Chivenor Medical Centre

The Barracks, Chivenor, Barnstaple, EX31 4AZ

Defence Medical Services inspection.

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

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

Contents

Summary

About this inspection

We carried out this announced comprehensive inspection on 15 October 2025. As a result of this inspection the practice is rated as good in accordance with the Care Quality Commission's (CQC) inspection framework.

Are services safe? – good

Are services effective? – good

Are services caring? – good

Are services responsive? – good

Are services well-led? – good

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

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:

- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted upon.
- The practice organised and delivered services to meet patients' needs. Patients could access care and treatment in a timely way.
- The way the practice was led and managed promoted the delivery of high-quality, person-centred care.
- Clinical and internal audit processes functioned well and had a positive impact in relation to quality governance.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Effective safeguarding arrangements were in place. Patients vulnerable due to their mental health and/or social circumstances were well managed and supported.
- Both the practice and the Primary Care Rehabilitation Facility were old buildings in need of refurbishment and space was limited. With the proposed increase in the patient population there was a significant risk that this was not sustainable in the long-term.

We found the following areas of notable practice

- Screening for Strongliodes (a parasitic roundworm that infects people. It could cause stomach-aches, diarrhoea, and rashes). The civilian doctor worked closely with the Liverpool School of Tropical Medicine. This disease was particularly relevant to the patient population and without treatment could have a real impact on the long-term health of patients.
- Access to Improving Access to Psychological Therapies (IAPT) NHS services, delivering face to face care for patients with the practitioner integrated into the carers forum. This resulted in improved access to therapy for patients with a limited wait time, whilst ensuring that any occupational risk for the patient could still be managed by the practice.
- Engagement with local orthopaedic services which included visiting with an exercise rehabilitation instructor to demonstrate the kit the royal marine soldiers needed to carry. This had resulted in faster access for patients and more appropriate treatment pathways, which resulted in returning them to fitness more quickly.
- The practice had just started running a specific service, called Royal Navy Medical Board of Survey TRIG,.This was an intervention for those approaching medical board (a medical board is a panel of medical professionals who evaluate a service members physical and mental health to determine their fitness for duty) and potential medical discharge. This was implemented as the doctors saw patients were stressed whilst waiting for their board. This service was aimed at patients without underlying mental health illness, and it helped them in managing uncertainty and dealing with change.

The Chief Inspector recommends to Chivenor Medical Centre

- Ensure when a chaperone is offered this is routinely recorded.
- Ensure nurses attend chronic disease monitoring courses.
- Ensure nurses and medics produce an Fmed 296 (military prescription) for vaccines and simple treatments
- Continue to improve standards of patient records within the Primary Care Rehabilitation Facility (PCRF).
- Ensure staff within the PCRF are involved in any emergency scenario training.

The Chief Inspector recommends to Regional Headquarters.

- Review the provision of civilian nursing hours to provide continuity and continued provision of nursing services.

The Chief Inspector recommends to Defence Primary Healthcare:

- Ensure the DPHC-wide clinical waste policy is updated in a timely way so the practice can confirm management of clinical waste reflects the 2023 revisions made to HTM 07-01: Safe and sustainable disposal of healthcare waste.
- Continue to support the practice to improve the infrastructure so that suitable facilities are available to patients. This should include extra clinical rooms for nursing services and audiometry testing.

Professor Bola Owolabi

Chief Inspector of Primary and Community Services.

Our inspection team

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

Background to Chivenor Medical Centre

Located near Barnstaple, Chivenor Medical Centre delivers a primary healthcare, occupational health, and force protection service to a patient population of 945 regular service personnel.

A Primary Care Rehabilitation Facility (PCRF) is located next to the medical centre and provides regular service personnel with a physiotherapy and rehabilitation service.

As there is no dispensary at the practice, medicines are dispensed from a local pharmacy.

The practice is open from 08:00 – 16:00 hours Monday to Friday. Emergencies can be accommodated in the afternoons when it is closed. From 16:00 until 18:30 duty staff provide emergency medical cover. Outside of these hours, including weekends and bank holidays, NHS 111 provide cover.

The staff team

Civilian Medical Officer	One (part time shared with the (MOD GP)
Ministry of Defence GPs (MOD GPs)	One (part time shared with the CSMO)
Regimental Medical Officer (RMO)	Two (one currently away)
General Duties Medical Officers	Two

Practice manager	One
Deputy practice manager	One
Nurses	One military One part time
Physiotherapist	One Officer Commanding Two part time Band 6 (about to be increased to three)
Exercise Rehabilitation Instructor	Two (both non-DPHC and one post currently vacant).
Administrators	Two full time equivalent (covered by 3 people)
Combat medical technicians* (CMTs) (referred to as medics throughout this report	One DPHC medic One part 4 medic Two non DPHC medics

*A medic is a unique role in the forces and their role is like that of a health care assistant in NHS GP practices but with a broader scope of practice.

