Harrogate Medical Practice

Uniacke Barracks, Penny Pot Lane, Harrogate, North Yorkshire, HG3 2SE

Defence Medical Services inspection report

This report describes our judgement of the quality of care at Harrogate Medical Practice. It is based on a combination of what we found from information provided about the service, patient feedback, our observations and 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?	**Outstanding**	
Are services well-led?	**Good**	

Contents

Summary

About this inspection

We carried out this announced comprehensive inspection across three dates: 11, 15 and 18 July 2023.

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

Are services safe? – requires improvement

Are services effective? – good

Are services caring? – good

Are services responsive to people's needs? – outstanding

Are services well-led? - good

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 improve 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 DMS.

At this inspection we found:

- Patients were able to access an appointment and urgent appointments were available the same day.
- Patient feedback about the service was overwhelmingly positive. Patients we spoke to confirmed that they felt comfortable coming to the medical centre to seek support and treatment. Patients told us that care they received in the PCRF and with their mental health was highly accessible and that they were treated with compassion, confidentiality, dignity and respect. Junior soldiers (who might feel less able to come forward and discuss their concerns due to their young age and low rank) all confirmed that medical centre staff spoke to them in a way that they could understand and that they felt involved in decisions about their treatment and medication.
- A programme of quality improvement activity (QIA) was in place based around the DPHC mandated audits and additional areas relevant to the patient population. This was driving improvement in areas which were relevant and impactful for patients.

- Arrangements were in place for managing medicines including high risk medicines. Patients had been reviewed and monitored in line with national guidelines although there was scope to ensure that these reviews were accurately Read coded.
- There was an effective programme in place to manage patients with long term conditions.
- The medical centre team were open with us about some cultural changes that were being implemented, including an improved safety culture. Staff felt valued and able to contribute to improved ways of working.
- The medical centre had positive lines of communication with the units they supported and the welfare team to ensure the wellbeing of service personnel. Proactive partnership arrangements had been forged with other agencies (Police, social services and local authorities) in order to safeguard vulnerable personnel. Command staff we spoke with confirmed that the medical team were involved in all case conferences and that the confidentiality of patient information was upheld as far as possible unless this posed a risk to someone.

We found the following areas of notable practice:

The PCRF team recognised that Medial Tibial Stress Syndrome (MTSS) represented one of the top 5 most common MSK injuries seen at AFC(H) and so introduced some targeted work to ensure consistency of treatment and outcomes for patients. External training courses had been delivered to the PCRF team, including Tom Goom's '*Running Repairs,'* which seeks to aid diagnosis of MTSS. A traffic-light system was adopted to categorise patients with regard to their individual recovery journey, doctor oversight of downgraded junior soldiers and implementation of a mini multidisciplinary injury assessment clinic (MIAC) to support patients through their rehabilitation pathway. Positive outcomes included more junior soldiers recovering more quickly.

- In recognition of the bespoke needs of female junior soldiers, the PCRF Team had worked in partnership with the Foundation College to design and deliver Project Athena, an initiative which sought to: 'Adapt basic training to the needs of adolescent servicewomen through psychological education, institutional change and biological understanding in order to remove barriers to inclusivity, reduce injury impact and increase retention.' Female junior soldiers benefitted from bespoke kit, education around menstrual health and hygiene, integration with male colleagues, mental health support and increased awareness of female role models. The 'Chimp Paradox model' had been explored to help people understand how the mind functions so they can develop the insight and skills needed to get the best from themselves and others. Feedback from female recruits had been largely positive.
- The nursing team had identified that prevalence of smoking amongst permanent staff was higher than that of the UK population and so designed a service improvement project (SIP) aimed to increase engagement with the existing Smoking Cessation Service (SCS). Whilst small, there was an increase in number of people engaging with the service and work will continue in support of patients quitting smoking.
- Clinicians went the extra mile to support injured junior soldiers to recover effectively within the best possible timeframe in order for them to be able to return to training. We discussed patients where clinical staff had gone the extra mile to secure swift access to

surgery and rehabilitation, allowing them to re-apply to the College post recovery. This supported the welfare needs of patients who might otherwise be discharged permanently.

- The Foundation College had been able to fund a CAMHS (Child and Adolescent Mental Health Service) practitioner who had been working with the medical team for 18 months. The CAMHS practitioner provided early intervention, mostly around anxiety and depression. The RCADS (Revised Child Anxiety and Depression Scale: a screening tool for depression and anxiety such as social anxiety and separation anxiety) was used to support junior soldiers. Swift access to this early intervention delivered dividends to young patients who benefitted from around 8 therapeutic sessions according to their need.
- The team had worked with local NHS services to arrange direct access to the local fracture clinic at Harrogate District Hospital. This meant patients with a fracture diagnosed elsewhere (across all four UK nations or overseas for example whilst on leave, military exercise or adventurous training) could be reviewed directly by orthopaedics without having to reattend the local A&E.

The Chief Inspector recommends to Defence Primary Healthcare (DPHC) and the contractor (PPP-Infrastructure Management Limited, a Compass Company):

- Review clinical capacity and fill staffing gaps (nurses, doctors and physiotherapists) at Harrogate Medical Centre to ensure that clinicians are not working excess of safe working hours as stipulated in the Defence Instruction and Notice guidance for service personnel and the Working Time Regulations (1998) for civilian staff.
- Provide clear lines of senior accountability to the medical centre team to ensure clear ownership of and optimal management of risks. Where risk ownership is shared across the Foundation College, PPP-Infrastructure Management Limited, a Compass Company and DPHC, clarify which organisation is leading on resolution implementation.
- There was scope to better integrate the physiotherapy and exercise rehabilitation teams and to improve the supervision arrangements for the junior ERIs.
- The PCRF space should provide an area where patient confidentiality and dignity can be adequately upheld.
- To ensure equity of access in line with the rest of Defence, consider Direct Access to Physiotherapy (DAP) clinics for permanent staff at Harrogate.

