Shorncliffe Medical Centre

Sir John Moore Barracks, Shorncliffe, Folkstone, Kent, CT20 3HF

Defence Medical Services inspection report

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

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

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Summary

About this inspection

We carried out an announced comprehensive inspection of Shorncliffe Medical Centre on 8 October 2024.

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

Are services safe? – good

Are services effective? – good

Are services caring – good

Are services responsive to people's needs? – good

Are services well-led? – good

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

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

At this inspection we found:

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

- Governance systems underpinning the safe running of the practice were up-to-date. The risk register was not configured in line with organisational expectations. Standard operating procedures for the Primary Care Rehabilitation Facility were underdeveloped.
- Not all non-patient related incidents were reported through ASER, organisational-wide system for reporting significant events.
- Evidence of appropriate recruitment and completion of mandated training was in place for all staff. The induction programme would benefit from a review to ensure the role specific element is sufficient.
- Medicines and medical products were well managed.
- There was a culture of improving the service through clinical audit. All mandated audits had been completed.
- Appropriate measures were in place to minimise the risk of infection. Infection prevention and control audits were undertaken. It was unclear how effective the deep clean programme was.

The Chief Inspector recommends to Defence Primary Healthcare (DPHC):

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

The Chief Inspector recommends to the practice:

- Review the induction programmes for permanent and locum staff to ensure the role-specific induction is adequate for new starters.
- Review the risk register so it is streamlined and configured in accordance with DPHC policy.
- Implement the direct access physiotherapy service so accessibility is enhanced for patients.
- Ensure the control solution for the blood glucose monitor has the expiry date endorsed and the reference values are the same as those recorded on the box.
- Ensure the emergency alarm system is regularly tested to ensure it is in working order.
- To support with the identification of themes, all incidents and events that meet the ASER reporting criteria should be managed in line with DPHC policy.
- Develop standard operating procedures for the PCRF.
- Ensure training in learning disability and autism is provided in accordance with the DSMR regulatory instruction issued in April 2024.
- Confirm the arrangements for regular deep cleaning of the premises.

Dr Chris Dzikiti

Interim Chief Inspector of Healthcare

Our inspection team

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

Background to Shorncliffe Medical Centre

Located in Folkestone, Shorncliffe Medical Centre occupies the ground floor of a building shared with the dental centre. The practice is part of the Kent Medical Centre Network (referred to as 'the Network' throughout the report) along with Chatham and Maidstone Invicta Park medical centres.

The practice provides a routine primary care, occupational health and rehabilitation service to a patient population of approximately 663. The practice also offers travel advice, vaccination clinics, audiometry, cervical screening and health checks. A dispensary is available at the practice and the PCRF is located in a separate building in the barracks.

The practice is open from 08:00 to 16:30 hours Monday, Wednesday and Thursday and from 08:00 to 12:30 hours on Tuesday and Friday. The dispensary opening times were displayed at the practice and in the practice leaflet.

Pirbright Combined Medical Practice provides medical cover from 16:30 to 18:30 hours. From 18:30 midweek, weekends and public holidays patients can access NHS 111.

The staff team

Senior Medical Officer	One part-time civilian – 18.5 hours
Civilian medical practitioners	Position vacant and covered by 2 locums - both work 12 hours each week.
Regimental Aid Posts (RAP)[1]	One Regimental Medical Officer - 40% of their time spent working at the practice. RAP nurse Medical Sergeant Six Combat Medical Technicians (medics)[2]
Practice nurses	Two civilian - 1 Band 5 on extended leave; 1 Band 6 part-time Healthcare assistant - full time
PCRF	Physiotherapist - part-time Exercise rehabilitation instructor - full time
Practice management and administration	Practice manager - part time Three administrators – 1 x full time; 2 x part-time (1 based in the PCRF)
Dispensary	Civilian pharmacy technician - full time

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

[2]A medic is a unique role in the forces 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

The Senior Medical Officer (SMO) and the Band 6 nurse were the safeguarding leads for the practice. Reviewed in July 2024 and accessible to staff, the safeguarding standard operating procedure (SOP) referenced adults and children and included contact details for the local safeguarding teams. All staff were in-date for safeguarding training at a level appropriate to their role.

Vulnerable patients were identified through the patient registration process, summarisation of patient records and through identification from the welfare team. A clinical code and alert were applied to individual DMICP (electronic patient record system) records to ensure the small number of patients recognised as vulnerable were readily identified. Regular DMICP searches were undertaken to identify vulnerable patients for review at the multi-disciplinary team meetings. The Regimental Medical Officer (RMO) attended the Commander's Monthly Case Review meetings (previously the Unit Health Committee meetings) at which the needs of vulnerable patients were reviewed. There were no patients under the age of 18 registered at the practice.

The chaperone SOP was reviewed in October 2023 and the availability of a chaperone was displayed on clinic room doors and in the patient waiting area. Training was facilitated by the SMO in February 2024 with follow up chaperone training planned for October 2024 to include staff from other practices within the Network.

