Catterick and Barrow Medical Group Practice

Catterick Medical Centre, Building 20, Cambria Lines, Munster Barracks, Catterick Garrison, DL9 3PZ

Barrow Medical Centre, D38 Main Building, Bridge Road, Barrow, Cumbria, LA14 1AF

Defence Medical Services inspection report

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

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

Contents

Summary

About this follow up inspection

We carried out an announced comprehensive inspection at Catterick and Barrow Medical Group Practice on 16 May and 1 June 2023. The CQC does not have the same statutory powers with regard to improvement action for the Defence Medical Services (DMS) under the Health and Social Care Act 2008, which also means that the DMS is not subject to CQC's enforcement powers. However, as the military healthcare Regulator, the Defence Medical Services Regulator (DMSR) has regulatory and enforcement powers over the DMS. DMSR is committed to improving patient and staff safety and will ensure implementation of the CQC's observations and recommendations.

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

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

- A high level of support was provided to service leavers who remained in the immediate area around Catterick. The Senior Medical Officer had established links with support groups and provided a seminar to local GPs on supporting veterans.
- Barrow Medical Centre (BMC) staff had developed links with the local sexual health service to reintroduce a sexual health clinic for the submarine crews.
- The Primary Care Rehabilitation Facility (PCRF) had developed their own comprehensive induction pack which had a clinical section completed over 3 months with a named mentor. Staff who had completed the induction spoke highly of its impact.

At this inspection we found:

- A person centred culture was embedded to ensure patients received quality and compassionate care to meet their individual needs. The leadership team recognised that further work was required to recognise the specific needs of patients at BMC.
- Patients received effective care reflected in the timeliness of access to appointments, reviews and screening/vaccination data. The travel time for patients based at BMC had been reduced through the use of technology. However, as the PCRF was sited at Catterick Medical Centre (CMC), patients based at Barrow were seeking alternative places to receive their treatment.
- The medical centres worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs. Care plans for complex patients drawn up jointly with other professionals to ensure the best care was provided.

- A regular set of meetings was established and extended to provide a two way communication platform for all staff.
- Comprehensive and effective processes were in place to identify patients who were considered vulnerable and coding was applied on the patient record. Staff had completed safeguarding training appropriate to their role.
- There was a safe system for the management of specimens and referrals. The process ensured that clinical oversight was maintained.
- Medicines management processes were in place but there was scope to improve storage arrangements and patient medication reviews.
- Suitable health and safety arrangements were in place to ensure a safe service could be delivered.
- Risks to the service were recognised by the leadership team. A range of risk assessments were in place but we highlighted a gap in COSSHH (Control of Substances Hazardous to Health) assessments.
- Facilities and equipment were sufficient to treat patients and meet their needs. Plans were in place to redevelop the buildings to make improvements and workarounds had been introduced in the interim.
- Staff were aware of the requirements of the duty of candour and monitored compliance. Examples we reviewed showed the practice complied with these requirements.
- The practice had effective leadership although this was being further developed to improve services at BMC.
- Staff worked well as a team and said they were well supported and included in discussions about the development of the service.

The Chief Inspector recommends to the practice:

- Review the ‘total triage’ system to ensure clinically safe working practices are followed. Patient triage must be carried out by a suitably qualified, trained, knowledgeable and experienced clinical practitioner. Appropriate oversight and supervision must be provided to ensure non-GPs are working within their competencies and providing appropriate advice and triage.
- Review the need for a welfare service at BMC.
- Implement a programme to complete the backlog of summarisation on patient notes.
- Ensure suitable cleaning arrangements are in place for the clinical rooms used at BMC.
- Improve the storage arrangements for medicines and medical gas to promote better safety and controlled access.
- Arrange for the blood glucose monitor to be recalibrated.
- Complete medication reviews on those patients on multiple medications found to be overdue.
- Assess the risk of products kept in the buildings that are potentially hazardous to health.

- Further develop the combined governance system to ensure that audits and monitoring are consistent across both sites.
- Approach the units to discuss the advantages of having more rehabilitation input at the unit health committee meetings.
- Address the issues around confidentiality for patients being seen in the primary care rehabilitation facility.
- Explore the impact and potential solutions for patients based at Barrow who needed to travel for rehabilitation treatment.
- Continue with plans to improve the access to a doctor for patients based at Barrow.

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Chief Inspector of Hospitals and Interim Chief Inspector of Primary Medical Services

Our inspection team

The inspection team was led by a CQC inspector supported by a second inspector (who visited BMC) and two colleagues from the CQC. The team comprised specialist advisors including a primary care doctor, a practice manager, a primary care nurse, pharmacist and a physiotherapist. A specialist advisor new to the CQC and two staff from the DMS Healthcare Assurance Team were also in attendance as observers.

Background to Catterick and Barrow Medical Group Practice

Located in North Yorkshire, Catterick Medical Centre (CMC) provides routine primary care and occupational health care service to a patient population of approximately 6,2000 military personnel. There are also approximately 700 patients who are the immediate family of serving personnel who are provided with a primary care service. The majority of patients serve in the army but the population also includes some naval personnel, RAF personnel, reservists, service leavers and veterans.

Based in Barrow in Furness, Cumbria, Barrow Medical Centre (BMC) has a patient population of approximately 150 Royal Navy submariners who work at the British Aerospace Systems site where submarines are built. The population at BMC was forecast to increase to 600 in future. The two medical centres formed a group practice in November 2022 and the patient lists were merged to form one. Prior to then, patients at Barrow received care by an NHS GP practice on a good will, ad hoc basis. A Primary Care Rehabilitation Facility (PCRF) is in the medical centre at CMC and provides personnel with a physiotherapy and rehabilitation service. The medical centre at Catterick is open from 08:00 to 18:30 hours Monday to Friday. The opening hours at BMC are 08:00 to 16:00 Monday to Friday. On weekdays from 18:30, at weekends and on public holidays, patients

are signposted to access medical care through NHS 111 and to access emergency care by calling 999.

The staff team

Doctors	One Senior Medical Officer (SMO) Five civilian medical practitioners (CMPs)
Regimental Medical Officer (RMO)	One (unit asset non DPHC)
Practice manager	One (Group Practice Manager) Two (Catterick) One (Barrow)
Nurses	One senior nurse Four military nurses Three civilian nurses Regional nurse proving regular sessions at BMC One healthcare assistant
PCRF	Eight physiotherapists Three exercise rehabilitation instructors (ERIs)
Administrators	Ten
Pharmacy technicians	Three
Combat Medical Technicians* (CMTs)	Fifty (DPHC assets, not unit)

*In the army, a medical Sergeant and CMT is a soldier who has received specialist training in field medicine. It is a unique role in the forces and their role is similar to that of a health care assistant in NHS GP medical centres but with a broader scope of medical centre.

Are services safe?

We rated the medical centre as requires improvement for providing safe services.

Safety systems and processes

The practice worked to the Defence Primary Care Healthcare (DPHC) Tri-Service safeguarding policies. A local safeguarding policy was in place and it included references to adults and children. The policy included contact addresses and telephone numbers for the local safeguarding teams, and these were displayed throughout the practice in the waiting areas and clinical rooms. The policies also included the codes that should be applied on DMICP (electronic patient record system) to ensure consistency and allow searches to be run with accuracy. Any changes to policy were emailed to all staff members which enabled them to identify who they would contact if they had a safeguarding concern. Staff interviewed during the inspection were fully aware of the policy, including how to report a safeguarding concern.