The Chief Inspector recommends to the medical centre:

- Audit the process for managing specimens & test results to ensure that it is failsafe.
- Ward staff should consider use of a ward treatment card to record supply and assessment of medicines to patients using the bedding down facility.
- Ensure that accurate and complete training records are maintained for all staff members.

- Before patients move to another facility, ensure the correct clinical coding is used for patients who are minors.
- Consider the use of pictograms on medicines to assist patients with reading challenges. Apply a reading age checker for the practice information leaflet and any patient advisory leaflets.
- Test the personal alarms held by PCRF staff to ensure that they can be heard across both floors.
- Invite patients who are eligible for bowel screening.
- Provide all staff with detailed terms of reference for their main role and separate terms of reference for key lead roles that they undertake.

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Chief Inspector of Healthcare

Our inspection team

The inspection team was led by a CQC inspection manager and comprised specialist advisors (SpAs) including a primary care doctor, nurse, physiotherapist, pharmacist, and an exercise rehabilitation instructor (ERI). The whole team were on site on 11 July, but it was necessary for some staff interviews to be conducted following this initial inspection day (on 15th and 18th July).

Background to Harrogate Medical Practice

Harrogate medical centre is located in the grounds of the Army Foundation College in North Yorkshire. The practice is provided within a public private finance initiative (PFI) facility through a contractor. Some nursing, physiotherapy and administrative staff are supplied by the contractor and they also manage the practice building. The Senior Medical Officer (SMO) who is a member of the armed forces, oversees clinical care.

The practice provides primary medical services to new army recruits aged

16–18 years, as well as to permanent staff members of the armed forces, based at the College. At the time of inspection, the practice patient register numbered approximately 1650 patients, with approximately 1,350 of these being 16–18 year-old army new recruits. The practice also provides occupational health services for up to 700 reserve members of the armed forces.

The practice runs primary health care clinics alongside its commitment to the Army Foundation College Training Programme which includes, amongst other commitments, vaccination of platoons, initial medical assessments, occupational medicals and provision of a bedding down facility for junior soldiers who require ongoing care at night. Minor surgical procedures are also provided.

The practice has a dispensary which is operated by military staff.

The practice is open for routine and urgent pre-hospital care from Monday to Friday, between 0800 hours and 1630 hours. The Senior Medical Officer was available for emergency referrals between 4.30pm and 6.30pm. Outside of these times, patients could access support from a Band 5 Nurse who provided triage & treatment and could support patients to access NHS 111 as required. The nearest accident and emergency unit is located at Harrogate District Hospital, which is approximately three miles from the practice.

The staff team

Medical team	One Senior Medical Officer (SMO) - Army One Civilian Medical Practitioner (CMP) – DPHC Reservist Medical Officer (MO) – Army One General Duties Medical Officer (GDMO) – Army (gapped)
Nursing team	One Senior Nurse/ Advanced Nurse Practitioner (ANP) – Contractor One Band 6 Nurse/Ward Manager – Contractor Twelve Band 5 Nurses - Contractor
Healthcare Assistants Medics Mental Health	Two Healthcare Assistants (HCAs) – Contractor Four Combat Medical Technicians (CMTs) – owned by Regimental Aid Post (Army) One CAMHS Practitioner - Contractor
Practice management	One Practice Manager (Army) One Office Manager (Contractor) Two Administrative staff (Contractor)
Pharmacy	Two Pharmacy Technicians - Army
PCRF	One lead Physiotherapist/ Healthcare governance lead - contractor Three Physiotherapists - contractor Two Exercise Rehabilitation Instructors (ERI) – Fox Coy (Army)

Are services safe?

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

Safety systems and processes

The SMO was the safeguarding lead at the medical centre and a deputy lead had been appointed, although neither staff member had terms of reference in place for their roles. All clinical staff had undertaken Level 3 training to safeguard children. The SMO (Safeguarding Lead) and Band 6 Nurse (Deputy Safeguarding Lead) submitted evidence of Adult Safeguarding Level 3. Other staff were trained to Level 2 Adult Safeguarding. There was no training record for one clinical staff member. Details of safeguarding contacts were held on the notice board within the waiting room.

The practice standard operating procedures (SOP) for both adult and child safeguarding had been reviewed and included contact details for local safeguarding teams. Clinicians attended monthly safeguarding meetings held by the college. The College took on board input from outside safeguarding agencies and partners on a quarterly basis. Bi-weekly safeguarding meetings were held within the medical centre.

As part of our inspection we spoke with the welfare officer, two padres and the Commanding Officer to solicit their views and active involvement with the medical centre team around safeguarding. Partnership working was strong and all staff we spoke with were knowledgeable and committed to safeguarding vulnerable people amongst their population. Early and proactive engagement with the recruiting group meant that any vulnerable personnel were identified prior to arrival at College and liaison with the relevant Local Authority helped smooth the transition. Upon arrival at the College, junior soldiers were seen by the welfare team within 72 hours in the wellbeing centre (a welcoming space fitted out with virtual reality headsets, X-boxes, beanbags and quiet spaces to relax – a recreational area with support on offer). Junior soldiers were made aware of the support available to them from Royal Voluntary Service (WRVS) staff (available early morning to 22:00 hours), the wellbeing support officer and the welfare officer. A families and community service was available to permanent staff and their families outside the camp. Medical centre and welfare staff met with platoon commanders on a monthly basis and all attendees could bring any concerns about vulnerable people to this forum. Two unit healthcare meetings were held (one for adults and one for junior soldiers). Chaired by the Adjutant and attended by the Commanding Officer, these meetings provided a forum for medical and dental updates, discussion around themes, trends and statistics and consideration of support plans for individual patients.