Although the full range of recruitment records for permanent staff was held centrally, the practice manager demonstrated that relevant safety checks had taken place at the point of recruitment, including a Disclosure and Barring Service (DBS) check to ensure staff were suitable to work with vulnerable adults and young people. One of the staff was awaiting an up-to-date DBS check and, as an interim measure, a risk assessment had been completed and signed by the Regional Clinical Director (RCD). DBS checks were renewed in accordance with Defence Primary Healthcare (DPHC) policy. Recruitment documentation was in place for locum staff working at the practice.

The infection prevention and control (IPC) SOP was reviewed in August 2024. The Band 6 nurse was the lead for IPC and the healthcare assistant (HCA) deputised. An action plan was in place from the last annual medical centre IPC audit (February 2024); 3 actions were outstanding. The IPC audit for the Primary Care Rehabilitation Facility (PCRF) was completed by the PCRF administrator. As they had not completed the IPC link practitioner training, we highlighted that it would be beneficial if the IPC lead had input into and oversight of this audit. IPC was a standing agenda item at practice meetings.

An environmental cleaning schedule was in place and was monitored by the practice manager in conjunction with the contract manager. The cleaning audit completed in May 2024 indicated a compliance of 94%. The deep cleaning log showed deep cleaning took

place between April and December 2023. However, the 2024 schedule was blank so it was unclear if deep cleaning had taken place this year. The practice manager advised that it was a challenge securing a comprehensive deep cleaning for the facility.

The gym used by the PCRF team was carpeted throughout. This was identified on the risk register as an IPC risk and had been escalated to the RCD. The flooring was due to be replaced within the current financial year.

A lead and deputy were identified for the management of clinical waste. A clinical waste log and consignment notes were in place and up-to-date. The co-located dental centre handed its clinical waste to the medical centre and transfer notes were completed. The most recent pre-acceptance audit, quarterly return and summary report were all in place. Sharps boxes were labelled, dated and disposed of appropriately. Clinical waste was stored securely outside of the building.

Risks to patients

Staffing levels were a standing agenda item at practice meetings so were routinely monitored. Although staff indicated allocated levels were appropriate to the service, we identified that available clinical staff hours coupled with vacancies was having an impact. For example, the SMO's hours (18.5 hours per week) were insufficient to fulfil the full range of activities required of an SMO. At the time of the inspection, the SMO was focussing their work hours on direct clinical care and undertaking managerial/administrative activities in their own time. A new civilian medical practitioner had been recruited almost a year ago. They were in the process of onboarding with the aim to start in January 2025. Furthermore, one of the nurses was on extended leave and the practice had not had success with recruiting a locum nurse.

The physiotherapist identified administrative gaps as the main challenge for the PCRF as the administrator worked term-time only. PCRF clinicians managed the administrative activities, queries and appointment booking when the administrator was on leave. The medical centre had supported the PCRF in this area depending on availability of other administrators. Clinicians said they had the option to reach into the Network if they needed support from other practices.

An SOP was in place for management of the medical emergency trolley, which was checked each week. Emergency medicines were checked monthly or if the trolley had been opened/used and they were compliant with the DPHC SOP. All medicines and emergency equipment were in-date. Medical gases were at sufficient capacity and stored correctly. Signage on the gases storeroom was not correct and the pharmacy technician rectified this on the day of the inspection. The control solution for blood glucose monitor did not have the expiry date endorsed and the reference values were different to that recorded on the box.

An automated external defibrillator (AED) was held in the main corridor of the PCRF gym so was easily accessible. Either the physiotherapist or exercise rehabilitation instructor (ERI) checked it each day. The physiotherapist had considered the action to take should a medical emergency occur in the PCRF. Although they said they were confident in

managing an emergency situation, a scenario-based PCRF training session had not been held. This had been identified as a future training need. The SOP for medical emergencies was in the process of being updated and the ERI had developed a document and flow chart that covered all the main points; it was awaiting a full team check before finalisation. The physical training instructors based in the gym were qualified in first aid.

The SMO was the lead for medical emergencies. The staff team was up-to-date with basic life support training, anaphylaxis and the use of an AED. Scenario-based or moulage training had been sporadic and the last session in 2023 was in relation to managing heat injury. The practice manager reported that plans were in place to implement Network-wide moulage training. Often administrative staff are the first point of contact for patients and not all non-clinical staff we spoke with were familiar with the symptoms of sepsis. We were advised that training in recognising the deteriorating patient/sepsis was scheduled for November 2024 and all staff would be expected to attend the training. Sepsis information was in displayed in various areas of the building. The staff team received thermal injury training in June 2023.

Information to deliver safe care and treatment

Staff reported minimal concerns with DMICP outages, aside from a 2 week outage whereby staff moved to another medical centre within the Network. During both planned and unplanned outages the practice initiated the business continuity plan. Clinic lists were routinely printed for the following day so patients could be contacted in the event of an outage. Hard copy consultation forms were available for use during these incidents and records scanned onto the system at a later point. The PCRF experienced a couple of power outages recently and staff had worked from the medical centre and also conducted telephone appointments from home.

The summarisation SOP was reviewed in August 2024 and the nurses primarily summarised records. A search during the inspection showed 78% of records were in-date for summarisation. The Band 6 nurse was the lead for summarisation and, in the absence of the Band 5 nurse, they planned to train the HCA to assist with the process.

