DPHC(O) Sennelager Medical Centre

Talbot Barracks, Sennelager, BFPO 16, Germany

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	**Requires improvement**	
Are services safe?	**Requires improvement**	
Are services effective	**Requires improvement**	
Are services caring?	**Good**	
Are services responsive to people's needs?	**Outstanding**	
Are services well-led?	**Good**	

Contents

Summary

About this inspection

We carried out an announced comprehensive inspection of Sennelager Medical Centre on 26 February 2025.

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

Are services safe? – requires improvement

Are services effective? – requires improvement

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 observations and recommendations within this report.

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 patients were central to service provision and were included in decisions about their treatment and care.
- Patient feedback about the service was positive. It demonstrated patients were treated with compassion, dignity and respect.
- Practice staff pro-actively responded to patient feedback, which was reflected in the range of improvements made based on feedback. Staff continually considered ways to improve the patient experience.
- Staffing levels were not adequate for the current and increasing patient population. This particularly impacted the Primary Care Rehabilitation Facility (PCRF).
- The process for managing long term conditions (LTC) had recently been reviewed and strengthened. However, many patients with an LTC were outstanding for a review.

- Effective safeguarding arrangements were in place.
- Flexible access and services were offered to patients, including those who were vulnerable, had a caring responsibility and children.
- Although staff described an inclusive and supportive leadership style, team morale declined in 2024 due to gaps in the senior leadership team (SLT) and inconsistent staffing levels. The SLT had addressed this issue.
- Medicines and medical products were well managed.
- Infection prevention and control (IPC) audits were undertaken. Clinical waste was managed well.
- The infrastructure was not fully compliant with IPC standards and the environmental cleaning contracted needed to be reviewed.
- Referrals to secondary healthcare were well managed by a dedicated team.

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

- Despite the pressure of insufficient and inconsistent staffing levels, staff listened to feedback and other concerns, pro-actively responding to ensure a positive experience for patients. Initiatives included:
    - A contract was agreed with SSAFA (Armed Forces charity) for patients to have increased access to a health visitor (HV). A local English speaking midwife was sourced as patients raised concern about inconsistent access to this service. Links had been strengthened between the HV, midwife, nursing team and wider practice as a result of this work. We discussed the value of formalising this initiative as a quality improvement project (QIP).
    - In response to the absence of a school nurse, the HV provided support to the school, including making referrals to the speech and language therapist. The HV visited the practice twice a week and also provided a remote service. Furthermore, they attended the regularly held ‘Tots of Fun’ sessions at the community centre.
    - In October 2024 the risk of a fragmented clinical pathway was identified when patients travelled to the UK to access the Multi-injury Assessment clinic (MIAC). Extended waiting times for investigations and follow-up appointments often resulted in the downgrading of service personnel. Since February 2025, the Regional Rehabilitation Unit Edinburgh had facilitated a peripatetic MIAC clinic at Sennelager. The clinic has resulted in financial savings and improved efficiency and effectiveness of the rehabilitation care pathway with the potential long-term effect of reducing long term musculoskeletal conditions and increasing personnel available for deployment.
    - A child provided feedback suggesting that the waiting room was boring. A colourful interactive children’s play area was developed in a space within the waiting area. It also included children’s books. The practice introduced a visual display of their pets with the challenge to guess which staff owned each pet. The board was popular with children and other patients.

  - The hospital liaison posts were de-established when the practice closed some years ago. Patients highlighted that the hospital liaison officers had been a valuable service for patients accessing emergency or secondary healthcare (SHC) facilities. They reported it provided guidance with navigating the German healthcare system, including support with the language barrier. To address this gap, the SHC team had visited each of the SHC facilities and mapped out the route through the premises to access each department used. This information was included in the appointment letter the patient received. Feedback indicated patients appreciated this detailed guidance as it helped with reducing anxiety when attending an unfamiliar healthcare facility.

- Repeat prescriptions could be requested via the group mailbox or through a quick-response (QR) code. The QR code had recently been introduced to offer patients an alternative option to request a repeat prescription. It was displayed and also included in the patient information leaflet.
- Through an audit in February 2025, the MOD GP identified that the local service providing hearing assessments did not include all the military required hearing frequencies. As a result, a specialist who carried out military standard testing was sourced. This work was raised as a QIP.
- The physiotherapist undertook a non-attendance (referred to as DNA) audit which highlighted a spike in DNA rates impacting on availability and access. As a result, text messaging was introduced and a unit-wide stakeholder engagement briefing led to a reduction in DNA rates so the PCRF was now meeting the key performance indicator for attendance. We discussed the value of formalising this initiative as a QIP.
- The Senior Medical Officer maintained an ‘eDesktop guide’ which included all information for processes specific to the practice. A link to this guide was given to new members of staff as part of their induction.

The Chief Inspector recommends to DPHC(O):

- Review staffing levels to ensure they are adequate at all times to meet the needs of the patient population and to safeguard the health, wellbeing and morale of staff. Specifically, explore options for a temporary exercise rehabilitation instructor (ERI) uplift until the appointed ERI joins the practice in January 2026.
- Ensure improvements are made to the infrastructure to meet the standards of the Health and Social Care Act 2008: ‘Code of Practice about the prevention and control of infections and related guidance’.

The Chief Inspector recommends to the practice:

- Continue to prioritise patients with a long term condition (LTC) so they are reviewed in a timely way. Ensure clinical staff are familiar with the LTC processes and monitor the use of relevant DMICP templates and clinical coding so the reliability of searches for patients with a LTC is strengthened.

- Review the staff skill mix, experience and training needs to ensure staff are suitably skilled for the roles they undertake. Ensure all clinical staff have access to continuing professional development and clinical supervision relevant to their role.
- Continue to engage with local secondary healthcare (SHC) providers with the aim to address the known risk associated with shared care and SHC prescribing.
- Ensure an automated external defibrillator is readily accessible when the physiotherapist facilitates rehabilitation classes in the main gym.
- Review the emergency alarm system to ensure alarms are audible in all areas of the building.
- Review the environmental cleaning contract to ensure the cleaning provided is in accordance with the NHS England National standards of healthcare cleanliness 2025.
- Review how the use of the building is configured so space is better utilised, particularly for the PCRF.
- Ensure all staff receive training in how to interact appropriately with people who have a learning disability and/or autism at a level appropriate to their role.

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 DPHC(O) Sennelager Medical Centre

The British Army-led NATO Forward Holding Base provides a UK strategic hub and firm base in Sennelager. The base hosts armoured vehicles, equipment, and logistics as well as providing a facility to integrate and train with NATO allies.

The 2010 Strategic Defence and Security Review to withdraw British Forces by 2020 was reversed in 2018 due to increased unrest in eastern Europe. British Forces returned to Sennelager. Consequently, primary healthcare facilities for service personnel and their families were re-instated in October 2020. The population has steadily increased since the base re-opened with a growth of 18%, including a 59% increase in military personnel and 16% for families.

The practice supports an approximate patient population of 9,000 who transit through the base each year. Of the 756 patients registered, 37% were military personnel. The 63% non-military patients included families of service personnel, UK based civilians and contractors.

At the time of the inspection, 15% of registered patients were under 9 years of age and 19% were aged between 50 and 79. Of this 19%, 6% of the population were over the age of 60.

The practice provides a Primary Care Rehabilitation Facility (PCRF); family planning; sexual health; chronic disease management; new patient health checks; travel advice and immunisation; a mental health service and smoking cessation. Medicines are dispensed from the practice.

Patients requiring secondary healthcare are referred to various local German healthcare facilities or can be transferred back to the UK. A range of external clinicians provide routine clinics at the practice, including a health visitor and midwife. The Multi-Injury Assessment Clinic team from Edinburgh Regional Rehabilitation Unit facilitate a regular peripatetic clinic at the practice.

The practice is open 08:30 to 12:30 hours Monday to Friday and 14:00 to16:30 hours Monday to Wednesday. It is closed Thursday and Friday afternoons.

The practice does not provide an out-of-hours service. For life threatening conditions patients are directed to contact 112 (contact number for a medical emergency in Germany). Alternatively, patients can contact Healix, an international company that has a contract with the UK government to provide healthcare and risk management services to Ministry of Defence (MOD) employees working overseas.