The SMO regularly attended case conferences alongside Command and welfare staff, the padre, representatives of the training company, the wellbeing support officer and the CAMHS practitioner. Subject matter experts were also invited if appropriate. Risk assessments were jointly agreed, alongside a care assessment plan. Referrals were made to the Army Welfare Service, North Yorkshire Children's services, the Local Area Designated Officer (LADO) and children's services. Packages of care were designed to meet the bespoke needs of the patient and could include access to counselling, therapy, a period of leave or input from chaplaincy. A follow-up case conference took place at 28

days to ensure that the care assessment plan was being followed and additional conferences were called in the interim as required. Where junior soldiers moved to Phase 2 establishments, their care plans transitioned across with them.

Our review of DMICP (electronic patient records system) demonstrated that alerts were not being applied to some records of patients deemed to be vulnerable, specifically patients aged under 18 were not coded as minors. Also, care leavers, whilst coded as vulnerable, were not coded as care leavers. This did not present an issue to patients whilst being cared for at Harrogate Medical Centre as staff were accustomed to providing care to patients who were minors. We noted that patients coded as care leavers has been retrospectively correctly coded after our inspection. However it is important that all minors are Read coded correctly when they leave Harrogate and move on to a different medical centre.

A list of staff who were trained and able to chaperone was held. The chaperone policy was displayed in the patient waiting area. A chaperone audit had been conducted and had led to additional staff training around correct clinical coding.

The full range of recruitment records for permanent staff was held centrally and for agency and contracted staff, was held by PPP Infrastructure Management Limited. The practice could demonstrate that relevant safety checks had taken place at the point of recruitment, including checks to ensure staff, including locum staff, were suitable to work with vulnerable adults and young people. Three staff were awaiting the return of their Disclosure and Barring Service (DBS) check and this issue had been recorded in the risk register. A process was in place to monitor the professional registration of clinical staff. All staff had indemnity insurance. Medical centre staff's immunisation status was monitored either by the military medical centre where they were registered or by the locum agency / contractor that employed them. DPHC had a system in place which placed reliance on these other stakeholders to manage the immunisation requirements of clinicians.

A band 5 nurse was the designated lead for infection prevention and control (IPC) and had received the appropriate training. Staff confirmed that the regional team provided IPC support as required. The annual IPC audit had been completed and any improvements actioned.

There was a cleaning contract in place through PPP-Infrastructure Management Limited, a Compass Company. Deep cleaning took place every six months. The medical centre was visually clean on the day of our inspection. Consignment notes was maintained by the practice, but there was scope to maintain a comprehensive log. Staff did not have evidence of an annual waste audit but one was scheduled for the autumn.

Arrangements to ensure safety of facilities and equipment were in place. Risk assessments had been undertaken and recommendations actioned covering fire risk, water safety, legionella and electricity. Station staff maintained a log of portable appliance testing (PAT) undertaken.

Risks to patients

From a patient perspective, clinical staffing levels were sufficient as patients interviewed told us they had prompt access to a clinician at all times, including out of hours. However, the SMO was working beyond reasonable hours to deliver his clinical and administrative roles and there was currently insufficient time available for leadership tasks. Physiotherapy and Exercise Rehabilitation Instructor (ERI) staff confirmed that they had sufficient time to deliver their roles. There was scope for the rehabilitation team to benefit from dedicated administrative input. Nursing staff levels were currently sufficient to deliver care, although pay and professional progression made it hard to recruit into nursing roles.

All staff, including locums, completed the DPHC mandated induction which included locum and role specific elements. The practice retained copies of competed induction packs.

The emergency trolley was accessible and regular checks were undertaken. We reviewed the medicines on the trolleys and found them to be appropriate and in date. Defibrillators were located in the medical centre and also in the gym. Oxygen was held and was accessible, although there seemed to be more oxygen cylinders on site than were recorded in the nurse's checklist. Appropriate signage was in place.

All staff had completed basic life support, sepsis, anaphylaxis and defibrillator training. Information about sepsis was displayed in various areas of the practice. Clinical staff had received extensive training across a number of mandatory and additional areas: including climatic illness, head injury, hyperbaric oxygen therapy (following a significant event), return to training for adolescents, adolescent orthopaedic hip pathology, management of stress and anxiety, lymes disease and an MSK complete hip case study. There was a named clinical lead for resuscitation on site. Suspected spinal injury training was due to be delivered in 2023.

Receptionists working across the practice had received training in recognising and reacting to emergencies. This training covered the deteriorating patient and sepsis. The sepsis recognition policy and aide memoire for prioritising patients were held at reception for easy reference. In addition, reception staff worked with a telephone consultation protocol which included a colour coded rating for condition priority. Patients we spoke with confirmed their opinion that reception staff were highly effective in their role.

Waiting patients could be observed at all times by staff working on the front desk. This included patients who had received vaccinations.