The status of safeguarding and vulnerable patients was discussed regularly with the welfare team. In addition, the needs of vulnerable patients were discussed at the monthly 'adults at risk' meetings. We contacted the Welfare Officer for the Catterick camp who told us they provided a welfare service to military personnel and dependents for matters such as home sickness, domestic abuse, sexual assault, self-harm, mental health, housing issues etc. They confirmed they had a good relationship with the medical centre and communication between the two was good.

The Senior Medical Officer (SMO) was the safeguarding lead with the Band 7 nurse acting as his deputy. Both were trained to safeguarding adults and children level 3. All other staff completed safeguarding training appropriate for their role with 4 exceptions. We could see that this training was planned and had only recently become due (2 staff having recently joined and 2 staff being unavailable to complete the refresher course in time). The safeguarding leads provided updates and training to the team and acted as a link between the medical centre, welfare and the chain of command. A teaching session on domestic violence had recently been held and included the HARK (humiliation, afraid, rape, kick) question set. Domestic violence posters were displayed in the toilets. We were given a recent example of when a safeguarding concern had been raised.

At Barrow Medical Centre (BMC), the Regional Nurse Advisor (RNA), who provided a clinical service at the practice, was the safeguarding lead and had completed level 3 safeguarding training. The practice manager was also trained to level 3. In the absence of the RNA, the safeguarding lead at Catterick Medical Centre (CMC) could be contacted. A practice adult and child safeguarding information leaflet was displayed. Links had been established with the local safeguarding service through the RNA visiting the team. The RNA also attended the regional safeguarding forum.

Staff at CMC made regular contact with all military personnel considered vulnerable. A large number of service leavers remained in the immediate area around Catterick. The SMO linked in with the Veterans Trauma Network and had engaged with GPs in Middlesborough to provide a seminar on supporting veterans. The team had a network of

contacts with internal and local services such as North Yorkshire Horizons (an adult drug and alcohol recovery service) and North Yorkshire Improving Access to Psychological Therapies. The medical centre worked closely with Department of Community Mental Health (DCMH) and the army and unit welfare services. The Defence Medical Welfare Service support worker visited the medical centre to inform clinicians on social referrals to support vulnerable or struggling patients or families.

Vulnerable patients were identified during consultation, DMICP searches and on referral from another department such as the welfare team. Coding was applied to clinical records to identify patients considered vulnerable and urgent appointments were offered. A monthly search of DMICP was undertaken to ensure the register of vulnerable patients was current and captured any joiners. The search was also used to ensure handovers of patients at risk took place when required. There was a regular link with the local health visitor and the local regiments as part of the WISMIS (Wounded Injured and Sick Management Information System) process. Doctors attended hastily convened risk conferences to discuss any patients of concern. When possible, the conferences were attended by the doctor who had most recently assessed the patient being discussed. Formal discussion to support vulnerable patients was carried out in quarterly meetings attended by all available clinicians and at Unit Health Committee meetings attended by the Regimental Medical Officer (RMO). At the time of the inspection, there were no patients under the age of 18 registered at BMC and no patients had been identified as vulnerable.

At BMC, there was no welfare service on the base. We spoke with Senior Naval Officers (SNO) and patients (line managers) who indicated this service was needed especially as no military accommodation was available on the base. Service personnel were accommodated in Barrow, including young sailors who had left home for the first time. Some of the senior Royal Navy staff had completed the mental health first aid training and one of the commanders delivered mental health awareness sessions on the base, including to British Aerospace (Bae) Systems staff. They told us there was good camaraderie between crews and would recognise if any of the crew needed additional support.

Chaperone training formed part of the induction and face to face group sessions were held to complement the online course. The training extended to the administration staff as they would be used if a clinician was not available to act as a chaperone. The staff we spoke with were fully informed and could clearly articulate what they would be doing during the examination. Chaperone posters were displayed throughout the building at CMC. Patients under the age of 18 were offered a chaperone by administration staff when booking an appointment. This was recorded on DMICP. At BMC, the chaperone policy was displayed and both staff had completed chaperone training.

The full range of recruitment records for permanent staff was held centrally. However, the practice could demonstrate that relevant safety checks had taken place for the majority of staff, at the point of recruitment, including a DBS check to ensure staff were suitable to work with vulnerable adults and young people. All staff were covered by Crown indemnity and the practice maintained a record that identified when each member of staff was required to renew their registration. The RMO’s DBS certificate had expired whilst deployed. A risk assessment was completed and added to the risk register. The recruitment checks for BMC were overseen by staff at CMC.

Staff were up to date with their Hepatitis B vaccination and there was a Hepatitis B register available to view.

A process and policy was in place to manage infection prevention and control (IPC). There were IPC leads for both BMC and CMC who had completed specific training for the role. The leads attended the monthly DPHC IPC link nurse monthly meetings and shared any updates with the wider clinical team.

Regular IPC audits were carried out, both BMC and CMC buildings had been audited within the last 6 months and no major issues had been identified. In addition, the IPC lead for CMC had also carried out an informal audit of BMC.

Environmental cleaning was provided by an external contractor and the medical centre buildings at both sites appeared to be clean with no issues identified. At the time of inspection, CMC was in the process of re-writing the contract to increase cleaning time for clinical areas and include deep cleaning (to date, deep cleaning had been provided by the contractor on request). The cleaner signed a daily checklist and this was reviewed by the cleaning supervisor. The IPC Lead conducted regular cleaning reviews, communicated any concerns or issues to relevant personnel and monitored the problem until resolved. At BMC, the contract for environmental cleaning was managed by BAe Systems and it was for office cleaning rather than clinical cleaning. Supported by a standard operating procedure (SOP), practice staff carried out the cleaning of the clinical room. There was evidence that this issue had been raised with the contractor and no resolution has been reached. The practice was exploring alternate options to secure clinical cleaning.

Consignment notes for healthcare waste were not being routinely held at CMC. An annual waste audit was carried out in April 2023 which identified that there was no waste log. Soon after the inspection, we were sent evidence of the implementation of a waste log and the last 6 months records of waste collection. Clinical waste was secured, labelled and locked in containers awaiting collection. Clinical waste was collected weekly. A waste disposal policy was in place at BMC and arrangements were in place for the management of clinical waste. The contractor did not provide consignment notes, so staff created their own. A log was not maintained (one was introduced soon after the inspection) as the practice generated very little clinical waste. An annual waste audit was completed in January 2023. Clinical waste was stored securely outside the building.

Three of the Primary Care Rehabilitation Facility (PCRF) physiotherapists were currently providing acupuncture to patients. They had all attended training held in the region. There was an in-date acupuncture standard operating procedure and risk assessment which all staff were aware of. No adverse events had occurred. Written consent was gained and scanned onto DMICP.

Gym equipment in the PCRF treatment area was maintained and monitored. Servicing on the equipment was in-date and checks were completed daily. All items were checked before and after use by a patient receiving treated by the PCRF team. An exercise rehabilitation instructor (ERI) conducted weekly checks on the cleaning of the personal training equipment.

