling.

SCP had recently been given permissions to ensure all those held at high readiness were given at least the first rabies and the tick-borne encephalitis vaccinations. Following this they changed their vaccination delivery programme to match patient need, initially undertaking a mass vaccination clinic to address the back log. They also provide vaccination drop-in clinics once a week at each site for vaccinations and audiometry.

The PCRF identified the waiting times for patients receiving electronic shock wave therapy (ESWT) via the Regional Rehabilitation Unit (RRU) were excessive and prolonged patient downgrade time. It was noted that the RRU EWST was sitting idle for long periods during the working day. As a result, a physiotherapist was trained to be able to provide ESWT and set up a peripatetic ESWT clinic based at the RRU solely for SCP patients. This reduced the waiting time for EWST from 8+ weeks to 1 week.

The team had successfully fostered a strong safety culture. Staff we spoke with all had in depth knowledge of the requirement to safeguard and we noted that team discussion had taken place around what constituted a vulnerable patient and the need to safeguard 'the hidden child' This included the need to safeguard all vulnerable people including those who were not registered with Stonehouse Combined Practice (SCP).

A comprehensive quality improvement programme was in place and covered an extensive range of administrative, clinical and managerial topics. The programme was ongoing and involved an ongoing cycle of audit work. Much of this work was leading to demonstrably improved outcomes for patients.

Access to the DMICP records of staff was audited regularly to ensure this access was appropriate and legitimate. This was conducted monthly by the practice manager. An annual report was produced in December 2023 that showed 31 breaches. On investigation it was identified that deployable medics (non-Stonehouse staff) were completing routine vaccination checks, vaccination clinics and fresh cases on each other rather than going through the correct routes. This had been missed in previous Caldicott searches because non-Stonehouse medics did not have the correct staff alert/code attached to their DMICP record. All breaches could be explained but were inappropriate. Due to the large number

of breaches, it was decided that retraining and reinforcing of consequences was the correct route of action. The practice manager discussed with the leaders of each unit and sent an email out twice throughout the year as a reminder and with immediate effect actions were enforced.

The dynamic leadership of the practice, primarily led by the Senior Medical Officer (SMO) and the Officer Commanding (OC) of the Primary Care Rehabilitation Facility (PCRF), drove a culture of empowerment, strong communication, and effective teamwork. The OC of the PCRF, along with the SMO, had been working on a comprehensive practice development plan, informed by the staff survey, and they sought input from all staff into its implementation. Their collaboration ensured seamless coordination, enhancing efficiency and fostered a supportive environment for all. This united approach ultimately optimized patient care and outcomes.

The Chief Inspector recommends to Stonehouse Combined Practice

The practice should continue to pro-actively progress access to training around supporting patients with a learning disability/autistic spectrum disorder (ASD) in line with the national requirement for all healthcare providers.

The practice should consider the introduction of a work/rest/hydration mitigation board for patients when exercising to maintain a safe use of activity.

The practice should request a health and safety inspection to be undertaken and raise a statement of need for an increase in sockets and/ or electric cabling/ trunking to be installed whilst temporary heaters are being used in the Primary Care Medical Facility rehabilitation area.

The Chief Inspector recommends to Defence Primary Healthcare (DPHC) and / or the Unit

Ensure adequate heating is provided in the gym at the Stonehouse site.

Ensure that all work to mitigate the risk of exposure to asbestos is fully completed.

Review the memorandum of understanding for non DPHC staff (Medic/ERI/MO) delivering care in to Defence Primary Healthcare facilities, to ensure they receive appropriate, support and training working to Defence Primary Healthcare standards.

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, exercise rehabilitation instructor and a nurse. We visited both Stonehouse and Bickleigh.

Background to Stonehouse Combined Practice

Stonehouse Combined Practice provides primary care, occupational health, and rehabilitation service to 1,380 military personnel. Care is provided across 2 sites: Stonehouse and Bickleigh. Up until October 2023 the combined practice had also included The Citadel, but this is closed as a temporary measure due to reduced staffing levels.

Since February 2022, DPHC has formally recognised the service as the Stonehouse Combined Practice. Families and defendants of military personnel are not registered at the practice but at NHS practices local to them.

The staff team

Senior Medical Officer (SMO) MOD GP Royal Navy GP Regimental Medical Officer General Duties Medical Officer	One Three (1.6 fulltime equivalent) (FTE) One One (0.2 FTE) Two
Business Manager	One
Group practice manager	One
Administrators	Four (3.5 FTE)
Military nurses	One
Civilian nurses	One (0.5FTE)
Medics	Three
Leading Medical assistant	Two
Exercise Rehabilitation Instructors (ERI)	Four
Officer Command PCRF	One

Physiotherapists	Two

*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 good for providing safe services.

Safety systems and processes

Standard operating procedures (SOP) for both adult and child safeguarding had been reviewed and included contact details for local safeguarding teams. The Senior Medical Officer (SMO) was the safeguarding lead. Safeguarding concerns were discussed at monthly meetings. All staff had the NHS safeguarding app on their phones which provided details of out-of-area contacts.

Updates to safeguarding policies were shared with staff including, for example, the release of the SOP on managing vulnerable patients. Following discussion at a clinical meeting in July 2023, the staff team was confident that their process was effective for ensuring all patients who were vulnerable were appropriately coded and were regularly discussed at the appropriate monthly clinical meetings monthly.

The register of patients was maintained on DMICP (electronic patient record system). The SMO searched for all vulnerable patients monthly and cross-referenced this with the previous month's clinic list to ensure patients were not missed and that when vulnerable patients left the practice, they were handed over to their new practice appropriately. When new patients registered, they were contacted to determine the support required. Patients not seen within 35 days were also reviewed to determine their support requirements. A rolling audit captured this as well, checking patients had a medication review undertaken appropriately.

The SMO searched for care leavers monthly to ensure these had appropriate alerts and coding added to their record. They were aware that these individuals may have additional needs that the medical team needed to be aware of (such as not having a home to go to if they needed sick leave). This was discussed in clinical meetings and all clinicians were asked to raise this at the Carers Forums on the base. The practice was aware of the latest National Institute for Health and Care Excellence (NICE) guidelines on looked after children and young people and this was discussed in one of the clinical meetings. They also discussed 'Children in Care' training, a bitesize session which provided an overview of prevalence of physical and emotional health issues in this population and the role of primary care in supporting them.

There was a good relationship with the Defence Primary Healthcare (DPHC) safeguarding lead and there was evidence of interactions with them. An example of this liaison led to a disclosure to the police relating to historical child abuse.

Staff we spoke with all had in depth knowledge of the requirement to safeguard and we noted that team discussion had taken place around what constituted a vulnerable patient and the need to safeguard 'the hidden child' This included the need to safeguard all vulnerable people including those who were not registered with Stonehouse Combined Practice (SCP).

All staff had received up-to-date safeguarding training. Clinical staff, physiotherapists and exercise rehabilitation instructors (ERIs) were trained to level 3. As well as completion of mandatory training, the practice provided in-service safeguarding training as a supplement to the mandatory training. This was last conducted in November 2024 and included both male and female domestic abuse. Specific training was also delivered on ICON (Babies cry, I can cope) including awareness of the impact on fathers.

There were notices displayed raising awareness of domestic violence. Plymouth Domestic Abuse Service provided support for men, women and children who needed advice and protection from domestic abuse. Their poster with contact details was displayed in the toilets across the sites to ensure discrete access to support if patients required.

Discussions were held at clinical meetings. We were given many examples including:

- Defence's Domestic Abuse Awareness Month 2024
- Whole force policy on domestic abuse (this was shared with the welfare teams)

Male domestic abuse was added to the practice development plan and posters were also displayed in appropriate places such as the gym. This included information regarding the Defence Domestic Abuse Survivor Community and Awareness Network's (DDASCAN).

SCP had begun work on spreading the message that MANKIND was available (a specialist charity in the UK focusing on male victims of domestic abuse). The whole practice was aware of the service MANKIND provided and this was discussed at a practice meeting. They aimed to invite MANKIND in to deliver education sessions including to the units.

New doctors had a bespoke induction pack and also had a desk top guide that included all areas on safeguarding. Safeguarding 'Alerters' posters were prominently displayed in each clinical room.

Notices advising patients of the chaperone service were displayed on posters throughout each site and in the practice leaflet. 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 practice could demonstrate that relevant safety checks had taken place for the staff at the point of recruitment, including a DBS check to ensure staff were suitable to work with vulnerable adults and young people. All staff had crown indemnity and all clinical staff held a professional registration which was recorded on the staff database.