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

The Civilian Senior Medical Officer (CSMO) was the safeguarding lead for the practice. All staff within the practice and the Primary Care Rehabilitation Facility (PCRF) were in-date for safeguarding training at a level appropriate to their role. Last reviewed in April 2024, a safeguarding standard operating procedure (SOP) was in place for children and adults which included links to external agencies. The CSMO had visited the local safeguarding services including Multi Agency Safeguarding Hub to familiarise them with the working practices and to familiarise the local team with the patients' needs at Chivenor.

Safeguarding policies were up-to-date with the local contact details. The CSMO had working links with the local safeguarding team in North Devon and the practice was invited to attend the local education and drop-in sessions.

There was a separate practice document which outlined key responsibilities for the practice safeguarding lead, and also clearly outlined the local NHS and Integrated Care Board leads which ensured easy escalation and sharing of information. There were links to NHS safeguarding apps (to ensure teams which were not local to the practice could be identified) and also clear guidance about involving the MoD media team if an incident might attract national attention. There were several regular forums where information could be shared. These included meetings with the Chain of Command, the Unit Healthcare Committee and carers meetings.

A DMICP (electronic patient record system) search was established to routinely check for patients under the age of 18. Care leavers were identified when they registered at the practice. A vulnerable patients register was held in a limited area of SharePoint and was monitored by the CSMO. Where applicable, clinical coding and alerts were applied to individual DMICP records to ensure vulnerable patients were readily identified.

There was a chaperone policy in place. Clinical staff had received chaperone training and a register of available chaperones was displayed in all clinical rooms both in the practice and the PCRF. We reviewed a sample of patients notes and the offer of a chaperone was not always documented. This is important to protect both the patient and the professional and to document patient choice. 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 professional registration of clinical staff had been checked. The nursing team managed the staff vaccination register, including the occupational health register with new staff providing documented evidence of their vaccination status.

There were good systems in place for the management of infection prevention and control (IPC). One of the military nurses was the dedicated lead for IPC and they had completed

the link practitioner training; another civilian nurse had also completed this course and was able to step in if the lead nurse was deployed. The IPC SOP was reviewed annually. Both nurses attended the quarterly headquarters Defence Primary Healthcare (DPHC) IPC lead meetings.

An annual IPC audit was undertaken and included the PCRF. Review dates were in place and all findings were recorded in the audit tool and any issues/ recommendations were discussed at the practice meeting. Risks were recorded in the practice healthcare governance workbook.

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

The practice was visibly clean throughout. A schedule was in place for environmental cleaning. There was a dedicated cleaner and regular cover in place for absences. The practice manager was able to give several examples of when the cleaner went above and beyond what is required to maintain high standards of cleaning throughout the practice. Spot checks were undertaken and no cleaning concerns were identified.

Clinical waste was safely managed. Consignment notes were in place and were up-to-date. Secure storage for clinical waste was located outside of the building. The last annual clinical waste audit was undertaken in April 2025. Sharps boxes were labelled, dated and used appropriately. Following some key changes to the HTM 07-01 in December 2024, Defence Primary Healthcare (DPHC) practices await guidance around the treatment of clinical waste.

Staff within the PCRF provided acupuncture to patients. There was an acupuncture SOP and risk assessment in place that had been reviewed. One physiotherapist practiced acupuncture with stock stored in their room, and written consent taken. An acupuncture audit had been completed in 2025; although the report seen was unclear what action would be required as no results were included.

Risks to patients

There was a good balance of well-trained civilian and military staff which afforded continuity of care. There was 1 military nurse in post and 1 part time civilian nurse.

Whilst the team demonstrated a committed and flexible approach to completing tasks, there were concerns around resilience in the nursing team when the military nurse was deployed, which happened regularly. The patient population was held at high readiness with last minute deployments frequent. When this happened, there was a reduction of non-essential nursing services and patients were invited to attend another military practice or be seen at specialist services, for example women eligible for a smear test were given information to book into the local cytology clinic.

Whilst there were 2 nurses in post, there was only 1 clinical room available to them due to the size of the building (the building was previously used for military transport before being made into a medical centre and was not purpose built or fit for purpose).

The practice had sufficient doctors to cover clinical care, extra cover during periods of staff absence was provided by locums that were local GPs who had integrated well and were experienced in military medicine. This had made a significant difference and had helped cover the Regimental Medical Officer (RMO) when they were away. The CSMO and the MOD GP staggered their leave which meant that adequate cover was in place. Within the PCRF, the Officer Commanding post was away on a course and was currently being covered by a regional headquarters physiotherapist.

All staff had received updated training in emergency procedures, including basic life support, automated external defibrillator (AED) and anaphylaxis. The CSMO, RMOs and 2 of the nurses were also trained in Immediate Life Support. An AED was available in both the practice and the PCRF. Both clinical and non-clinical staff were familiar with the signs and symptoms of sepsis and had received training.