Risks to patients

The leadership team believed that the establishment of the practice was adequate for the patient list size. All posts were filled with permanent or locum staff. However, the RMO posts were often gapped due to deployment with locum agency often unable to provide backfill which put additional strain on the other doctors. Staff absences were managed by using departmental rotas with locum backfill requested to cover long term gaps. CMPs could also draw on support from Infantry Training Centre (ITC) Catterick and Dishforth Medical Centres. We received feedback from 14 patients at BMC (28% of the patient population) through both inspection feedback cards and direct interviews. A key theme raised by patients and SNOs was limited face-to-face access with clinicians at the medical centre, in particular physiotherapy. Although patients could travel to CMC or other medical centres, this involved a significant amount of time out of their working day.

At CMC, we found that access to appointments was good and a system was in place which facilitated same day face to face appointments with a doctor when needed. All patients could access the 'total triage' system by sending an SMS message. A team of nurses and medics supervised by a doctor would respond by telephone on the same day. The 'total triage' system was a virtual clinic being piloted at CMC. The combat medical technicians (CMTs) were involved in the initial triage of patients. Telephone consulting is a higher risk evolution and would normally be conducted by GPs or Advanced Nurse Practitioners. Whilst the practice had provided the CMTs with aide memoires and consultation checklists to follow, close supervision by a GP is essential to ensure safety is maintained. On the inspection day a General Duties Medical Officer was the supervisory doctor. We reviewed the notes of the entire virtual clinic list for that day to assess quality and safety: Whilst the triaging conducted by the nurses appeared to be of high quality with robust medical notes and safety netting, the CMT notes were far less detailed and the aide memoires did not appear to have been utilised in several cases. We discussed our findings with the SMO and it was agreed that changes would be made to the SOP to ensure that the CMT debriefs every patient they have triaged with the duty GP. A documentation review would also take place daily to ensure quality of notation.

Patients from BMC who needed physiotherapy highlighted that the length of time driving time could be counterproductive to their recovery from injury. SNOs also voiced this concern. Service personnel with medical issues precluding them from going to sea were transferred to BMC for shore-based work. Commanders suggested that limited access to clinical care, including rehabilitation, could impact the timeliness of their recovery. We were advised that a physiotherapist had completed their induction and had started to hold clinics. However, as there was only one clinical room, this room was used to provide a physiotherapy service as effectively as possible. If this room and the available resources were insufficient to provide adequate care, this would be explained to the patient who would then be offered care at Catterick, Weeton or a PCRF of their choice, even if for a one off appointment that required specific equipment.

Arrangements were in place at CMC to check and monitor the stock levels, temperature and expiry dates of emergency medicines. We saw evidence to show that an appropriately equipped medical emergency kit and trolley were in place and were regularly checked. Emergency training courses completed by staff online had been supplemented by face to face training delivered by the clinical team. We fed back to the staff that the blood glucose

monitor was giving readings out of range despite both the testing solution and test strips being in-date.

The emergency resuscitation trolley at BMC was stored in the clinical room along with an automated external defibrillator and oxygen. The practice manager checked the equipment and emergency medicines in accordance with policy and maintained records of the checks. Flowcharts from the Resuscitation Council (UK) were displayed for anaphylaxis and adult advanced life support. Risk assessments were in place for emergency medicines not held at the practice. An oxygen sign was displayed on the door where the oxygen was stored. Both staff were in-date for medical emergency training. 'Red flag' information was displayed about various conditions, including chest pain, mental health, skin rashes and sepsis. Staff had received training in recognising the signs and symptoms of sepsis.

The staff team across the group practice was suitably trained in emergency procedures, including basic life support, sepsis and anaphylaxis. Sepsis and heat Injury training was on the training programme, sessions were recorded and uploaded to SharePoint for people use for reference.

At CMC, a closed circuit television system (CCTV) in the waiting rooms allowed patients to be observed whilst waiting. The monitors covered all of the cameras situated in the key waiting areas such as the PCRF, clinical area, pharmacy, lobby and the upstairs and downstairs waiting areas. It was the responsibility of the designated receptionist to monitor the CCTV cameras. Patients at BMC could be observed in the waiting area through a portable monitor.

Areas where physical activity took place in the PCRF were not appropriate for intense activity due to the limited space and there being no air conditioning. There were small rooms separated for specific rehabilitation activity and every effort was made to control the temperature where an increase in intensity was likely (fans were in each room and windows opened to provide ventilation). All class based activity took place in the Regional Rehabilitation Unit where Wet Bulb Globe Temperature (WBGT), used to indicate the likelihood of heat stress, was carried out. PCRF staff were aware of actions to take in accordance with WBGT monitoring.

Information to deliver safe care and treatment

The DPHC standard operating procedure (SOP) was followed for the summarisation of patients' notes. There was also a practice SOP at CMC but this was not linked into the Healthcare Governance Workbook (HcG Wb). The process for scrutinising and summarising records of new patients to the medical centre and conducting the 3 yearly review was managed by the nursing team who were allocated protected time. A programme for summarisation was in place. However, the RNA acknowledged that there was a backlog of patients' records (70%) awaiting the re-summarisation carried out every 3 years.

A peer review programme of doctors' DMICP consultation records was in place. A clinical notes audit was present for 2023. It was not clear from the document if all of the doctors had been included in this but 10 different clinicians were audited. DMICP record keeping of CMC's nurses was audited in October 2022 and showed good compliance. These notes

audits were repeated annually and discussed in the nurses' meetings and formed part of the nurse appraisal process. All meetings were recorded and documented on SharePoint.

Notes audits were conducted as part of the induction of new staff and regularly repeated in accordance with the audit calendar. Clinical supervision was provided by the Band 7 physiotherapist with one appointment slot per week dedicated to this. This provided the ability to do a joint assessment with or to discuss complex cases. Staff described an open environment in which they were able to talk to anyone about cases for advice or support. Case discussion was encouraged and protected time was set aside for this and each physiotherapist had a different area of expertise. There was a peer review process in place for all PCRF staff. ERIs were formally reviewed for class therapy at six-month intervals (or sooner if required).

Co-ordinated by the administration team, an effective system was in place for the management of external referrals. Each referral was added to a tracker using DMICP numbers for confidentiality. A paper record was kept mitigating any IT issues. Urgent referrals were highlighted and prioritised using a colour coding system. The administration team monitored the referral tracker daily and the SMO and the doctor who was the lead for cancer performed audits to maintain clinical oversight. We highlighted that internal referrals were not monitored and these were added to the referral tracker on the day of inspection.

A process was in place for the management of specimens at CMC. All samples sent were logged in the 'pathology book' at CMC. A recent audit from April 2023 showed good compliance with results being retuned within the target of 2 days. Any result retuned that was out of range was referred to the duty medical officer. Due to non-operability of pathology links with Morecombe Bay Hospital Trust, BMC had experienced issues with receipt of bloods from Furness General Hospital, mainly delays in receiving results. The matter had been added to the risk register and had been appropriately escalated within Defence including to Defence Digital, and to the NHS. Despite numerous attempts, a resolution had not been found. The practice had built in mitigation involving emailed results which were scanned or uploaded to the patient's DMICP record and the result tasked to the requesting clinician. A register was held at CMC and also at BMC. The RNA carried out an audit in February 2023 and it showed 37% of patients received results within 2 working days with 63% of patients receiving results outside of 2 working days. The average time for receipt of results was 6 working days. A further audit was planned in June 2023.