The senior nurse was the dedicated lead for infection prevention and control (IPC) and they had had completed the IPC link practitioner training. Regular IPC audits had been undertaken across both sites and the Primary Care Rehabilitation Facility (PCRF) and the findings and actions were discussed at the practice meetings. We discussed this with the SMO and suggested that another member of staff could be trained to undertake the PCRF audit as this was a huge piece of work for one person to undertake alone. 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 both sites.

Environmental cleaning was provided by an external contractor twice daily. Regular checks were undertaken by the practice staff. Although signed checks made by the cleaners were visible there was no confirmation this was done in conjunction with the IPC lead. We discussed the benefit of having a joint walk round with the practice manager of IPC lead to ensure standard of clean completed to Defence Primary Healthcare (DPHC) standard for assurance purposes.

We visited both sites and both were clean and tidy throughout. Arrangements were in place for deep cleaning.

The management of healthcare waste was in line with policy. Clinical waste was bagged, secured and marked with the practice code before being recorded in a waste log held in a dry store. Consignment notes were held at both sites and clinical waste audits completed.

Acupuncture was practiced at both sites and sharps bins were present for safe disposal of needles. A medical questionnaire and consent form was completed and scanned on to patient notes. The defence acupuncture audit had been completed to ensure comprehensive documentation.

Servicing of physical training equipment was managed by the ERI. There was a mixture of DPHC and unit-owned equipment across the sites, so this was managed by more than one individual. We discussed this with the staff and recommended that it would be good practice if the ERIs could have access to the equipment care database to ensure they knew that all equipment was being maintained. Servicing stickers were seen on equipment in gym spaces and clinical rooms to confirm in was in date.

Risks to patients

Although there were staff vacancies particularly in the administration and medics groups, staff said they had sufficient capacity to meet the needs of the patient population and service requirements. Despite this, leaders were mindful that the need for rapid deployment of service personnel meant little resilience for leave or sick absence. Staffing was highlighted within the risk register with the risk transferred and accepted by headquarters southwest regional team. The risk to patients was manageable due to the strong, well led team and clinical staff that went above and beyond for their patients. The non-clinical staff were also pivotal in maintaining care and patient rapport.

Within the PCRF, staffing levels were sufficient with a physiotherapist and ERI for each unit. When the Officer Commanding was off this was covered by one of the Band 6 physiotherapists acting up as a Band 7, and by the regional Band 7 physiotherapist providing clinical cover. There was a period in 2024 when 1 of the 2 ERI posts at Bickleigh was vacant and the other ERI was deployed. This was raised through an ASER as it had direct impact on patient care This was managed by the physiotherapist who provided the required level of care for that period. Locums were requested but we were told it was difficult to get locums in the southwest region.

The heating system in the gym at Stonehouse had broken and had been appropriately raised through the unit and contractors and raised to region. Therefore, all appropriate stakeholders were involved in active discussions, but with no successful solution yet. The PCRF made the decision to cease sessions in the gym at Stonehouse because of the cold environment. Patients had to travel to Bickleigh (approximately 30-45 minutes travel time in rush hour) to receive their rehabilitation sessions in a safe environment. This also impacted the units as they had service personnel away for longer periods of time.

All staff undertaking vaccinations received training annually. Information and medicines were in all clinical areas for the management of anaphylaxis. A vaccination training audit was completed in December 2024 and, following this, the Royal College of Nursing competency spreadsheet for staff giving vaccinations was introduced and all staff had to complete these before giving vaccinations. This was also discussed at a practice meeting.

Unplanned admissions to hospital were managed well, including effective communication and monitoring between SCP and the hospital itself. Staff often visited the patient whilst in hospital to ensure any onward care requirements was understood by the clinicians there and to aid with ongoing arrangements. Upon discharge from hospital, the patient was given a follow-up appointment with a doctor.

The medical emergency trollies were sealed, 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. Automated external defibrillators (AED) were available at each site and both gyms had access to unit AEDs. Medical gas cylinders were stored alongside the emergency trolley and appropriate signage in place.

The SMO was the lead for medical emergencies. All administrative staff had received training in recognising and reacting to emergencies, which was last conducted in October 2024. Both receptions held aide memoirs for prioritising patients and a telephone consultations protocol which included a RAG (red, amber, green) rating for condition priority. Reception staff were encouraged to seek immediate advice should they have any concerns about a patient’s health condition that needed prompt action. The practice was also continuing to explore funding for administrative staff to attend formal triage for receptionists training, one member of staff had already completed this.

Emergency scenarios were regularly practiced including cardiac arrest, management of chest pain and trauma presentations. Other examples of training for emergency situations included an update for doctors on how the emergency trollies were laid out, catastrophic haemorrhage and cannulation procedures.

The SMO attended a medical emergency and was able to provide supportive debriefing for these non-medical personnel immediately after the incident. As a clinical team they then undertook a review of the patients notes to ensure appropriate risk factors had been explored in the run up to the event.

A training session for all staff on recognising the deteriorating patient/sepsis was held in October 2024. In-service training had also been provided for the management of climatic injuries including heat illness in September 2024. There was a heat injury protocol displayed in all treatment rooms.

Information to deliver safe care and treatment.

Staff reported IT outages were occasional. The business continuity plan outlined that in the event of an extended outage of the DMICP system, clinical services would be relocated to another site within the practice group. If there was a widespread outage affecting DPHC, the practice temporarily provided care exclusively for emergency patients. Hard copy forms were maintained at the practice for use during such situations, and any documentation would be scanned into the DMICP system once it became operational again.

There was a thorough process in place for the summarising of patients notes. Note summarising was conducted in accordance with DPHC policy. All new joiners completed an online questionnaire which was then transferred to the DMICP record by an administrator who then forwarded it to the nurses and then onto a doctor for completion of the summarisation. In addition to the new joiner's process, summarisation was undertaken for all patients every 5 years. The SMO undertook a monthly search of patients who had not had their notes summarised in the past 5 years. An audit was completed in January 2025 and it showed 99.9% compliance.

Much work had been undertaken to improve the management of specimens dating back to 2023 when there were issues with the laboratory rejecting some samples. Processes had improved through liaison with other practices in the region and the local NHS hospital at Derriford (Plymouth). The practice initiated electronic forms which proved an improved and effective process for the management of specimens. There were procedures and processes in place to track specimen requests, transportation, receipt results and subsequent uploading of results to the patients' record. There was a specimen and results management SOP in place to support this. Specimens were sent to Derriford Hospital for processing. The practice also ensured that it audited sample compliance and completed the mandated audit. The last audit was undertaken December 2024 and it showed 98% compliance. An online sample log was kept and allowed access from each site, replacing the paper logs, which were site specific and which led to a level of risk that results were not always being checked. Staff said they have found this system much easier to use as well as providing more assurance.

An effective system was in place for managing both internal and external referrals including urgent and 2-week-wait referrals. The practice was using the new Defence Primary Healthcare (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. Referrals were reviewed each week with the register updated accordingly and outstanding referrals followed up and/or outcome letters. DMICP allows for electronic referral to the PCRF, caseload management and tasking between all clinicians. Referral to the rehabilitation troop enhances the rehabilitation pathway and care for patients due to the nature of the training and this is now being recorded on DMICP

The SMO had successfully negotiated with the Practice Plus Group based in Plymouth, which aimed to ensure that patients were seen within 18 weeks of a referral orthopaedic (not spinal) and some general surgery conditions (and a 2 week wait for lower

endoscopies). This service has since been extended to patients registered at other military practices in the Plymouth area.

All clinical staff undertook reviews of their peer's clinical notes. An appropriate notes review template was in use. Nursing notes were regularly audited with the last being competed in August 2024. The audit showed good compliance of note keeping throughout, encompassing a wide range of different types of consultation. PCRF notes were audited on an ongoing basis. There had been previous issues identified with ERI notes and, after some training input, this has been reaudited several times and was now at a good level. Physiotherapists and ERIs were regularly managing patients jointly showing open and effective collaborative working.

Safe and appropriate use of medicines

The SMO was the lead for medicines management for SCP. The medic was responsible for the day-to-day management of medicines. Neither of the two sites dispensed medicines to patients – this was delivered through an arrangement with a local pharmacy.

Patient Group Directions (PGD), which allow practice nurses to administer medicines in line with legislation, were in place and had been signed off. Nurse had completed training in using PGDs and administering vaccines and annual competency assessments were carried out. Medicines dispensed under a PGD were recorded in DMICP. A PGD audit had been undertaken in June 2024 by the SMO. Patient Specific Directions (PSD) were also being used and we saw the details of medicines and patients being administered within a PSD had been maintained and staff competency was up to date.