Information to deliver safe care and treatment

Staff confirmed that access to patient records was an issue at times and particularly on Thursday nights when DMICP routinely went down for 4-5 hours but that this did not pose a significant risk to continuity of patient care. For patients who needed to be admitted to the ward at this time, FMed10s (inpatient care sheets) were used. The Business continuity plan contained detail around action to take when patient records access was not possible. In the event of a DPHC wide outage, the medical centre would revert to seeing emergency

patients only. Hard copy forms were held in the medical centre for use in this scenario and documentation would be scanned onto DMICP when available.

Summarisation of notes for newly registered patients was undertaken mainly by nurses working the night shift. No backlog was identified during this inspection.

All clinical staff undertook reviews of peer clinical notes. An appropriate notes review template was in use. All staff were encouraged to use DMCIP templates as much as possible to capture all relevant information. PCRF notes were audited on an ongoing basis. Exercise rehabilitation note taking had been audited separately and improvements had been identified and delivered through the use of a template. An audit of nurse notes had been undertaken and was particularly thorough in its application. The need to record the use of chaperones had been acted upon.

The process for managing specimens and test results was not failsafe and audit work was needed to ensure that all test results were received back in a timely way. We noted that a number of results had not been recorded as returned and that some samples had gone missing. There were clear risks in this.

There was a system in place to manage referrals. There was a dedicated referral clerk. However this staff member sent reminders to themselves to follow up urgent referrals, leaving a gap during their leave. We discussed the utility of highlighting all urgent referrals differently for easy identification and more regular follow-up and this was implemented on the day of our inspection. The register also included internal referrals to the PCRF, regional rehabilitation unit, occupational health team and department of community mental health and were also tracked to ensure that appointments were both secured and attended.

Safe and appropriate use of medicines

The CMP was the lead for medicines management. Two pharmacy technicians were responsible for the day-to-day management of medicines and their terms of reference reflected this.

Patient Group Directions (PGD), which allow practice nurses to administer medicines in line with legislation, were in place and had been signed off. Nurses had completed training in using PGDs and administering vaccines and annual competency assessments were carried out. With one exception, medicines dispensed under a PGD were recorded in DMICP. A PGD audit had recently been undertaken by the lead nurse.

Patient Specific Directions (PSD) were also being used and we saw that details of medicines and patients being administered within a PSD had been maintained and staff competency was up to date. A nurse prescriber had assessed each patient to ensure that administration of medicine within a PSD was appropriate.

A process was in place for the management of information about changes to a patient's medicines received from other services. Incoming correspondence, such as from out-of-hours services, hospital discharge letters and out-patient clinics was scanned and then

tasked to doctors. If a patient brought a secondary care script into the medical centre, they were seen by the doctor who decided what action to take.

All blank prescriptions were stored safely. There was a logbook for receiving new blank prescriptions, but there was scope to record stock numbers more clearly.

A process for the safe processing of repeat prescriptions was in place. Where appropriate, medication reviews were taking place and were Read coded. Prescriptions were authorised by doctors or nurse prescribers.

Uncollected prescriptions were checked monthly and a note was made on the patient's record and the medicine destroyed including the prescription serial number. The prescriber was alerted if the medicine was high risk.

A temperature log was maintained for the medicine fridges and the ambient temperature of the dispensary. A standard operating procedure (SOP) was in place and we saw that recently recorded temperatures had remained within appropriate parameters.

The practice followed the DPHC protocol and local SOP for high risk medicines (HRMs). We reviewed the clinical records for five patients who were taking HRMs and saw that national guidance had been followed. However there was no alert on the system for one patient who was registered with a different practice but collected their medication from Harrogate Medical Centre.

The bedding down facility had an assessment process for self-administration of medication by patients. The medicine was dispensed by the pharmacy technicians who then counselled the patients on the ward. The ward nurses carried out an assessment with each patient to determine whether it was appropriate for the patient to self-administer their medicines with a nurse taking accountability for recording. One patient we saw had not had a nurse assessment prior to taking their medication.

Controlled drugs were managed in line with the JSP 950 leaflet and the Misuse of Drugs (safe custody) regulations 1973. This included the dispensing and destruction of controlled drugs.

An emergency trolley contained drugs and equipment which were checked monthly by both pharmacy technicians and nurses. All items were in date.

An audit on antimicrobial prescribing was undertaken in May 2023 which showed that prescribing was appropriate in all cases and that compliance with antimicrobial guidelines was 88% overall. The audit results had not yet been discussed in the clinical meeting, but the SMO had created an action plan to ensure that only necessary antibiotic prescribing was used.

We spoke with some patients on the day of our inspection who told us that they had a concern about reading the instructions on their medication. They told us that the pharmacy staff ensured that they understood what dose they needed to take and with what frequency. Given that it is possible to forget this advice, we discussed the utility of pictograms to assist patients who had reading challenges. There was also scope to use simple English and to apply a reading age checker for the practice information leaflet and any patient advisory leaflets.

Track record on safety

There was a risk register, retired risk register, issues log and retired issues log on the healthcare governance workbook. All risks included detail of the 4T's (treat, tolerate, transfer or terminate) and had a review date. There was scope to clarify ownership of and optimal management of risks. Where risk ownership was shared across the Foundation College, PPP Infrastructure Management Limited and DPHC, it was not always clear which organisation held the levers for resolution implementation. We saw that some risks had been transferred to Regional Headquarters and DPHC HQ. There were a range of both clinical and non-clinical risks including lone working, Control of Substances Hazardous to Health (COSHH) and Covid-19 Standard Operating Procedures (SOPs).