Arrangements were in place for the auditing of consultation records for each clinician. The Band 6 nurse audited the records for the nursing team. The SMO audited the records of the doctors and also their own records. We discussed with the SMO repeating the audit in 3 months and sourcing a doctor within the Network to undertake the audit to ensure objectivity. The RMO reviewed clinical records maintained by the medics. The physiotherapist and ERI conducted joint appointments and had completed a record keeping audit of each other’s notes.

The HCA 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). An electronic specimen register was maintained. The nursing team checked daily for results received and scheduled an appointment for the patient if required. The SMO also checked all results each day.

An effective system was in place for managing both internal and external referrals including urgent 2-week-wait referrals. A lead and deputy were identified for managing referrals. The practice had transitioned to the new DPHC centralised process for referral management. This provided a variety of functions to support the monitoring of referrals, including an alert to prompt follow-up and the ability to transfer details of the referral if the patient moved to another practice. The administrator reviewed the referrals each week, updated the register accordingly and followed up on outstanding letters.

For referrals made by the PCRF, a plan was in place to add referrals to the existing PCRF tracker (currently captured the referral date, injury causation, and the date of the move to reconditioning) to provide a more formal tracker. Referrals were managed by the physiotherapist who regularly checked if appointments had been received. Patients informed the physiotherapist when they received an appointment so a 'safety netting' review appointment could be set up immediately after. We considered the 'safety netting' and caseload reviews a safe system and the addition to the tracker will strengthen the process.

Safe and appropriate use of medicines

The SMO was the lead for medicines management. The pharmacy technician (PT) deputised and was responsible for the day-to-day operation of the dispensary. Both the lead and deputy had terms of reference for these key roles.

An older version bound book (BMed 12) was used to record movement of prescriptions. We highlighted during the inspection that the date for receipt of prescriptions and signature of the person receiving the prescriptions were required to be recorded. In addition, the date of supply should be recorded. These issues were rectified during the inspection.

Controlled drugs (medicines with a potential for misuse) were stored securely. Access to these drugs was captured in an SOP. An exemption from the local constabulary was in place as the controlled drugs (CD) cabinet was not being compliant with the Misuse of Drugs (Safe Custody) Regulations 1973. The stock and documentation was correct and accurate. The specimen signature log had been completed accurately by all involved in the accounting of these medicines. The SMO had delegated authority for CDs from the Commanding Officer of the barracks and the SMO had delegated this authority to the PT. Records showed internal monthly CD checks and quarterly external checks were administered correctly. The annual self-declaration was due to be completed. An audit of CDs was completed in September 2024.

The PT and nurses were responsible for ordering vaccines and our check of these showed all were in-date. The medicines fridge was locked and was an adequate size to hold the stock required. Vaccines were appropriately stored in the fridge away from the walls and with adequate airflow. Stock was in-date and vaccines with the shortest expiry date was at the front of the fridge. Fridge temperatures were correctly monitored and were in range. The nurses had completed vaccination training. We noted that the thermometers for checking ambient temperatures were out-of-date. The PT ordered replacement thermometers during the inspection.

Even though a very low number of patients were prescribed a high risk medicine (HRM), regular searches were undertaken and a register maintained. One patient was prescribed a 'red drug' by the hospital and this was correctly recorded and managed. No patients were prescribed a HRM that required monitoring at the practice, other than patients who were monitored through the chronic disease management process. A HRM audit was completed in July 2024. Its main issue identified clinical coding was not always applied correctly. An action plan was developed following the audit and was discussed with the staff team.

There were no non-medical prescribers at the practice. Patient Group Directions (PGD) for nurses to administer medicines in line with legislation were used. PGD training was current and PGDs had been signed off by the SMO. Appropriate PGD templates were used. Patient Specific Directions were not used at the practice.

Requests for repeat prescriptions were handled via the group mailbox or presentation of the report section of the prescription. There were 92 patients receiving repeat prescriptions; 63 had been reviewed. The 29 not reviewed were due to legacy prescribing. Twelve patients were prescribed 4 or more repeat medicines and 10 had been reviewed. Information was provided with each prescription and we observed patients being verbally counselled about their medicine before it was issued.

Correspondence related to the prescribing of medicines from other health services and secondary care was scanned to the patient's records and the doctor tasked to review the information. On the day of the inspection, the PT put a local working policy in place to capture this arrangement.

The PT had recently started carrying out monthly searches for patients prescribed valproate (medicine to treat epilepsy and bipolar disorder). At the time of the inspection, no patients were prescribed this medicine. On an ad hoc basis, the SMO undertook an audit of repeat medication prescribing and planned to formalise this review in the coming months. The regional pharmacist was undertaking a region-wide review of prescribing and the outcome of the review was expected in December 2024.

Track record on safety

The practice manager and administrator were the leads for risk management and health and safety (referred to as SHEF). The practice risk register did not use the DPHC '4 T's process' (transfer, tolerate, treat, terminate) to illustrate at what level risks were being managed. We discussed with the practice manager sourcing support/guidance to ensure both the risk and issues registers are reviewed and configured in line with DPHC policy.