The staff team

Doctors	Senior Medical Officer - military MOD GP Foundation Year 2 resident doctor
Practice nurses	Senior Nursing Officer - military Band 5 Band 6 locum nurse
PCRF	OC (lead) physiotherapist - military
Pharmacy	Pharmacy technician - civilian
Combat medical technician (medic)[1]	One
Practice management and administration	Practice manager – military Deputy practice manager – **post vacant** Two receptionists Two dedicated administrators for secondary health care Finance clerk

[1] A medic is a unique role in the forces. Their role is similar to that of a health care assistant in NHS GP practices but with a broader scope of practice.

Are services safe?

We rated the practice as requires improvement for providing safe services.

Safety systems and processes

The Senior Medical Officer (SMO) was the safeguarding lead for the practice and the Senior Nursing Officer (SNO) deputised as required. All staff were in-date for safeguarding training at a level appropriate to their role. In May 2024, the SMO provided the staff team with level 1 safeguarding training specific to Germany.

Last reviewed in January 2025, the adult safeguarding policy was accessible to staff via the SharePoint site. Although there was no separate child safeguarding policy, a flowchart was included as an appendix to the adult safeguarding policy. It included telephone contact details to report both adult and child safeguarding concerns. This was displayed on noticeboards throughout the premises. Staff we spoke with said they would refer to the SMO and/or the health visitor if they had safeguarding concerns about a patient.

Reception staff confirmed alerts were applied to the DMICP (electronic patient record system) record for patients identified as vulnerable. The alert meant reception staff could ensure an appropriate and timely appointment for the patient. A clinical code was added to the records of patients assessed as vulnerable. The SNO undertook regular DMICP searches to check for vulnerable patients. We confirmed through a DMICP search that there were no care leavers registered at the practice. At the time of the inspection, there were 11 adults and 8 children coded as vulnerable. A vulnerable patients audit was completed in July 2024.

Service personnel and others were assessed for vulnerability prior to taking up post in Sennelager. This was undertaken by the Regional Command Centre as there was limited access to specialist services in Germany. A Vulnerable Risk Management system was held for each unit, which was reviewed by the unit and SMO and, if appropriate, a care assessment plan developed for each vulnerable patient. There were 3 units based at Sennelager and the practice was represented at the unit Commanders Monthly Case Review meeting. Vulnerable patients were also tracked and discussed as part of the monthly practice clinical meetings.

Sennelager supported multiple lodger units and not all were based in Germany. As there were no specific safeguarding processes or point of contact for each lodger unit, the Commanding Officer’s weekly operational group meeting providing a forum to discuss any emerging trends in relation to safeguarding.

A contract was in place with the British Forces Social Work Service (referred to as BFSWS), who provided a 24-hour telephone service. A flowchart detailing how to access BFSWS was displayed at the practice. In addition, BFSWS visited Sennelager 2 to 3 times a year and could undertake additional visits if requested. Unit commanders described how they had good links with BFSWS. A safeguarding board meeting was held quarterly, which the SMO or SNO attended.

Clinicians provided examples of concerns with patients and/or families that were effectively managed with multi-agency involvement, including the input of BFSWS. The practice team

identified the need to support families with vulnerable children. Consequently, 2 nurses and the health visitor recently received training in ‘early help’ and had implemented this approach for a small number of families registered at the practice.

The staff team received chaperone training in February 2025. A list was held in reception and included a mix of male and female chaperones. Both clinical and non-clinical staff were trained as chaperones and all those we spoke with were aware of the role of a chaperone in a healthcare setting. The availability of a chaperone was prominently displayed throughout the practice and outlined in the patient information leaflet. Our review of patient records showed the physiotherapist consistently recorded/coded the offer/use of a chaperone on DMICP. The SMO advised that an audit of clinical records identified that not all clinicians coded/recorded the offer/use of a chaperone. Interviews with clinicians confirmed this. The SMO planned to discuss this at the next clinical meeting.

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 DPHC(O) policy. Records showed professional registration was in-date for clinical staff. Both a DBS and professional registration audit was completed in February 2025. The staff induction included a list of all recruitment checks required and the induction was used for both permanent staff and locums. The practice manager maintained the vaccination records for all staff.

The SNO was the lead for infection prevention and control (IPC) and had completed the link practitioner training. All staff were up-to-date with mandated IPC training. Measures were in place to minimise the outbreak and spread of communicable diseases. Hand sanitiser was available and hand washing technique posters were displayed in various areas of the building. Appropriate equipment was in place for bodily fluids spills and health care related waste. Promptly after the inspection, the practice developed a flowchart to aid staff with the management of infectious patients. An IPC audit was completed in December 2024 and the action plan identified many of the issues we found in relation to the infrastructure.

The medical centre was located in one of the oldest buildings on the base and was not fully compliant with IPC and health and safety standards. Our review of the building identified both IPC and trip hazard issues with the flooring in various clinical areas, exposed pipes and non-compliant IPC sinks. In addition, deterioration of plasterwork and paintwork was evident. The inside of strip lights in all areas needed to be cleaned. Some equipment such as sanitary bins, clinical waste bins and toilet brushes needed to be replaced to meet IPC standards. The practice addressed some issues promptly after the inspection, such as reporting the trip hazards and laminating posters.

The known IPC risks related to the infrastructure were identified on the risk register as a transferred risk. A User Requirement Document (referred to as a URD) was submitted by the SMO to both the Commanding Officer and project team who had assessed the infrastructure. The project team’s report identified the need to rebuild/refurbish the building. Painting some areas of the building had been agreed and this was due to start in the coming weeks.

Staff reported that a proposal had been discussed to co-locate the dental and medical centres by building an annex onto the medical centre building. Shortly after the inspection,

a representative from the DPHC infrastructure team visited the practice specifically to review the infrastructure concerns.

The cleaning contract was provided by NAAFI, a not-for-profit organisation supporting British Armed Forces across the world. The practice manager was the point of contact and described effective relationships with NAAFI managers. Environmental cleaning records were maintained and signed each day to confirm cleaning had taken place. The practice manager recorded their review of the premises each week. Records showed deep cleaning took place twice a year during summer and Christmas leave periods.

Cleaning staff provided a total of 13 hours of cleaning each day. The cleaning undertaken was an office standard clean rather than a clinical clean as clinical and patient areas were only cleaned once a day. Although a carpet cleaner was available, cleaning staff reported they did not know how to use it so it was unclear if the carpets in non-clinical areas had been cleaned. There was minimal storage space and no separate handwashing sink in the room used by cleaning staff. This had been identified on the IPC audit. Clinical equipment and other items were stored in the area used as a sluice, which was a contamination risk.

The premises had capacity to open up an area for the medical team with transient units but the cleaning contract did not accommodate for the additional cleaning involved. Equally, cleaning staff reported the dedicated area for the peripatetic Multi-Injury Assessment Centre team was not routinely cleaned. Cleaning staff advised they had not received training in needle stick injuries or bodily fluid spills. We discussed whether this could be addressed as part of the contract monitoring process. After the inspection the practice confirmed the cleaning team had been briefed on the management of bodily fluid spills.

Acupuncture was provided by the physiotherapist. IPC measures were taken with this procedure to minimise the risk of infection.

Records showed that clinical waste was safely managed. All yellow bags, sharps bins and pharmaceutical waste was stored in plastic bins in a dedicated secure room. A register was held of each clinical waste item. The contractor weighed the waste and charged for collection based on weight. Receipts of collection were retained by the practice manager. A pre-acceptance clinical waste audit was completed in March 2024. A separate process was in place for the removal of cytotoxic waste. Sharps boxes were labelled and dated appropriately.

Risks to patients

It was identified on the risk register that the practice was staffed to cater for a patient population of 650. With a large transient and increasing population, the SMO reported that the number of registered patients can vary between 800 and 3,000. The practice recognised that the current workforce was not adequate to ensure a safe and adequate service. A workforce review undertaken in December 2023 identified an uplift in staffing was required.

When additional military doctors were available then the practice had sufficient capacity to manage a surge in the patient population. However, the availability of extra doctors was inconsistent. Although a unit-attached medic was working from the practice, there was limited administrative support to manage the extra work generated by the transient

population, such as audiology and vaccination management. During periods of insufficient clinical cover, Regional Headquarters (RHQ) supported with sourcing locum cover.

In 2024 the practice experienced a turnover of staff including a change in SMO, SNO and the loss of the MOD GP. There was a gap in SMO presence between April and September 2024. During this period, locum doctors provided cover. In the absence of a deputy practice manager (DPM), the practice manager has relied on the civilian workforce to assist with some of the practice management roles. A deputy practice manager was due to start working at the practice in March 2025.