The Business Continuity Plan (BCP) had last been reviewed in October 2022 and included actions to be carried out in the event of any DMICP outages and system freezes. Copies of the BCP were displayed around the buildings. In the event of an outage, each clinic would be reviewed, and non-urgent appointments would be re-scheduled accordingly and only essential/urgent patients would be seen during this period. Hard copies would be utilised for recording consultations and then scanned onto DMICP once the system was serviceable If DMICP was compromised for several days, patients and staff could be diverted to either ITC Catterick or Dishforth Medical Centre to perform clinics, or the clinicians could provide a telephone consultation service working remotely. CMC told us that they did not have a role in the station major incident plan.

Safe and appropriate use of medicines

Systems were in place for the safe handling of medicines. A number of minor improvements were raised to make systems and processes fully effective.

Arrangements were established for the safe management of controlled drugs (CD), including destruction of unused CDs. We saw that monthly and quarterly checks were completed. The keys for the CD cabinet were controlled but not sealed meaning that there was no way of knowing if anyone had gained access. The practice told us that this had been actioned soon after the inspection. The CD cabinet did not comply with the Misuse of Drugs Act Staff Custody. However, a certificate of security was available and an annual audit of CDs completed.

Emergency medicines were easily accessible to staff in a secure, temperature controlled area of the medical centre and all staff knew of their location. The storage of medical gases required improvement to remove debris and have appropriate signage. The blood glucose monitor required recalibration as it was giving out of range readings despite the test strips and solution being in-date.

Medication requiring refrigeration was monitored twice a day to ensure it was stored within the correct temperature range. All records we viewed were within temperature range and dispensary staff were aware of the process to follow in the event of cold chain failure. There was a regular rota for fridge cleaning.

A set of SOPs governed activity in the dispensary. One of the 3 pharmacy technicians supervised dispensing. Prescriptions were signed prior to medicines being dispensed.

All staff who administered vaccines had received the immunisation training as well as the mandatory anaphylaxis training.

Prescription pads were stored securely. There was a system to track their issue and usage so all prescription numbers could be traced to the prescriber.

Patient Group Directions (PGDs) had been signed off to allow appropriately trained staff to administer medicines in line with legislation. The PGDs were current and signed off by the authoriser. Medicines that had been supplied or administered under PGDs were in-date.

Patient Specific Directions (PSDs) were all validated and in-date. A total of 5 records were checked and all had been assessed by a prescriber.

There were 5 non-medical prescribers who had been given authority to prescribe medicines by DPHC Headquarters..

Requests for repeat prescriptions were managed in person or by email, in line with policy. A process was in place to update DMICP if changes to a patient’s medication was made by secondary care or an out-of-hours service. The repeat prescription process was detailed in the practice leaflet. We reviewed patients on 4 or more medications and found 32 who were overdue a review. Following the inspection, the practice confirmed that they had started work to address this issue.

The group practice followed North Yorkshire Clinical Commissioning Group antimicrobial guidance and used current NICE guidance on antimicrobial prescribing. For resistant or atypical infections, clinicians sought advice from the James Cook University Hospital microbiology department or from the military infectious disease consultant team in Birmingham. There had been audits carried out on the use of antibiotics in treating middle ear and lower urinary tract infections.

A process was established for the management of and monitoring of patients prescribed high risk medicines (HRM). The register of HRMs used at the medical centre was held on DMCIP and all doctors and relevant clinicians had access to this. We looked at a sample of patient records, we saw that all had been coded, monitored appropriately and had shared care agreements in place.

Track record on safety

Measures to ensure the safety of facilities and equipment were in place at CMC. Electrical and gas safety checks were in-date. Water safety measures were regularly carried out with a legionella inspection undertaken in October 2018. A fire risk assessment of the building was undertaken annually. Firefighting equipment tests were current. Staff were up-to-date with fire safety training and were aware of the evacuation plan. The building used by BMC was owned by BAe Systems and health and safety checks were arranged by BAe. As a lodger unit, the medical centre did not routinely receive copies of checks. However, the contractor provided evidence that a periodic electrical check was undertaken in August 2021 and equipment checks were carried out in July 2022. There was no piped gas to the building.

A system for logging and monitoring the servicing of all clinical/non-clinical equipment was established, this included equipment in the PCRF.

The practice had adopted the current risk template as per DPHC guideline and worked to the 4Ts (treat, tolerate, transfer or terminate) principles. A quarterly risk review meeting was held with the most recent in May 2023. Newly identified risks were discussed at either the monthly practice meeting or fortnightly Heads of Department meeting. At the time of the inspection, no risk assessments (RAs) could be found but a wide range of clinical and non-clinical RAs were sent following the inspection. However, there was no evidence provided of a COSHH risk assessment. Following the inspection, the practice confirmed that they had started work to address this issue.

The HcG Wb contained active and retired risk registers. The active risk register was last reviewed in May 2023. Risk management was a standing agenda item at the monthly practice and fortnightly heads of department meetings.

At BMC, staff used handheld alarms to summon for assistance in the event of an emergency. The practice manager frequently worked alone so it was doubtful the alarm would be heard or responded to by other people who used the building. A lone worker SOP was in place (March 2023) as the issue had been raised on a recent Internal Assurance Review. CMC was informed when a member of staff working alone started and finished their shift.

At CMC, one of the three buildings had a fixed alarm system and the other two buildings had handheld alarms. An SOP was in place for the use of panic alarms, we noted they were not being checked for audibility or response times. These checks were implemented on the inspection day.

Staff had the information they needed to deliver safe care and treatment to patients most of the time. If there was an unplanned DMICP outage, staff would use laptops and Wi-Fi if it was a server issue. The BCP detailed workaround steps should problems with connectivity continue.

Lessons learned and improvements made

All staff had access to the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events and incidents. This was completed as part of the induction programme. The staff database showed that all staff had completed ASER training and discussion around learning took place at the monthly practice management and healthcare governance meeting. A record of ASERs was maintained by the SNO (as ASER lead) and we saw they were completed in a timely manner and included a note of any lessons learnt. The SNO conducted most of the investigations, but when appropriate, would refer ASERS to colleagues with specific expertise for investigation.

From interviews with staff and evidence provided, it was clear there was a culture of reporting incidents from those staff able to access the system. Both clinical and non-clinical staff gave examples of incidents reported through the ASER system including the improvements made as a result of the outcome of investigations. An ASER log was maintained on the HcG Wb including any changes made. This was linked to the Duty of Candour log to ensure consideration was given on whether or not the patient should be informed.

A system was in place for managing patient safety alerts. All alerts were received into ITC Catterick who forwarded to CMC and BMC for action. There was a centralised spreadsheet which detailed the alert and the action taken in response. The register included details of action taken by the practice in response to each alert and was up-to-date. Alerts pertinent to the practice were distributed to all staff and discussed at the monthly practice meeting.

Are services effective?

We rated the medical centre as good for providing effective services.

Effective needs assessment, care and treatment

Arrangements were in place to ensure staff had a forum to keep up-to-date with developments in clinical care and guidance. These included a weekly clinical meeting informal 'huddles' and an email sent to notify all clinicians of any updates. The formal meetings included an agenda item to discuss national clinical guidance, including NICE (National Institute for Health and Care Excellence) and the Scottish Intercollegiate Guidelines Network (SIGN).

Our review of clinical records demonstrated that clinicians carried out assessments and provided care and treatment in line with national standards and guidance, supported by clear clinical pathways and protocols.