A range of regularly reviewed clinical and non-clinical risk assessments was in place for the practice and PCRF, including risk assessments for substances hazardous to health (referred to as COSHH). The ERI oversaw risk assessments for the PCRF and discussed any clinical areas with the wider team when the assessments were reviewed.

The practice provided a SHEF quarterly return for the camp 'Army Safety Group'. Either the practice manager or the administrator represented the practice at the camp-wide

health and safety meetings. Minutes showed that risk and SHEF were standing agenda items at the practice healthcare governance meetings.

Processes were in place and up-to-date for the checking of electrics and portable electrical appliances. Evidence was in place to confirm the legionella risk assessment was reviewed in December 2023 and that water outlets were flushed each week. Although the practice was not provided with the outcome of the checks, we were advised that the contractor tested the water temperatures each week.

An equipment inspection (referred to as a LEA) was undertaken in September 2024 and the practice was awaiting the report. Pre-user equipment checks (referred to as 373s) were routinely undertaken. Although the practice manager was overall responsible for equipment, the physiotherapist oversaw equipment and checks for the clinical room and the ERI managed the gym equipment. The PCRF administrator coordinated the equipment forecasting and managed the servicing dates. All PCRF equipment was in-date for servicing. Equipment was cleaned weekly by PCRF staff and by patients after use.

Gym staff carried out wet globe bulb testing (WGBT) to indicate the potential for heat stress. The practice and/or PCRF were made aware of WGBT readings and disseminated this information to PCRF staff. Work/rest ratios were followed in accordance with the policy displayed in the gym.

The fire risk assessment for the premises was completed in June 2023 and was valid for 5 years. Weekly and monthly checks of the fire alarm system and firefighting equipment were up-to-date. Fire evacuation drills had been completed in the last 12 months for both the medical centre and PCRF. The medics held the role of building custodian and were the lead for fire safety. We discussed the risk with this, notably that medics are primarily responsible to the unit and may not always be available to complete the required checks. For continuity, we indicated that it would advantageous if one of the DPHC staff was either lead or deputy for fire safety and the building. The dental centre had a nominated building custodian and we discussed with the practice manager whether their role could incorporate the medical centre.

There was an integrated alarm system in the medical centre for staff to alert colleagues in the event of an emergency. We were advised that checks of the alarm system were not undertaken to ensure it was in working order. Records showed the emergency alarm in the PCRF was tested regularly. Although a lone working SOP was in place, we were advised that no lone working took place. Gym staff were always available when PCRF staff were on duty.

Lessons learned and improvements made

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

Prior to February 2024, ASER information recorded was sparce. Since then more structure had been introduced to illustrate the actions taken, recommendations, learning points and date the ASER was closed.

The ASER register indicated 4 events/incidents were recorded in 2024. We queried this low number and the practice manager advised that there had been very few events that met the criteria for reporting through ASER. We were also informed that there was a reluctance within the team to raise ASERs due to blame culture and very little feedback received. We were assured that significant events/incidents related to clinical care or harm (including potential harm) to a patient were always reported. Despite this, the September 2024 healthcare governance meeting showed an ASER was discussed in detail. In addition, staff were reminded at the meeting that ASERs can be raised even if there is no harm to patients as the ASER system is an effective learning tool to identify trends.

The practice received alerts from the Central Alerting System via the regional team. The pharmacy technician checked the alerts each day and recorded on the log the action taken. Alerts were a standing agenda item for discussion at the practice meetings. In the absence of the pharmacy technician, the practice manager checked the alerts.

Are services effective?

We rated the practice as good for providing effective services.

Effective needs assessment, care and treatment

Processes were in place for clinical staff to keep up-to-date with developments in clinical care including National Institute for Health and Care Excellence (NICE) guidance, the Scottish Intercollegiate Guidelines Network clinical pathways, current legislation, standards and other best practice (BCP) practice guidance. Staff were kept informed of clinical and medicines updates through the Defence Primary Healthcare (DPHC) newsletter circulated each month.

BCP guidance, NICE and internal guidance was a standing agenda item at practice meetings. Minutes from August 2024 showed various guidelines/updates were discussed, including atrial fibrillation (irregular heartbeat), epilepsy and cardiovascular disease. In addition, updates were discussed at the Network meetings. Dedicated time was established for clinical case discussions with the option to extend this to the Network and the wider region.

Our review of Primary Care Rehabilitation Facility (PCRF) patient records confirmed an assessment of lifestyle factors including mood, sleep and diet were routinely checked and recorded. The physiotherapist used the Musculoskeletal Health Questionnaire (MSK-HQ) a standardised outcome measure for patients to report their symptoms and quality of life. The use of the MSK-HQ was clinically coded via the DMICP template. It was used at the initial appointment but was not always at the point of discharge. The physiotherapist recognised this needed improving and had discussed it with the team.