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

Practice-wide scenario-based training was held regularly. Most recently a ‘scoop and run’ moulage exercise was held by one of the doctors and the practice combined with the dental centre to exercise a dental emergency in September 2025. Thermal injuries training was run regularly as this was a particular risk to the patient population. Staff within the PCRF had good awareness of how to respond in an emergency but they said they had not been involved in any scenario training; there was no evidence on the training log of their involvement. This meant there was a risk of an inability to provide effective aid during a real crisis.

All staff knew where the emergency medicines were located. We found medicines on the emergency trolleys were appropriate, in-date, and were accompanied by a risk assessment.

The layout of the waiting rooms allowed patients to be observed whilst waiting for their appointment.

Each staff member was issued an individual panic alarm as there was no working alarm system installed in the building. Within the PCRF, all rooms had personal alarms, including the office in the PCRF gym. We noted the alarm in the gym could not be heard outside of the building (separate to the practice) and when we tested it during the inspection, no one was aware. Following the inspection, we were informed an alarm had been fitted that could be heard outside. There was no record of the alarms being previously tested but this was added to the monthly check list during the inspection and a test conducted. This was also added to the risk register.

Information to deliver safe care and treatment.

In the event of an IT outage the business continuity plan was followed. Clinic lists were printed the day before in case of an outage so staff were aware of which patients they were expecting that day. The team reverted to seeing only patients with an urgent need when the electronic patient record was unavailable. Paper documentation was used and uploaded to system at a later point.

The nurses coordinated the summarisation of patient records. They reviewed the records of newly registered patients, including a review of recalls, clinical coding and alerts. Anything of concern was tasked to a doctor for review. At the time of the inspection, 94% of records had been summarised.

Arrangements were in place for the auditing of consultation records for each clinician including the doctors who reviewed each other's. Audits were conducted on the medics' record keeping, this was undertaken by the doctors.

Within the PCRF, a notes audit was completed using the DPHC notes audit template; this was last completed in April 2024 although we were unable to see the results as the results table within the template was blank. Some areas were highlighted throughout the audit as needing improvement, there was a planned reaudit for 6 months to re-evaluate this.

DMICP permissions were set correctly for physiotherapists and exercise rehabilitation instructors (ERIs) allowing the correct access to patient records.

The practice had a weekly multi-disciplinary team (MDT) meeting that included all PCRF staff. If required, patients could also have a joint appointment with a physiotherapist or ERI and the doctor.

The team was using the new DPHC referrals database. Administrative staff were tasked by clinicians when a referral was completed, then the administrative team actioned it appropriately. Urgent referrals were managed in the same way and reviewed frequently. Within the PCRF, staff tracked their own referrals by checking that relevant appointments had been arranged during the monthly caseload review, also patients needing onwards referral would be discussed at the weekly MDT.

The nursing team described the start-to-end process for the management of samples. The SOP for sample management was followed and included guidance regarding the interface with Path Links (NHS clinical pathology service). A specimen register was maintained and the duty doctor checked daily for results received and scheduled an appointment for the patient if required.

Safe and appropriate use of medicines

There was no dispensary at the practice, medicines were dispensed from a local pharmacy. The CSMO was the dedicated lead for medicines management.

Medication requiring refrigeration was monitored twice a day to ensure it was stored within the correct temperature range. Fridges were locked in the treatment rooms and the ambient temperature in these rooms was monitored. Prescription pads were held securely and their usage recorded.

Patient Group Directions were managed in line with policy and had been audited. Medics were trained to assess and treat using Medication Issuing Protocols. We discussed with nurses and medics on the day that an Fmed 296 (military prescription) needed to be completed for vaccines and simple treatments, they agreed to action this moving forward.

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

We found a good process was established for the management and monitoring of patients prescribed high risk medicines (HRM). The register of HRMs was held on DMICP and all doctors and relevant clinicians had access to this. We looked at a sample of patient records and saw that all had been coded and monitored well.

Track record on safety

The practice manager was the risk manager as well as the lead for health and safety (referred to as SHEF). The practice manager was also the building custodian and fire representative. Training needs and responsibilities were detailed within terms of reference and role specific training had been completed. Good links had been established with the SHEF lead for the station. There was a risk register, retired risk register, issues log and retired issues log on the healthcare governance workbook. A health and safety policy was in place and in-date, risk assessments had been completed and were current. They considered the DPHC ‘4 T’s process’ (transfer, tolerate, treat, terminate) to illustrate at what level each risk was being managed. Risk was a standing agenda at the monthly practice meeting.

Risk assessments for substances hazardous to health (referred to as COSHH) were reviewed annually or if there was a change to the products used. Appropriate COSHH risk assessments were in place. However, the COSHH cupboard would not lock; this had been added to the risk register and the cupboard within the disused pharmacy was being used in the interim to reduce any risk.

