Maidstone Invicta Park Medical Centre

Invicta Park Barracks, 36 Engineer Regt, Maidstone, Kent, ME14 2NA

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?	**Outstanding**	☆
Are services well-led?	**Good**	●

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Summary

About this inspection

We carried out an announced comprehensive inspection of Maidstone Medical Centre on 15 September 2022. The practice was rated requires improvement overall, with a rating of requires improvement for the safe and well-led key questions. The effective, caring and responsive key questions were rated as good.

A copy of the previous inspection report can be found at:

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

We carried out this announced comprehensive follow up inspection on 7 and 15 November 2023. The report covers our findings in relation to the recommendations made and any additional improvements made since our last inspection.

As a result of this inspection the 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? – outstanding

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 used various means to seek patient feedback about the service and then acted on feedback to improve the patient experience. Feedback about the service was positive. It showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.

- Effective safeguarding arrangements were in place and the practice had good lines of communication with the unit, welfare team and local safeguarding team.
- The practice was well-led and the leadership team had the vision, capability and commitment to provide a patient-focused service. At the time of the inspection, staffing levels were adequate. However, there was a history of inconsistent staffing levels to ensure sustainability of the provision of safe clinical care, maintain governance systems and to safeguard the health and wellbeing of staff.
- An effective system was in place for managing significant events and staff knew how to report and record using this system.
- The arrangements for managing medicines, including obtaining, prescribing, recording, handling, storing, security and disposal minimised risks to patient safety.
- Quality improvement was embedded in practice, including various approaches to monitor outputs and outcomes used to drive improvements in patient care.
- Healthcare governance processes were well-developed and routinely used to monitor service performance. Quality improvement activity was consistently used to monitor if healthcare was provided in accordance with standards.

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

- The practice promoted the Sunflower scheme, an initiative with the aim to support inclusivity. Staff wore a sunflower badge to indicate they had a hidden disability so may require additional support or other adjustments. This scheme was also open to service personnel.
- The practice employed a variety of methods to obtain patient feedback, including seeking views on targeted topics using a token system. This focussed token system was also used to prompt patients. For example, it was used as a reminder for patients to update their details on the Joint Personnel Administration (JPA) platform. It also gave the practice a gauge of the numbers who had not updated their JPA.
- Twenty-five patients attended a face-to-face patient participation group (PPG) shortly before the inspection. Three PPG sessions were held based on rank. This approach was taken to ensure lower ranked personnel had the opportunity to speak up freely without rank presenting as a barrier. Set questions were asked and a report produced outlining the key feedback and the response to each issue raised. The practice was working on actioning the suggestions made by patients. At the request of patients, it was planned to hold a PPG every 6 months.
- Evidence was in place to show the practice responded to patient feedback. For example, a leaflet was developed that provided contact details for mental health support and the full range of Defence Primary Healthcare quick response or QR codes for additional support. In addition, patients highlighted that telephone calls from the practice were from a ‘withheld number’ so the patient did not recognise the origin of the phone call. In response, the practice now sends a text to the patient to inform them the practice called.

- To raise awareness of sepsis, a sepsis information day was held at the medical centre. A board was displayed and patients received information about recognising sepsis and the action to take. Approximately 40 patients attended and were given a pocket card with key sepsis information. Three weeks later a bake sale was held, which raised approximately £100 for the UK Sepsis Trust.

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

Ensure staffing levels are adequate at all times to meet patient need, safeguard the health and wellbeing of staff and ensure sustainability of governance requirements for the practice. Timely action should be taken to ensure the planned staffing gaps in early 2024 do not adversely impact service delivery.

The Chief Inspector recommends to the practice:

Ensure the risk assessments for substances hazardous to health (referred to as COSHH) are reviewed every 12 months as required.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

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 Maidstone Medical Centre

Maidstone Medical Centre provides primary health care to a military patient population of 750 service personnel. Families and dependents are not eligible to register at the practice so are signposted to local NHS practices. The practice is part of the Kent Network that includes Chatham and Shorncliffe medical centres.

In addition to routine primary care services, the practice provides a physiotherapy and rehabilitation service from the Primary Care Rehabilitation Facility (PCRF) located a short distance away in the unit gym. Occupational health services are also provided for service personnel. Family planning advice is available. Maternity and midwifery services are provided by NHS practices and community teams. The practice does not have a dispensary. Patients can use a local pharmacy or the dispensary at Chatham Medical Centre, a Defence Primary Health Care practice.

The practice is open 08:00-16:00 hours Monday to Thursday and 08:00-12:00 hours Friday with cover provided by Chatham Medical Centre until 16:00 hours. From 16:00 until 18:30 hours medical cover is provided by Pirbright Medical Centre. From 18:30 hours midweek, weekends and public holidays patients can access NHS 111.

The staff team

Senior Medical Officer	One full time civilian
Regimental Aid Posts[1]	One Regimental Medical Officer – 0.6 full time equivalent (FTE) One General Duties Medical Officer – deployed until February 2024 One Medical Sergeant Two Combat Medical Technicians (medics)[2] – both deployed
Practice nurse	One full time locum Band 6
Physiotherapist	One 0.3 FTE locum Band 6
Practice management	One 0.46 FTE civilian
Administration clerk	One 0.95 civilian

[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.