A process was in place for the management of information about changes to a patient's medicines received from other services. Incoming correspondence, such as from out-of-hours services, hospital discharge letters and out-patient clinics was scanned and then tasked to doctors. This system had been audited.

Uncollected prescriptions were checked monthly, if the medicines were not collected within 28 days, they were returned to the supplying pharmacy for destruction and a consultation entered into the medical record of the patient. This was included in the prescription policy. It was identified that there had been a rise in uncollected prescriptions and so an audit was conducted in September 2024. This showed 30% of prescriptions were not collected by patients. As a result, the practice changed the process of informing patients that their medicines had arrived instead of telephoning them they sent a text message on GOV.UK Notify. Although the repeat audit had not yet been conducted, staff indicated there had been a reduction in uncollected medication as a result.

Military prescriptions (FMed 573 and FMed 296) were stored securely. However, we noted that there was no record of the receipt of FMmed296s in the register. We saw they were counted and were correct, but there was no record of who had issued them to the doctor or nurses and no running totals. The practice took immediate action to rectify this.

The SMO controlled the logging and issuing of prescriptions. We noted that 4 pads of handwritten FMed 296s had not been used and these were not accounted for on the register. The practice agreed to take immediate action to record and remove them.

The controlled drugs (CD) keys were kept in a safe, which only the SMO and the stores medic had access to. The BMed 12 (CD register) was held in the outer section of CD cabinet. An annual CD audit was completed. Only 1 CD was held, this was managed appropriately and records of destruction were held. We noted that, although the keys were held separately, these were not sealed at the end of the day as per DPHC policy. The practice agreed to address this. On the day of the inspection, we found there was no delegated authority from the Commanding Officer of the unit allowing the SMO to hold CDs, there was no further delegation to the stores medic from the SMO as required by the DPHC SOP. Prompt action was taken, and this was undertaken the following day for both sites.

A process for the safe processing of repeat prescriptions was in place. Where appropriate, medication reviews were taking place and were clinically coded. Prescriptions were authorised by doctors.

Temperature checks of the medicine fridges completed twice daily were held and were recorded in the practice's daily check sheet. At the previous CQC inspection in March 2022 it was noted that there had been several breaches of temperatures for the vaccine fridge at one of the practices and no action had been taken. As a result of this they added the acceptable temperature range to the temperature check logs for both fridge and ambient temperature monitoring as an aide memoire with re-education of staff on appropriate actions that should be taken. They also introduced data loggers with instructions on what to do if they are found to be flashing near every fridge.

An SOP was in place, and we saw that recently recorded temperatures had remained within appropriate parameters. We noted there was no ambient temperature monitoring in the treatment room nor in the audio room at Stonehouse and these rooms held some intravenous fluids, dressings, and testing strips. Prompt action was taken, and a thermometer was put in place.

Electricity generators were not available at either of the 2 sites. This was highlighted at the last CQC inspection in March 2022 as a risk due to power outages. A statement of need was submitted via regional headquarters, but this was declined. As a workaround, the practice was acquiring plug monitors for refrigerators that would send a text message to an appropriate person should an unexpected power outage occur. In addition, they had labelled the plugs of the fridges to avoid fridges being turned off accidentally. The actions to be taken in the event of a power failure were included in the practice business continuity plan.

SCP followed the DPHC protocol and local SOP for high-risk medicines (HRMs). Regular searches to identify patients on HRMs requiring a shared care agreement were undertaken. There was an extensive HRM register in place and all patient records we looked at showed they had been correctly coded and had the appropriate monitoring protocols in place.

An audit on antimicrobial prescribing was undertaken in November 2024 which showed that prescribing was appropriate. Each clinician was given their results for reflection.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. The storage of nitrous oxide and oxygen (an inhaled gas used for pain relief) cylinders was safe and the area was clear of clutter. Appropriate signage was displayed on treatment room doors, however, as the practice is located within a larger building there were Hazchem notifications needed to the entrance to the practices themselves. This was rectified on the day.

There was one medicine on the emergency trolley which was not in line with the emergency medicines list and there was no risk assessment in place signed off by the Regional Clinical Director (RCD). This was rectified on the day as the RCD was in attendance. All other emergency medicines had a risk assessment in place.

At the time of the inspection, we found there were no patients prescribed sodium valproate (medicine to treat epilepsy). A valproate pregnancy prevention programme audit had been undertaken that showed no concerns

Track record on safety

There was a comprehensive risk register, retired risk register, issues log and retired issues log on the healthcare governance workbook. All risks included detail of the 4T's, treat, tolerate, transfer, or terminate and had a review date. There was evidence that some risks have been transferred to regional headquarters and DPHC headquarters, such as staffing.

The disability access audit and risk assessment highlighted any patient or member of staff with a disability or injury that may not be able to access the practice at Stonehouse (and Citadel although now temporarily closed) due to them only having stair access. Bickleigh had level access including access for all patients, staff, and wheelchair users.

There was a mix of both clinical and non-clinical risks including lone working. Risk assessments for substances hazardous to health (referred to as 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. Other risk assessments included hydrotherapy, acupuncture, therapies and PCRF gym use.

Processes were in place for the regular monitoring of utilities. There was no gas provision at either site, electrical testing was conducted by an outside contractor every year. There were management plans in place for the control of Legionella. In addition, taps in the buildings were flushed after periods of leave.

The 5-yearly fire risk assessment had been completed for each of the premises. 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 2024.

An equipment inspection (referred to as a LEA) was undertaken earlier in January 2025 and the practice was awaiting the report. In October 2023 it was noted during a review of equipment by the Regional Warrant Officer that there was an issue with the completion of

checks on emergency equipment (373 forms). The practice raised this as a significant event and was recorded on the ASER system. As a result of this ASER, the practice had implemented a significant quality improvement project to ensure that emergency equipment has been checked daily: This included

- rewriting the opening and closing checks for each day with the requirement for these to be signed daily
- training administrative staff on how to conduct these checks should clinical staff not be available.
- introduced a nominated daily checker for all sites
- pre-vaccine sign off sheet prior to any vaccination clinic, the doctor overseeing the clinic was to sign a check sheet confirming that they are satisfied that the emergency equipment checks and fridge temperature monitoring have been completed.

There had previously been issues with the heating working in the winter at Stonehouse or when the temperature has been too hot as practice staff could not manually control the temperature. All issues were reported to the contractor and significant negotiation was held with them, and the unit to provide evidence of why the practice needed to maintain specific temperature ranges. The unit purchased standalone air conditioning units for Stonehouse in May 2022 which helped being the temperature control.

Several walls at the Stonehouse practice were made of asbestos so there was a risk that damage to the walls in any way may lead to asbestos exposure to staff. This risk was owned by the unit at Stonehouse who maintained a unit asbestos register. All walls containing asbestos were identified. A hole developed in one of the asbestos-containing walls (store cupboard) in May 2022. This was reported for fixing without any response from the contractor. After multiple complaints, the practice raised a Navy Safe and Navy Lessons and Incident Management System (NLIMS) in December 2023 resulting in a temporary fix in February 2024 (the outside contractor has declined to fix this any further). A risk assessment was conducted for the physiotherapist who accessed this store and until the temporary fix was complete access to this store was forbidden. The practice continued to work with the unit to ensure a permanent fix could be agreed.

We noted loose electrical cabling found within the PCRF rehabilitation area. This was discussed and it was agreed that a statement of need should be submitted for an increase in sockets and/or electric cabling/trunking to be installed.

The guardroom carried out wet globe bulb testing for the barracks across both sites to indicate the potential for heat stress. We discussed the introduction of a work/rest/hydration mitigation board for patients according to JSP 375, and any other information deemed a requirement to maintain safe levels of activity.

Staff had personal handheld alarms to summon assistance in the event of an emergency. In the PCRF alarms could not be heard in the clinical rooms and this had been raised and escalated but no solution has been found yet. Staff were aware of this and made sure doors were left open when appropriate. There was a lone working policy that was based on a buddy system between physiotherapists and the ERI at each site and there was no clinical working out-of-hours. Staff reported they always informed their ‘buddy’ when

leaving, and if needed would inform the guardroom. They were clear on the procedure for dealing with an emergency in the gym.