The PCRF facility was well provisioned to meet the specific needs of the patient population. A range of physical training, rehabilitation and medical equipment had been procured and was managed within servicing agreements. A faults register was in place and any work needed had been undertaken. Wet-bulb globe temperature (WBGT – a heat stress index) readings were taken in hot weather and activity managed accordingly.

Staff had personal alarms and weekly tests were carried out in the main medical centre building, although not in the rehabilitation gym.

Lessons learned and improvements made

Significant events and incidents were reported through the electronic organisational-wide system (referred to as ASER) in line with the DPHC ASER policy. A local ASER SOP was in place. All staff had an ASER login. An ASER spot check had been undertaken in July 2023 and found that 90% of staff had a login (one locum did not have a login at that time) and that 80% knew how to initiate a part 1 submission. Our interviews with staff across the whole team and our review of the ASERs raised and investigated to date, indicated that the safety culture was in a state of flux. Staff described a previous culture where they had felt discouraged from raising concerns, but that within the last 6 months they had been encouraged and supported to raise issues. ASERs were routinely discussed at the practice meetings and identified in the minutes, but there was scope to widen this discussion to include ERIs.

The medical centre had a system in place to distribute Medicines and Healthcare products Regulatory Agency (MHRA). Discussion took place at clinical meetings and was recorded in minutes. The Pharmacy Technician circulated any alerts that required priority action to other clinicians. The CAS (Central Alerting System) alert log was held on health governance workbook including detail of action taken. Alerts were also discussed at the healthcare governance meeting as a standing agenda item.

Are services effective?

We rated the practice as good for providing effective services.

Effective needs assessment, care and treatment

Processes were in place to support clinical staff to keep up to date with developments in clinical care including NICE guidance, clinical pathways, current legislation, standards and other practice guidance.

Clinical meetings were attended by all clinicians and were held monthly. We saw that the heat injury policy had recently been discussed along with high-risk medicines, referrals, Duty of Candour and chaperone/consent. Doctors' meetings were also held monthly where NICE and Scottish Intercollegiate Guidelines Network) SIGN updates were discussed. Records of these meetings were seen.

Primary Care Rehabilitation Facility (PCRF) staff were familiar with Department of Defence Rehabilitation Guidance and provided examples of treatment provided based on evidence-based guidelines and care pathways. ERIs and physiotherapists used Rehab Guru (software for rehabilitation exercise therapy) and use of this software was recorded.

Monitoring care and treatment

The Advanced Nurse Practitioner (ANP) and the Civilian Medical Practitioner (CMP) (absent at the time of this inspection) held the lead roles for chronic disease management and ensured that patients with chronic disease were appropriately monitored. There were very few patients with a long term condition within the patient population and so this area of work was not extensive.

There were 6 patients recorded as having high blood pressure. All patients had a record for their blood pressure taken in the past nine months. Five patients had a blood pressure reading of 150/90 or less which is an indicator of positive blood pressure control.

There were 2 patients on the diabetic register. Treatment was being delivered in line with NICE standards.

There were 4 patients with a diagnosis of asthma. All 4 patients had an asthma review in the preceding 12 months which included an assessment of asthma control using the three RCP (Royal College of Physicians) questions. An asthma SOP was followed by clinicians. Whilst a consistent asthma review template was in use, there was scope to utilise it more fully.

57% of patients' audiometric assessments were in date (within the last 2 years). During COVID-19 routine audiometry had ceased in line the April 2020 DPHC directive. The practice had resumed audiometry as restrictions relaxed and were working to reduce the backlog.

Patients with mental health needs were supported in a number of ways:

- Junior soldiers could rapidly access support from the CAMHS practitioner who provided early intervention, mostly around anxiety and depression.
- Northumberland self-help guides or Scottish self-help guides were used to support patients who were also able to access Headspace, an app which offers advice and guidance on mental wellbeing, tips on sleeping better and different exercises to improve mood. It also had articles to listen to including how to reduce worrying, improve focus and manage anxiety.

A quality improvement programme was in place and included the DPHC mandated audits. Additional audit work targeted to be meaningful for the patient population was also undertaken:

The CMP had undertaken initial audit work around body mass index (BMI) and weight gain in the permanent patient population. This had led to the CMP attending the Defence Wellbeing Health Advisory course with a view to using the exercise medicine experience to look at tackling and helping people with obesity. A future aim is to set up a system with physical training teams to help people with high BMIs, pre-diabetics to manage their weight.

The PCRF team recognised that Medial Tibial Stress Syndrome (MTSS) represented one of the top 5 most common MSK injuries seen at AFC(H) and so introduced some targeted work to ensure consistency of treatment and outcomes for patients. External training courses have been delivered to the PCRF team, including Tom Goom's 'Running Repairs,' which seeks to aid diagnosis of MTSS. A traffic-light system was adopted to categorise patients with regard to their individual recovery journey, doctor oversight of downgraded junior soldiers and implementation of a mini multidisciplinary injury assessment clinic (MIAC) to support patients through their rehabilitation pathway. Positive outcomes included more junior soldiers recovering more quickly.

Effective staffing

All staff, including locums, completed the DPHC mandated induction which included locum and role specific elements. Copies of competed induction packs were retained and doctors were signposted to 'Desk Top Instructions' for additional guidance. The PCRF had a standardised induction process for all new staff, including a tick list of all essential activity and mandatory training.