Following our previous inspection, we rated the practice as requires improvement for providing safe services. We identified shortfalls in processes to keep patients safe including shortfalls in:

- risk assessments
- immunisations for staff
- infection prevention and control
- servicing of gym equipment
- staffing levels.

At this inspection we found the recommendations we made had been actioned.

Safety systems and processes

The Senior Medical Officer (SMO) and the Regimental Medical Officer (RMO) were the safeguarding leads for the practice. All staff were in-date for safeguarding training at a level appropriate to their role. New staff, including locum staff, were made aware of safeguarding arrangements at induction. Reviewed in June 2022, the safeguarding standard operating procedure (SOP) referenced adults and children and included contact details for the local safeguarding teams. Local safeguarding arrangements were displayed in the patient waiting area and in reception.

A vulnerable patient SOP was in place and it also took account of care leavers. Vulnerable patients were identified through the patient registration process, the search built into DMICP (electronic patient record system) and through identification from the welfare team. A clinical code and alert was applied to individual DMICP patient records to ensure the small number of patients recognised as vulnerable, under 18 or a care leaver were easily identified. A register was held that included vulnerable patients, those on long term sick and downgraded patients.

Vulnerable patients were reviewed each month at the practice clinical multi-disciplinary team meeting. The SMO or RMO attended the monthly regimental vulnerability risk management meetings whereby safeguarding concerns and the needs of specific patients were discussed. The welfare team was also represented at the meeting. In addition, the SMO attended the Kent and Medway regional quarterly safeguarding meeting. The SMO had developed links with the safeguarding leads for local schools, which the children of service personnel attended.

A chaperone SOP was in place and all the staff had received chaperone training. The availability of a chaperone was included in the patient information leaflet and was displayed throughout the premises.

Although the full range of recruitment records for permanent staff was held centrally, the practice manager demonstrated that relevant safety checks had taken place at the point of recruitment, including a Disclosure and Barring Service (DBS) check to ensure staff were

suitable to work with vulnerable adults and young people. DBS checks were renewed in accordance with Defence Primary Healthcare (DPHC) policy.

An infection prevention and control (IPC) SOP was in place. The SMO was the lead for IPC. The last annual IPC audit was undertaken in November 2022.

An environmental cleaning contact and schedule was in place which included a clean of the premises early morning and mid-day. The practice manager and cleaner checked the cleanliness of the building each month. The premises was deep cleaned twice a year with the last clean taking place in August 2023.

The nurse was identified as the lead for clinical waste and updated the clinical waste log. Consignment notes were in place and up-to-date. Sharps boxes were labelled, dated and used appropriately. The last annual clinical waste audit showed the practice was fully compliant.

Risks to patients

At the previous inspection, we identified staffing levels were insufficient to ensure sustainability of the practice's provision of safe clinical care. There was also a risk the low staffing numbers could impact the health and wellbeing of staff. Initially after the inspection, staffing levels deteriorated further resulting in significant events being raised, activation of the business continuity plan and the practice closing for short periods. At one point there was just the SMO and a part time practice manager working at the practice. When the practice was closed, patients were redirecting to either Chatham or Shorncliffe medical centres, both a drive of 30 minutes or less from the barracks.

Recruitment was a challenge for the practice and staff indicated this was because of the close proximity to London which attracted better pay. In the last 8 months an administrator had been recruited. Despite numerous recruitment cycles, the practice had not been successful in recruiting a practice nurse. A further recruitment cycle was in progress. A locum nurse took up post in July 2023. One of the job-share practice managers had been on long term leave and subsequently left the practice. The permanent physiotherapist was on extended leave and there had been a gap in rehabilitation provision for 7 months until the current locum physiotherapist was recruited to work 2 days a week.

The civilian team had a close working relationship with the regimental aid post (RAP) team based at the practice. The RMO facilitated 5 clinical sessions a week. The General Duties Medical Officer and 2 of the 3 medics were deployed. The RAP team consistently supported the practice in the context of DPHC staffing gaps. We highlighted at the last inspection that this was not a sustainable solution as the RAP's primary commitment is to the unit and RAP staff could be recalled by the unit at any stage, including at short notice.

A significant event was raised each time the staffing level was low. Impoverished staffing levels frequently meant that the SMO had to cover reception. An analysis of the SMO's time indicated they had spent in the region of 4 months on reception duty.

Despite this staff turnover over the last 12 months, the practice had adequate staff at the time of the inspection to meet the needs of the patient population. This was reflected in feedback from patients and staff and appointment waiting times. However, staffing levels

remained a risk as we were informed a member of staff was leaving early in 2024 and another would be taking extended leave.

The medical emergency trolley and medicines were checked daily and monthly or if the trolley had been opened/used. Tags were in place with a list of expiry dates held. We checked all the emergency medicines and kit and they were in-date, including medical gases, which were at sufficient capacity. We highlighted to the practice staff during the inspection that best practice would be to store gases in padded cases.

The emergency medicines protocol was comprehensive with a clear well thought out rationale. While it was not in accordance with the DPHC SOP, it had been signed off by the Regional Clinical Director (RCD). A risk assessment for emergency medicines not held at the practice had been signed by the RCD in September 2023.

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 automated external defibrillator (AED). An AED was located in the gym and was checked daily by site health and safety officer. We made staff aware that the expiry date should be routinely checked also.