Processes were in place for the regular monitoring of utilities and equipment. Gas and electrical safety checks were up-to-date. Legionella risk assessments had been completed and the safety of water was regularly monitored. Regular checks of equipment (referred to as LEA) were up-to-date. Electrical equipment testing (previously PAT testing) was completed in December 2024.

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

The PCRF gym was well resourced for the space available, including some additional outdoor space, it did not have the space to conduct group classes, but they had access to the main gym in required. The main gym was a large space and well-resourced with equipment. The equipment in the PCRF was serviced and in date, this was managed by one of the ERIs.

The gym was climate controlled; Wet Bulb Globe Temperature (WBGT) readings were available outside the main gym.

Lessons learned and improvements made

The practice worked to the DPHC policy for reporting and managing significant events, incidents and near-misses, which were recorded on ASER (organisational-wide system for reporting significant events). All staff had completed ASER training to access the system. There was an ASER log on the healthcare governance workbook. The CSMO acknowledged that as a practice they did not raise a lot of ASERs, this was as they felt that they solved things at a local level rather than raising them formally. We discussed that this was an area that could be improved to ensure that the opportunity for organisational learning was captured. Learning points from ASERs were discussed and recorded at the practice meetings.

A safe process was in place for managing notices from the Medicines and Healthcare products Regulatory Agency (MHRA) and National Patient Safety alerts. Alerts were logged on a register and actioned in a timely way. There was a register on the healthcare governance workbook. Relevant alerts were discussed at the practice meeting where it was a standing agenda item. At the time of the inspection, the actions were recorded as ‘not applicable.’ We discussed the need for more detail to be added and this was done on the inspection day.

Are services effective?

We rated the practice as good for providing effective services.

Effective needs assessment, care, and treatment

The clinical meetings were the main forum to discuss any new developments in clinical care including the National Institute for Health and Care Excellence (NICE) and the Scottish Intercollegiate Guidelines Network, clinical pathways, current legislation, standards and other best practice guidance (BPG). In addition, developments in clinical care were issued to the team via the Defence Primary Healthcare (DPHC) updates. Relevant departmental clinical updates were also shared and discussed at the Primary Care Rehabilitation Facility (PCRF) meetings and nurses 'meetings. Furthermore, clinical staff told us that continuing professional development (CPD) provided the opportunity to consider developments in primary healthcare.

Our review of PCRF patient records confirmed the physiotherapists used the Musculoskeletal Health Questionnaire (MSK-HQ). The MSK-HQ is the standardised outcome measure for patients to report their symptoms and quality of life. The MSK-HQ was used at the initial appointment and on discharge of the patient. The use of the MSK-HQ was clinically coded via the DMICP (electronic patient record system) template.

Patients accessed rehabilitation exercise programmes through Rehab Guru (software for rehabilitation exercise therapy). Our review of PCRF patient records confirmed a holistic approach was undertaken including an assessment of lifestyle, such as diet, sleep and smoking habits. Group based therapy sessions were planned and delivered by the exercise rehabilitation instructor (ERI) for patients in the rehabilitation troop.

Through a review of clinical records and discussions with the doctors, we were assured that the care of patients with a mental illness or depressive symptoms was being effectively and safely managed, often in conjunction with the Department of Community Mental Health (DCMH). Patients initiated Step 1, self-directed work for patients via the Defence Gateway and the 'My Healthcare Hub'. Followed by step 2 on the 'Silvercloud' platform (on-line). The practice used this to manage their patients. A consistent clinical code was used in patients' notes to avoid duplication or error.

The practice had just started running a specific service, called Royal Navy Medical Board of Survey TRIG, this was an intervention for those approaching medical board (a medical board is a panel of medical professionals who evaluate a service members physical and mental health to determine their fitness for duty) and potential medical discharge. This was implemented as the doctors saw patients were very stressed whilst waiting for their board, this was aimed at patients without underlying mental health illness, and it helped them in managing uncertainty and dealing with change. DCMH at Drake Medical Practice also undertook face to face video calls for patients. There were good links in place with the regional psychiatrist.

Monitoring care and treatment

The numbers of patients with chronic disease was low. We reviewed the delivery of care for known patients, registered at the practice, with a chronic condition including asthma, diabetes and high blood pressure. Our review of a range of patient records showed these patients were recalled and monitored in a timely way appropriate to their needs. Both nurses had chronic disease monitoring experience although currently neither had received formal training nor attended annual updates for chronic disease monitoring.

There was 1 patient on the diabetic register. For this patient, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. The last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.

There were 17 patients recorded as having high blood pressure. All had a record of their blood pressure taken in the past 9 months. Eleven patients had a blood pressure reading of 150/90 or less.

There were 3 patients with a diagnosis of asthma. All had received an asthma review in the preceding 12 months which is in line with best practice.

Hearing Conservation searches showed 71% of patients were in date for a hearing check, recalls were in place and patients were being managed in line with DPHC policy. Over 40 health checks were completed opportunistically or by direct patient request.