Performance appraisals were conducted by line managers for all staff and uploaded to Human Resources (HR) systems. All doctors were in date for appraisal and all doctors and nurses had completed timely revalidation. Regular clinical supervision and reflection took place for doctors and nurses. Physiotherapy staff received regular appraisals and attended regular multi-disciplinary team meetings. ERIs were being line managed by the gym staff which was not an appropriate arrangement. One ERI we spoke with had not completed their post graduate mentoring programme. ERIs were not recording their CPD in accordance with the Standards of Proficiency to Practice. There was scope to better integrate the physiotherapy and exercise rehabilitation teams and to improve the supervision arrangements for the junior ERIs.

Mandatory training was recorded on the staff database. All staff had protected time for the completion of mandatory training and attendance at group training.

Coordinating care and treatment

The medical centre team had forged effective links with units including welfare staff and we were told that a mutually supportive communication stream was in place. We interviewed a welfare officer, 2 padres and a support worker as part of our inspection. They confirmed that regular meetings took place with the aim of supporting personnel and that conversations were two way such that each party could raise concerns about vulnerable personnel.

We also spoke with the Commanding Officer who represented the unit registered with the medical centre and they were complimentary about the proactive approach taken by the medical team to support personnel who may be vulnerable. The care offered on the ward to junior soldiers was considered to be an effective safeguard to ensure that minors were given the best possible care out of hours.

Clinicians had identified a barrier to patients accessing X-rays and a resolution was sought to ensure that patients with fractures were able to swiftly access orthopaedic and fracture clinics. Private healthcare funding had been made available by the College to enable this. The medical team had established positive links with Ear Nose and Throat (ENT) providers in York.

Patients could be referred to a ‘mini’ MIAC (multi-disciplinary injury assessment clinic) when required. This facilitated early multi-disciplinary management of the patient pathway. A weekly clinic was in place offering discussion of clinical cases and timelines for management. Patients were offered interim support to manage any injury in the interim and Chain of Command were made aware if personnel needed to be downgraded whilst they awaited assessment and treatment.

The team had worked with local NHS services to arrange direct access to the local fracture clinic at Harrogate District Hospital. This meant patients with a fracture diagnosed elsewhere (across all four UK nations or overseas for example whilst on leave, military exercise or adventurous training) could be reviewed directly by orthopaedics without having to reattend the local A&E.

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 of the patient’s health needs was provided. For patients with complex needs moving to another medical centre, a summary letter was given to the receiving medical officer. Patients were also made aware of the Veterans Health Service and, if appropriate, the Veterans Mental Health Transition, Intervention and Liaison Service (TILS).

Helping patients to live healthier lives

The health promotion lead within the practice kept the information up to date on the notice boards in line with national priorities when appropriate. We saw a number of health promotion boards in the waiting area and corridors and these included information around sexual health, hydration, smoking cessation and the symptoms of sepsis.

The ANP was qualified and led sexual health sexual health screening. There were established links with both the local NHS provider and the military sexual health consultant. Free condoms and chlamydia kits were available at the practice. Information about sexual health, contraception and pregnancy was displayed in the patient waiting area.

The nursing team had identified that prevalence of smoking amongst permanent staff was higher than that of the UK population and so designed a service improvement project (SIP) aimed to increase engagement with the existing Smoking Cessation Service (SCS). Whilst small, there was an increase in number of people engaging with the service and work will continue in support of patients quitting smoking.

Searches to find patients eligible for health screening had been undertaken but we noted gaps in recalling patients. We saw that one patient was eligible for bowel screening but had not been invited. There were no patients eligible for either abdominal aortic aneurysm or mammogram screening. Ninety-five percent of women who were eligible for a cervical smear had received one in the last five years which exceeded the NHS target of 80%.

Immunisations were regularly reviewed and administered to patients when they were required. Due to the transience of the patient population at a phase 1 training establishment, we acknowledge that we took these figures as a snapshot during the training calendar and so many junior soldiers will not have yet completed the vaccination cycle. Our review of records showed that the vaccination programme was delivering what patients required.

- 65% of patients were recorded as being up to date with vaccination against diphtheria.
- 65% of patients were recorded as being up to date with vaccination against polio.
- 88% of patients were recorded as being up to date with vaccination against hepatitis B.
- 94% of patients were recorded as being up to date with vaccination against hepatitis A.
- 65% of patients were recorded as being up to date with vaccination against tetanus.
- 99% of patients were recorded as being up to date with vaccination against MMR.

Consent to care and treatment

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. They had a good understanding of the Mental Capacity Act (2005) and how it would apply to the patient population. Mental capacity training was incorporated into the safeguarding training.

Consent was appropriately recorded in the clinical records we looked at for physiotherapists, nurses, mental health staff and doctors. The offer and use of a chaperone had been checked and recording improved.

An audit of consent recording had been completed and was also routinely checked as part of peer note reviews.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

We interviewed 11 patients as part of the inspection and feedback indicated that medical centre staff treated patients with kindness, respect and compassion at all times.

Four patients were using the bedding down facility at the time of our inspection and we spent some time to understand their view of the quality of 24-hour care provision. They had all spent at least 1 night in the facility and 1 patient had spent 3 nights on the ward. They all told us that medical centre staff were approachable, kind and caring and that they had access to drinks and snacks. They all felt safe and supported at night. Whilst all patients in the facility told us that entertainment on the ward was limited (access to personal phones was permitted only after ward rounds), they understood that College rules needed to be adhered to ensure the legitimacy of admissions.

We reviewed the records for a number of patients who were experiencing anxiety or depression. Clinicians were responding to patients with kindness and compassion, ensuring that patients had the space and time to talk when they needed to.