Scenario-based medical emergency training last took place in November 2022. Staff were trained in recognising the deteriorating patient and thermal injuries. The UK Sepsis Trust 'GP/OOH Telephone Triage Sepsis Tool' was displayed in clinical areas.

Information to deliver safe care and treatment

Although timely DMICP access was an ongoing issue DPHC-wide, staff reported minimal concerns with DMICP outages. During both planned and unplanned outages the practice initiated the business continuity plan. Routine clinics were cancelled and only emergency patients were seen. In addition, 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 DMICP outages and records scanned onto the system at a later point.

The SMO was the lead for the summarisation of patients' records. At the time of the inspection, summarisation was up-to-date. The SMO was a member of the DPHC working group for summarising notes and the aim of the group was to develop an organisational-wide policy to standardise records summarising.

Opportunities were taken for an independent review of the doctors' record keeping. For example, A locum who was a retired Medical Officer reviewed 10 sets of notes for the SMO and RMO in April 2023 and provided each of the doctors with feedback. The locum nurse's record keeping was reviewed in June 2023 and the physiotherapist's in September 2023. The RMO or Medical Sergeant reviewed the record keeping for medics.

The practice nurse was identified as the lead for the management of pathology samples. An entry was made on the electronic log when a sample was collected/sent to the laboratory. At the end of each week the nurse and SMO cross-checked to ensure all samples had been received. Results were received via Path Links, the system used to manage results. They were then filed electronically in the patient's clinical record and actioned accordingly by the doctors. The duty doctor reviewed the results every day as a

failsafe to ensure no results had been missed If the requesting doctor was away, the duty doctor actioned the results in accordance with the patient's preference.

An effective system was in place for managing both internal and external referrals including urgent 2-week-wait referrals. A referrals SOP was in place. Doctors completed referrals and uploaded the details to the electronic register. The administrator reviewed the referrals each day, updated the register accordingly and followed up on outstanding letters. Patients were prompted if they had not booked an appointment via the NHS e-Referral Service. The SMO reviewed the register each month.

Safe and appropriate use of medicines

The SMO was the lead for medicines management. There was no dispensary at the practice. The medical store contained a vaccine fridge, medical emergency trolley and cabinets containing outsourced prescriptions and stock. Prescriptions were dispensed by a local pharmacy or the dispensary at Chatham Medical Centre.

The medical store contained a locked cabinet which held the FMED296 prescriptions. A bound book was used to record all movement of prescriptions with serial numbers recorded. A running total was used and the member of staff signed for the issuing and receiving of prescriptions. There was no evidence that 6 monthly checks were undertaken However, when a prescription was issued the balance was recorded as checked.

There were no non-medical prescribers and Patient Group Directions or Patient Specific Directions for clinicians to administer medicines in line with legislation were not used at the practice. We discussed with the SMO the possibility of the nurse administering core vaccines under PGDs where appropriate.

The stock room where the medicines fridge was located was unlocked during practice opening hours for access to the emergency medicines trolley. The fridge was unlocked but secured by a clip. The medicines fridge was an adequate size to hold the stock. In the absence of a permanent nurse, the SMO ordered the vaccines. They were appropriately stored in the fridge away from the walls and with adequate airflow. Vaccines were in-date and those with the shortest expiry date were at the front of the fridge. A data logger was used to monitor fridge temperatures; 2 red lights flashed to indicate a temperature breach had occurred. The SMO downloaded datalogger data and no temperature breaches were evident. The thermometer used was the correct specification and in-date for calibration. It was due to go out-of-date at the end of November 2023. The temperature probe was within a vial of liquid but was not immersed. This was corrected and the probe immersed during the inspection. The dates of fridge cleaning were not recorded and this was promptly rectified after the inspection. A new fridge had been delivered and was awaiting commissioning.

Requests for repeat prescriptions were handled via eConsult or during consultations. The SMO indicated that eConsult was the preferred option as requests could be made 24 hours a day 7 days a week, was auditable and reduced waste as patients requested what was required rather than all medicines.

Patients were given the choice of processing their prescription through a local pharmacy or via Chatham Medical Centre dispensary. Medicines dispensed from Chatham Medical Centre and held at the practice for collection were stored in a secure temperature

controlled room. Patients provided positive feedback regarding the arrangements for collecting prescriptions from an outsourced pharmacy (a leaflet was available outlining how to do this) or having it dispensed at Chatham Medical Centre and delivered the next day. A process was in place for uncollected prescriptions. Patients were contacted up to 3 times and if prescriptions remained uncollected then the SMO was informed.

Controlled drugs (medicines with a potential for misuse) were not held at the practice. Prescriptions for controlled drugs were stored in the controlled drug cabinet. Keys were secured in a locked cabinet and signed in and out.

The SMO carried out monthly DMICP searches for patients prescribed medicines from secondary care services. They checked medication reviews and shared care agreements to ensure patients were in-date for monitoring. A recall system was in place to invite patients for a review.

Even though a very low number of patients were prescribed a high risk medicine (HRM), the SMO carried out monthly HRM searches in line with both the DPHC and the Specialist Pharmacy Service recommended lists. We reviewed the records of patients prescribed an HRM and the consultations were thorough. An HRM audit was completed in August 2023.