Staff were kept abreast of clinical and medicines updates through the Defence Primary Healthcare (DPHC) newsletter circulated to individual staff and to the medical centre each month. Participation with regional events and forums also provided an opportunity for clinicians to keep up-to-date.

The Primary Care Rehabilitation Facility (PCRF) staff all used Rehab Guru (software for rehabilitation plans and outcomes) for exercise programmes for patients. A review of (PCRF) notes carried out as part of the inspection highlighted that best practice guidance was followed. We discussed how improvements could be made in monitoring outcomes pertaining to clinical effectiveness (the musculoskeletal health questionnaire was the only evaluation in the PCRF that related to outcomes). Staff told us that they planned to incorporate more clinical based audit in the coming year (one was planned on achilles tendinopathy) and all staff had been asked to set an objective relating to this.

PCRF 'gym' areas did not provide the appropriate space for patient list size. Staff were having to use gym space at regional rehabilitation unit (RRU) for classes but for only short periods around the RRU timetable. There had been situations when classes had to be temporarily stopped due to changes in the RRU timetable. Although this issue was due to be resolved in future (planned build of a new facility) a formal agreement with RRU would reduce the possibility of further disruption.

Monitoring care and treatment

Long-Term Conditions (LTCs) management was led by two of the nurses as Catterick Medical Centre (CMC) with involvement from the Regimental Medical Officers for their respective units. Most LTCs had a named nurse and doctor who worked as team to give advice and support. Signage on clinical room doors at CMC named the leads for each LTC so clinicians knew who to approach with a specific query. Patients were regularly monitored and there was an effective patient recall system in place. There was a standard operating procedure in place for the management of long-term conditions that outlined the

monitoring arrangements. However the SOP for CMC conflicted with that for Barrow Medical Centre (BMC). We looked at a sample of patients' notes, they were comprehensive and in good order. The following data was provided to us:

There were 21 patients on the diabetic register. For 12 patients on the register, the last measured total cholesterol was 5mmol/l or less which is a positive indicator of positive blood pressure control. Processes were in place to identify and monitor patients at risk of developing diabetes.

Of the 89 patients recorded as having high blood pressure, 72 had a record for their blood pressure taken in the past 9 months. 57 patients had a blood pressure reading of 150/90 or less.

All 70 patients with a diagnosis of asthma had received an asthma review in the preceding 12 months using the asthma review template.

Audiology statistics showed 84% of patients had received an audiometric assessment within the last two years.

Through review of clinical records and discussions with the doctors, we were assured that the care of patients with a mental illness and/or depressive symptoms was being effectively and safely managed, often in conjunction with the Department of Community Mental Health (DCMH). DCMH waiting times for initial assessment were reasonable, urgent cases seen within a week, routine ones were seen within 1-2 weeks. Waiting lists for therapy could be longer (step 3 and psychology in particular). Individual doctors maintained the responsibility for monitoring their own patients while they are waiting for therapy. After the pandemic and a return to the 'new normal', a significant rise in mental health presentations was noted by the practice. Patients were requiring same day assessments but 15 minute appointments would only be available. As a result of this, two 30 minute assessment slots are reserved for same day assessments. This allowed patients needing urgent mental health to be accommodated for help and assistance.

We looked at the clinical records of patients currently receiving support from the PCRF. We saw that it took a holistic view of patients, including mood, sleep and lifestyle. Patients could be signposted to different outside agencies for further support and advice.

We saw that referrals to the RRUs and multidisciplinary injury assessment clinics were made promptly with manageable wait times for the patients.

An audit calendar was in place and we saw evidence of quality work that was driving improvement. The majority of audits carried out by the nursing team at CMC were combined with BMC. However, it was not clear what audits BMC needed to complete separate to CMC; for example, the LTC audit was managed by CMC but there was a BMC specific diabetes audit that had been completed.

Effective staffing

All staff had completed the bespoke DPHC mandated induction programme which had been amended accordingly to include role specific elements. The programme was manged

by the practice managers who received a notification when it had been started followed by prompts when not completed. The induction programme included links to key documents and generic policies. The CMC induction was used with an addendum for BMC.

On arrival, all locum staff completed the DPHC mandated locum induction programme which has been amended accordingly to include cadres specific elements and information relevant to the unit. According to the staff database, all locums had completed their induction programme and evidence of this was shown at the time of the visit. We highlighted that the programme did not include key information on local polies and processes that would be particularly helpful for locum staff.

The PCRF had their own comprehensive induction pack. Part 1 contained general information and checks and part 2 was clinical and was completed over 3 months with a named mentor. The new starters we spoke with described it as the best induction they had had anywhere in their career and felt it helped them to understand the department and wider practice. Locum staff received the same induction as permanent staff. Occasionally, physiotherapists that were non-DPHC (field unit based assets) worked clinically at the PCRF. Regional headquarters were informed and all completed an induction prior to starting that included a check of mandatory training.

The practice had a training calendar and there was a record of mandatory training, compliance was good across the team. The training lead monitored compliance for both CMC and BMC and sent individuals an email detailing the training required for completion. Time was available to staff every Wednesday afternoon to complete training. Compliance was good across all areas of mandatory training. Administrative staff spoke positively about how face-to-face training had supplemented on-line courses in subjects such as safeguarding and sepsis. Some frustration over funding for courses was felt within the nursing team. Although this has not affected patient care, it has impacted on individuals being able to remain competent, for example ear irrigation.

As the clinicians at CMC were more focused on the needs of army personnel, the Principal Medical Officer from Neptune Medical Centre provided training specific to the needs of the Royal Navy and undertaking medicals. Staff at BMC were invited to in service training held for the combined practice.

Peer reviews had been undertaken recently by the doctors, nurses and PCRF. All doctors were up-to-date with their appraisal and revalidation requirements. The nursing team had a programme of peer review and clinical supervision was carried out quarterly. There were online continued professional development events that staff could dial into and staff who attended courses shared key learning points with the wider team. Support was provided for placements from medical regiments.

There was role-specific training and updating for clinical staff. For example, most nurses had completed smoking cessation, asthma and yellow fever training, As most of the administration staff were contractors, they were unable to access the Ministry of Defence provided training other than that provided online. Some administrative staff had completed the ‘DMICP Administrator’s’ course.

Staff administering vaccines had received specific training which included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to

date with changes to the immunisation programmes, for example by access to online resources and discussion at nurses' meetings.

The CMTs were involved in the initial triage of the virtual sick parade system. On the inspection day a GDMO was the supervisory doctor so direct GP level supervision was lacking. We reviewed the notes of the entire virtual clinic list for that to assess quality. Whilst the triaging conducted by the nurses appeared to be of high quality with robust medical notes and safety netting, the CMT notes were far less detailed. We discussed our findings with the SMO and it was agreed that an experienced doctor would be a more suitable supervisor to the 'total triage clinic' (this was implemented after the inspection with the duty doctor delegated as the supervisor). However, the reviews done at the end of each clinic did provide a safety net.

Coordinating care and treatment

The RMOs attended their respective Unit Health Committee meetings at which the health and care of vulnerable and downgraded patients was reviewed. When not available, one of the doctors would attend in place of the RMO.