The exercise rehabilitation instructor (ERI) used the functional gym-based tests in accordance with BPG. Rehab Guru (software for rehabilitation exercise therapy) was used consistently, other than for very acute injuries when exercise sheets were used to cover basic exercises required at that stage. Staff were aware of the rehabilitation BCP guidance held between SharePoint and the Defence Learning Environment. The PCRF team held a monthly caseload review to discuss the patients.

Although the PCRF was well equipped, a business case had been submitted to secure additional equipment. The previous business case was supported with the requested equipment provided.

Step 1 of the DPHC mental health pathway was delivered at the practice. The Senior Medical Officer (SMO) routinely used ‘stress reaction’ as the initial clinical code and later reviewed the code to ensure the correct diagnosis was captured. The SMO indicated a PHQ-9 (patient health questionnaire to screen for depression) and GAD-7 (to screen for generalised anxiety disorder) were regularly used. These tools supported with risk stratification to determine the level of risk for the patient. Patients who needed intervention beyond step 1 were referred for a Department of Community Mental Health (DCMH). Our

review of clinical records showed patients with a mental health need were well managed and appropriate clinical coding was used.

Monitoring care and treatment

The Band 6 nurse was the lead for chronic conditions and managed patients with a chronic disease and those with a potential to develop a chronic disease in line with the practice's standard operating procedure (SOP), which was reviewed in August 2024. The lead undertook monthly DMICP searches and patients were invited for a review via email or text.

Our review of records showed the small number of patients with a diagnosis of diabetes were well managed. Over 40's lifestyle checks were also carried out and patients with a raised HbA1C (test to check blood sugar levels) were added to the chronic disease register and offered an annual blood test. Similarly, the low number of patients with asthma had been appropriately reviewed in the last 12 months. The DMICP asthma monitoring template was consistently used by clinicians when annual reviews were undertaken. Forty-five patients were diagnosed as having high blood pressure and records showed had their blood pressure checked in the past 12 months. Our review of clinical records showed patients with a chronic disease were well managed and appropriate clinical coding was used.

Audiometry assessments were in date for 97% of the patient population. Our review of patient records showed Joint Medical Employment Standards (referred to as JMES) were appropriately managed.

The SMO, who had a keen interest in clinical audit, was the lead for quality improvement activity (QIA). An integrated audit programme was established for the medical centre and PCRF. Reminders were in place to prompt clinicians to undertake DPHC mandated (MUST do) and desirable (SHOULD do) audits, both of which had been completed.

Clinical audit was used to evaluate the quality of care and improve patient outcomes. The process followed a clear structure, including reference to BPG, measurement standards, methods, and recommendations. Repeat cycles of clinical audit were evident, including for microscopic haematuria (blood in urine) and gout (type of arthritis). We discussed these 2 audits with the SMO including changes made to practice as a result. Other audits undertaken included: cervical screening (June 2024); diabetes type 2 (June 2024); high blood pressure (May 2024) and atrial fibrillation (irregular heartbeat) in June 2023. The SMO provided long-acting reversible contraception (referred to as LARC) and planned to start auditing outcomes.

Although audits linked to BPG had not been completed by the PCRF, an injury causation service evaluation had been undertaken and presented to the unit. This resulted in a discussion with the physical training instructors about improving the gym induction process as it was noted a high number of injuries occurred through the patients' own training programme. Even though the data had not yet been analysed to show the impact, it had potential through improved working with the gym staff. Minutes showed clinical audits were

discussed with the staff team at the healthcare governance meetings. In addition, best practice, including audit, was shared at the Network and regional meetings.

Effective staffing

The practice used the standard DPHC induction pack for all new staff joining the practice. Although role-specific induction packs were not available, we were advised that new starters shadowed a colleague within their area of speciality to gain an understanding of the role and expectations. The physiotherapist had developed a checklist of issues to talk through with new staff. It was identified as a formal action to develop a PCRF specific induction in line with DPHC guidance. Both the physiotherapist and administrator had worked there for many years and had a comprehensive knowledge of the service and processes. Despite this, not all PCRF processes were captured in an SOP to support new starters.

The Band 6 nurse was the training lead and the practice manager oversaw mandatory training. The training register did not provide a true reflection of the status of staff training due to migration/IT issues (MyHR was not integrating fully with the training log). To ensure staff mandated training was current, we checked training by other means, including training certificates and all were in-date for mandated training. The practice manager or administrator reminded staff when they needed to update any training. In addition, minutes showed training was a standing agenda item at practice meetings. The August 2024 meeting minutes included links to access mandated training topics.

Staff had training relevant to the needs of the patient population and the service. In-service Network training was facilitated on a Tuesday afternoon. Attendance at internal/external training programmes was encouraged. For example, the Band 6 Nurse had completed the link practitioner infection prevention and control training to lead in the area. The SMO had a Diploma of the Faculty of Sexual and Reproductive Healthcare. The clinical work of medics was supervised by the nurse with the Regimental Medical Officer having oversight of the training and development needs of the medics.

The physiotherapist had completed an external course on cauda equina syndrome (condition affecting the lumber spine) and had since presented it to the East Kent physiotherapy Network and was scheduled to present it to the practice staff. The ERI had completed the post graduate mentoring programme. Both the physiotherapist and ERI had undertaken the Defence Health and Wellbeing Advisors course and engaged with regular continual professional development (CPD) in this area. The physiotherapist participated in the East Kent physiotherapy Network, which was developed to share training and updates amongst the PCRFs in the area. The meeting minutes indicated this was a valuable forum for sharing information.