The SMO carried out regular searches for patients prescribed Valproate (medicine to treat epilepsy and bipolar disorder) searches were undertaken each month. Antibiotic stewardship guidance was followed and the SMO undertook an antibiotic audit in August 2023. No regional pharmacy audit had been completed for some time as the regional pharmacist post was vacant. Prescribing was peer reviewed between the Kent practices.

Track record on safety

Although the SMO was identified as the lead for risk management, both the practice manager and the SMO managed risk together. Taking into account the ‘4 T’s process’ (transfer, tolerate, treat, terminate), the risk register was comprehensive, regularly reviewed and included detail of action the practice had taken to address each risk. Minutes demonstrated that risks for the practice were discussed at the practice meetings.

A range of regularly reviewed clinical and non-clinical risk assessments was in place. We noted some of the risk assessments for substances hazardous to health (referred to as COSHH) had not been reviewed for more than 12 months. Since the last inspection, the practice manager’s plan to enrol on the Institution of Occupational Safety and Health (IOSH) course had been hampered by a shortage of staff. In the interim, the practice manager had completed internal training with the regional health and safety lead. The plan was to seek support with revising the COSHH risk assessments from an IOSH qualified staff member from one of the other medical centres within the network. The risk assessments for the PCRF were out-of-date. We were advised these would be reviewed when the full time physiotherapy returned to work at the end of November 2023.

Processes were in place and up-to-date for the checking of electrics and portable electrical appliances. Evidence was in place to confirm water safety checks were carried out monthly. An equipment inspection (referred to as a LEA) was undertaken in September 2023. The absence of servicing contract for equipment in the PCRF gym had been addressed following the previous inspection and all equipment was in-date for servicing.

Gym staff carried out wet globe bulb testing (WGBT) to indicate the potential for heat stress. The practice manager was made aware or WGBT levels and disseminated this information to PCRF staff. The physiotherapist reduced levels of physical activity depending on temperature readings.

The fire department carried out a formal fire risk assessment of the premises in March 2022 which was valid for 5 years. The Defence Infrastructure Organisation was responsible for addressing the recommendations made as a result of the risk assessment. This was being undertaken as part of a wider infrastructure review. The Quarter Master carried out weekly and monthly checks of the fire alarm system and firefighting equipment. Fire evacuation drills were held every 6 months with the most recent in September 2023. Risk assessments had been undertaken for staff who may benefit from a Personal Emergency Evacuation Plan (referred to as PEEPs).

All staff had WIFI handheld personal alarms. One of the alarms was activated during the inspection and staff responded immediately. An alarm linked to the medical centre was available in the PCRF. A record was available of the alarm checks made each month.

Lessons learned and improvements made

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

An ASER tracker was maintained, including actions required/taken and completion date. All staff we spoke with knew how to raise an SE or incident. Minutes confirmed SEs were routinely discussed at the practice meetings including lessons learned. A trend analysis was completed every 6 months.

We were provided with an example of a missed diagnosis and the action taken. A significant event was raised and a peer review undertaken of the doctor’s consultations with appropriate reflection. A letter sent to the patient informed them of the potential delay in diagnosis and offered the opportunity to meet to discuss the issues.

The SMO and RMO were registered to access the Medicines and Healthcare products Regulatory Agency (referred to as MHRA) website for alerts. The SMO and RMO discussed alerts in the first instance. The alert was then forwarded to staff and also discussed at the practice meetings.

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 practice guidance. Staff were kept informed of clinical and medicines updates through the Defence Primary Healthcare (DPHC) newsletter circulated to staff each month. A weekly practice multi-disciplinary team (MDT) meeting was held at which NICE and other updates were discussed. In addition, updates were discussed at the Kent Network meetings. Patients with complex needs were discussed at the MDT meetings. Audit was used to monitor if care and treatment was delivered based on evidence-based guidance.

The range of primary care rehabilitation facility (PCRF) clinical records we looked showed evidence of multi-disciplinary discussion. The Musculoskeletal Health Questionnaire (MSK-HQ) was the standardised outcome measure for patients to report their symptoms and quality of life. Rehab Guru (software for rehabilitation exercise therapy) was in use to monitor individual patient progress. Quick response or QR codes were available for patient's to complete outcome measures. The use of the MSK-HQ was clinically coded via the DMICP template. In the absence of the permanent physiotherapist, the Senior Medical Officer (SMO) routinely tracked PCRF key performance indicators (KPI).

The PCRF included a good sized clinical room with a well-equipped separate gym area.

Monitoring care and treatment

The SMO was the lead for long term conditions (LTC). The nurse undertook monthly DMICP searches and recalled patients due a review. Both the RMO and SMO reviewed the patients and followed NICE/best practice guidance to ensure patients were managed in a consistent way. Audits and key performance indicator (KPI) tracking via PowerBI (Microsoft business intelligence platform) was used to track care and identify any deviation from national benchmarking. We observed PowerBI used repeatedly throughout the inspection to check and/or provide data. This information was checked during the rolling annual audit for LTC management. Each year a bespoke audit was created in order to ensure no patients were missed.

There were low numbers of patients diagnosed with diabetes, asthma or high blood pressure. The range of clinical records we looked at showed patients with an LTC were well managed. The standard of record keeping was good including a timely recall, detailed assessment and accurate clinical coding. LTC pathways were consistently followed and appropriate templates were used.