A range of quality assessment and improvement work was undertaken by the practice and PCRF team. There was an audit calendar which was monitored as part of the meeting rotation with clinicians all encouraged to contribute to the audit process. We discussed with the nurses on the day that for clinical chronic disease audits the use of the Quality Outcomes Framework 2025-26 criteria was required to ensure that they are monitoring their practice against current best practice.

Examples of recent audits undertaken included;

- Depression, this highlighted the documentation of symptoms, it showed variability between practice, but clinicians' notes were good.
- A gout audit was regularly repeated and showed improvement between 2023 and 2025, their learning as a practice was on improving the information given to patients around the management of gout to support better compliance with treatment.
- A recent asthma audit from January 2025 showed 100% compliance with the standards for their 3 patients. From this audit they looked at education for staff on the diagnostic tests needed and for the passive smoking questionnaire to continue and to be discussed as part of asthma reviews.
- A notes audit was conducted annually, this highlighted that staff were not Read coding consistently, the CSMO worked with the individual to support them to improve.
- Chaperone/consent audit -the outcome was good but it found that patients' notes could have been coded better. Staff were supported to improve this.
- Firearms audit showed good compliance with standards.

Within the PCRF, additional audits had been undertaken to assess compliance with referral timelines in line with BPGs. We looked at a sample of patients notes; they lacked sufficient detail with minimal assessment recorded. We discussed this with staff and they agreed to introduce improvements. Following the inspection they had introduced an action plan, with clear actions and timeframes for improvement. These included lessons learnt feedback, notes re-audit and education sessions together with spot checks.

Other examples of quality improvement activity for the PCRF included minor changes that had been made to the structure of the rehabilitation troop, this was going to be audited once these changes had been implemented. An ERI had arranged for the rehabilitation troop to compete in some adaptive games to promote the social wellbeing of those under longer term rehabilitation.

Effective staffing

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

Mandatory training was recorded on the healthcare governance workbook which captured internal and external training. At the time of the inspection, the log showed good compliance across the staff group for mandatory training. 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. Staff with lead roles had completed the necessary training for the role, for example the practice manager was Institute of Occupational Safety and Health trained, the deputy practice manager was attending the Joint Practice Managers course in November 2025 and 2 nurses had received the training for infection, prevention and control. Another nurse was trained in travel health, one physiotherapist had commenced a non-medical prescribing course and another had commenced a hand therapy course. The doctors had considerable experience in different fields; for example, non-freezing cold injuries, occupational diving medicine and sports and exercise medicine.

General Duties Medical Officers (GDMOs) had frequent dedicated supervised time with their supervisor. The GDMOs felt well supported and said that that the practice supported them in meeting their portfolio requirements and with the challenges of their changeable timetable.

The CSMO completed CPD webinars and encouraged the locums to as well so that they could understand more about military practice. The CSMO was also keen to explore whether they could become a training practice, perhaps considering a split rotation with an NHS practice.

The Regimental Medical Officer confirmed that the medics were well supported, although the infrastructure challenges prevented them doing more in the practice. This was challenging as they needed to do enough clinical time for their development plus to

achieve the force generation required in the unit. At present they did some afternoon/evening clinics to achieve this.

The medics were supported by the nurses with conducting vaccination clinics. They had received vaccination training and maintained clinical competency through supervision with the nurses. The medics also facilitated the total triage clinics. The PCRF team maintained a register of clinical supervision, peer review and case discussions.

Coordinating care and treatment

The practice had strong relationships with the station Commanding Officers and squadron/unit commanders, so concerns about the health and wellbeing of patients was promptly addressed. The practice had implemented a number of quality improvement initiatives that the CSMO oversaw, but all staff were encouraged to contribute to it. The key themes were safeguarding and domestic violence. The CSMO felt strongly that there was inequity of provision compared to NHS, and that this was particularly important to their patient population and therefore wanted to be prepared and integrated fully with family and local services. The CSMO had strong links with the welfare officers and they sent updates to the station Facebook page so that the families could see services that were available to them. There were established strong links with local domestic violence services.

To ensure continuity of care for patients undergoing rehabilitation, follow-up was routinely undertaken with the same clinician. There was a weekly multi-disciplinary meeting held in the practice for all clinical staff. The PCRF also had a fortnightly virtual meeting with the Multidisciplinary Injury Assessment Clinic (MIAC) team to discuss any cases which needed advice or referral.

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through DMICP. This included care and risk assessments, care plans, medical records and investigation and test results. Information was shared between services, with patients' consent, using a shared care record.

We spoke with 2 members of the welfare team who described how the practice worked well together to effectively support patients.

The practice had developed a robust leaving medical process where all personnel leaving service were given a detailed booklet which helped them understand how their care would be delivered in the NHS and links into the charity sector for veterans. Furthermore, patients were advised about the Armed Forces Covenant, which was a guarantee that those who have served in the armed forces were treated with fairness and respect.