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). We saw that 26 events had been reported between January 2024 and December 2024. These had been raised by many different members of staff including administrative staff, cleaning staff and clinical staff. There was a very clear culture of transparency and investigations and real evidence this led to changes to practice. Some examples included:

- improvements in management of samples and results
- an improved induction programme with introduction of induction packs for the PCRF and desk top Instructions.
- development of the way incoming mail was handled by the unit.
- a review of the walk-in clinics to ensure sufficient staff breaks
- retraining of deployable medics and a General Duties Medical officer (GDMO) after a patient was given a vaccination although they had a severe allergy to it. This led to the inclusion of an updated allergy check sheet and was added to the tabletop instructions.

We saw an incident had been recorded as a patient with an elevated QFIT (test for bowel cancer) result were returned later than was acceptable. This led to a 2 week wait referral to the colorectal clinic being made and an ASER being raised. On further investigation the practice found there had been issues around both the way that the request for QFIT had been handled and it had not been documented on the samples log when the doctor handed the patient the kit. As a result, the practice's QFIT policy was updated, training was provided and it was agreed that doctors would hand the kit to the patients. Prior to this ASER being raised, the senior nurse had undertaken significant liaison with the laboratory at Royal Devon University Healthcare NHS Foundation Trust as they were unable to receive the results electronically (which had also contributed to the ASER as the laboratory had misunderstood the process). Upon further discussion it was agreed that the practice would explore the possibility of receiving these results via LabLinks. The practice had recently learnt that this would be the case in 2025 and they were currently conducting a trial on receiving QFIT results electronically. This process would be safer and more effective.

All SEs were discussed in the healthcare governance meetings and a trend analysis was completed every 6 months.

Are services effective?

We rated the practice as outstanding for providing effective services.

Effective needs assessment, care, and treatment

Clinicians had opportunities to attend regional forums, such as regional governance meetings and nurse development forums. All doctors were signed up to receive the National Institute for Health and Care Excellence (NICE) and the Scottish Intercollegiate Guidelines Network clinical update emails. The Senior Medical Officer (SMO) reviewed sources monthly including new NICE Guidelines, Information for Defence Primary Healthcare (DPHC) and the DPHC newsletter.

New guidelines were presented to the monthly clinical meeting as part of the standing agenda and a log of new NICE guidance and the practice actions was kept. Where clinical guidelines, including prescribing recommendations changed, this was discussed in the clinical meeting, added to the NICE updates log, the practice development plan and the practice standard operating procedure (SOP) was amended to reflect any changes. For example, some discussed included:

- Updated General Medical Practice (GMC) good medical practice
- NMC fitness to practice updates
- Assessment and initial management of suspected acute respiratory infections.
- Access to Royal Navy personnel medical records by Royal Navy occupational health professionals for occupational health purposes. This policy removed the requirement for Royal Navy doctors to seek patient consent before referring to an occupational health professional. The practice challenged this policy with the Head of the Royal Navy Medical Service.
- Direction from Defence Medical Rehabilitation Centre (DMRC) was given for physiotherapists to conduct practice-level exercise tolerance testing for patients managing traumatic brain injury (mTBI). It was not clear that the policy had been ratified or cancelled and unclear whether DPHC had agreed to hold the risk for tolerance testing.
- This was discussed at a clinical meeting and the Officer Commanding (OC) of the Primary Care Rehabilitation Facility (PCRF) took the lead on this issue. They attended DMRC where training was being delivered on vestibular rehabilitation (physiotherapy that helps with balance and dizziness) where they raised concerns as well as engaging with the regional rehabilitation lead to raise the risk for transfer to the Regional Clinical director (RCD). It was clarified by DMRC that the policy had not been fully ratified by Defence Primary Healthcare (DPHC). The training delivered on vestibular rehabilitation was a significant upskill for the PCRF team and helped them in their management of patients with dizziness and long-term residual dizziness after mTBI. Following this training it was determined the 3 physiotherapists would undertake assessment of the

next patient who was referred. The practice will also be updating the head injury protocol and the OC PCRF will deliver training sessions on this topic.

The PCRF used robust end-stage rehabilitation outcome measure testing to ensure patients were ready to return to full duties, this was documented fully by all clinicians.

Our review of PCRF patient records confirmed the physiotherapist used the Musculoskeletal Health Questionnaire (MSK-HQ) and Functional Activity Assessment (FAA). Both the MSK-HQ and FAA were 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.

The care provided for patients with mental health conditions was managed well. We saw evidence that all areas of mental health were discussed at clinical meetings, for example depression, self-harm including suicide prevention and Letter of Hope (support for suicidal ideation). The practice audited any patients diagnosed with depression to ensure they had received a follow-up appointment within 10-56 days, this showed 100% compliance. The practice undertook an audit on the use of antidepressants in practice and it showed that best practice was being followed. The practice had regular liaison with the mental health nurse and they also invited them to attend clinical meetings if appropriate.

A specific Step 1 therapy programme was developed between the practice and UK Commando Forces' mental health nurse. This service, called TRIGPOINT, was a 6 hour session for Step 1 intervention run from the welfare offices by the mental health nurse with support from the practice if required. Administative staff booked the appointments for patients to attend this course. Pre and post course improvement scores were measured to monitor effectiveness. Patient feedback has been positive. Patients who needed intervention beyond step 1 were referred for a Department of Community Mental Health (DCMH).

The practice had engaged with 'Harbour', Plymouth's substance misuse charity. The practice was in the process of facilitating them to attend each of the sites every month to provide a drop-in service for patients for support and to raise awareness, they had also engaged with welfare and the Chain of Command to support this. This would also strengthen practice delivery of the DPHC SOP on gambling.

Across the sites, PCRF staff had appropriate clinical spaces and resources to delivery care, including appropriate rooms for individual assessments over at the rehabilitation gyms. Staff had access to a wide range of equipment, much of which was provided and maintained by the units. There was 1 gym space that has a carpeted floor and was quite cramped but the clinical room next to this had just been refurbished and this space was to be updated next. The exercise rehabilitation instructors (ERIs) were also in discussions to replace some of the unit-owned kit with DPHC kit and had an appropriate separate space to do so. When using the unit gyms, the access was protected for only those on rehabilitation.

Monitoring care and treatment

The practice used a standardised chronic disease management tool (CDMT) and SOP to manage all chronic disease with at least quarterly searches being undertaken to direct recalls. This has been recognised as best practice across the region and formed the basis for the new DPHC chronic disease SOPs with the SMO having been appointed as the chair of DPHC's clinical working group which was developing these. In addition, the practice used a standardised set of clinical codes. The population manager facility (referred to as 'POPMAN') was used via DMICP to align chronic disease to the MHS Quality and Outcomes Framework (QoF) and this was reviewed as part of the standing agenda for the practice meeting as part of the healthcare governance programme.

The practice was a pilot site for the new DPHC chronic disease/long term condition policies. This pilot started in February 2024. This meant they were early adopters of the new DPHC CDMT.

The practice asthma SOP and CDMT detailed how patients were managed including diagnosis, treatment and monitoring. This included the use of the asthma control test questions and spirometry. Clinical spirometry was in use and all staff measuring this had been trained in its use including cleaning and calibration of the machine (last delivered in November 2024). Following an ASER in April 2024 when occupational spirometry was conducted without the daily calibration check being done, further training was provided to staff and the use of the daily check lists reinforced.

The CDMT and diabetes SOP included details on how to manage patients at risk of developing diabetes for instance those with pre-diabetes or a history of gestational diabetes.

Patients over the age of 40 were invited in for the appropriate health checks which included a check of HbA1c (blood test that measured the average blood sugar levels). The SOP also covered NICE guidance on cholesterol control in patients with diabetes.

There were 7 patients on the diabetic register. For 3 patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For 6 patients, the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control. NICE recommends that all Type 1 diabetic patients over the age of 40 years old (and that have had diabetes for less than 10 years) that suffer with nephropathy (kidney disease) or have other cardiovascular risk factors should be prescribed a statin (a medicine to lower cholesterol). All patients with Type 2 diabetes patients with no risk of cardiovascular risk factors should be offered a statin if their QRisk (a computerised tool that estimates a patients risk of having a stroke or heart attack) is less than 10% or be on a statin if they have a past medical history of cardiovascular disease. The practice ran an audit in October 2024 and it showed 100% of patients met this standard.

As a routine part of their chronic disease management protocols the combined practice actively searched for and monitored patients with the following conditions:

- Gestational diabetes ensuring annual HbA1c was done and this was audited in December 2024 and showed good compliance.

- Pre-diabetes looking at all cardiovascular risk factors and ensuring an annual HbA1c blood tests was completed. The last practice audit in December 2024 showed 100% of patients had had this completed.

One hundred percent of diabetic patients with a baseline blood pressure of 140/90 had a record confirming their blood pressure was checked in the past 12 months.