The SMO audited each LTC in accordance with the audit calendar. By checking the audits and comparing them to the previous year we noted clear evidence of continuous monitoring and improvement.

Audiometry assessments were in date for 92% of the patient population.

Doctors delivered step 1 of the DPHC mental health pathway. Army Welfare Services were utilised for 6 weeks of counselling, which could be accessed within 10 days of referral. Patients who needed intervention beyond step 1 were referred for a Department of Community Mental Health (DCMH) appointment via the London and south regional single point of access (referred to as LS-SPA). Our review of clinical records showed patients with a mental health need were well managed and appropriate clinical coding was used.

The SMO was the lead for quality improvement activity (QIA) lead. QIA comprised both clinical audit, DPHC mandated audits and data searches. Despite the challenge of inconsistent staffing levels, QIA was both continuous and comprehensive. Only the SMO was undertaking clinical audit at the time of the inspection as the other 2 clinicians were locums. We identified some innovative practice, in particular the use of PowerBI to illustrate KPIs in a visual format. We looked at 2 clinical audits in detail. Both had been subject to several audit cycles. They followed a clear structure, standards and referenced evidence-based medicine guidance. Appropriate action was taken if analysis identified shortfalls. The outcome of clinical audits was discussed with the staff team if appropriate.

Effective staffing

All new staff completed the DPHC standardised induction. One of the staff recruited in the last year described how the induction involved a week of mandatory training and time shadowing the SMO and practice manager. The 2 locums had completed the DPHC mandated induction programme for locum staff.

The practice manager was the lead for staff training. Staff with mandated training due were sent a reminder email, including the Regimental Aid Post (RAP) team. When training certificates were returned, the practice manager updated the training dashboard. The practice was 80% compliant with mandated training. There were mitigating circumstances for staff out-of-date, mainly related to deployment of RAP staff. A mandated training programme was in place with protected time regularly allocated.

Clinicians had training specific to the needs of the patient population. For example, the SMO and Regimental Medical Officer (RMO) were trained to undertake diving medicals. The SMO was currently undertaking training in order to interpret clinical spirometry. In addition, the RAP team had completed the Battlefield Advanced Trauma Life Support (referred to as BATLS) and Military Pre-Hospital Emergency Care training (referred to as MPHEC).

Staff were supported with individual professional development. For example, the Medical Sergeant was in the process of completing a nursing degree. The practice manager was waiting to complete both the health and safety course and practice manager course.

Doctors were up-to-date with their continual professional development (CPD), revalidation and annual appraisal. The doctors provided clinical support to each other through peer review and the SMO met regularly with the RMO on both a formal and informal basis. The

Medical Sergeant was responsible for the medics. However, the nurse provided supervision for medics during allocated clinic time.

Coordinating care and treatment

The SMO attended the Commanders Monthly Case Review meetings whereby the needs of specific patients with vulnerabilities were discussed. In addition, all clinicians attended the Unit Quarterly Health Reviews at which trends in relation to vulnerability and safeguarding were reviewed. Externally, the SMO participated in the Local Medical Committee meetings. The practice had good links with internal 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, all patients received a summary of their healthcare record, including immunisations and medication and information on how to obtain a full copy of their records. Service leavers also received a patient information leaflet detailing how to register with an NHS GP, how to find a dentist and information about the Armed Forces Compensation Scheme. Patients were also made aware of the Veterans Health Service and, if appropriate, the Veterans Mental Health Transition, Intervention and Liaison Service (TILS). Through the LMC and other local networks, the SMO provided guidance and advice to NHS primary care clinicians regarding support for veterans.

Helping patients to live healthier lives

At the time of the inspection, the administrator oversaw health promotion activities with the involvement of the whole practice team. The practice followed the DPHC health promotion calendar. On occasions when there had been insufficient staff, the practice rolled the health promotion topic/s on to later months, such as with the World Sepsis Day which was delivered in October rather than September.

A wide range of health promotion/lifestyle information leaflets was available in the waiting area for patients. Information about cervical screening, sepsis and mental wellbeing was displayed along with a range of health information leaflets. In addition, the waiting room television was used to share health promotion information and the content was updated each month.

Clinicians were not trained in sexual health (referred to as STIF) so were signposted to the Rubin Clinic, a level 3 sexual health service provided by Maidstone and Tunbridge Wells NHS Trust. Information about the clinic was displayed in the patients' toilet. Condoms were also available for patients. Patients could be referred to the military sexual health service in Birmingham.

The SMO carried out monthly searches for bowel, breast, cervical and abdominal aortic aneurysm screening in line with national programmes. There were no patients who met the criteria for screening.

The number of eligible women whose notes recorded that a cervical smear had been performed in the last 3 to 5 years was 9 which represented an achievement of 90%. The

NHS target was 80%. At the time of the inspection, eligible female patients were offered appointments at Chatham or Shorncliffe medical centres as there were no cytology trained staff at the practice.

Regular DMICP searches were carried for patients due a vaccination. The vaccination statistics were identified as follows:

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

The units at Maidstone deployed frequently so there was a focus on deployment vaccinations. Although routine recalls were maintained by the unit medics, patients were also encouraged to use the ‘MyHealth’ app to track the status of their audiology and vaccinations.