Helping patients to live healthier lives

The nurses were the leads for health promotion and the medics deputised. The practice followed the NHS health promotion programme so health topics were refreshed regularly. There was a wide variety of thoughtful health promotion materials displayed. Information was readily available about how to undertake strength and condition exercises safely.

The CSMO was the sexual health lead, and was sexual health trained (known as STIF), 1 of the nurses was also STIF trained and delivered education to the squadrons. Patients were also signposted and could self-refer to local NHS sexual health services.

Cervical screening was managed and provided by the practice if the military nurse was not deployed. If needed patients were signposted to another military practice or the local NHS clinic. Monthly searches were carried out to identify patients eligible for the national screening programmes. Patients were sent 3 invitations for cytology screening. If there was no response, then the nurse followed up with the patient to encourage them to engage with the screening programme.

The number of women who had a cervical smear in the last 3-5 years was 89% of the eligible population. The NHS target was 80%.

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

- AAA – 0 eligible.
- Bowel – 31 eligible, 74% had been screened.
- Breast – 1 eligible who had been screened.

Newly registered patients' due vaccines were captured as part of the new joiners notes summarising. Statistics were as follows:

- 94% of patients were in-date for vaccination against diphtheria.
- 94% of patients were in-date for vaccination against polio.
- 98% of patients were in-date for vaccination against hepatitis B.
- 97% of patients were in-date for vaccination against hepatitis A.
- 94% of patients were in-date for vaccination against tetanus.
- 100% of patients were in-date for vaccination against MMR.
- 98% of patients were in-date for vaccination against meningitis.

Consent to care and treatment

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. A review of patient notes evidenced that verbal consent was recorded and coded appropriately on DMICP. Clinicians advised us that implied consent was accepted for basic procedures. Verbal consent was taken was taken for more intimate examinations and recorded on the patients' health record. A chaperone and consent audit were completed annually. Clinicians understood the Mental Capacity Act (2005) and how it would apply to the patient population.

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

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect, and compassion

In advance of the inspection, patient feedback cards were sent to the practice, feedback was from patients that had been seen by the Primary Care Rehabilitation Facility (PCRF), and the practice staff. A total of 42 patients responded and feedback was positive including comments about the good level of care received and kindness of staff.

We were given some examples whereby clinicians went over and above to ensure patients were well cared for. For example, an overseas soldier who had gone home unwell with poor mental health, there was limited help available to them at home. The practice helped to coordinate the care despite the time zone difference and issues with connectivity. They managed to get Defence Community Mental Health (DCMH) overseas psychologist to engage with them, good support, was given by all including the practice, the unit and the welfare officer. Eventually they returned to the UK where they went to a new unit, the practice made sure there was a comprehensive handover of care and the soldier is now doing well.

If nurses were concerned about an unwell patient that lived in single living accommodation, both nurses, with prior consent from the patient, visited them in their accommodation together to check on their wellbeing.

The practice provided extended appointments to a patient who had increasing anxiety about their current health issue. They gave time, reassurance, understanding and education to the patient, since then the patient had returned return to full health and if passing the practice, they always called in to chat as they appreciated the care they had received.

The last patient survey showed 52 patients had provided responses through the Defence Primary Healthcare (DPHC) Patient Experience Questionnaire. The responses were positive with 98% confirming they were treated with kindness and compassion. Two people did not respond to this question.

Involvement in decisions about care and treatment

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

Feedback indicated patients were involved with planning their care and this was confirmed by our review of patient records. A translation service was available for patients who did

not have English as a first language and information was displayed for patients about how to access the service.

Privacy and dignity

Patient consultations/assessments took place in clinical rooms with the door closed. Regularly changed disposable privacy curtains were available in all clinical rooms for intimate examinations. The reception area was situated at a distance from the reception meaning that conversations between patients and reception would unlikely be overheard.

There was no dedicated room for patients if they wanted to talk confidentially due to lack of space. However, the practice manager and deputy practice manager both said they would happily give up their office if needed.

The practice team consisted of both male and female clinicians so patients could request a clinician of a specific gender.

Are services responsive to people's needs?

We rated the practice as good for providing responsive services.

Responding to and meeting people's needs

The practice team were acutely aware of the schedule of activities of the troops and their ongoing needs and requirements. Careful planning provided the patients with an improved journey and enhanced service when needed. Mass vaccination clinics were put in place to support deployments as the unit was held at extremely high readiness to deploy. Patient feedback identified the need for more afternoon appointments which the practice had facilitated.

The practice has a range of appointments available including acute, occupational and routine, they could offer longer appointments for vulnerable patients as needed. The Regimental Medical Officers could do dive medical appointments. The MOD GP ran a cold injury clinic.

An Equality Access Audit as defined in the Equality Act 2010 was completed in November 2024. Any points identified were discussed and put onto the issues register.