Clinical staff were up-to-date with their CPD, revalidation and annual appraisal.

Coordinating care and treatment

Effective relationships were established with the unit and Chain of Command (CoC). The Regimental Medical Officer (RMO) attended the Commander's Monthly Case Review (CMCR) meetings at which the health needs of the service personnel population was discussed, including vulnerable patients and downgraded patients. The PCRF team provided the RMO with patients updates prior to the CMCR meetings. PCRF staff also attended the CMCR to provide statistics for referral numbers, injury causation and non-attenders. In addition, the SMO held a meeting each month with PCRF staff to discuss specific patients.

Clinicians could also discuss issues of concern with the CoC outside of the CMCR meetings. The practice had good links with internal Defence services including the welfare team, DCMH, Regional Occupational Health Team and Regional Rehabilitation Unit.

For patients leaving the military, pre-release and final medicals were offered. During the pre-release phase, patients received a summary of their healthcare record. Patients were also made aware of the Veterans Health Service and, if appropriate, the Veterans Mental Health Transition, Intervention and Liaison Service (referred to as TILS).

Helping patients to live healthier lives

The healthcare assistant was the lead for health promotion and the Band 6 nurse deputised. The practice followed the NHS health promotion programme so health topics were refreshed each month. The practice also participated in the annual unit-led health promotion fair.

A wide range of health promotion/lifestyle information leaflets was available in the patient waiting area in the medical centre. Awareness information about breast cancer, smoking cessation and drink driving was displayed and the quick response/QR codes for mental health resources from DCMH Aldershot were displayed for patients to access. The PCRF had a health promotion board at the entrance that was visible to service personnel using the gym. It displayed a range of health promotion information, including the Defence nutrition advice service leaflets.

The SMO provided a long-acting reversible contraception service and also fitted coils. The nurses provided sexual health screening and patients could also be signposted to local sexual health services. The practice had links with the Sexual Assault Referral Centre in Maidstone who had offered to provide training for staff within the Network.

An SOP was in place for NHS screening and the Band 6 nurse managed the health screening programmes. Regular searches were carried out for patients eligible for bowel, breast, cervical and abdominal aortic aneurysm screening, and patients recalled for screening.

The SMO was the lead for cervical cytology within the Network The number of eligible women whose notes recorded that a cervical smear had been performed in the last 3 to 5 years was 2, which represented an achievement of 100%. The NHS target was 80%.

The nurse monitored the vaccination status of service personnel and this information was shared with the CoC at the CMCR meetings. The vaccination statistics at the time of inspection were identified as:

- 97% of patients were in-date for vaccination against diphtheria.
- 97% of patients were in-date for vaccination against polio.
- 99% of patients were in-date for vaccination against hepatitis B.
- 99% of patients were in-date for vaccination against hepatitis A.
- 97% of patients were in-date for vaccination against tetanus.
- 100% of patients were in-date for vaccination against measles, mumps and rubella.
- 100% of patients were in-date for vaccination against meningitis.

Service personnel were encouraged to use the 'MyHealth' app to manage and track the status of their audiology and vaccinations.

Consent to care and treatment

Implied and verbal consent was taken depending on the procedure. Consent was captured on DMICP templates and was always sought for LARC. All the patient records we looked at indicated consent had been appropriately taken. Record keeping audits incorporated a review of consent.

Clinicians understood the Mental Capacity Act (2005) and how it would apply to the patient population.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

As part of the inspection, we received feedback about the service from 72 patients. In addition, we considered the practice's patient survey from June to August 2024 (22 respondents). All feedback indicated staff were friendly and accommodating. Patients said they were treated with kindness and described the staff as respectful, helpful and caring.

Staff provided various of examples of when the practice had 'gone the extra mile' to support patients, including one of the nurses accompanying a patient to hospital as they were uncertain about what was happening.

Involvement in decisions about care and treatment

Feedback indicated patients were involved with planning their care and this was confirmed by our review of patient records.

The patient population comprised a large cohort of Nepalese service personnel. Many of the patient notices were displayed in both English and Nepalese, including access to the out-of-hours service, patient information leaflet and the Defence Primary Healthcare Patient Charter. An interpretation service was available for patients who did not have English as a first language and this was used along with a clinician at the practice who was fluent in Nepalese. Information was available in clinical rooms about how to access the translation service.

A standard operating procedure was in place to support patients a caring responsibility. Carers were usually identified through the patient registration process or opportunistically. A clinical code and alert was applied to the record of patients identified as a carer, which facilitated the routine monitoring of the number of carers. There were 7 carers identified at the time of the inspection. Carers were offered the flu vaccination and an annual heath check. Information about services to support carers was displayed in the waiting area.

Privacy and dignity

The patient confidentiality and patient privacy notice were displayed in the waiting area. Patient consultations took place in clinic rooms with the door closed. If headphone sets were used for telephone consultations then the patient's ID checked prior to any information being disclosed. Privacy curtains were available in all clinical rooms for intimate examinations. A radio for background noise was used in the waiting area.