The PCRF communicated well with the medical centre both in person and electronically, they told us this worked well. Representatives from the PCRF attended the monthly full practice meetings and any actions arising were discussed at their departmental staff meetings. PCRF staff were invited to attend unit health committee meetings but could rarely attend and therefore staff were concerned that appropriate occupational information may not be communicated. The RRU provided a fortnightly regional catch-up that all PCRFs in the region engaged with. As part of the referral's tracker, there was a log for recording referrals to the RRU and Multidisciplinary Injuries Assessment Clinic.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred or after they were discharged from hospital.

For patients leaving the military, pre-release and final medicals were offered. During the pre-release phase the patient received an examination and a medication review. A summary print-out was provided for the patient to give to the receiving doctor, and in some cases a referral letter when additional information was required. If the patient was mid-way through an episode of care, clinical staff would contact the receiving medical centre to ensure the receiving team were aware of the patient's requirements. Additionally, if a patient (serving personnel only) had complex additional needs, a referral was be made to the Veterans Trauma Network using a referral form on DMICP. Monthly vulnerable adult searches identified any high risk patients who were leaving BMC and CMC without completing leaving routines. Clinicians were aware that those patients under DCMH care at point of discharge were still eligible for up to a further 6 months of treatment. Alternatively, they could use the TILS (transition, intervention, liaison service). For patients undergoing medical discharge, there was a clinical facilitator assigned to them from the Personnel Recovery Unit to smooth transition into all aspects of civilian life including medical care.

Helping patients to live healthier lives

There was a named lead for health promotion at CMC who was supported by the PCRF team. BMC had a named lead and deputy for health promotion. For continuity, the same health promotion calendar was used at BMC and CMC. Promotions and board rotations happened throughout the year. On the day of inspection, a seasonal health promotion was prominent at the entrance and provided information on hay fever. There were boards around the practice with various health promotion posters and information, including separate boards specialising in information for men's and women's health issues. Health promotion leaflets were available in patient waiting areas.

Two doctors were trained and current with the Faculty of Sexual and Reproductive Healthcare Diploma and conducted regular women's health clinics. Nurses were STIF (Sexually Transmitted Infection Foundation Course) trained. They provided sexual health support and advice. Patients were signposted to local sexual health services for procedures not undertaken at the medical centre. Details of clinics were available in the building on a patient noticeboard. BMC had developed links with the local sexual health service. As a result, the service came to the base and facilitated a sexual health clinic for the crew. The service also provided the practice with condoms and chlamydia testing kits.

The PCRF staff had not had any specific input in unit health fairs but 4 of the team were 'Defence health and Wellbeing Advisers'.

The number of eligible women whose notes recorded that a cervical smear had been performed in the last 3-5 years was 542 which represented an achievement of 92%. The NHS target was 80%.

Regular searches were undertaken to identify patients who required screening for bowel, breast and abdominal aortic aneurysm in line with national programmes. At the time of the inspection there were a small number of patients identified that met the criteria for screening. A recall system was in place that monitored uptake and those eligible were in-date for screening.

Serving personnel due a vaccination were identified when summarising patient notes. The units were responsible for ensuring their individuals booked in for their own vaccines. Force protection performance vaccination statistics were as follows:

- 83% of patients were in-date for vaccination against polio.
- 86% of patients were in-date for vaccination against hepatitis B.
- 70% of patients were in-date for vaccination against hepatitis A.
- 82% of patients were in-date for vaccination against tetanus.
- 86% of patients were in-date for vaccination against MMR.
- 79% of patients were in-date for vaccination against meningitis.
- 80% of patients were in-date with vaccination against diphtheria.

Consent to care and treatment

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw evidence that showed consent for minor surgical procedures was obtained and coded appropriately on DMICP. A review of consent was carried out as part of the peer review.

Clinicians had a good understanding of the Mental Capacity Act (2005) and how it would apply to the population group. All staff received training as part of their mandatory programme.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

In advance of the inspection, patients were invited to fill in a comment card to provide feedback on the services provided at both Catterick Medical Centre (CMC) and Barrow Medical Centre (BMC). A total of 14 patients responded at Catterick feedback was positive. Of note, patients complimented the staff members for being kind and courteous. There were a number of examples of when staff had provided support for specific health problems. We also observed staff being courteous and respectful to patients in person and on the telephone.

We received feedback from 14 patients at CMC. They were positive about the service provided and this included positive comments from families of serving personnel. A theme throughout the comments was how friendly and supportive the staff team had been.

The 14 patients who provided feedback about BMC were complimentary about both staff at the practice and said they were treated in a professional, respectful and kind way. We heard examples of when the practice manager had gone ‘the extra mile’ to sort appointments and respond to patient queries, including when they were off duty.

Service personnel and their families could access the welfare team and various military support networks for assistance and guidance. An information network (known as HIVE) was based on station at CMC. This was advertised in the waiting room and details were also displayed in garrison routine orders.

Involvement in decisions about care and treatment

Patients with caring responsibilities and cared for patients were identified through the new patient registration form, at new patient medicals and via the Unit Welfare Officer. In addition, the practice information booklet invited carers to make themselves known to the practice.

Patients identified with a caring responsibility were captured on a DMICP register. Alerts were added to all registered carers and they were offered flexibility with appointments. Information around the building signposted carers to reception for information on what support is provided to carers. Information was available on SharePoint and there was a carers’ standard operating procedure.

At CMC, carer’s were signposted the reception to ask about information and support. This signposting was also included in the practice information leaflet. There was a standard operating procedure (SOP) that detailed what services should be offered to carers. These included new patient checks, annual flu jabs and annual carer health checks. The SOP

had a letter attached which was sent out to carers asking for their feedback regarding what support they would like from the practice.

There were 4 registered carers, new patients could indicate if they are a carer on their registration form. We discussed that the numbers on the register were low in relation to the patient list size and percentage of families and dependents included being 10%. In response, the Senior Medical Officer emailed all staff and units with a copy of the carer's SOP asking that it be publicised with a view to identifying those with caring responsibilities or cared for patients who were not on the register.

The carer's lead for the practice was one of the nursing team. Carers were flagged on the system and the carer lead made regular calls to carers to ensure they were coping. The welfare of carers was discussed at safeguarding meetings. We were given a detailed account of an example where the medical centre had gone above and beyond to support a cared for patient.

Staff could access 'The Big Word' translation service but told us that there had not been any recent occasions when the service had been needed.

Primary Care Rehabilitation Facility (PCRF) staff used 'physical training chits' (used to lighten the workload to aid rehabilitation) to guide the patients' rehabilitation transition phase to physical training instructor led fitness sessions. An audit of these undertaken in May 2023 showed improvement from the previous audit but future audits were planned to ensure 100% compliance.

Privacy and dignity

Screening was provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. Clinic room doors were closed during consultations. Doors were not soundproof but waiting areas were set far enough away for conversations not to be overheard.

The PCRF had mainly individual treatment rooms but 4 rooms did not have full walls at one end allowing patients to be clearly heard for one room to another. Although no complaints had been raised, one patient had commented that they recognised their friend in the next room by the sound of their voice. We discussed the use of radios or providing some form of additional filler to the gapped walls to mask the sound and promote confidentiality.

The layout of the reception area and waiting area meant that conversations between patients and reception would unlikely be overheard. If patients wished to discuss sensitive issues or appeared distressed at reception, they were offered a private room to discuss their needs. Patients were informed of this through a sign on the reception door.