We interviewed the majority of staff working across the medical centre through this inspection. Most staff told us that Harrogate Medical Practice was a good place to work and that they could rely on their work team to discuss and mitigate any concerns they faced. They spoke about colleagues who were supportive, compassionate and caring.

Three registered patients responded to the DPHC patient satisfaction survey in the last 12 months. All patients who responded to a question about how well clinicians listened to them, said that their experience was very good or good. Similarly, all respondents stated that they felt that they had been treated with appropriate care and concern.

Involvement in decisions about care and treatment

All 11 patients we spoke with said they were involved with decision making and planning their care. All patients we spoke with had received smoking cessation, sexual health and addiction information and advice. All the patients we spoke with had been offered support to properly understand their medication and to take the right dose at the right time. Most patients told us they were confident they knew how to access medical care whilst they were on block leave at home. Those who were not sure said they would contact the Harrogate Medical Centre for signposting.

Of the 3 patients who responded to the DPHC patient satisfaction survey, all stated that they had been fully involved in decisions about their care and treatment.

The PCRF used light duties chits and used downgrade maintenance physical therapy and reconditioning physical therapy prescriptions appropriately.

Patients with a caring responsibility were identified through the patient registration process. A clinical code to denote the patient's potential vulnerability was assigned to their records. There was scope in future to assign the Read code for 'carer'. The medical centre team had identified the need to ensure that only those patients who have a caring role are coded as such and staff training was planned.

An interpretation service was available for patients who did not have English as a first language.

Privacy and dignity

All patients we spoke with stated that they were confident that the medical centre would keep information about them confidential. All stated that they felt that their dignity and privacy were upheld by medical centre staff. This included the junior soldiers who were residing in the bedding down facility. We accompanied the SMO on his ward round and noted that curtains were drawn around beds during conversations with patients. Care was taken to ensure that junior soldiers owned their healthcare information and could control who they shared this with. Interviews with the two padres, welfare officer and Commanding Officer confirmed that medical staff always protected the healthcare information of junior soldiers and permanent staff. Medical staff took great care to protect the healthcare information of patients during meetings to discuss vulnerable patients – information was only divulged in order to mitigate a risk to a patient or those around them.

Patient identity checks were completed prior to any information being disclosed. Consultations in the medical centre took place in clinic rooms with the door closed. There were privacy curtains in all clinical rooms. The PCRF space did not provide private rooms for consultations with physiotherapy staff. Curtains divided patients which meant that confidentiality was breached.

There was a notice in reception advising patients they could speak with a member of staff in private if required. All staff had completed the Defence Information Management Passport training which incorporated the Caldicott principles. The waiting room was large and meant that patients speaking with staff at the welcome counter were not easily overheard.

Patients were able to see clinicians of either gender according to their preference. All patients who responded to the patient survey stated that they were able to see a clinician who suited their needs.

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 medical centre was a purpose built clinical facility and was well provisioned to meet the specific needs of the patient population, including access for patients using a wheelchair. Patients we spoke with did not report any concerns with accessing the facilities. An Equality Access Audit had been carried out and no barriers had been noted.

The medical centre was constantly ready to respond at very short notice to the occupational needs of patients. Additional clinics were arranged at short notice and during non-office hours if required. Patients and unit staff we spoke with confirmed how valuable this rapid response was.

A policy was in place to guide staff in exploring the care pathway for patients transitioning gender. Medical centre staff had received training to support the appropriate and effective care of people who were transitioning gender.

Clinicians went the extra mile to support injured junior soldiers to recover effectively within the best possible timeframe in order for them to be able to return to training. We discussed patients where clinical staff had gone the extra mile to secure swift access to surgery and rehabilitation, allowing them to re-apply to the College post recovery. This supported the welfare needs of patients who might otherwise be discharged permanently.

In recognition of the bespoke needs of female junior soldiers, the PCRF Team had worked in partnership with the Foundation College to design and deliver Project Athena, an initiative which sought to: 'Adapt basic training to the needs of adolescent servicewomen through psychological education, institutional change and biological understanding in order to remove barriers to inclusivity, reduce injury impact and increase retention.' Female junior soldiers benefitted from bespoke kit, education around menstrual health and hygiene, integration with male colleagues, mental health support and increased awareness of female role models. Feedback from female recruits had been positive.

The medical centre and PRCF had acted on patient feedback. Patients had reported that the rehabilitation room was too busy, so a dynamic risk assessment was undertaken and group therapy sessions were increased. Patients using the ward had fed back about lack of menu choice and the fact that they could not access their mobile phones. Changes were made to provide more menu choice and to allow access to mobile phones once ward rounds were completed.

Timely access to care and treatment

We spoke with 11 patients as part of this inspection and all confirmed that they could access a convenient appointment quickly. One patient told us that they found it difficult to

get through be phone to make an appointment, but that if they attended in person they could secure an appointment with ease.

The medical centre was providing very responsive care for its patient population. Urgent and routine appointments with either a doctor or a nurse or physiotherapist could be accommodated on the same day if required. Sick parades were run to accommodate the needs of junior soldiers and additional clinics were run at short notice to accommodate requirements such as vaccinations. Vulnerable patients were seen promptly and offered longer appointments. Telephone consultations were available if requested. The medical centre was manned 24/7 and access to a doctor was available if required. Home visits could be accommodated if required. If a junior soldier needed 24 hour care, this was accommodated in the ward.

The patients we spoke with during the inspection confirmed they received an appointment promptly and at their preferred time. In the patient survey, 100% of respondents stated that their experience of making an appointment was very or fairly good.