Consent to care and treatment

Implied, verbal and written consent was taken depending on the procedure. DMICP templates captured consent. All the patient records we looked at indicated consent had been appropriately taken. Clinicians understood the Mental Capacity Act (2005) and how it would apply to the patient population. Record keeping audits incorporated a review of consent.

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 35 patients. Feedback indicated staff were friendly and accommodating. Patients said they were treated with kindness and respect. Furthermore, patients acknowledged receiving a good service despite the practice being short of staff on occasions.

Contact details about the welfare service and additional services were including in the practice information leaflet. Information about local or national support services was displayed in the waiting area. Patients could access local coffee mornings run by Armed Forces and Veterans breakfast club once a month.

Staff provided various of examples of when the practice had ‘gone the extra mile’ to support patients, including a patient who had had an accident and a patient receiving palliative care. The additional support involved increased levels of both health and wellbeing support, weekly reviews and liaison with the Chain of Command.

Involvement in decisions about care and treatment

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

The patient population comprised a large number of Nepalese service personnel. Some of the patient notices were displayed in both English and Nepalese, such as access to the out-of-hours service. An interpretation service was available for patients who did not have English as a first language. Information was displayed in clinical rooms about how to access the service. The practice leaflet outlined what to do if an interpreter was required. Clinicians adapted their approach to consultations to ensure patients understand what was being discussed. For example, speaking slower, clearer and directly to the patient.

The Senior Medical Officer (SMO) was the lead for patients with a caring responsibility. A carers standard operating procedure was in place. Carers were identified through the patient registration process, through the welfare team or opportunistically. A clinical code was applied to the record of patients identified as a carer, which facilitated the SMO’s routine monitoring of the number of carers. There were 5 identified at the time of the inspection. Carers were offered the flu vaccination and an annual heath check.

Privacy and dignity

Patient consultations took place in clinic rooms with the door closed. Headphone sets were used for telephone consultations and the patient’s ID checked prior to any information

being disclosed. Privacy curtains were available in all clinical rooms for intimate examinations. Information was displayed in various areas of the building advising patients they could speak to staff in private if required. A radio for background noise was used in the waiting area.

The staff team had completed Defence Information Management Passport training which incorporated the Caldicott principles.

A male and female doctor was 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 outstanding for providing responsive services.

Responding to and meeting people's needs

The practice considered the occupational needs of the patient population when planning clinics. For example, the emergency clinic (referred to as sick parade) was held at 08:00 hours to accommodate those starting or finishing work shifts. Clinics specific to deployment were held in liaison with the chain of Command. The practice often readjusted its clinic times to accommodate short notice vaccination clinics.

In line with the Equality Act 2010, an access audit for the medical centre was completed in October 2023. Improvements needed were identified and reported to Quarter Master's department and Defence Infrastructure Organisation. To illustrate the barriers, the practice manager accessed the whole building in a wheelchair. Issues identified included the handrail outside the building, unlevel surface from the accessible parking space, and the main entrance door. An induction hearing loop was not available (not needed at the time of the inspection) as the practice was trying to establish who would fund this; the unit or Defence Primary Healthcare. The Primary Care Rehabilitation Facility (PCRF) was located in the unit gym on the first floor. Any patients with limited mobility needs attending the PCRF were seen in a clinical room at the medical centre.

The practice promoted the Sunflower scheme, an initiative with the aim to support inclusivity. Staff wore a sunflower badge to indicate they had a hidden disability so may require additional support or other adjustments. This scheme was open to service personnel also.

The practice employed a variety of methods to seek patient feedback, including targeted topics using a token system. For example, in September/October 2023 the topic posed was - Would you prefer a face-to-face appointment or telephone consultation? Out of 162 responses, 72% of patients said they preferred face-to-face appointments. This focussed token system was also used to prompt patients. At the time of the inspection, it was used as a reminder for patients to update their details on the Joint Personnel Administration (JPA) platform. It also gave the practice a gauge of the numbers who had not updated the JPA.

The practice started holding a patient participation group (PPG) in 2019. During Covid-19, the PPG was not successful as it was held online and no patients participated. A face-to-face PPG was facilitated shortly before the inspection and 25 patients attended. Three sessions were held to accommodate different ranks. This approach was taken to ensure lower ranked personnel had the opportunity to speak up freely without rank presenting as a barrier. Set questions were asked and a report produced outlining the key feedback and the response to each issue raised. The report was due to be discussed at the next practice meeting before providing the unit with a copy. At the request of patients, it was planned to hold a PPG every 6 months. We suggested the practice consider raising the approach taken to PPG as a quality improvement project. Other Defence medical services could benefit from how the practice achieved such good attendance at a PPG.

Evidence was in place to show the practice responded to patient feedback. For example, a leaflet was developed that provided contact details for mental health support and the full range of Defence Primary Healthcare QR codes for additional support. We suggested the practice consider raising this initiative as a quality improvement project.

Patients identified that telephone calls from the practice were from a 'withheld number' so the patient did not recognise the origin of the phone call. In response, the practice now sends a text to the patient to inform them the practice called.

A patient was worried that as soon as they were upgraded after a downgrade, they were expected to go straight back to regular physical training risking further injury. In response, the SMO was exploring the option of introducing a return to work physical training programme before patients returned to mainstream physical training.