Issued by the Defence Medical Services Regulator in April 2024, we asked about the Regulatory Instruction, 'Training for staff in learning disability and autism' and how it was being implemented. The practice was unaware of this requirement as it was not currently mandated training. However, the practice immediately added this to the training calendar for the day after the inspection and identified appropriate training material during the inspection. We received confirmation following the inspection that group training was held and staff would now complete further individual training.

Clinicians had experience of providing support for patients in the initial stages of gender transition and followed the standard operating procedure in relation to the management of transgender personnel in the military.

Timely access to care and treatment

The practice had a flexible approach to the management of appointments to meet patients' needs. There was a daily walk-in clinic, referred to as 'fresh cases', available for urgent appointments. Telephone and appointments by eConsult were also available.

Direct Access Physio (known as DAP) had just been introduced which meant patients could self-refer. Routine physiotherapy appointments were available within 11 days and follow up appointments within 5 days. To see an exercise rehabilitation instructor (ERI), a new patient appointment was available within 2 days and for a follow up appointment there was no wait. Urgent physiotherapy appointments were available within 2 days. There was always availability at the rehabilitation classes. The waiting time for the Multidisciplinary Injury Assessment Clinic was 5 weeks. Routine appointments with a doctor or nurse could be facilitated the same day.

Listening and learning from concerns and complaints

The practice manager was the lead who handled all complaints. Complaints were managed in accordance with Defence Primary Healthcare policy complaints policy and local procedure. There had been no complaints raised in the last 12 months. Both verbal and written complaints would be logged onto a register and monitored.

Are services well-led?

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

Vision and strategy

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

The practice worked to the Defence Primary Healthcare (DPHC) mission statement. They also worked to their own vision and mission statement.

The practice Vision was to enhance the health, well-being and lives of those we care for; provide a safe and fulfilling working environment.

The practice's mission statement was

Chivenor Medical Centre is committed to providing our patients the highest standard of care through our patient driven, holistic approach and the provision of convenient and continuous access to a well-trained and highly motivated primary healthcare team, in a safe, responsive and caring manner.

The practice team worked closely with Regional Headquarters regarding the possible uplift in patient population scheduled over the next 18 months. Concerns were ongoing about staffing levels and the infrastructure should there be an increase in the patient population. Close collaboration with the host unit allowed for changes and forward planning to minimise any impact on patients and service delivery. The Primary Care Rehabilitation Facility (PCRF) felt well integrated into the practice team, they said they were well supported by the whole leadership team and were flexible in managing a very deployable population.

There was evidence during the inspection of a very holistic approach to patient care. Staff had developed close links with local services due to the needs of the population. Of note, their links with the local orthopaedic services was of great benefit to patients, ensuring faster access and more appropriate treatment pathways. As part of their vision and strategy the practice was currently working to increase their skillset in caring for perpetrators of domestic violence due to the fact that the military population was more likely to be at risk of this, linking in with local services and arranging training for the staff.

The Civilian Senior Medical Officer (CSMO) had recognised the benefit of providing enhanced muscular skeletal services having previously delivered these services. A business case had been developed to deliver this from Chivenor therefore saving the patient the time travelling to Plymouth Regional Rehabilitation Unit. This opportunity had not yet been supported by Defence Medical Services. Whilst this would not be standard in most practices, with the high muscular skeletal injury rate at Chivenor, the high readiness and the long travel time, this enhanced service would benefit patients.

To address environmental sustainability, the practice aimed to reduce the use of paper by communicating via email and the use of links rather than producing paper booklets. Staff were vigilant with switching off lights, closing windows and the use of heating. Recycling bins were positioned around the building.

Leadership, capacity, and capability

There was clear leadership and the capacity and capability to deliver a safe service. The CSMO had considerable experience in DPHC plus their work locally in the NHS meant they were well placed to lead the practice and to develop strong ties to the local services to the benefit of the patients giving both continuity and resilience. The mix of civil servants throughout the staff group minimised the impact of military staff changing at regular intervals. Both practice manager posts were non-deployable for routine scheduled deployments. They were subject to short notice trawls but it was unlikely they would both be selected to go at the same time. The Regimental Medical Officers (RMO) were usually assigned for 3-year drafts, although this was not always the case and could cause some challenges when they were drafted at short notice. Recent integration and training of General Duties Medical Officers had reduced the challenge of the RMOs deploying/posting. The rest of the team were also experienced and could help cover key roles during absences. All staff reported feeling included within the practice and their input valued by their line managers and wider leadership team.

The leadership team described effective support from Regional Clinal Director (RCD) including support with staff vacancies. We were told this could be further developed by linking in and further developing relationships to ensure contextual understanding of the practice itself. The regional area manager was supportive and visited termly especially to support the civilian staff.

Culture

There was a positive culture throughout the practice. The CSMO reported fostering an inclusive environment, they led with flexibility and approachability. They did not have a formal whitespace policy in the practice but was able to give staff flexibility in the workplace to cope with the many demands of life. The CSMO and MOD GP job shared for the clinical element of the role, they both felt that this worked well, they had different skillsets which complemented each other.