The practice ran an annual 'Diabetes Case Finding' audit where they searched for patients with a recorded glucose of more than 6.9 or the HbA1c blood test of more than 47 at any time in the past. If so, they were reviewed to determine if any patients not diagnosed with diabetes had been recalled for testing following the elevated reading. As of the last audit in August 2024, no patients with a previously elevated reading needed recall for retesting as they all had been managed appropriately.

The practice conducted systematic searches at least annually to identify patients who have high cholesterol and glucose/HbA1c levels who may not have had any action taken on these results. Where patients were found, they were actively recalled and appropriate action taken.

The group practice invited patients over the age of 40 to have NHS health screening which includes measuring their blood sugar levels.

There were 21 patients recorded as having high blood pressure. Nineteen patients had a record for their blood pressure taken in the past 12 months. Twelve patients had a blood pressure reading of 140/90 or less. The practice audit (October 2024) showed 68.2% of patients met this standard. Scrutiny of the notes of the 7 patients with hypertension not at target showed that all but one had had appropriate discussion with the doctor following their last blood pressure reading (all of which had been in the preceding 3 months) and therefore had either a management plan in place or the patient had declined medication after discussion. The 1 patient who had not been seen had had three attempts documented in the notes of contact for a review.

There were 8 patients with a diagnosis of asthma. We saw that 7 have had been reviewed in last 12 months. The asthma review template was consistently used.

Audiometry assessments were in date for 79% 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.

There was a comprehensive audit programme in place and PCRF audits were fully integrated within the programme. Many audits had multiple cycles, and any changes required were actioned through the practice development plan. All staff members were encouraged to undertake audits and quality improvement programmes and had received training. Meetings were held to encourage staff to discuss their ideas for quality improvement. Audits were conducted regularly within the practice to demonstrate compliance with evidence-based guidelines. Where compliance was not demonstrated, action was undertaken via the practice development plan to ensure improvements followed best practice. Audits were usually self-generated within the practice but were also done when mandated (for instance the antimicrobial audits) or related to key processes or risk. Staff were encouraged to undertake audits in areas they were interested in, had concerns about, or had had feedback about from patients or staff members. In addition, the practice

ran a rolling audit programme each year. Audits and quality improvement projects (QIP) were discussed are part of the standing agenda for the clinical and healthcare governance meetings.

There was a wide-ranging audit programme which covered topics including, case finding of conditions (e.g. missed diagnoses of diabetes), and a variety of clinical and non-clinical topics. Eighty-five audits had been competed in the past 12 months.

All audits undertaken were uploaded to SharePoint by the SMO. Audits and QIPs were discussed were part of the standing agenda for the clinical and healthcare governance meetings.

Examples of improvement were extensive but some examples include:

- Notes summarisation
- Chronic disease management
- High risk medicines
- Summarisation audit
- Staff records
- Depression
- Gout
- IPC
- Vaccination training
- Acupuncture notes audit.
- Benchmarking exercise to audit health and wellbeing behaviours amongst patients attending for physiotherapy.
- Service evaluation of referrals to Regional Rehabilitation Unit (RRU) Plymouth Multidisciplinary Injury Assessment Clinic (MIAC) to investigate waiting times, diagnostic accuracy and appropriateness of referrals for imaging.
- Physiotherapy telephone consultation audit
- Hydrotherapy audit

PCRF staff undertook an audit of referrals to the RRU it found that the quality of referrals was excellent and the outcomes from the referral were what clinicians expected, but also identified that timeframes for patients to be seen were longer than they should be for a MIAC appointment. An audit of referrals was undertaken to ensure that all referrals were captured on the referral tracker – initially there was poor compliance with referrals to the RRU being added but a reaudit now has this at 100% - the process put in place to capture all these referrals meant that all referrals could be followed-up and discussed at the clinical meeting if required

One of the physiotherapists was running an audit of the anterior cruciate ligament best practice guidelines, looking at outcome measures across all phases of rehabilitation to

determine whether all objective outcome measures were being completed and recorded, and were in line with patient reported outcomes. This work was ongoing.

When Medicines and Healthcare products Regulatory Agency or similar advice was issued, it was discussed in the monthly meeting and the practice routinely responded to relevant alerts by conducting audits to ensure that advised practice in these areas was adopted. For example, an alert in December 2023 regarding Sodium Valproate and new safety measures and educational materials was discussed by the practice team. Following this a Central Alerting System alert was received regarding organisational response to new regulatory measures for patients prescribed sodium valproate. The practice emailed this to the Regional Clinical Director asking for a DPHC response. This was received shortly after and discussed at a clinical meeting.

Effective staffing

There was an extensive and bespoke induction programme with a separate induction for locum staff. There was an induction register on SharePoint. Both DPHC and workplace inductions were recorded on the staff database. There was mentoring in place for all new staff, this was tailored to the role that they were employed in. There were also comprehensive tabletop instructions available for all departments.

Mandatory training was recorded on the healthcare governance workbook which captured internal and external training. At the time of the inspection the log showed good compliance of training overall. Protected time was allocated for mandatory training as well as continuing personal development (CPD).

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. Clinical supervision took place regularly with good supportive cross working between Stonehouse and Bickleigh.

Clinical supervision issues were part of the practice meeting standing agenda. Doctors discussed clinical cases at the monthly clinical meeting and also through their annual medical appraisal. Junior doctors had protected time given for supervision as needed. The SMO and one of the MOD doctors were Associate Trainers and educationally supervised General Duties Medical Officers (GDMOs) in practice and remotely. GDMOs in the practice all had an assigned clinical supervisor. When in clinic, dedicated, protected time was set aside for case discussion and review as required. Nurses had protected time for regional nurse management meetings and supervision took place between nursing staff or via the regional team at DPHC (Southwest). The nurses managed their own CPD in line with guidance from Nursing and Midwifery Council and maintenance of an appraisal portfolio for the nurse revalidation process. Nurses were encouraged to take study leave to complete appropriate CPD to meet this requirement.

The PCRF team had been integral in setting up the ERI in-service training and clinical supervision model for the southwest region and this model had been taken up for distribution on a national scale by DPHC Headquarters as good practice. All staff could access educational events both internally and externally. All the rehabilitation team

managed their own CPD in line with their regulatory body's requirements. Specific supervision sessions had been set up for the ERIs. All the ERIs were non-DPHC staff but belonged to individual units, there was a memorandum of understanding in place but there were challenges in managing the governance for these clinicians. The OC physiotherapist had worked hard at engaging with the units and the individuals and there was evidence that the ERIs were attending training and meetings. The ERI notes audit had demonstrated that documentation was at an appropriate standard, and joint working with physiotherapists ensured standards were being maintained. The ERI-specific induction package set out the expectations of the PCRF, and ERIs who had been out of the rehabilitation setting completed the return to practice programme, assisted by the RRU.

A process for supervision of medics was in place and they had at least weekly protected supervision with the doctor. Medics felt this was beneficial. Medics were part of the urgent (fresh case) clinics and had direct access to the duty doctor for guidance and advice.

Coordinating care and treatment

The transfer of complex patients to other defence medical centres was usually done via email and if necessary, would lead to an online case conference with relevant professionals attending. For patients leaving the military, pre-release and final medicals were offered. During the pre-release phase, the patient received a review of their medical history and a medication review. A summary print-out was provided for the patient to give to the receiving doctor, and a letter if the patient was mid-way through an episode of care.

Additional care was taken to ensure that those patients on the vulnerable adult register had their care handed over to their new doctor either in service or to the NHS when leaving the practice.

Doctors were encouraged to discuss Veteran Accredited GP practices with patients at their leaving medical. The practice provided all services leavers with a leaflet at their leaving medical which covered various topics including how to register with an NHS GP, prescription charges, signposting to charities such as the Royal Marine Association and access to additional services such as Operation Courage and Operation Restore who provide mental and physical health support for veterans, service leavers and reservists.

The practice was also aware of the risks presented to vulnerable service leavers including the legal duty for all Commanding Officers to refer service leavers who may become homeless under the Homelessness Reduction Act. Being aware of this information had been of benefit in reassuring patients who faced loss of their homes on medical discharge.

DMICP allowed for electronic referral to the PCRF, caseload management and tasking between all clinicians. A virtual multi-disciplinary (MDT) clinic was available on the DMICP diary daily to allow for physiotherapists and doctors to record any case discussions about patients. Regular MDT discussions took places for all departments.

The average wait for MIAC was 6 weeks, the PCRF were proactive at looking for alternative pathways and engaging with local services. The increased use of alternative funding had improved waits for patients to be referred directly to secondary care. The department could deliver a high level of rehabilitation input with their rehabilitation troops.