Throughout 2025 further staff changes are expected for a variety of reasons, including redeployment, retirement and contract expiry. This staff loss will impact the dispensary, nursing team, Primary Care Rehabilitation Facility (PCRF) and practice management. Many clinical staff due to leave had key lead roles which will further impact the service, including the physiotherapist who was the healthcare governance lead.

The PCRF was particularly vulnerable and lacked any resilience as there was just 1 physiotherapist working in the department. This had impacted the PCRF consistently not meeting new patient key performance indicators. Any absence of the physiotherapist resulted in a significant backlog of clinical and non-clinical duties. Whilst RHQ supported the use of a locum, it was rarely achieved due to the short duration of each absence. The PCRF had appropriately captured and escalated this risk. Following detailed work, the physiotherapist managed to secure an exercise rehabilitation instructor (ERI) but the ERI was not due to start until January 2026.

The physiotherapist post was open to a range of ranks, meaning a junior inexperienced military physiotherapist could take up this position. With no other clinicians in the PCRF, continuing professional development, supervision and rehabilitation focused in-service training was not readily available; essential for more junior staff. This deficit was further enhanced due to the broader clinical caseload seen at the PCRF, including families. The risk had been escalated to the Chain of Command in January 2025. We were advised that a DPHC overseas rehabilitation lead had been appointed as project lead for this issue. At the time of the inspection, the practice had not received a progress update.

The SNO was the lead for medical emergencies. The medical emergency trolley was stored in the emergency treatment room close to the dispensary. The red tags used to secure the trolley were checked and signed for each day. Minimal medicines were held on the trolley so to enable quick access, a dispensary key was held within the trolley. The documentation completed and signed after an emergency event was forwarded to dispensary staff for tracking and new paperwork issued for the resuscitation trolley.

A full check of the kit and emergency medicines was undertaken monthly or if the trolley had been opened/used. These checks were recorded. Medical gases were stored in accordance with policy. There was no automated external defibrillator (AED) in the main gym and an AED was not taken to the gym when the physiotherapist held rehabilitation classes there. The nearest AED was in the main guardroom, which was not close by. We discussed taking the AED held in the PCRF to the gym for rehabilitation classes following discussion with the practice's resuscitation and equipment leads.

The staff team was in date for basic life support training, anaphylaxis and the use of a defibrillator. Annual refresher training was scheduled for March 2025. Following emergency procedure training session in 2023, the practice manager developed a local working practice protocol for managing emergencies.

Scenario-based training was periodically facilitated. As a result of a patient attending the practice with anaphylaxis (severe life-threatening allergic reaction), the team received specific training (referred to as a ROC drill) in January 2025 so staff were aware of their role in the event of a medical emergency. They also received further anaphylaxis training, including a consolidation practice exercise. Staff we spoke with said they felt better prepared for managing a medical emergency following this training.

A further example of an emergency incident involved a road traffic accident on the base. German emergency services were called and the Defence fire service attended to support and transfer the patient. The patient was subsequently transferred to the Defence Medical Rehabilitation Centre at Stanford Hall.

Staff had not received training in the recognition and management of the deteriorating patient/sepsis. Although not mandated DPHC training, it is considered good practice that staff are aware of sepsis. Promptly after the inspection, the practice confirmed a sepsis flow chart was placed in reception and sepsis added to the in-service training programme. Military staff had completed heat/cold illness training online.

Information to deliver safe care and treatment

Staff reported minimal disruptions with DMICP outages. To mitigate the risk to patients in the event of an outage, the practice followed the business continuity plan, including printing the clinic list for the next day. With an unplanned outage, patients were made aware of the outage through a variety of methods, including the base social media platform and the British Forces Broadcasting Service (referred to as BFBS).

The lack of IT connectivity between the NHS system, German hospital providers and DMICP was identified on the risk register. The risk was mitigated by obtaining hardcopy clinical records which were translated.

Record summarisation was totally nurse-led. All new patients to the practice were offered new patient medicals. Ninety-two percent of clinical records for military patients and 93% for civilian patients were in-date for summarisation.

Arrangements for the annual auditing of clinicians' record keeping were established. The SNO reviewed the records for each of the nurses and the SMO audited the SNO's records. The SMO also reviewed the record keeping for the doctors and the MOD GP audited the SMO's records to ensure objectivity. The foundation doctor (FY2) was due to have their record keeping audited. The medic's notes had been audited by the MOD GP who joined the practice in January 2025. The medic reported that this had been useful in supporting them to improve their record keeping. One of the nurses audited the physiotherapist's records using the DMICP rehabilitation notes audit tool. We discussed with the physiotherapist adapting the synonym (short cut to standardise clinical activity) to ensure all mandatory areas of notes were captured.

A comprehensive approach for sample management was in place involving a 2-layer process. All samples included a barcode, were entered in the sample book and recorded on DMICP. Samples were sent each day to the local hospital for testing. All results were returned in paper form and in German. They were translated by the German speaking nurse who flagged anything urgent to the clinician who requested the test. If the nurse was unavailable, staff used the local translation service. However, they described this service

as ‘clunky’ with delays in receiving translated results. For urgent access to results, Google Translate was used. Results were recorded on DMICP and all results were checked by the requesting clinician or duty doctor. The nurses reported that since this system was introduced all results were returned to the practice in a timely way. On the day the sample was taken, the patient was asked to make a follow-up appointment to receive their results.

Two dedicated administrators who both spoke German oversaw referrals to secondary health care (SHC). In the absence of the administrators, one of the nurses could take over as they understood the referral process and spoke fluent German. The majority of patients were referred to SHC in Germany with a small number of patients referred back to the UK. At the time of the inspection, only the SMO held an NHS smartcard to access the NHS e-Referral Service (e-RS). In the absence of e-RS smartcards, the SHC team contacted UK hospitals directly. We were advised that the SMO had requested smartcards for the SHC team to access e-RS directly.

A detailed process was in place for the management of referrals with a number of steps required for each referral. The referring clinician tasked the SHC team on DMICP who then faxed or emailed the referral to the relevant SHC facility (10 German SHC facilities were used by the practice). A comprehensive referrals register was maintained, which was monitored and updated daily. A separate register was held for breast screening and obstetrics. Collectively, the registers showed 200 referrals had been made during January and February 2025. We were advised that a similar NHS ‘2-week-wait process’ was not available in Germany. Patients with a suspected cancer were seen promptly as the SHC team had well established relationships with the hospitals so requests for referrals to be fast tracked were responded to promptly.

Under the brand name, ‘One HMG’, Healix International managed healthcare services for UK Government employees and their families oversees. A Defence Instruction Notice (referred to as a DIN) was in place and outlined the arrangements with One HMG/Healix, including the organisation’s role with SHC.

Since the medical centre re-opened in October 2020, the SHC team has progressively brought German SHC providers into the Healix network. For each referral, a form was completed for Healix. Following treatment, medical bills received from German SHC providers were forwarded to the finance team at Healix for payment. If a patient rearranged their appointment then the process with Healix was re-started. If a SHC facility was not an approved Healix provider, the finance officer arranged direct payment.

Patient outcome letters from SHC were faxed or emailed to the practice. The German speaking nurse reviewed the letters to ensure clinical language was accurate and to identify any patients who needed to be seen promptly by a practice clinician. The letters were then forwarded to the ‘Big Word’ for translating. Once received back to the practice, they were scanned to the patient’s DMICP record. The SHC team followed up on any outcome letters that were not received back from SHC within 28 days.

The SHC team reported that very few patients failed to attend their SHC appointment. If a failure to attend pattern was identified (usually 3 missed appointments) then the patient was referred to a practice doctor to discuss the matter.

Physiotherapy referrals were sent electronically via the Regional Rehabilitation Unit. The physiotherapist maintained a referral database and monitored whether patients had received their appointment and/or plan.

Safe and appropriate use of medicines

The MOD GP was the lead for medicines management and the pharmacy technician (PT) was responsible for the day-to-day management of the dispensary. DPHC standard operating procedures (SOP) were followed for managing the dispensary and a signature log was in place. The management and security of prescriptions was compliant with DPHC policy and all prescriptions were signed before they were released. A process was in place for uncollected prescriptions, including antibiotics and psychoactive (affecting brain function) medicines. The last full stock check was carried out in October 2024.