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. All staff attended the practice meetings where they could put forward suggestions or raise concerns. All staff we spoke with told us that it was a happy place to work and that they could rely on each other, they felt able to openly raise and discuss any concerns they faced. Staff felt respected, supported and valued at the practice with staff regularly thanked for their hard work at the end of the day and staff were thanked openly in meetings.

Morale among staff in the PCRF was high with individuals enjoying being in work and feeling positive about their teams. All staff spoke well of their line managers and the support they provided.

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

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

Governance arrangements

Communication was strong across all departments. There was a healthcare governance workbook in place for monitoring governance activity.

A clear reporting structure was in place and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. Terms of reference for staff were up-to-date and reflected the responsibilities of individuals. The PCRF governance functions were integrated into the main practice to include the risk register, audit and ASER log.

There was evidence of quality improvement activity to monitor the outcomes and outputs of clinical and administrative practice. There was an audit lead and results were presented and discussed with staff at the practice meetings.

Formal and informal communication channels were established, including regular structured meetings. Practice and healthcare governance meetings were held monthly. They had multi-disciplinary coffee breaks each morning which allowed staff to gather and support each other. Regimental staff were welcomed and integrated into the team.

Managing risks, issues, and performance

An effective process to identify, understand, monitor and address current and future risks including risks to patient safety was in place. Risks were actively monitored and managed in line with DPHC policy and through the ongoing review and revision of a risk register. Risks were escalated as appropriate to DPHC and beyond. The main risks identified at the time of inspection were:

- Deployments
- Lack of time for supervision and peer-to-peer support
- Other Commitments (Readiness & Unit Commitments)
- Risk of burnout

- Infrastructure
    - Not fit for purpose treatment room
    - Not fit for purpose audio room
    - No panic alarm system
    - Not fit for purpose rehabilitation gym
    - No privacy room
- Talk of increasing of the population at risk but not yet reassured that physiotherapy or exercise rehabilitation instructors (ERI) staffing numbers would increase, or infrastructure and equipment would change.

Processes were in place to monitor national and local safety alerts, incidents, and complaints.

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

An internal assurance review (IAR) was undertaken in December 2024 and the rating was 'substantial assurance' in the safe, responsive and well led domains and 'full assurance' in the effective and caring domains. A number of improvement points were identified and a detailed action plan developed. Many of the actions had been completed and the action plan was reviewed at governance meetings.

The Healthcare Assurance Framework (HAF) was the internal system used by the practice as a development tool and to monitor performance. Staff contributed to the HAF and, where their role required, had dedicated management time for this activity. The HAF was fully populated and had 141 actions on the management action plan of which 138 had been completed. These included self-assessment actions and some from the last IAR.

Appropriate and accurate information

There were arrangements at the practice in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

The Caldicott Principles, guidelines for the management of patient identifiable information were followed. The practice manager was the Caldicott guardian responsible for ensuring that all information about patients was kept confidential and only shared when necessary. Checks were carried out each month to ensure records were not being accessed inappropriately. Any concerns identified were promptly addressed.

Engagement with patients, the public, staff and external partners

Options were available for patients to provide feedback on the service including QR codes throughout the practice and an iPad in the waiting area that patients could use to give

direct feedback. Some examples of changes made following patient feedback included the introduction of further afternoon clinics.

The CSMO worked in the local NHS and as a result has made noteworthy progress with integrating them into the local services. Examples of this included access to an IAPT practitioner who saw patients face to face. Fast access to orthopaedic services who, having now understood more about the military context and role, tailored their treatment pathway for the patients and links with the local safeguarding services.

Links with Improving Access to Psychological Therapies (IAPT) were good including the IAPT practitioner attending the carers forum, with patients having faster access to services without the risk often associated with delayed outsourced mental health care. Training and education on sexual health was also noted to be required for this population and the practice had linked in with the units to provide education and support.

Continuous improvement and innovation

The team was committed to continually improving the service. Examples included:

- Screening for Strongliodes, (a parasitic roundworm that infects people. It could cause stomach-aches, diarrhoea, and rashes). The civilian doctor worked closely with the Liverpool School of Tropical Medicine. This disease was particularly relevant to the patient population and without treatment could have a real impact on the long-term health of patients.
- Domestic Violence training was planned; ‘Care of the Perpetrator’ domestic violence training was planned to be delivered by an external organisation.
- Engagement with local orthopaedic services including visiting with an ERI to demonstrate the kit the royal marine soldiers needed to carry, this has resulted in faster access for patients and more appropriate treatment pathways, returning them to fitness more quickly.
- Local safeguarding contacts including a visit to the Multi Agency Safeguarding Hub and access to their training/meetings.
- The implementation of Royal Navy Medical Board of Survey TRIG, an intervention for those approaching medical board.