Male and female doctors were available so patients had the option to see a doctor of a specific gender. Patients could be seen at another practice within the Network if they had a preference for a male nurse or male physiotherapist.

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 needs of patients were considered when scheduling appointments. Through the use of DMICP alerts, vulnerable patients and carers were promptly identified and prioritised for an appointment. Extended appointment times could be facilitated. Even though eConsult and telephone appointments were available and utilised, the patient population had a preference for face-to-face consultations. Vaccination clinics were coordinated depending on the needs of the unit.

The physiotherapist was the diversity and inclusion (D&I) lead for the practice and had completed the D&I practitioner course. D&I information was displayed. Staff we spoke with were aware of the protected characteristics under the Equality Act 2010. In line with the legislation, an access audit for both the medical centre and Primary Care Rehabilitation Facility (PCRF) had been completed within the last 12 months. There were 2 accessible toilets within the medical centre and 1 in the gym.

The access audit indicated a hearing loop was not needed, although we confirmed during the inspection that a small number of patients used hearing aids. The practice manager had submitted a request for a hearing loop and a discussion was ongoing as to who would fund this.

Even though no patients were transitioning at the time of the inspection, a transgender standard operating procedure was in place and reviewed in October 2023.

Issued by the Defence Medical Services Regulator (DMSR) in April 2024, we asked about the Regulatory Instruction, 'Training for staff in learning disability and autism' and how it was being implemented. The leadership team were unaware of this DMSR instruction at the time of the inspection and said they would ensure it was followed up.

Timely access to care and treatment

Feedback secured as part of the inspection along with the outcome of the patient survey indicated patients were satisfied with access to a clinician. An emergency clinic (referred to as sick parade) was held each morning. Appointments with a doctor, nurse, medic, exercise rehabilitation instructor and physiotherapist were available within 2 days. The physiotherapist retained an emergency slot for patients who needed to be seen on the same day. Rehabilitation classes were organised based on need and/or demand.

The Direct Access Physiotherapy (DAP) pathway had not been initiated by the PCRF as we were advised there was never more than a 1-2 day wait to see a doctor. In addition, the practice considered it more beneficial for the doctor to be involved at all stages of the patient's journey. DAP was introduced by the Defence Primary Healthcare (DPHC) to

facilitate choice and enhanced accessibility care for patients rather than reducing waiting times.

The physiotherapist referred to Colchester Regional Rehabilitation Unit (RRU). At the time of the inspection, the wait for referral to the RRU was 20 working days but the physiotherapist had been able to get patients seen in the same week if clinical need merited an earlier consultation. Access to a rehabilitation course at the RRU showed they were booked until the end of 2024. Patients could also complete a course at another RRU close to their home.

Although home visits could be facilitated if clinically appropriate, there had not been a situation whereby a home visit was required. Grading reviews were accommodated within 7 days. Specialist medicals were not facilitated so the practice sourced these through the Network or wider region. For example, diving medicals could be facilitated by the Senior Medical Officer (SMO) at Maidstone Invicta Park Medical Centre.

Pirbright Combined Medical Practice provided medical cover from 16:30 to 18:30 hours. From 18:30 midweek, weekends and public holidays patients can access NHS 111.

Listening and learning from concerns and complaints

The SMO was the lead for complaints and the practice manager deputised. Complaints were managed in accordance with the DPHC complaints policy and the practice standard operating procedure. The last complaint was received in April 2023 and had been appropriately managed to the satisfaction of the complainant. Complaints and compliments were a standing agenda item at practice meetings.

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

Are services well-led?

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

Vision and strategy

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

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

In the last 12 months the regional strategy to develop a formal network between Maidstone, Shorncliffe and Chatham medical centres had progressed. The aim of the Kent Medical Centre Network was to optimise patient care through shared resources and strengthened resilience for all 3 practices. Progressing to a 'combined practice' was being considered. Furthermore, plans were in place to introduce 'total triage'.

Practice staff told us they valued being part of the Network as it gave patients better access to timely services, such as diving medicals at Maidstone Invicta Park Medical Centre. In addition, the practice could lean into the Network if it was experiencing a staff shortage. We also heard that being part of the Network supported with staff training, succession planning and onboarding the new civilian medical practitioner (CMP).

To address environmental sustainability, recycling was encouraged and the use of QR codes and electronic information rather than printed information. The practice was involved with in the 'Re-Hale' project to encourage the recycling of inhalers; a collaborative project involving NHS Kent and Medway integrated care board.

Leadership, capacity and capability

We queried whether the working hours of the leadership team were sufficient to ensure service requirements were met whilst safeguarding the health and wellbeing of staff. Although the Senior Medical Officer (SMO) had worked at the practice previously, they were new to the role of SMO and contracted to work 18.5 hours per week. The SMO advised they were working many extra hours to balance clinical activity and managerial tasks whilst familiarising themselves with the role of SMO. It was anticipated the imminent appointment of a CMP would relieve the pressure on the SMO through task/activity delegation. Although the practice manager was also part time (29.6 hours per week), they had worked at the practice since 2014 so were familiar with governance structures and processes. They were supported by an administrative team, including an experienced administrator who took the lead for some of the governance processes.