To raise awareness of sepsis, a sepsis information day was held at the medical centre. A board was displayed and patients received information about recognising sepsis and the action to take. Approximately 40 patients attended and were given a pocket card with key sepsis information. Three weeks later a bake sale was held, which raised approximately £100 for the UK Sepsis Trust. We suggested that this work to enhance the health literacy of the patient population be considered as a quality improvement project.

Timely access to care and treatment

Feedback, including the outcome of the PPG, indicated patients were satisfied with the access to a doctor, nurse and medic. This wait time for physiotherapy was the main issue raised by patients through various feedback sources. Patients were assured at the PPG that capacity would increase when the full time physiotherapist returned to practice at the end of November 2023.

The practice monitored the wait times each month, which were displayed in the reception area. For November 2023, the wait time for both urgent and routine appointments with a doctor, nurse or medic was 1 day. The wait for an occupational medicals was 6 days.

The Direct Access Physiotherapy pathway (referred to as DAP) had been paused whilst a locum physiotherapist was in post. There was a 12 day wait for a routine physiotherapy appointment and a 10-12 day wait for a follow up appointment. For a quicker appointment, patients could attend other rehabilitation facilities in the Kent Network. There was a 6-8 week wait for a Regional Rehabilitation Unit course.

Home visits were not offered by the practice. Access to medical cover (shoulder cover) was provided by Chatham Medical Centre from 16:00 hours and from 12:00 hours each Friday. From 18:30 hours Monday to Friday medical cover was provided by Pirbright Medical Centre. Patients had access to NHS 111 from 18:30 hours midweek, during the weekends and public/bank holidays. We highlighted that a minor adjustment to the patient information leaflet would make clearer the arrangements for shoulder cover and NHS 111.

Listening and learning from concerns and complaints

The practice manager was the lead for patient complaints. Complaints were managed in accordance with the Defence Primary Healthcare complaints policy (JSP 950) and the practice standard operating procedure. Both verbal and written complaints were recorded on the complaints log. The Senior Medical Officer (SMO) was mainly involved with complaints about clinical care. If the complaint was about care provided by the SMO, then the SMO from one of the practices in the network was asked to review the complaint. We discussed a recent complaint and were satisfied it was effectively managed in accordance with policy.

Between the beginning of January 2022 and the beginning of October 2023 15 complaints were received. The main theme was access to appointments during periods of staff shortages in the first half of 2023. Complaints was a standing agenda item at the practice meetings and changes made or lessons learnt shared with the team. A complaints and compliments audit was undertaken in June 2022.

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

Are services well-led?

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

Following our previous inspection, we rated the practice as requires improvement for providing well-led services. We found inconsistencies in processes to keep patients safe including shortfalls in:

- practice management capacity
- review of standard operating procedures
- staff training in using new systems.

At this inspection we found the recommendations we made had been actioned.

Vision and strategy

The vision for the practice was identified as ‘unique and not ubique’.

The aim of the practice was:

“To provide a psychologically safe environment with the welfare and development of staff at its core and, in doing so, safeguard the delivery of high quality care to entitled patients, and support to 36 Engineer Regiment outputs.”

Although staff capacity and skill mix had improved since the last inspection, there was very little resilience to provide for unplanned staff absences so maintaining consistent staffing levels remained a key risk for the service. Due to limited resources, the practice team adopted a reactive or tactical approach to service delivery. In response to requests from the Chain of Command, the practice reviewed its capacity and modified working arrangements to ensure the needs of the units were met.

At the previous inspection, we heard about the regional strategy to develop a formal network between Maidstone, Shorncliffe and Chatham medical centres. The aim of the Kent Network was to share resources and strengthen resilience for all 3 practices. We were advised this network had not developed as intended due to staffing gaps across all the services.

Despite periods of inadequate staffing levels over the last year, the practice continued to provide a safe and effective service for patients. This was reflected in prompt access to appointments (except for physiotherapy), appropriate and timely management of patients with long term conditions, screening statistics and responsiveness to the occupational health needs of the units. Furthermore, the practice had found positive ways to engage with patients to gain meaningful feedback about the service, including the setting up of a well-attended patient participation group (PPG).

Leadership, capacity and capability

Since the last inspection, practice management capacity had decreased as one of the job share practice managers had left the service. This meant the leadership team comprised the Senior Medical Officer (SMO) and a part time practice manager. Despite this change, we found the SMO and practice manager worked in an efficient way to ensure governance processes were effectively used to monitor the safety and quality of the service.

At the last inspection, we identified that the leadership team was spread too thinly across too many processes. The SMO was undertaking administrative and nursing duties over and above their routine clinical role. This was still the case as the both the practice nurse and physiotherapist were locums. We were assured work and lead roles would be more evenly distributed when the permanent physiotherapist returned at the end of November 2023 and recruitment for a full time practice nurse was complete.

At the last inspection, we highlighted that the reliance on the Regimental Aid Post (RAP) team to cover Defence Primary Healthcare (DPHC) administration gaps was not a sustainable contingency solution as the RAP's primary role is to the unit, and RAP staff can be recalled by the unit at any stage. Although the RAP team continued to work well with practice staff to support in the delivery of clinical care, workarounds had been found to ensure clinical availability. For example, when both the SMO and Regimental Medical Officer (RMO) were in work together pre-booked appointments were offered. If just 1 doctor was available, then book-on-the-day appointments were offered. This change was implemented to support the team to deliver appropriate timely care to patients.