Helping patients to live healthier lives

The senior nurse assisted by a medic managed health promotion. There was a structured programme of health promotion activity with a yearly planner aligned with the DPHC calendar. The health promotion displays were comprehensive, clear and positioned in the waiting areas. The practice health promotion programme includes for example specific advice posters around safer sex as well as leaflets on contraception, patients were signposted to websites to allow them to understand their choices including the Family Planning Association. Posters about the services offered by local sexual health service (referred to as SHiP) were also displayed throughout the practice and free condoms were offered to patients to pick up across the sites to promote safer sexual activity.

There was a detailed local working practice to support NHS screening. All eligible female patients were on the national cervical screening database and were recalled by the nurse. The latest data confirmed an 92% uptake; the NHS target was 80%. Regular searches were undertaken to identify patients who required screening for bowel, breast, and abdominal aortic aneurysm in line with national programmes. Alerts were added to their DMICP record which allowed for opportunistic discussion with a health professional. DMICP searches had been created for all national screening.

The practice has undertaken quality improvement on the delivery of vaccinations. They provided weekly drop-in clinic for vaccinations at all sites and uptake was very good. Recall had been vastly improved following a mass re-coding of patients with no recall dates for vaccination.

Vaccination statistics were identified as follows:

- 95.5% of patients were in-date for vaccination against diphtheria.
- 95.5% of patients were in-date for vaccination against polio.
- 93% of patients were in-date for vaccination against hepatitis B.
- 97% of patients were in-date for vaccination against hepatitis A.
- 95.5% of patients were in-date for vaccination against tetanus.
- 96% 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. Written consent was taken for invasive procedures and implied consent for non-invasive examinations. Consent was included within the chaperone audit undertaken in September 2024 and showed good compliance.

Minor surgery was conducted at Bickleigh and a risk assessment on minor surgery had been undertaken. In April 2023 the practice discussed the regional headquarters about

employing an experienced local locum doctor to undertake a regional minor surgery clinic out of Bickleigh site. This service started in June 2023. Referrals to the service were received from all practices across the region with patients being able to book in via the reception team. The medical notes of all patients who had minor surgery over a 6-month period from December 2023 to May 2024 were reviewed. There was a total of 46 patients over 17 sessions. All 46 patients had their consent form correctly completed and filed in the medical record showing a target of 100% compliance.

The SMO had since engaged regularly with regional headquarters regarding making this service permanent and had produced a business case for this.

Clinicians all considered the patient's mental capacity during their interactions with patients, ensuring that information was shared in a way that allowed the patient to understand it and make their own decisions. Staff complied with the Mental Capacity Act 2005 and understood that capacity was fluid and situation dependent. In house training on consent covered the assessment of mental capacity. This was last delivered in September 2024.

The practice could evidence a case where concerns were raised about a patient's capacity. This was documented in the patient's DMICP records. The case led to urgent liaison with DPHC safeguarding lead, the Naval Welfare Service and other primary care and DCMH clinicians.

Are services caring?

We rated the practice as outstanding for providing caring services.

Kindness, respect, and compassion

People were truly respected and valued as individuals and were empowered as partners in their care. Feedback from people who used the service was continually positive about the way staff treated them. People thought staff went the extra mile and the care they received exceeded expectations. Some examples were:

- A partner of one of the patients who lived a long way from Stonehouse had little support when their partner was deployed and they had additional medical needs. The Senior Medical officer (SMO) met with the unit, their Chain of Command (CoC) and the welfare team to support the person's wish to move and so allow better support and access to secondary care. As the situation changed the SMO worked further with the CoC in enabling the registered patient to support their partner.
- A patient with their own health needs and who had concerns over the health of a loved one was supported to help understand the services available to them as a carer, getting support for themselves as well as their family member.
- The SMO continued to support a patient who had been posted away as it was crucial for the patient to have continuity of care. This meant the SMO travelled in their own time for several hours to support this patient. We saw a very appreciative and special letter from the patient thanking the SMO for the continued support.
- A patient from another practice was deploying and required the cholera vaccination which their practice had been unable to source so asked if the patient could be seen in the vaccination walk-in clinic at Stonehouse. The vaccine was held at Bickleigh and due to the patient's strict pre-deployment schedule, they were unable to attend the Bickleigh walk-in or the nurse clinic. The SNO came into work early and collected the vaccine from Bickleigh ready for patient to be seen at Stonehouse.
- A patient who had received care from one of the physiotherapists following an injury wrote to them expressing their thanks for the care they received. They described how the physiotherapist had worked hard not only to find the most appropriate rehabilitation package but also introduced them to the hydrotherapy pool which had been a turning point for them. The patient described how much their morale had been boosted and how they felt the physiotherapist had genuinely cared about their recovery.
- A patient who had received rehabilitation described the outstanding support and care provided to them. They commented on the positivity, that was described as infectious, during the rehabilitation journey making them feel hopeful, comfortable and overall had had a huge impact on their life.
- A patient was visited in hospital following a cardiac arrest, and following discharge, checks on their and their family's welfare were made. Medicines were delivered to them during a period of being unable to drive.

In advance of the inspection, patient feedback cards were sent to the practice, feedback was from patients that had been seen by the PCRF, and the medical and administrative staff. A total of 59 patients from both sites responded and all feedback was positive, reflecting a general theme of kind and caring staff that provided person centred care. Some of the comments were particularly complimentary about the receptionist, described them as helpful, friendly and willing to go the extra mile for them including making them a cup of tea if they were waiting long or were in any distress or pain. We saw several examples of this on the day and patients were truly grateful.

The last patient survey undertaken for the combined practice showed 108 patients had provided responses through the DPHC Patient Experience Questionnaire between January and December 2024. The responses were positive with 100% confirming they were satisfied with their healthcare professional and they were treated with dignity and kindness.

Patients could access the welfare team and various support networks for assistance and guidance. Information regarding these services was available in the waiting areas and the clinical staff were fully aware of these services to signpost patients if required. We met with a representative for the welfare officer who described a collaborative relationship with the practice team and that they were kind, helpful and responsive to patient's needs.

Involvement in decisions about care and treatment

Carers were identified when patients registered at the practice. There were also posters around both sites asking carers to identify themselves. There were 8 carers on the register with appropriate alerts and monthly searches were undertaken to ensure any new carers were recognised. They were offered flu vaccines, health checks and longer appointments if needed. There was information for carers included in the practice leaflet and on the notice boards at both sites. The receptionist, kept in touch regularly with the carers by telephone ensuring they had everything they needed. Coffee mornings were also set up for carers to attend.

Staff were aware that additional resources regarding translation for deaf and blind patients could be found at various websites such as Deafblind UK. Links to these were available on the front page of the practice SharePoint for easy reference. The practice had the ability and knowledge to use additional resources to aid patients' communication when needed such as visual pain scores. The SMO gave an example of when a patient was provided with a visual aid to point out words/letters when affected by a severe stammer.

Patients with educational needs were considered when updating the practice information leaflet checked, it was checked on an online reading age checker to ensure it was appropriate for the average reading age of the Armed Forces. In addition, patients were signposted to the education centres for formal learning needs assessments when indicated.

Supported by a standard operating procedure, a translation service was available for patients who did not have English as a first language.

Privacy and dignity

Consultations took place in clinical rooms with the door closed. Patients at reception 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 area at Stonehouse was small and in view of the reception desk but had a television playing to mitigate any conversation that might be overheard. At Bickleigh the waiting room was in view of the reception and conversations could not be overheard.

The practice manager completed monthly Caldicott searches to ensure all clinical staff had a staff alert which was cross referenced with staff attached to the units. They ensured no SCP staff were registered within the practice and sent regular reminders to all staff on Caldicott breaches.

Access to the DMICP records of staff was audited regularly to ensure this access was appropriate and legitimate. This was conducted monthly by the practice manager. An annual report was produced in December 2023 that showed 31 breaches. On investigation it was identified that deployable medics (non-Stonehouse staff) were completing routine vaccination checks, vaccination clinics and fresh cases on each other rather than going through the correct routes. This had been missed in previous Caldicott searches because non-Stonehouse medics did not have the correct staff alert/code attached to their DMICP record. All breaches could be explained but were inappropriate. Due to the large number of breaches, it was decided that retraining and reinforcing of consequences was the correct route of action. The practice manager discussed with the leaders of each unit and sent an email out twice throughout the year as a reminder. With immediate effect the following actions were enforced:

- No medic was to see another medic at urgent on the day clinics, they are to be seen by a doctor only.
- No medic was to vaccinate another medic this is to be completed by the nurse.
- Medical administration was to be completed by a civilian administrative staff or nurse not a medic.