A secure process was in place to access both the dispensary and controlled drugs (CD) cabinet. However, we discussed with the PT maintaining a key log for access to CD keys. This was promptly put in place after the inspection. Duplicate keys for the dispensary were held in the practice manager's office. The key to the dispensary was held in a tamper proof container on the medical emergency trolley for emergency access when the dispensary was closed.

Controlled and accountable drugs (medicines with a potential for misuse) were held in a cupboard with external hinges. This has been risk assessed by the regional pharmacist and was a 'tolerated' risk. A copy of the DPHC SOP for CDs was held in the dispensary. The regional pharmacist held the self-declaration which was in-date at the time of inspection. Monthly and quarterly CD checks were carried out in line with policy. The destruction of CDs was safely carried out in accordance with policy. The annual CD audit was completed in October 2024.

Medicines for medical emergencies were recorded on DMICP in a separate stock location to that for routine medicines as directed by the regional pharmacist. The emergency medicines list was practice specific and had been approved, countersigned and complied with DPHC medicines management policy. Although no risk assessments had been completed for optional emergency medicines, we were provided with evidence after the inspection that risk assessments signed by the Regional Clinical Director were now in place. The medicines we checked were all in-date.

The PT was the lead for the cold chain and ordered the vaccines. Two of the nurses were aware of the requirements for cold storage in the event the PT was not available when vaccines were delivered. Fridge temperatures were correctly monitored and were in range. Thermometers were in-date. Our check of the fridges showed all vaccines were in-date and stock rotated appropriately with longer expiry dates to the rear of fridge. Fridge cleaning was carried out in accordance with policy.

Vaccines were recorded on DMICP and the PT used the 'Vaccine Bulletin' to inform purchasing. Approved insulated boxes to maintain medicines at a stable temperature were held for the occasional transfer of medicines to SHAPE, NATO's Allied Command Operations Headquarters in Belgium.

Patient Group Directions (PGD) to administer medicines in line with legislation were used by the nurses. PGD training for the nurses was current and the PGDs had been signed off by a doctor. No delegation of PGD processes took place and the PT tracked the expiry dates of the PGDs. An annual PGD audit was undertaken. Equally, the practice was compliant with the use of Patient Specific Directions.

The locum nurse was a non-medical prescriber (NMP). In line with the DPHC SOP, 'Conferring Prescribing Rights to Non-Medical Prescribers', the practice had formal

authority from Commander DPHC to permit the nurse to prescribe. Their registration as an NMP was checked when they took up post and was subsequently checked as part of the annual registration audit; last completed in February 2025. In addition, the NMP's prescribing was included in the antimicrobial prescribing audit for the practice. The MOD GP provided informal supervision to the NMP in the form of reflective conversations and advice when required.

The process for the management of high risk medicines (HRM) had been revised since the MOD GP took up post in January 2025 and staff acknowledged that further work was needed. One of the nurses conducted regular searches (DMICP shared searches) to check for patients prescribed an HRM. As there was low confidence with the search, the team also relied on local knowledge and the PT's local list. A register had been developed and was almost completed at the time of the inspection. The PT agreed to add shared care agreement (SCA) medicines that were not routinely considered high risk. All patients prescribed a HRM requiring follow-up had been contacted. An audit was in progress and the MOD GP planned to create an action plan for sharing and monitoring with the team to ensure follow up.

Prescribing via German SHC was a known risk. Unlike the NHS and in the absence of contractual arrangements, SCAs were not provided by German SHC services. As there was no shared electronic medical systems, the practice was not always aware of SHC prescribing for all medicines, including those deemed to be a high risk; unless the practice was informed by the patient. For example, if a patient registered at the practice was a German citizen, they were not entitled to sick pay if they were referred via the practice. Therefore, some patients did not inform the practice about their health condition. This risk was a challenge to mitigate besides persistent requests from SHC services and escalation of the risk to RHQ. In addition, the Royal Centre for Defence Medicine could provide advice via the patient tracking cell or the Pando app, an encrypted instant messaging platform for healthcare.

Repeat prescriptions could be requested via the group mailbox or through a quick-response (QR) code. The QR code had recently been introduced to offer patients an alternative option to request a repeat prescription. It was displayed and included in the patient information leaflet. We discussed further promoting this method of requesting a repeat prescription by including the QR code in prescription bags. No telephone requests were accepted. A recent review of the management of HRMs identified inappropriate repeat prescribing, which was being addressed by the MOD GP.

DMICP searches for patients prescribed Valproate (medicine to treat epilepsy and bipolar disorder) were undertaken. The PT was aware of the risks and action required for patients prescribed this medicine. An antibiotic audit was in progress at the time of the inspection. It was due to be discussed at a clinical meeting when completed.

Track record on safety

The practice manager was the building custodian and the lead for health, safety and fire (referred to as SHEF) and non-clinical risk. The SMO was the lead for clinical risk and the physiotherapist was the risk manager for the PCRF. A range of regularly reviewed risk assessments were in place. SHEF was a standing agenda item on practice meetings and

minutes showed the views of staff were sought about how to improve the infrastructure. The contractor periodically visited to monitor the infrastructure.

The risk register took into account the DPHC '4 T's process' (transfer, tolerate, treat, terminate) to illustrate at what level each risk was being managed. The risk register was a standing agenda item on the healthcare governance meetings and was last reviewed by the SMO and practice manager in January 2025. An issues log was also in place along with a building faults log for issues reported.

Two lockable cabinets were in use for substances hazardous to health (referred to as COSHH) used by practice staff. Both stored COSHH items and the data sheets were stored in one cabinet. We discussed how it would be more efficient to use just 1 cabinet and ensure the data sheets were easily accessible to staff. Cleaning staff were responsible for monitoring the COSHH products they used and had access to the product data sheets and risk assessments via the contractor.

Processes were in place for the regular monitoring of utilities. The electrical inspection certificate was dated January 2019 so was due to be updated. The gas safety certificate was issued in February 2025 and water safety checks were undertaken in February 2025.

One of the reception staff was the fire custodian. The 5-yearly fire risk assessment for the premises was completed in March 2024. Checks of the fire alarm system and firefighting equipment were in place and records showed firefighting equipment was tested in February 2025. Staff reported that a fire evacuation drill was held annually.

The practice manager was the lead for equipment. The annual equipment inspection (referred to as a LEA) for the medical centre was completed in November 2024. Clinical equipment was serviced by the UK-based medical and dental servicing section (a military capability referred to as MDSS). Broken items could take time to repair so to mitigate this risk, duplicate smaller pieces of equipment were held. MDSS could fly out at short notice to repair emergency equipment. The annual electrical portable appliance testing (referred to as PAT testing) was being undertaken by the contractor on the day of the inspection. The physiotherapist managed the PCRF equipment. From our review, the equipment was in good working order. Documentation to confirm equipment checks and routine servicing were up-to-date. RHQ carried out a 'snap inspection' of equipment in December 2024.

Wet globe bulb testing (WGBT) to indicate the potential for heat stress was not required for the PCRF as no rehabilitation classes and limited cardiovascular activity took place. When using the main unit gym, the physiotherapist referred to the WBGT readings undertaken by gym staff.

Non-recording cameras were in place and reception staff could observe patients in all waiting areas. The lone working SOP was reviewed in January 2025. Personal alarms were available in all areas used by patients. The use of personal alarms was covered in the induction package and all staff had been briefed by the practice manager to respond promptly when an alarm was activated. The alarms had recently been checked for response times. A forecast for the testing of each alarm was in place. We tested the alarm in the dispensary during the inspection and there was a prompt response from staff. Due to the size and configuration of the building, we were advised by staff that alarms were not always heard in all areas of the building. For example, if the PCRF activated an alarm, it was not audible at reception. The physiotherapist had a location board to indicate their whereabouts if not in the PCRF.

Lessons learned and improvements made

The practice worked to the DPHC policy for reporting and managing significant events, incidents and near-misses, which were recorded on ASER (organisational-wide system for reporting significant events). All staff had completed ASER training to access and use the system. Paper copies of ASER reporting forms were held in the event of a system outage.

An ASER register was in place that included a summary, outcome and actions/closure details. ASER was standing agenda item on the healthcare governance meetings. Staff we interviewed provided various examples of ASERs discussed. An ASER audit was completed in December 2024 with the main theme identified as clinical processes. A summary of the audit was included in the healthcare governance meeting in January 2025. The practice manager developed a briefing of lessons learned which was emailed to all staff in February 2025.