The appointment of an almost full time administrator meant less reliance on RAP staff for administrative duties. We were advised that further movement of staff in early 2024 would significantly impact the service. The Regional Clinical Director (RCD) and regional team were aware of this. While staff indicated the regional team was supportive in some areas, they highlighted that more could be done to improve staffing resilience.

To address environmental sustainability, recycling was encouraged, appliances were switched off when not in use and the heating turned off at weekends. The SMO had advanced technological skills and was successfully making the practice 'paper light' by the introduction of smart electronic processes. QR codes and electronic information was used where possible. The SMO had plans to undertake an audit of prescribed inhaler devices to establish if environmentally friendly alternatives were available.

Culture

Despite limited resilience in staffing levels, the staff team, both individually and collectively demonstrated a 'can do' approach to ensure care delivered met the needs of patients and the units. From discussions with staff, feedback from patients and our review of clinical records a responsive and patient-centred focus was clearly evident. The practice was keen to capture patient views so improvements could be made to the service.

All staff we spoke with highlighted that morale had significantly improved since the last inspection, although inconsistent staffing levels still had a negative impact on morale. New staff, in particular locums, said leaders prioritised their needs by facilitating a detailed induction and being available for support and advice. We heard it was a strong, supportive

and inclusive team that effectively communicated with each other. The team, including RAP staff, participated in regular social and sporting activities.

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.

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. We were given an example of how a duty of candour breach was effectively managed.

Governance arrangements

Formal and informal communication channels were established including monthly practice/healthcare governance meetings. Minutes showed meetings were well attended by DPHC and RAP staff. Weekly multi-disciplinary clinical meetings were held.

At this inspection, we found governance processes were better understood by staff involved in using and maintaining the systems. Rather than the commonly used defence healthcare governance workbook (HGW) to monitor a range of governance activities, the practice predominantly used PowerBI and SharePoint. Staff were proficient with using this system. Non-attendance at appointments was closely monitored and followed up.

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 (TOR) for staff were not current or signed. Following our previous inspection, the practice requested the generic DPHC TORs for specific roles. However, the practice received these a week before the inspection so had insufficient time to process them. This deficit was identified on issues log and a plan was established to put the TORs in place. We noted since the last inspection that the allocation of lead roles/tasks had been reviewed to ensure a more equal distribution across the staff team.

A programme of quality improvement activity was established to monitor the outcomes and outputs of clinical and administrative practice.

Managing risks, issues and performance

A comprehensive register was maintained of risks staff had identified. The concerns in relation to insufficient staffing resources was clearly articulated as a transferred risk to region on the register, which the regional team had access to. The practice manager oversaw risk management, including the risk register and risk assessments. The plan was for the practice manager to take over this role once they had received the appropriate training and staffing capacity stabilised. The practice manager at Chatham Medical Centre was trained in health and safety and, as part of the network, has supported the practice with risk assessments.

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

The SMO was familiar with applying policy and processes for managing performance and ensuring staff were supported in a sensitive way taking account of their wellbeing. Appraisals were up-to-date for all staff.

A business resilience plan was in place. It took account of all the likely generic system failures. It was activated recently when 2 ceilings collapsed due to poor weather. The affected areas were closed and patients were seen in alternative clinical rooms. A significant event was raised and the regional team informed.

Appropriate and accurate information

The Health Assessment 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.

Recommendations identified from the previous Internal Assurance Review (referred to as IAR) and previous CQC inspection had been actioned. The majority of actions outside the control of the practice had been added to issues log and escalated to region or the unit for support/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.

Engagement with patients, the public, staff and external partners

Despite inconsistent staffing levels, the practice prioritised engagement with patients in order to improve the patient experience. This was reflected in a well-attended and successful patient participation group (PPG), surveys on specific topics and a high attendance at a sepsis awareness day.

The practice had well developed internal and external relationships including with the units and the welfare team. These relationships meant vulnerable patients were promptly identified and supported. The SMO or RMO attended monthly vulnerable risk management meetings with chain of command and the Commanders Monthly Case Review (referred to as CMCR) run by the Chain of Command. The SMO attended quarterly meetings with external safeguarding and participated in health promotion activities with local agencies.

An anonymous feedback box was in the staff kitchen for staff to provide comments or suggestions about the service. Practice staff participated in a 360 degree Multi-Source Feedback (MSF) last year. The results were collated anonymously by a colleague outside of the team, were reviewed and feedback provided. Although acknowledging a lack of

capacity, the SMO said the team would benefit from a further MSF to include group team building work.

Continuous improvement and innovation

The leadership team was committed to continually improving the service. There was evidence of this, such as the successful PPG and making changes suggested by patients. In addition, audit, quality improvement activity clearly demonstrated that the practice continually sought to improve the service for patients. Despite inconsistent staffing levels, the practice was delivering effective care for patients while maintaining the governance of the practice.

Although there was evidence of innovative practice being raised as quality improvement projects (QIP), we identified additional good practice initiatives which were not identified as a QIP, such as the sepsis awareness event and the successful PPG. Raising QIPs and uploading them to the DPHC Healthcare Governance webpage showcases positive performance and also enables the sharing of good practice with other DPHC facilities.