The last annual report from December 2024 showed no breaches. The practice conducted in house Caldicott training. This was last delivered in March 2024. All DMICP access was regulated for all staff including deployable medics and only granted on signing of Caldicott principles and they had shown evidence of Disclosure and barring Service (DBS) to the practice manager. Permissions for the level of access was determined by role and monitored by the practice manager and the business manager.

Are services responsive to people's needs?

We rated the practice as outstanding for providing responsive services.

Responding to and meeting people's needs

Bickleigh was a purpose-built clinical facility and was well provisioned to meet the specific needs of the patient population, including access for patients using a wheelchair. Stonehouse was a listed property which brought challenges around temperature control and accessibility. Nevertheless, the team had mitigated any risks as far as possible, and any risks had been escalated appropriately. Any patient with access requirements could be supported to attend the Bickleigh site. The team could meet in large groups for meetings and training using rooms at the Stonehouse site or at the Bickleigh site. Patients we spoke with did not report any concerns with accessing the facilities. A disability access audit for both buildings and the Primary Care Rehabilitation Facility (PCRF) had been carried out and barriers had been noted.

The practice was constantly ready to respond at very short notice to the occupational needs of patients. A large proportion (75%) of patients had to be ready to rapidly deploy which presented challenges to ensuring patients were always medically ready. The practice had been working to gain formal direction on the most suitable vaccinations for all the population at risk who were at high readiness to deploy. The practice had recently been given permissions to ensure all those held at high readiness were given at least the first rabies and the tick-borne encephalitis vaccinations. Following this they changed their vaccination delivery programme to match patient need, initially undertaking a mass vaccination clinic to address the back log. They also provide vaccination drop-in clinics once a week at each site for vaccinations and audiometry.

Patients presenting with an emergency would be seen at any time including during the lunch closure period and there were notices outside the practice highlighting this. All patients also had access to urgent care clinics, routine booked appointments telephone appointments and eConsult. Training has been provided for staff in managing urgent/emergency cases including for sepsis, chest pain, trauma, and climatic injuries. Clinical staff had been trained to assess patients with minor injuries. For example, the senior nursing officer (SNO) and a medic had completed the Minor Injuries training courses.

As a practice supporting a patient population who provided arctic warfare, they provided medicals to those patients who required them prior to ice breaking drills. They maintained their awareness of changes in policy for these medicals, and reviewed their clinical procedures around cold injuries, they had conducted an audit on cold injury referrals in July 2024 and Raynaud's (condition affecting blood circulation) most recently in December 2024.

Physiotherapy demand increased during Potential Commando Preparation Training (PCPT) which took place in a remote location located 1.5 hours away. The PCPT was a physically arduous course which led to an increase in the numbers of musculoskeletal injuries. Access to medical care could be difficult due to its location. On review of this a

triage telephone system had been set up and an additional physiotherapy clinic was made available. The physiotherapist worked with the training team giving them immediate course of action for the individual and created an initial management plan.

The PCRF identified the waiting times for patients receiving electronic shock wave therapy (ESWT) via the Regional Rehabilitation Unit (RRU) were excessive and prolonged patient downgrade time. It was noted that the RRU EWST was sitting idle for long periods during the working day. The practice therefore trained 1 physiotherapist to be able to provide ESWT and set up a peripatetic ESWT clinic based at the RRU solely for Stonehouse Combined Practice (SCP) patients. This reduced the waiting time for EWST from over 8 weeks to 1 week.

The practice had pro-actively progressed access to training around supporting patients with a learning disability/autistic spectrum disorder (ASD) in line with the national requirement for all healthcare providers. All staff had received the introductory session to the Oliver McGowan training as part of the in-house safeguarding training. The SMO had completed the first part of the tier 1 Oliver McGowan training and the rest of the staffing team would complete this moving forward. One of the doctors had completed 3 training modules on neurodiversity including sessions on dyslexia, autism and attention deficit hyperactivity disorder.

Timely access to care and treatment

A policy was in place to guide staff in exploring the care pathway for patients transitioning gender. All staff had received training to support the appropriate and effective care of people who were transitioning gender

Routine appointments with a doctor and nurse could be facilitated within a day. A routine physiotherapy new patient and follow up appointment was accommodated within 1 week. An urgent physiotherapy appointment was available on the same day. New patient and follow up appointments with the exercise rehabilitation instructor (ERI) were available within 5 days. There was always availability at the rehabilitation classes. The Direct Access Physiotherapy (DAP) pathway was available for patients to use. There was a physiotherapist and ERI allocated to each unit who maintained oversight of all patients under rehabilitation.

When Stonehouse Combined Practice (SCP) was closed further cover was provided by HMS Drake Medical Centre from 1600 to 1830 hours. After this, patients were directed to the NHS 111 service. The patient information leaflet, answerphone message, unit orders, and patient information board provided details about opening times and access to medical care out-of-hours.

Listening and learning from concerns and complaints

The business manager, supported by the SMO was the lead who handled all complaints in the practice. The practice had implemented a process to manage complaints in accordance with the Defence Primary Healthcare (DPHC) complaints policy and

procedure, 3 complaints had been recorded within the past 12 months. A trend analysis of compliments and complaints was undertaken annually to review any themes. The most recent analysis showed the practice were delivering a good service to the patients, the units and the wider military. It was identified that they needed to broaden the reach of the Patient Experience Questionnaire. As a result, they now send a Quick Response (QR) link to every patient after their consultation via GOV.UK notify (text service).

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

Are services well-led?

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

Vision and strategy

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

Stonehouse Combined Practice (SCP) worked to the Defence Primary Healthcare (DPHC) mission statement which was:

> ‘DPHC is to provide safe, effective healthcare to meet the needs of our patients and the chain of command to support force generation and sustain the physical and moral components of fighting power’.

The practice also worked to its own philosophy:

> ‘Stonehouse Combined Medical Practice is a welcoming environment where the team feel valued and patients want to come for their care.
>
> It is an accessible, high-quality health care service offering a timely, prompt and genuinely caring service that understands the role the patient plays in defence, maximising their health and deployability. The team is proactive and cohesive, supporting all staff to develop their careers and knowledge.’

The implementation of the combined practices 3 years ago was to improve access to care for the patient population at the 3 sites (now 2 due to the closer of The Citadel). SCP was operating to a very high standard. The nature of the population at risk and their unique roles across defence and often held at high readiness, creating many challenges. There was a lot of unit engagement and positive feedback from the Chain of Command.

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 electrical items at the end of the day. The practice had an aspiration to undertake the Royal College of General Practitioners Green Impact for Health Toolkit Awards.

Leadership, capacity, and capability

The dynamic leadership of the practice, primarily led by the Senior Medical Officer (SMO) and the Officer Commanding (OC) of the Primary Care Rehabilitation Facility (PCRF), drives a culture of empowerment, strong communication, and effective teamwork. Within the wider senior management team (SMT) were the Senior Nursing Officer, and the practice manager. There was a temporary business manager to supplement the team. Their collaboration ensured seamless coordination, enhancing efficiency and fostered a

supportive environment for all. This united approach ultimately optimized patient care and outcomes. The OC of the PCRF, along with the SMO, had been working on a comprehensive practice development plan, informed by the staff survey, and were looking for input from all staff into its implementation.

The governance and culture were used to drive and improve the delivery of high-quality person-centred care. Staff were proud to work for the practice and spoke highly of its culture. The practice provided care in a way that kept patients safe and protected them from avoidable harm.

Previously The Citadel was part of the SCP, this site was closed in October 2023 as a temporary measure following activation of the business continuity plan due to reduced staffing levels. This allowed consolidation of staff at 2 sites which increased safety and resilience. The staffing situation had not been resolved. As soon as the instruction was given by regional headquarters (RHQ) to close the site, the SMO engaged with the commanding officer to explain the decision. An impact review of this was ongoing and would include the views of all stakeholders. In the meantime, the management team continued to engage with the unit and were monitoring the patient experience questionnaire for patient feedback. This was recorded on the issues log and the Regional Clinical director (RCD) had accepted this as a transferred issue. We talked to a unit commander from The Citadel, they were entirely complimentary about the level of care received by the patients, they described the care provided as responsive and thorough. They commented that they felt the standard of care provided was better now that the patients were at Stonehouse.

There was a comprehensive meeting structure that underpinned the governance structure and promoted an inclusive leadership approach. Staff we spoke with consistently praised the leadership and this was echoed in the feedback from affiliated staff and patients.