A process was in place for managing notices and alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) received through the Central Alerting System (CAS). MHRA and CAS alerts were received via the group mailbox, reviewed by the pharmacy technician and added to the alerts register. As the pharmacy technician was due to leave in 3 weeks, we discussed how this role would be covered. We were informed that both the SNO and practice manager had signed up to receive alerts directly. Practice meeting minutes showed MHRA alerts were discussed and included a link to each alert.

Are services effective?

We rated the practice as requires improvement for providing effective services.

Effective needs assessment, care and treatment

To ensure staff were up-to-date with clinical practice, they received regular updates on developments in clinical care including National Institute for Health and Care Excellence guidance, current legislation, standards and other best practice guidance (BPG). Updates were received through clinical meetings and via the Defence Primary Healthcare (DPHC) newsletter circulated each month. The physiotherapist attended regular BPG meetings and shared relevant information with the team.

Patients with complex needs were identified initially through scrutiny of their clinical records when they first registered at the practice. If appropriate, their needs were discussed at clinical meetings and/or through multi-disciplinary team (MDT) engagement with other clinicians units and departments, such as the mental health team, welfare and the health visitor.

Our review of patient records for the Primary Care Rehabilitation Facility (PCRF) confirmed a holistic approach was undertaken including an assessment of lifestyle, such as diet, sleep, smoking habits and fitness testing. The physiotherapist used relevant questions in the Musculoskeletal Health Questionnaire (MSK-HQ) to explore issues related to sleep. If patients needing wider holistic input, they were discussed at the MDT or contact was made with Defence and National Rehabilitation Centre.

In accordance with Defence and national clinical guidelines, the physiotherapist used the MSK-HQ and Functional Activity Assessment (FAA) as well as condition-specific measures. Both the MSK-HQ and FAA are standardised outcome measure for patients to report their symptoms and quality of life. These tools were being used to support clinical decision making and care delivery rather than for service evaluation to determine the quality of care. We discussed including an integrated service evaluation in the annual audit cycle whilst acknowledging that the physiotherapist's time and capacity was limiting given they were a sole clinician in the PCRF. Rehab Guru (software for rehabilitation exercise therapy) was used although not consistently due to capacity and time-limiting factors.

Space in the PCRF was insufficient as the facility was split across 3 small rooms; 2 of which had been re-purposed as small PCRF gym spaces. In addition, equipment scaled for the PCRF was not available as the spaces were of an inadequate size to accommodate further equipment. With an exercise rehabilitation instructor starting in January 2026, we highlighted that additional clinical space was essential.

The PCRF and its waiting area was at the end of long corridor within the medical centre. When the floor was wet during cleaning periods, there was a risk of slipping especially for patients with mobility issues. An option was being considered for the PCRF to move to the dedicated area used when there a 'surge' of service personnel was scheduled. This would increase space, clinical rooms and reduce the transit for patients.

Monitoring care and treatment

The practice had a higher than average number of patients aged between 50 and 79 (19%) compared to other DPHC practices. From the outset of the inspection, the Senior Medical Officer (SMO) acknowledged that long term conditions (LTC) had not been effectively managed during 2024. This was in part due to limited primary healthcare (PHC) expertise within the nursing team. In addition, the practice had been short of doctors for approximately 5 months in 2024 and relied on locum doctors providing clinical input. Furthermore, it was identified that clinicians, including locum doctors, had not always adhered to local standard operating procedures, including the use of templates, alerts and accurate clinical coding. This created a challenge with the reliability of searches. Our review of a range of records confirmed clinical coding and alerts were not in place for all patients with an LTC and mental health conditions and recall dates had not always been set. Some of these issues were addressed for individual patients during the inspection.

An ex-military experienced PHC MOD GP joined the practice in December 2024 and had taken on the lead for medicines and LTCs. Along with the nurses, the lead was in the process of revising the approach to LTC management, including the recall of patients. The first of quarterly LTC meetings was held at the beginning of January 2025. The use of searches, spreadsheets and Population Management (referred to as POPMAN) were discussed and the team agreed that the various search processes were not always coherent. Although acknowledging further work was needed, the following structure had been put in place:

- Leads for each LTC were identified.
- The setting up of LTC registers. At the time of the inspection, an asthma register had been created and further registers were scheduled to be developed.
- Pre-formed searches and POPMAN were agreed as the methods to identify patients for recall. The Senior Nursing Officer (SNO) confirmed that all the searches had now been completed.
- One LTC search to be undertaken each month with a focus on that work stream until it was completed.
- Patients out-of-date for a review to be contacted and offered an appointment.
- The nurses to undertake up to 25 reviews each week.
- The first working day of each month was dedicated to auditing LTCs and managing recalls.
- An LTC audit calendar was developed.
- The monitoring of LTCs to be included in the nurses' meetings.
- Guidance on managing LTCs was being developed to support temporary staff including locums.

Following the monthly search, the nurses described how the reception team contacted the patients to invite them for a review. Patients were contacted twice by telephone and then emailed if no response was received. This was a time consuming process as the GOV.UK Notify text system was not available in Germany. Prior to review by a doctor, the nurses completed baseline tests, such as, blood tests, blood pressure and weight. Whilst we

acknowledged that improvements had been made in a very short period of time, not all patients had been reviewed.

LTC statistics were provided pre-inspection. Some of these figures differed to information we received during the inspection. For example, pre-inspection information indicated 67 patients were identified as having high blood pressure and 45 had their blood pressure taken in the past 12 months. We were advised during the inspection that there were 70 patients with high blood pressure and most had not been reviewed in the last 12 months.

There were 21 patients on the diabetic register. For 12 patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For 18 patients, the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.

In addressing the deficit with LTCs, the focus had been on recalling patients with asthma. This followed an audit completed by the locum nurse in December 2024, which indicated templates were not consistently used. In January 2025, training was delivered to all clinicians regarding the templates and clinical codes to use and also an update on the recent changes to guidelines. Asthma data showed 18 of the 24 patients identified had received a review. Not all patients with asthma had a plan in place; this was being addressed as each individual asthma review was undertaken.

Audiometry assessments were in-date for 83% of the patient population. Our review of patient records demonstrated Joint Medical Employment Standards (referred to as JMES) were appropriately managed. Patients with reduced hearing identified through screening at the practice were referred to a local secondary healthcare (SHC) specialist. Through an audit in February 2025, the MOD GP identified that the specialist testing did not include all the military required hearing frequencies. As a result, a specialist who carried out military standard testing was sourced. Patients who had not been tested appropriately were in the process of being re-referred. This work was raised as a quality improvement project (QIP). The SNO agreed to follow up with the SMO a patient we noted who was 6 years overdue an audiometry assessment.

Step 1 of the DPHC mental health pathway was mainly delivered at the practice or patients could be referred to the overseas mental health team. Staff described good support from the consultant psychiatrist and wider mental health team, including the psychologist and community psychiatric nurse who provided face-to-face or remote support. It was rare that children and young people were referred to UK mental health services. Staff reported that it was a challenge as the families living in Germany did not have a UK registered address therefore the NHS would not accept the referral. Workarounds had been found, such as using a relative's UK address. However, the SMO was exploring a long term solution for this matter.

Used to evaluate the quality of care and improve patient outcomes, clinical audit was in the early stages of development. Due to inconsistent/insufficient staffing levels in 2024, audit had predominantly focused on process rather than clinical care, especially to ensure the DPHC required or 'must' audits were completed.

Now that staffing levels had improved, the SNO was leading on clinical audit and had a plan to develop the audit programme. First cycle asthma, diabetes and atrial fibrillation audits were recently completed and further LTC audits were scheduled, including repeat cycle audits. Minutes of the January 2025 healthcare governance meeting showed the

status of audits was discussed, including ‘must’ audits to be completed by 13 February 2025 and ‘should’ audits by 25 March 2025.

The physiotherapist undertook a non-attendance (referred to as DNA) audit which highlighted a spike in DNA rates impacting on availability and access. As a result, the text messaging patients appointment reminders alongside unit-wide stakeholder engagement led to a reduction in DNA rates so the PCRF was now meeting the key performance indicator for attendance. We discussed with the physiotherapist the value of formally recording this work as QIP and uploading it to the DPHC Healthcare Governance webpage so this initiative could be widely shared.