The leadership team reported that they were very well supported across by the regional team, notably the Regional Clinical Director, operations manager and area manager.

Culture

From patient feedback, interviews with staff, a review of patient records and outcomes/outputs for patients, we were assured patients were central to the ethos of the practice. Staff understood the specific needs of the patient population and organised the service to meet those needs.

Although staff described a period of readjustment with the change of clinical leadership, they said there was good support at the practice and that morale had improved. We heard the team worked well together and staff were valued and respected by leaders. There was an open-door policy with everyone having an equal voice, regardless of rank or grade. Staff were aware of the whistleblowing policy and access to Freedom to Speak Up Champions. The team, including Regimental Aid Post staff, participated in regular social and sporting activities.

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. The practice maintained a duty of candour log. The duty of candour standard operating procedure (SOP) was reviewed in August 2024. We were given an example of how a duty of candour breach was effectively managed and also raised through the ASER system.

Governance arrangements

The SMO was the lead for healthcare governance (HCG) and the Band 6 nurse deputised. The SMO was working with region to ensure they were administrating governance requirements effectively, including the audit timetable.

A range of regularly reviewed local SOPs, policies and guidance underpinned HCG for the practice. Although the physiotherapist and Primary Care Rehabilitation Facility (PCRF) were very familiar with operational processes for the PCRF, SOPs to capture these processes were limited. Having information recorded is important for staff to reference should key PCRF staff be unavailable.

There was a clear staff reporting structure 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. Staff training was in-date. We noted that the induction programme would benefit from a review to ensure the role specific element of induction is adequate.

Formal and informal communication channels were established within the practice, including a rolling programme of structured meetings. These included practice, HCG and multi-disciplinary meetings. Meetings were well attended and the minutes were comprehensive. The practice also participated in regional forums including meetings for clinical leads and the Kent Medical Centre Network meetings.

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

Managing risks, issues and performance

Risks identified for the service were logged on the risk register and kept under scrutiny through review at HCG meetings. There was scope to improve how the risk register was structured as it did not include the DPHC ‘4 T’s process’ to illustrate at what level each risk was being managed. Risk assessments were in-date for the medical centre and PCRF. Although we queried the low number of incidents reported through the ASER system, we were assured that incidents involving clinical care or harm (including potential harm) to patients were always reported.

An integrated business continuity plan (BCP) for the Kent Medical Centre Network was developed in July 2023 with a review date for September 2025, and a copy was located in the practice manager's office. A major outbreak plan (July 2024) was held on SharePoint. We highlighted during the inspection that it would be beneficial if these plans were easily accessible to staff in the event that they needed to be referenced quickly. The BCP had been instigated in April 2024 during an outage for 2 weeks. Staff used the PCRF building and Network facilities to continue providing patient services.

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

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

Appropriate and accurate information

The practice used SharePoint, incorporating links, rather than the traditional HCG workbook to manage and monitor governance activity. The practice manager indicated that staff members favoured this approach as it was user-friendly, making it easier to navigate and oversee governance activity. The Health Assessment Framework (HAF), the internal system used by the practice as a development tool and to monitor performance, was reviewed at the HCG meetings. We noted from the September 2024 minutes that staff were reminded to contribute to the HAF. A practice management action plan (MAP) was in place and it identified the owner, priority and a clear description of the action.

Arrangements at the practice were in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. National quality and operational information was used to ensure and improve performance. The practice manger carried out a Caldicott check each week to ensure records were not being accessed inappropriately. The staff team had completed Defence Information Management Passport training which incorporated the Caldicott principles.

Engagement with patients, the public, staff and external partners

Options were available to prompt patients to provide feedback on the service. Complaints, suggestions and compliment forms were available for patients to complete and submit in both the medical centre and PCRF. In addition, patients could contribute to the DPHC patient experience survey. A notice board in the patient waiting room provided patients with a response to their feedback. There was evidence that the practice acted on patient feedback. For example, additional equipment for the gym was secured based on feedback.

Staff were encouraged to provide feedback at the scheduled monthly meetings and via the open-door policy. Staff reported that developing a survey for staff was currently under discussion.

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

Continuous improvement and innovation

The leadership team was committed to continually improving the service and this was evident through quality improvement activity, notably clinical audit. Several strategies were identified to enhance service quality and staff well-being. These included the implementation of SOPs, providing training opportunities, and strengthening resilience and access to resources via the Network

An example of improvement included the PCRF securing equipment, including a leg press machine which meant it was possible to complete full testing in line with best practice guidelines. In addition, the procurement of air conditioning units and heart rate monitors for treating patients with heat illness meant staff could ensure an appropriate work-rate for the patients.

A quality improvement project had been initiated by the practice manager in January 2024 in relation to improving vaccination and audiology statistics. As service personnel were not responding to telephone calls/voicemails, Gov.UK.Notify text messaging was introduced and responses improved which led to an improved uptake for audiology and vaccinations.