Job descriptions and terms of reference were in place for all members of staff. There was a list of roles and responsibilities which involved a wide range of staff and each lead had an appointed deputy.

Staff felt well supported the regional team, the RCD was present on the day of the inspection and was actively supportive of the SCP team recognising their hard work and resilience.

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 practice. Staff felt that their contributions to the development of the service were valued.

We interviewed a cross section of staff, and all told us that it was a happy place to work and that they could rely on their work team to discuss and mitigate any concerns they faced. They spoke about colleagues who were supportive, compassionate, and caring.

Staff said they would feel comfortable raising any concerns and were familiar with the whistleblowing policy. The practice has introduced an anonymous whistleblowing portal with quick reference codes displayed throughout the buildings.

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 across both sites was strong and an appropriate meeting structure and healthcare governance approach was in place. There was a healthcare governance workbook in place for monitoring governance activity.

SCP was part of the Southwest DPHC region and was accountable to the RCD, acting under their direction to deliver safe and effective health care. The SMO was the healthcare governance lead for the combined practice and supported and developed healthcare governance across the practice.

Healthcare governance within SCP fed into every aspect of care delivery. Every member of staff was aware of their duties and this was reinforced through training. There was a comprehensive range of standard operating procedures (SOPs) in place for all key processes and these were kept under review. There was an SOP tracker in place which identified the document owner and the required review date for monitoring purposes.

Health care governance was a continual process in the practice. It was driven by risk management, complaints, significant events and active seeking of feedback. These fed into the practice development plan which was reviewed monthly. In addition, healthcare governance was part of the standing agenda for the monthly clinical meeting. All staff members were encouraged and supported to be a champion for healthcare governance and to act and develop new ways of working and to support others.

Managing risks, issues and performance

There was an active risk register, there was also an issues log. All the known key risks and issues were recorded on the registers. The 4Ts process' (transfer, tolerate, treat, terminate), were clearly applied to risks and a review date was evident.

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

The leadership team understood the policy and processes for managing staff performance, including underperformance and the options to support the process in a positive way.

A business continuity plan (BCP) was in place and this had been reviewed, it detailed the action to be taken in the event of loss of any services. The BCP was a combined document covering all practices and the PCRFs but could also be used independently.

Appropriate and accurate information

Accessible to all staff, the SCP used the healthcare governance workbook to manage and monitor governance activity. In addition, the Health Assessment Framework (HAF), an internal system to DPHC, was used by the practice as a development tool and to monitor performance. SCP recognised early that the HAF used by DPHC did not reflect the combined practice set up, escalating this as a transferred risk to DPHC headquarters. Direction was given from Commander DPHC not to complete the online HAF. SCP maintained a paper version of the HAF in preparation for upload. This document was extensive and it comprehensively covered all aspects of the HAF and was fully evidenced. Since concerns were raised by DMSR about the lack of visibility, SCP have uploaded this to the online site. The practice management action plan was maintained on SCP's practice development plan which was more accessible to the practice team and allowed a more co-ordinated approach across the multi-site practice.

All staff members were trained in the Caldicott Principles to the appropriate level and sign the up to Caldicott as part of their induction process. The confidentiality and Caldicott lead for the practice was the practice manager, supported by the SMO. This was detailed in their terms of reference.

Engagement with patients, the public, staff, and external partners

Staff were highly motivated and inspired to offer care that was kind and promotes people's dignity. Relationships between people who used the service and staff were strong, caring and supportive. These relationships were highly valued by all staff and promoted by leaders.

Civilian staff had access to the Employee Wellbeing Service to help support them with both domestic and workplace issues and work-related stress. They could self-refer to these services and involvement was confidential.

SCP utilised the 'Civilian Thank You' scheme to award staff. Recipients of these were announced in the practice meeting as part of the on compliments. They are also recorded on the compliments log of the SMT. Where possible within policy, they also included military staff in the Thank You scheme. For example, for the nursing team (military and civilian) in recognition of their diligence and commitment to the practice. The practice announced every compliment and there was a link on the SharePoint front page to an area where staff can complement each other.

Staff views on service development was also important to the SMT and in addition to regular input by all the practice meetings, they had undertaken specific sessions and surveys inviting them to identify areas for development as well as providing an anonymous feedback service for staff through the innovation link on SharePoint. Also, the OC PCRF was working on developing a personal development plan with staff engagement. Staff were asked to complete a questionnaire in November 2024 on what issues they wanted the practice to focus on over the next 12 months. This was being collated and would be presented at the first practice meeting of 2025.

Monthly team building events were undertaken, these included events such as a practice 'Task Master' event, a practice session on appropriate challenge with a quiz, synchronised swimming, paddle boarding, walks and annual summer BBQs and Christmas parties.

A quality improvement projects (QIP) on improving medic's experience at SCP was led by one of the medics, this was instigated after it was identified that there was low morale amongst them. At the initial meeting in July 2023, they reviewed the issues they were experiencing including the need to work as a team. They then presented their issues to the practice manager and SMO. They identified several things that would enhance their working life and careers. For example, using their learning credits to fund courses, to undertake moulage training and travel health courses, and they wished to undertake placements, for example in secondary care. The improvement project was discussed in the healthcare governance meeting in 2024 and had led to changes in the practice including improvements in clinical supervision with dedicated time set aside with the doctor weekly and a change to the format of the medic's clinics.

Following on from this to enable medics to raise issues amongst their peers, a medic meeting was held every month. This had been successful and had improved awareness of the issues the medics felt needed addressing. The practice had also extended this to have administrative team meetings for them to raise specific issues.

The practice has trialled end of placement reviews for medic trainees in practice and fed back the responses back with the aim to embed this for all trainees at the end of their placements.

There was a 'You said, we did' board in the reception of each site. Examples of changes that have occurred as a result of patient feedback included:

- Ordering new chairs for the waiting area.
- Ordering of new rehabilitation equipment.
- Improvement in the way patients were notified about their appointment. The practice utilised the SMS appointment reminder system which had been effective in reducing patients not attending. They had now amended the information on the clinics to ensure that the automated SMS system reflected which site and with which person the appointment was with.

The practice had a highly effective relationships with the Chain of Command at all 3 sites (although the Citadel was temporarily closed) The PCRF was integral to the practice across the group. The SMO has developed highly effective links with some local secondary care providers to ensure enhanced access for certain specialities. The practice were supported by DCMH team at Drake.

The SGMP has good links with the Devon Integrated Care Board, and charities such as the Mankind Initiative and HARBOUR.

Continuous improvement and innovation

SCP had a comprehensive and effective audit programme that was integral in driving improvement. A total of 9 QIPs had been recorded on the DPHC national SharePoint and there were 10 on the practice's internal register, with a further 6 on the way. Of note:

The PCRF identified that waiting times for receiving Shockwave therapy at the Regional Rehabilitation Unit (RRU) were excessive and potentially delaying patient recovery. One of the Stonehouse physiotherapists was training in delivering Shockwave therapy and set-up a clinic for Stonehouse patients, which has significantly reduced the waiting times for treatment. This was being done under a memorandum of understanding (MOU) with the RRU.

Following patient feedback, the PCRF had negotiated slots for patients to use the hydrotherapy pool at Drake. We saw numerous examples where patients had expressed their thanks and stated that the treatment had directly impacted positively on their recovery.

PCRF staff had developed a system managing end-stage rehabilitation, recognising the arduous level of training and job roles that their patients were going back to as soon as they as they were discharged from rehabilitation. They had recognised that they needed to provide the build-up element between level 1 and level 3 physical training and were ensuring end-stage robustness to reduce risk of reoccurring injuries.

The PCRF were auditing waiting times for orthopaedic referrals and the practice now looked at 'long waits' during their clinical meetings where alternative referral pathways and sources of funding could be discussed. The impact had not yet been measured as it was a relatively new process but had the potential to have a big impact on patient access to secondary care, and therefore time downgraded.

There has been an ongoing QIP since 2022 looking at the quality of Exercise Rehabilitation Instructor (ERI)notes, which has been repeated on a 6 monthly cycle and has shown increasing quality of ERI documentation. The action points from these audits have involved team discussions at PCRF meeting, ERI training, putting a process in place for a physiotherapist to monitor ERI CPD hours, engagement with RHQ around the ERI MOU as they were non-DPHC staff.

The practice had engaged with Harbour, Plymouth's substance misuse charity. The practice was in the process of facilitating them to attend each of the sites every month to provide a drop-in service for patients for support and to raise awareness, they had also engaged with welfare and the Chain of Command to support this. This would also strengthen practice delivery of the DPHC SOP on gambling.