Effective staffing

The practice manager oversaw the induction of new staff including locums. The induction pack was updated in January 2025 and a copy of all completed induction packs were retained by the practice manager. Once the generic induction was completed and depending on their job role, new staff were rotated around the departments. The SMO developed an ‘eDesktop guide’ which included all information for processes specific to the practice. A link to this guide was given to new members of staff as part of their induction.

One of the reception staff monitored the mandatory training. They checked the training register each month and sent reminder emails to staff to complete the training. There were gaps on the DPHC Regional Headquarters (RHQ) mandatory training database, including overdue courses. The practice manager was aware of this and had prioritised the completion of key mandatory training courses, such as safeguarding, infection prevention and control (IPC) and basic life support, to ensure patient-facing clinical roles were not impacted.

Staff described how time was flexible to accommodate training, administration, continuing professional development (CPD) and peer review. In-service training (IST) regularly took place and the IST register illustrated a wide range of training topics were facilitated. Staff had training specific to their lead and secondary roles. For example, IPC link practitioner training for the SNO, the Band 5 nurse was trained in sexual health and the medic was trained in immunisations. The MOD GP was scheduled to complete diving training and the SMO had a GP trainer update planned. Practice staff had not yet completed the learning disability and autism training. The practice manager said they would action this and ensure the training was completed.

The physiotherapist specialism was to treat adults not children. They treated children over the age of 14 and this risk was identified on the risk register with the action to investigate if DPHC(O) accepted the risk. The physiotherapist was exploring options to complete a paediatric course. In addition, they sought out opportunities to maintain their clinical competence and assurance for the provision of acupuncture, including through CPD courses and IST. We discussed sourcing formal acupuncture CPD opportunities to maintain and confirm clinical competence and assurance.

As the SHEF lead, the practice manager had tried unsuccessfully to secure a place on the ‘Managing Safely’ course required for this role and this gap had been added to the issues register. The SMO highlighted there was a need for additional training and mentorship

within the nursing team, in particular PHC training to develop knowledge, including the management of LTCs.

Supervision/peer review was available for clinical staff. For example, the nurses completed clinical supervision within the nursing team and there was the opportunity to undertake this with other overseas medical facilities if required. Although the medic was supervised through regular review of their record keeping, we discussed with the nursing team the option of including the medic in this process. Although informal, the foundation doctor (FY2) received periodic supervision from the SMO and was also supported informally by the MOD GP. We highlighted that this supervisory arrangement would benefit from being formalised to demonstrate the FY2 doctor received regular on-going supervision.

The physiotherapist had limited access to CPD and clinical supervision due to working overseas and being a sole member of staff in the PCRF. They did have access to an Edinburgh-based Band 7 physiotherapist for support/CPD and attended quarterly regional IST days facilitated by Edinburgh Regional Rehabilitation Unit (RRU). However, there was a need for formal clinical supervision and training for the physiotherapist to ensure clinical competence to manage the broader/diverse patient population at PCRF Sennelager. We highlighted that there was the opportunity for peer review to take place when the RRU provided a clinic at the practice.

On Thursday afternoons following the team meeting and IST training, staff were encouraged to complete their CPD. The practice manager informed staff of any CPD opportunities available and CPD requests were submitted to the RHQ overseas training lead.

Coordinating care and treatment

We spoke with the Welfare Officer, Padre and Commanding Officer who described how the practice worked well with the wider base to ensure service personnel and their families, particularly those who were vulnerable, were effectively supported. The SMO and MOD GP shared the workload for attending the Commanders Monthly Case Review (CMCR) meetings. If time permitted, the physiotherapist also attended the CMCR.

Practice staff were in regular contact with the health visitor, midwife and liaised with BFSWS as required. The health visitor attended the practice meeting and facilitated a coffee morning at the practice each month. The mental health team was responsive to any queries or concerns clinicians had. The physiotherapy had a good relationship with the RRU, which had been key to securing a peripatetic Multidisciplinary Injury Assessment Clinic and podiatry service. The physiotherapist was awarded a Commanding Officer's commendation for this initiative. We discussed with the physiotherapist the value of formally recording this work as a QIP. In addition, the relationships developed with German SHC services meant urgent referrals were managed in a timely way.

We were advised that many patients leaving the military settled in Germany. There was no process for direct transfer of records for the German healthcare system. For those leaving, a Subject Access Request (referred to as SAR) was completed. The practice had discussed the option of having a veterans lead as approximately 50% of permanent personnel were veterans.

Helping patients to live healthier lives

The SNO oversaw the health promotion programme. Health promotion leaflets and displays were well organised with a wide variety of information for patients to access. Health displays at the time of the inspection included managing ticks, healthy eating and prostate cancer. Information for the 'tactical athlete' was displayed along with women's health information, including physical activity during and after pregnancy. The practice supported with the unit-led health fairs.

The physiotherapist was a Defence Health and Wellbeing Advisor and supported service personnel with improving their physical activity and diet. They could also refer patients to the Defence Occupational Fitness Programme (referred to as Dofit).

Sexual health advice and screening was provided by clinicians, in particular the nurse who was qualified in sexual health. A female MOD GP recently joined the practice and was keen to expand the service for women, including implants and intrauterine devices. Through the Pando app, sexual health advice was available from the Royal Centre for Defence Medicine. Information was displayed in the toilets about sexually transmitted infections and screening. Patients could request a chlamydia screening kit. Condoms were available in the dispensary and treatment rooms.

A process was in place to identify patients eligible for the national screening programme. Screening statistics were:

- Bowel – 101 patients were eligible and 96% had been screened
- Breast – 44 patients were eligible and 98% had been screened
- Abdominal aortic aneurysm – 44 patients were eligible and all had been screened
- Cervical – 167 patients were eligible and 95% had been screened which exceeded the NHS target of 80%

Systems were in place to check the vaccination status of service personnel and children. These included the new patient registration process, routine DMICP searches and the use of diary dates.

The status of childhood vaccinations was:

- The percentage of children aged 1 who had completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (i.e., 3 doses of DTaP/IPV/Hib/Hepatitis B) was 83%
- The percentage of children aged 2 who had received their booster immunisation for Pneumococcal infection was 75%
- The percentage of children aged 2 who had received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) was 79%
- The percentage of children aged 2 who had received immunisation for measles, mumps and rubella (one dose of MMR) was 77%
- The percentage of children aged 5 who had received immunisation for measles, mumps and rubella (two doses of MMR) was 68%

As the vaccination statistics were lower than the national average, we explored this with staff and a number of reasons were indicated. The practice had 120 registered children aged 0-9, including 59 children under the age of 5. It was recorded that vaccinations had been declined for just 1 patient. Staff explained that some children were showing as unvaccinated as their medical records had not yet been received by the practice.

In addition, some children attended boarding school in the UK and were registered as a temporary patient if they returned to Germany for a period of time. The children who boarded in Germany were absorbed into the German recall system. These exceptional circumstances meant tracking the vaccination status of children was a challenge as German healthcare services were not contracted to engage or share information with the military.

For service personnel, the vaccination statistics were:

- 92% of patients were in-date for vaccination against diphtheria.
- 92% of patients were in-date for vaccination against polio.
- 96% of patients were in-date for vaccination against hepatitis B.
- 97% of patients were in-date for vaccination against hepatitis A.
- 92% of patients were in-date for vaccination against tetanus.
- 99% of patients were in-date for vaccination against measles, mumps and rubella.

Consent to care and treatment

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. This included the Mental Capacity Act (2005) and how it could apply to the patient population group. Staff reported that they had received mental capacity training.

Implied and verbal consent were mostly used. A risk assessment was completed and informed written consent was taken for acupuncture. These documents were then scanned to the patient's DMICP record. The patient records we reviewed showed patient consent was mostly recorded. A consent audit had not been completed within the last 12 months.

Clinicians were aware of the 'Gillick competence' (process to assess whether a child has capacity to consent to medical treatment) and the 'Fraser guidelines' (process to decide if a child can consent to contraceptive or sexual health advice/treatment). One of the nurses provided contraceptive advice to 14 and 15 year olds so was mindful of ensuring correct consent processes were in place. Any concerns were raised with the SMO in their capacity as safeguarding lead or were discussed at MDT meetings.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

To understand the patients' experience of the service, we interviewed 9 patients during the inspection and reviewed patient feedback from the practice's January 2025 survey (29 responses). Collectively, all feedback suggested staff were friendly, understanding and compassionate.