The mix of male and female staff allowed the medical centre to facilitate patients who wished to see a clinician of a specific gender. This included patients booking into the PCRF. However, there was no female exercise rehabilitation instructors in the PCRF or region. Patients requesting a female ERI would be accommodated by one of the female physiotherapists.

Are services responsive to people's needs?

We rated the practice as good for providing responsive services.

Responding to and meeting people's needs

The appointment system facilitated consultations in person or remotely by phone or using video conferencing facilities. Catterick Medical Centre (CMC) had been used as a test centre for a number of initiatives during lockdown that promoted remote working.

Patients were offered a range of bespoke services to support the population group. Examples included a virtual sick parade, 'attend anywhere' access for patients based at Barrow, diving and boxing medicals, midwife services and family planning. Patients were also offered minor surgery at CMC.

An access audit as defined in the Equality Act 2010 had been completed for the premises at CMC in April 2023. The audit identified the requirement for a disabled access toilet in one of the buildings. This had been requested via a statement of need. The building was not purpose-built but had been adapted for ease of access. For example, vehicles could be parked close to the main entrance and as the front doors were not automatic, a bell allowed patients to call for assistance. There was no lift in the building but treatment rooms were available on the ground floor.

The Equality Access Audit for the premises at BMC was completed in July 2022. It identified the building was not accessible for people with mobility needs. The medical centre was on the first floor with no lift access. There were no dedicated toilets for patients. The patient population were mostly based in the crew facility on the ground floor of the building. Toilets were available on this floor. The practice manager advised us that BAE Systems would not permit anyone to work on site with a significant condition/injury impacting their mobility. However, this meant patients could not attend the medical centre. A hearing loop was not required based on the current needs of people who used or accessed the building. We heard from one of the SNOs that the medical centre would be housed on the ground floor of a new built building (Project Spartan – work due to start at the beginning of 2026).

A hearing induction loop was available on the premises and there was clear signage at the main entrance to inform patients. A wheelchair was stored by the front entrance for any patient that may need support due to limited mobility. Quick review or QR codes were available for patients to access Dementia UK, a colitis helpline, the Armed Forces Charity (SSAFA), local focus groups and the neurodiverse community at Catterick.

Dependant on the patient's clinical need, the option of a telephone or face-to-face appointment or e-mail reply could be offered. A 'total triage' service allowed patients to request a same day call back by sending a text message.

At Barrow Medical Centre (BMC), a doctor carried out 1 face-to-face clinical session each month. A remote consultation with a doctor at CMC could be facilitated within a few days

or patients could travel to Catterick for a face-to-face consultation. Remote consultations were not reliable for a variety of reasons including poor signal in parts of the base, working patterns and accessibility to a phone (mobiles are not permitted in some areas). An emergency clinic was facilitated each morning by the practice manager who was also a Chief Medical Assistant. The patient was triaged and, if appropriate, a task sent to the duty doctor for a remote consultation. The Regional Nurse Advisor (RNA) provided clinical sessions every 2 weeks. They were flexible with provision to accommodate patient need. For example, the RNA altered the days they visited to accommodate a patient who needed dressing changes. On average, the RNA saw between 12 to 15 patients each month. The doctor saw 5 to 6 patients each month. These were mostly for medical gradings.

Telephone requests were routinely available and added to a doctor's or nurse's routine clinic as appropriate. Home visits requests would be triaged via the virtual sick parade.

There was a designated diversity and inclusion (D&I) lead and staff completed the mandated D&I course.

A direct access physiotherapy (DAP) service (through self-referral) had been implemented and was well utilised. The process was detailed on orders to all units and via Defence Connect on the My healthcare App. All new unit medics had an induction which included awareness of the DAP process.

We were informed by staff that patients had refused to go to Catterick for physiotherapy because of the distance and time out of work. Many had found their own workarounds including going to Weeton, Cosford and Neptune PCRFs. These facilities were en-route for patients travelling to their homes at weekends so they tried to coordinate appointments with their travel arrangements.

Timely access to care and treatment

CMC was open Monday to Friday 08:00-18:30 hours and the dispensary opened at 09:00 to 16:00 on a Monday to Friday except for Wednesdays and Fridays when it closed at 12:30. Outside of these hours, patients were signposted to the NHS111 service or 999 service. BMC was open from 08:00 to 16:00 hours Monday to Friday. From 16:00 to 18:00 hours, access to emergency medical cover was provided by CMC. Outside of these hours, including weekends and public holidays, cover is provided by NHS 111.

Details of how patients could access the doctor when the medical centre was closed were available through the patient information leaflet, on the main entrance to the building and on the recorded message relayed when the practice was closed. Details of the NHS 111 out-of-hours service was in the medical centre leaflet and instructions were displayed at the main entrance so could be seen when the practice was closed.

There was good availability of appointments for all clinicians. For example, urgent slots with a doctor were available on the day and routine appointments were available within 2 weeks. An appointment with the nurse could be secured within 2 days at CMC. At BMC, the wait time to see a nurse for a face-to-face appointment was 2 weeks.

Routine and follow up physiotherapy appointments were available within 7 to 10 days and an urgent appointment was available the next day. New patient and follow up appointments were available within 7 days to see an Exercise Rehabilitation Instructor. Gaps in staffing had led to reduction in ability to meet key performance indicators (KPIs) (only 40% of patients were seen within 10 working days). The PCRF team had attempted to manage in-house but a learning point raised from this was to engage with regional headquarters (RHQ) to discuss the provision of additional resource. We noted that this had happened and with support from RHQ, KPIs were being met. A patient satisfaction questionnaire had been undertaken for both CMC and BMC. Although the PCRF scored well on satisfaction, it had scored lower on accessibility. This was attributed to specific time when staffing levels were low.

Listening and learning from concerns and complaints

The group practice manager was the lead for complaints which were managed in accordance with the Defence Primary Healthcare (DPHC) complaints policy and procedure. Written and verbal complaints were recorded and discussed with staff at practice meetings. The complaints process was displayed in the waiting area and detailed in the practice leaflet.

We reviewed the one complaint received to find it was handled appropriately and in a timely manner. All practices are now required to complete an online complaints audit and although not completed at the time of the inspection, evidence provided after the inspection showed this was completed within one week of the visit.

The PCRF had not received any complaints in the previous 12 months. The Officer in Command for the PCRF managed complaints if informal and escalated to the practice manager if formal.

Are services well-led?

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

Vision and strategy

The medical centre worked to the Defence Primary Healthcare (DPHC) vision of: ‘Safe practice by design’ and mission statement ‘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’. They had also developed their own team ethos which was: ‘Mission and team focused collaborative care.’ This was displayed throughout the practice.

The management team highlighted future challenges as evolving the services provided at Barrow Medical Centre (BMC) and dealing with the infrastructure challenges at Catterick Medical Centre (CMC) resultant from having 3 separate buildings.

CMC had been used as a test site for a number of new initiatives that formed part of the DPHC health improvement programme. These included total triage, network group practice structure, SMS messaging and eRegistration.

Leadership, capacity and capability

The heads of department (HODs) had a wealth of experience between them with key roles shared across the whole team. CMC had a long period of time without a military practice manager and this gap had been managed by delegating duties to other staff, accepting some temporary cessation of activity, and requesting support from regional headquarters (RHQ). The Officer in Command for the primary care rehabilitation facility (PCRF) attended the HODs meeting.