We heard examples of when the practice had 'gone the extra mile' to support patients, including supporting a patient who returned to the UK for health reasons. Patients provided examples of when they had received additional care. In particular, new mothers told us input from the midwife and health visitor (HV) was very supportive, especially as they were in a different country without the same level of support they would have in the UK. Breast feeding and baby changing facilities were available at the practice.

We spoke with the base Commander who had a good knowledge of the patient population, including the needs of service personnel and their families. They provided examples of support that had been provided to vulnerable patients. We heard 'coffee mornings were facilitated by the Welfare Officer. In addition, social activities were regularly held, including trips and a mobile cinema. A 'community forum' was held annually at which families could raise queries.

Patients had access to the 'Sennelager Hive' which provided general and local information for the UK military community in Sennelager including serving personnel, families, veterans, and civilian staff.

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. Patients reported that they were given sufficient time to ask questions and their condition was explained in a way that they understood, including prescribed medicine.

Staff had access to the 'Big Word' translation service and a nurse was fluent in German. Google Translate was occasionally used for the translating of secondary healthcare letters if the nurse was unavailable.

Patients with a caring responsibility were identified through the new patient registration process, DMICP searches or through the Commander's Monthly Case Review meetings. The flu vaccination was offered to the small number of carers identified who also had access to additional services through the welfare team. The needs of carers were discussed at the multi-disciplinary team meeting if needed. The practice's patient information leaflet included information for carers.

Privacy and dignity

Patient consultations/assessments took place in clinical rooms with the door closed. Regularly changed disposable privacy curtains were available in all clinical rooms for intimate examinations. Measures were in place at reception for patients to talk to the receptionist discreetly.

If a patient had a preference to see a nurse or physiotherapist of a specific gender and this could not be accommodated then they were offered a gender of choice chaperone.

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 specific needs of patients were identified when scheduling appointments through the use of DMICP alerts, such as those for vulnerable patients and carers. This meant these patients were promptly identified and prioritised for an appointment. A walk-in clinic was held each morning and extended appointment times could be facilitated. Appointments were arranged to accommodate working and school hours.

Despite the pressure of insufficient and inconsistent staffing levels, staff listened to feedback and other concerns, pro-actively responding to ensure a positive experience for patients.

For example, a contract was agreed with SSAFA (Armed Forces charity) for patients to have increased and consistent access to a health visitor (HV). With the support of the Senior Nursing Officer (SNO), the secondary healthcare team (SHC) had worked hard to secure a contract with a local English speaking midwife based on patients raising concern about inconsistent access to a midwife. This service provided pre and post-natal holistic care including lifestyle advice. Links had been strengthened between the HV, midwife, nursing team and wider practice as a result of this work. We discussed the value of formalising this initiative as a quality improvement project.

In response to the absence of a school nurse, the HV provided support to the school, such as making referrals to the speech and language therapist. The HV visited the practice twice a week and also provided a remote service. Furthermore, they attended the regularly held 'Tots of Fun' sessions at the community centre.

We were advised that the pharmacy technician had delivered medicines to patients who were unable to collect it.

In October 2024 the risk of a fragmented clinical pathway was identified when patients travelled to the UK to access the Multi-injury Assessment clinic (MIAC). Extended waiting times for investigations and follow-up appointments often resulted in the downgrading of service personnel. Since February 2025, the Regional Rehabilitation Unit Edinburgh had facilitated a peripatetic MIAC clinic at Sennelager. The clinic has resulted in financial savings and improved efficiency and effectiveness of the rehabilitation care pathway with the potential long-term effect of reducing long term musculoskeletal conditions and increasing personnel available for deployment.

A child provided feedback suggesting the waiting room was boring. A colourful interactive children's play area was developed in a space within the waiting area. It also included children's books. The practice introduced a visual display of their pets with the challenge to guess which staff owned each pet. The board was popular with children and other patients.

A social media group was in place for families and the practice used this platform to share updates and information relevant to the practice and primary healthcare.

In response to feedback about the Primary Care Rehabilitation Facility (PCRF), the infrastructure and use of the building was under review. Moving the PCRF would create more space for additional equipment. This matter was awaiting a Defence Primary Healthcare (DPHC) infrastructure review.

The hospital liaison posts were de-established when the practice closed some years ago. Three patients we spoke with highlighted that the liaison team had been a valuable service for patients accessing emergency or SHC facilities. They reported that it provided guidance with navigating the German healthcare system, including support with the language barrier and accessing the correct department for appointments. To support patients, the SHC team had visited the SHC facilities and mapped out the route through the premises to access each department used. This information was included in the appointment letter the patient received. Feedback indicated patients appreciated this detailed guidance as it helped with reducing anxiety when attending an unfamiliar healthcare facility.

The Senior Medical Officer (SMO) reported that, on average, 8 patients accessed SHC each week. Even though SHC provided a translation service, the option of re-introducing a hospital liaison service was being explored at the time of the inspection. The use of 10 German healthcare facilities meant this was a challenge so the model of liaison was being carefully considered, including the option of a hospital liaison team based at the practice.

In line with the Equality Act 2010, an access audit for the building had been completed. Although an accessible toilet was available, it was not fully compliant as the automatic door was broken and there was no emergency alarm. The matter had been added to the issues register and building fault log. A work request was submitted to the contractor in January 2025.

Clinicians were aware of the military policy in relation to the management of transgender service personnel. Patients transitioning were identified at registration. Although not currently a clinical need, we noted there was no formal process to identify females transitioning to male for inclusion in the health screening programme.

Timely access to care and treatment

Feedback indicated patients were satisfied with the responsiveness of the service as they told us there was minimal wait times for an appointment. The medic said if they were concerned about a patient seen at the morning walk-in clinic and were unable to manage the patient's issue then they referred to a doctor. They said approximately 60% of the patients seen needed the input of a duty doctor.

Routine appointments with a doctor could be facilitated within a day and on the same day with a nurse or medic. Same day urgent appointments were available with a doctor, nurse or medic.

An analysis indicated that the lateness of a clinic and extra patients being added resulted in clinician fatigue. To minimise this risk, clinics were reorganised with separate times for children, those under the age of 65 and patients over 65.

No specific urgent appointments were assigned for the physiotherapist due to the risk of unfilled appointments. Any urgent requests were managed on a case-by-case basis. If

required, the physiotherapist created space to assess patients with an urgent need. The physiotherapist facilitated a mobility class once a week and it was available to all on the base.

It was a 7-14 day wait for a follow-up appointment, which had limited the ability of the physiotherapist to progress patients often leading to extended duration of their care. There was a 14-21 day wait for a routine appointment. The Primary Care Rehabilitation Facility (PCRF) was consistently not meeting the new patient key performance indicator due to insufficient staff and high referral rates of service personnel to the PCRF. When the physiotherapist was absent, the PCRF was shut and waiting times for new patients increased. This pressure on the PCRF will likely reduce when the exercise rehabilitation instructor starts in January 2026. The practice was exploring if this start date could be brought forward.

The Direct Access Physiotherapy (DAP) pathway was available for military patients and the physiotherapist reported it was used by 4-5 patients each month. The opportunity to audit DAP was limited due to other priorities within the PCRF. Civilian patients were referred to the PCRF by a doctor.

Home visits were not routinely provided as there was no capacity to provide this service. Out-of-hours access to medical care was displayed on the front door and outlined in the patient information leaflet, including the Healix helpline. An ambulance service was available and was in close proximity to the base.

Listening and learning from concerns and complaints

The practice manager was the complaints manager. Complaints were well managed and in accordance with the DPHC complaints policy. Patients were made aware of the complaints process through the practice information leaflet.

Both verbal and written complaints were logged and monitored. The complaints log showed 4 complaints were received since 2024. Complaints about clinical care were referred to the SMO.

Complaints were discussed with the team at the healthcare governance meetings. We were given an example of complaint about secondary healthcare (SHC). The resulting change meant that the SHC team now attended the multi-disciplinary team meetings to ensure continuity of care. A further complaint related to a confidentiality breach was referred to Regional Headquarters and resulted in an external doctor providing training for the staff in September 2024. A complaints audit was due to be completed.

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 addition, the local mission statement was identified as:

> "DPHC(O) Sennelager will deliver a unified, safe, efficient and accountable primary healthcare service for entitled personnel to maximise their health and to deliver personnel medically fit for operations, training and contingency."

Inadequate and inconsistent clinical staffing levels in 2024 meant it had been a challenge for the practice to ensure provision of safe clinical care in line with the mission statements, notably the safe and effective management of long term conditions.

To address environmental sustainability, paper and battery recycling was encouraged. Plastic bottles were recycled in Germany so many staff took these back to the shop. Staff took other items home to recycle in the normal way to reduce waste within the facility. Lights were switched off and windows closed if rooms were not in use. Radiators were turned down if rooms were too hot.

The pharmacist shared stock with SHAPE to minimise medicines expiring. In addition, there was a shift from using metered dose inhalers to more environmentally-friendly alternatives. Primary Care Rehabilitation Facility (PCRF) resources were laminated, which meant they could be reused. The patient experience questionnaire was electronic thus reducing paper usage.

Leadership, capacity and capability

Last year was a turbulent period for the practice in terms of senior leadership turnover. The Senior Medical Officer (SMO) and Senior Nursing Officer (SNO) joined the practice mid-2024. In the absence of an SNO for part of 2024, the physiotherapist had taken on the role of healthcare governance lead and was also assigned the role of second-in-command to maintain links with the unit and wider community. Given they were the only member of staff in the PCRF, this additional responsibility had added to their workload.

Furthermore, the absence of a deputy practice manager (DPM) had increased the workload for the practice manager. Although this post was vacant at the time of the inspection, a DPM was due to start in March 2025. The practice manager had outlined the main responsibilities for the incoming DPM to ensure they understand their responsibilities.

In addition, the practice manager had liaised with the DPM to identify any skill/training gaps in order to plan for training required.

Workforce resilience was a key risk for the practice and was captured as a transferred risk on the risk register. The workforce will continue to be a challenge as significant staff changes are due throughout the next 10 months, including the loss of staff with key secondary roles.

Despite this staffing context, we recognised that the senior leadership team (SLT) were working tirelessly to ensure patients received a service that met their needs and met the operational requirements of unit commanders. From a capability perspective, the SLT was making changes to improve the skill mix, knowledge and experience of the team, notably for the nursing team and PCRF. All staff we spoke with said the SLT was supportive.

The SLT described how the practice was well supported by the regional team particularly with securing locums and equipment. The nursing team reported how they had good links with the Regional Nurse Advisor. The Regional Clinical Director visited the practice twice a year.

Culture

From patient feedback, interviews with practice staff, a discussion with the Welfare Officer, Padre and Unit Commanding Officer along with our review of patient records, we confirmed patients were central to service development. This patient focus was maintained despite inconsistent staffing levels during 2024.

The practice manager initiated a staff ‘Climate Survey’ which identified low morale and dissatisfaction with the team dynamics. Key issues raised included a military/civilian divide, inconsistent communication and gaps in the SLT and wider staff team. Staff reported stress and burnout due to increased workload as a result of insufficient staffing levels. Cultural issues were further impacted due to 4 different groups of employees with 4 different terms and conditions of service. This staff configuration was outside the control of the SLT.

To address some of the concerns, a range of actions were taken by the SLT. These included a reduction in the use of rank, a rebranding of the management meeting (previously only attended by military staff) to heads of department meeting (HoD) with attendance widened to include both military and civilian leaders. Further action undertaken involved an inclusion/teamwork session in February 2024, values training session in March 2024 and an Op Inclusion (initiative to create an inclusive and compassionate staff culture) session in October 2024. Furthermore, team objectives were developed.

In addition, the sudden passing of a member of the staff team had impacted morale. All staff contributed ideas for a memorial for their colleague resulting in the planting of a tree within the grounds of the medical centre. ‘White space’, staff lunches and social events were held, including the team attending the Christmas market and German Festival. Staff we spoke with during the inspection described how working relationships within the team had greatly improved.

Staff reported that they knew how to access the policy on whistleblowing and said they would have no hesitation using the policy if they had concerns. The whistle blowing policy

and information about 'freedom to speak up' were displayed for staff awareness. Staff had completed the 'Freedom to Speak Up' training.

Processes were established to ensure compliance with the requirements of the duty of candour (DoC), including giving those affected reasonable support, information and a verbal and written apology. A DoC register was maintained and accurately correlated with the ASER log for DoC issues identified as a significant event. Staff provided examples demonstrating that the DoC principles were adhered to.

Governance arrangements

The SMO was the clinical lead and the physiotherapist was the lead for healthcare governance (HCG). The practice manager oversaw non-clinical elements of governance and maintained the systems to capture governance information. The HCG workbook was well developed and used to manage and monitor governance activity. All staff we spoke with were aware of the workbook and its use.

The physiotherapist had worked hard to improve the governance culture. They were due to leave the practice and we perceived this as a significant risk given their experience, seniority and key leadership role for HCG.

A clear reporting structure was established 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. Nurses reported that they have recently were allocated protected time to ensure secondary care duties were completed.

Formal and informal communication channels were established, including regular structured meetings. Practice meetings were held monthly and HCG meetings bi-monthly. HoDs and clinical meetings were held weekly. In addition, the practice manager circulated information and updates to staff via email. The receptionists maintained the group mailbox and emailed any relevant information to staff.

Required or 'must' DPHC audits had been completed as part of the quality improvement programme. The SLT recognised that clinical audit was underdeveloped. Since the MOD GP joined the practice in December 2024, first cycle clinical audits had been completed for some long term conditions (LTC) with further audits scheduled to evaluate the quality of care against best practice guidance. Audits were discussed with staff at the practice and/or HCG meetings.

Managing risks, issues and performance

The SLT were aware and transparent about the risks for the service and these were captured on the risk register. A SWOT analysis identified the weaknesses and threats as:

- Staff vacancies and inadequate staffing levels to meet the needs of fluctuating and increasing patient population.
- The infrastructure impacting compliance with infection protection and control standards.
- Secondary healthcare, including shared care agreements.

Whilst we acknowledged a significant amount of work to improve the management of LTCs had taken place since the MOD GP took up post, many patients with an LTC were yet to be reviewed. This needed to be addressed in a timely way given the population demography, including a high number of patients with an LTC.

Minutes demonstrated that the risk register was regularly reviewed and discussed at HCG meetings. Any forecasted gaps in the workforce were discussed and solutions considered at the practice meetings. Significant events and incidents were discussed at HCG meetings, including any improvements identified.

The unit and practice business continuity plans (BCP) had both been recently reviewed. We were provided with examples of when the BCP and major incident plan had been exercised or actioned. The German ambulance service was used in emergencies. The defence fire service supported the ambulance service and provided interpretation and escort in an emergency. The fire service was connected to all emergency service calls received by the ambulance service.

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. A process was in place for staff appraisals.

Appropriate and accurate information

An internal assurance review was undertaken in March 2024 and the practice was rated as having ‘substantial assurance’. Many of the action points for improvement had been completed.

Actions from the Health Assessment Framework (HAF), an internal governance tool, were added to the work progress tracker. This tracker was maintained by the practice manager and reviewed by the team at practice meetings. Staff reported that due to other commitments and significant workload demands, the practice had concentrated other activities with a higher priority than the HAF.

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. The Caldicott Principles, guidelines for the management of patient identifiable information, were followed. The SMO was the lead for Caldicott and Caldicott reports were actioned by the practice manager. The staff team had completed Defence Information Management Passport training which incorporated the Caldicott principles.

Engagement with patients, the public, staff and external partners

Patients could provide formal feedback about the service through the DPHC patient survey. The practice positively responded to feedback and also used informal feedback

and issues raised through complaints to make improvements suggested by patients. A notice board illustrated actions the practice had taken in response to patient feedback.

The practice worked closely with commanders, welfare support services and other defence services to ensure a collective approach with meeting the needs of the service personnel population. As there was no local Department of Community Mental Health (DCMH), the SMO engaged with DCMH overseas. In addition, the SMO had links with the local environmental doctor specialist. The secondary health care (SHC) team had developed strong relationships with host nation care SHC providers.

Continuous improvement and innovation

Despite inconsistent staffing levels throughout 2024, the practice continually considered ways the service could be developed. This commitment to continually improving the service for patients was evident through patient focussed quality improvement activity, much of which was in response to patient feedback.

Indicated throughout the report, very few of the improvement initiatives had been raised as quality improvement projects (QIPs). QIPs showcase positive performance and also enable the sharing of innovative practice with other DPHC facilities.