Leaders within the medical centre provided direction, decision making and structure. Practice, heads of department and huddle meetings took place regularly and minutes were provided to team members who were unable to attend.

The staff spoke of a good working relationship with the regional team, of note the SMO and practice managers had regular dialogue with the Regional Clinical Director and felt well supported by RHQ whenever seeking help or guidance. The area manager visited regularly and was supportive with resourcing requests (locum staff and equipment). The Information System Security Officer (referred to as ISSO) had supported the team with the rollout of Microsoft Windows 10 and the migration to a new SharePoint site.

The Senior Medical Officer (SMO) did not have a named deputy but was supported by one of the Regimental Medical Officers (RMOs) through any period of absence. There was a significant number of civilian staff in HODs so there was continuity when SMO, Senior Nursing Officer, and Officer in Charge of the Primary Care Rehabilitation Facility (PCRF) were posted or gapped during leave. The nursing team was a mix of military and civilian staff to ensure continuity and resilience. The group practice manager and practice

manager were both civilian to ensure tasks could be covered if the military practice manager was away or post gapped

Job descriptions and terms of reference ToR) were in place for all members of staff. Staff had a separate ToR for their main role from secondary roles and responsibilities.

Culture

Staff at CMC were consistent in their view that the medical centre was patient-centred in its focus. At BMC, staff stated the combined practice model has improved over the last year including a better understanding of issues overall. Individual staff at Catterick had been very helpful and now there was good communication between the services.. The main issues expressed were in relation to how the change has been managed, including addressing the cultural and occupational differences between army and navy. It has been difficult for patients to break away from Neptune Medical Centre and navy culture. Staff and patients we spoke with felt that there had been an erosion of services and that the combined approach could have been better coordinated.

We heard from staff that the culture was inclusive with an open-door policy and everyone having an equal voice, regardless of rank or grade. Staff felt supported and spoke of a good working culture with everyone happy in their jobs. Regular social nights and team building days were held and those we spoke with at CMC reported on a good working relationships between managers and staff. All were familiar with the whistleblowing policy and said they would feel comfortable raising any concerns. To further encourage this, meetings were held within each core group or ‘cadre’ such as the administration team to provide a safer place for staff to raise concerns.

The monthly meetings were inclusive with all staff encouraged to attend. Staff were encouraged to be involved and raise any concerns or issues within their department.

Processes were established to ensure compliance with the requirements of the duty of candour, including giving those affected reasonable support, information and a verbal and written apology. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. We were provided with examples of when duty of candour had been applied. These were captured and recorded in the Healthcare Governance Workbook (HcG Wb).

Governance arrangements

A comprehensive understanding of the performance of the medical centre was maintained. The system took account of medicals, vaccinations, cytology, summarising and non-attendance.

There was a clear staffing structure in place and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. ToRs were in place to support job roles, including staff who had lead roles for specific areas. Lead roles were displayed in clinical areas and on SharePoint.

The practice had a HcG Wb; the overarching system used to bring together a range of governance activities, including the risk register, training register, policies, quality improvement activity (QIA) and complaints. The provision of care was monitored through an ongoing programme of QIA. Further development of the HcG Wb was underway to ensure a consistent approach to governance across BMC and CMC.

All staff had access to the HcG Wb which included various registers and links such as the risk register, Automated Significant Event Reporting tracker, duty of candour log, information technology faults and cleaning issues log. A range of information was accessible though quick links from the HcG Wb. These included risk assessments, ToRs, and the standard operating procedure index. The workbook was continually being developed and was managed by the HCG lead nurse.

An established audit programme was in place and had a positive impact on clinical outcomes. The programme of audit for the Primary Care Rehabilitation facility (PCRF) was integrated and available for all to see on SharePoint.

A range of meetings with defined topics for discussion were held to ensure a communication flow within the team. The practice had a designated meeting matrix in place which included the following clinics:

- Huddle meetings held daily.
- Heads of Department meetings held fortnightly.
- Group practice meetings held monthly.
- Clinical meetings held weekly.
- Healthcare governance meetings held weekly.
- PCRF staff meetings held monthly.
- Full practice meetings held monthly.
- Vulnerable patient held quarterly.

Managing risks, issues and performance

Effective processes were in place to monitor national and local safety alerts and incidents.

An effective process to identify, understand, monitor and address current and future risks including risks to patient safety was in place. Risks to the service were well recognised, logged on the risk register and kept under scrutiny through review at the practice meetings.

The medical centre has both an active and retired risk register and a separate issues log. There was a separate risk register for the PCRF which was duplicated onto the main CMC risk register. The 4 T principles of tolerate, terminate, treat and transfer had been applied appropriately. Quarterly risk review meetings with newly identified risks discussed sooner at either the monthly practice meeting or fortnightly Heads of Department meeting. We were sent completed risk assessments after the inspection that covered a wide range of

clinical and non-clinical risks. However, there was no evidence provided of COSHH risk assessments.

Appraisal was in-date for all staff. Although there had not been a need to use, the leadership team was familiar with the policy and processes for managing under-performance and ensured staff were supported in an inclusive and sensitive way taking account of their wellbeing.

A business continuity plan (BCP) was in place and had last been reviewed in October 2022. The BCP was available on SharePoint and hard copies were displayed around the buildings.

Appropriate and accurate information

Quality and operational information was used to ensure and improve performance. The DPHC electronic health assurance framework (referred to as eHAF) was used to monitor performance. The eHAF is an internal quality assurance governance tool to assure standards of health care delivery within defence healthcare. There was a combined eHAF for BMC and CMC.

There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. This extended to the PCRF.

Engagement with patients, the public, staff and external partners

An ongoing patient questionnaire was accessible at BMC and CMC via a quick review or QR code. In addition patients attending CMC were provided with an electronic table to submit a response. There were suggestions box along with ‘smiley face’ feedback forms.

Despite a number of attempts, the formation of a patient participation had not been successful due to zero attendance.

The PCRF had acted on responses to their own patient feedback. For example, they had increased the amount of time that grace was given to patients who showed up late for appointments from an initial 5 minutes to 10 minutes for a review and 20 minutes for a new appointment.

The SMO conducted a staff satisfaction survey, and the results were last collated in October 2022. These results showed significant improvement from the survey which was run in October 2021. The staff held regular ‘whitespace’ events and team lunches.

Good and effective links were established with internal and external organisations including the Welfare Officer, Regional Rehabilitation Unit, Department of Community Mental Health and local health services.

Continuous improvement and innovation

The healthcare governance nurse was the quality improvement project (QIP) lead and supported colleagues with identifying and recording QIPs. In 2023, there had been a total of 7 QIPS recorded, 1 for BMC and 6 for CMC. Of note:

- the reduction in clinical time required to prescribe antimalaria medication and improve the understanding of malaria risk among service personnel. This QIP was implemented to reduce the burden at CMC when large groups deploy to an area of malaria risk. CMC developed a patient questionnaire (based on the DMICP template for antimalarial prescribing) with a QR link to an educational video on malaria and prophylaxis (treatment for prevention).
- Re-organisation of clinical rooms in the PCRF allowed more space for physical training equipment in the building (previously staff had to take patients to another building).
- Recommencement of the ‘pain group’ which meant that patients who required more time than the basic appointment time to discuss persistent pain had somewhere to be referred to.