When junior soldiers went away during periods of leave, private health care appointments near their home could be provided. During block leave, if there was a requirement to open the ward, the contractor did this. Where junior soldiers needed support to access care during their leave, their section Commander would assist them. There was also a Facebook page where parents could ask for help which was monitored by permanent staff.

Direct access to the local fracture clinic at Harrogate District Hospital meant that patients did not need to wait in A&E and could be seen directly for a fracture diagnosis. Direct Access Physio (DAP) clinics were not available for junior soldiers: they would be seen promptly by the SMO and referred on if PCRF input was required. There was no DAP clinic for permanent staff which meant that this cohort were not receiving equitable access in line with the rest of Defence.Rapid access to PCRF support was available with patients being seen well within the key performance indicators (same day for acute referrals). Routine physiotherapy appointments were available within two days for JS and within ten days for permanent staff. Non-attendance of appointments was not an issue at the time of our inspection. To see an ERI, a new patient appointment was available the same day and follow up appointments could also be accommodated on the same day. Access to rehabilitation classes was available the same day.

Listening and learning from concerns and complaints

The practice manager was the lead for complaints, although there were no terms of reference in place for their role. One complaint had been received in the last 12 months. Learning had been identified and discussed.

Patients were made aware of the complaints process through the practice information leaflet and a poster in the waiting room. Patients we interviewed were aware of how to complain but said they had no reason to make a complaint about the service.

Are services well-led?

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

Leadership, capacity and capability

The medical centre benefitted from the expertise of an experienced SMO, CMP, nursing team, administrative and PCRF team. The practice manager and office manager worked closely together and a deputising arrangement was useful for continuity. The healthcare governance lead worked well to ensure that quality remained at the heart of daily tasks, However, there was scope to ensure that all staff owned detailed terms of reference for their main role and that separate terms of reference were in place for key lead roles that they undertook.

The Army directly funded 2 locum GP posts to support the intake of new junior soldiers which was very useful support during these busy periods. The Army also provide doctor support for times of surge work e.g. to cover boxing medicals.

The SMO was currently the only full time GP working in the medical centre. Their clinical duties were therefore significant, leaving insufficient capacity for optimal leadership activities. The SMO was working in excess of the hours deemed to be safe and was therefore not in accordance with the Defence Instruction Notice (DIN). Exhaustion presented a risk to clear decision making.

Throughout this inspection we met with patients and unit staff who described a medical centre team that went the extra mile to ensure that patients' needs were met as quickly as possible in order to ensure their health and wellbeing, alongside their role in facilitating operational capability.

Whilst Harrogate Medical Centre was not a 'DPHC' practice, the regional team afforded support to the medical centre. This included invitations to healthcare governance (HCG) meetings, regional nursing meetings and the area manager and regional pharmacist undertook advisory visits.

Vision and strategy

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

The medical centre worked to DPHC's 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.' However the team also worked to achieve the vision statement of the Army Foundation College (Harrogate) :

‘To train Junior Soldiers to the output standard required by the CMS (JE) in order to provide the right inflow to initial trade training to meet the Army's operational requirements.’

The medical centre had forged close links with all the unit it supported and tailored the service to their specific needs, such as force protection clinics. Duty doctors, nurses and medics were routinely on hand to facilitate urgent access to care.

The team strove to deliver a preventative approach which involved proactive health promotion support, lifestyle advice and prompt barrier-less access to mental health provision.

Consistent quality improvements were driven by the team. A business plan had been developed to drive Healthcare Governance performance over the next 12 months. The new PM told us about plans to implement a Practice Development Plan to strengthen resilience. The team had invested the use of QR codes via Office App to streamline activities and capture evidence such as training, evaluation, feedback, building fault reporting and legionella flushing with further plans to implement more.

Culture

Staff we spoke with described a strong team ethic with patients’ individual requirements held at the centre of all decision making. We observed staff going the extra mile to provide a comprehensive service to their patients, often accommodating short notice requests, providing accessible bereavement care, ensuring that carers could access the support they might need.

Leaders operated an open door policy for staff to use and everyone we spoke with confirmed that this was the reality in practice. Staff we interviewed pointed to a cultural shift being underway and that they now felt confident and empowered to discuss issues and concerns they had identified and escalated. Staff were aware of the whistleblowing policy and were also aware of the Freedom to Speak Up (FTSU) process within the region.

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 given examples of when duty of candour had been applied appropriately, but they admitted that they needed to record these instances more readily.

Governance arrangements

A staff structure was in place which included non-DPHC staff, contracted staff and Regimental Aid Post (RAP) staff. A detailed lead/deputy roles and responsibilities list was in place and accessible to all staff and displayed within the MTF.

Staff had multiple additional roles to fulfil such as deputizing roles. The healthcare governance workbook (HGW) was the overarching system used to bring together a range of governance activities, including the risk register, ASER tracker, training register, SOPs, QIA and complaints.

A meeting's matrix was used to deliver a robust schedule of meetings which included HcG Meetings, practice meetings and multi-disciplinary meetings. It was clear that all staff contributed. The PCRF was operating as a fully integrated part of the medical centre team. A risk register was in place and all risks were monitored and reviewed.

A quality improvement programme was in place and covered DPHC mandated work as well as audit of areas that were meaningful for patients.

Managing risks, issues and performance

There was a current and retired risk register on the HGW along with current and retired issues. The register articulated the main risks identified by the practice team. All risks included detail of the four T's: 'treat, tolerate, transfer or terminate' and had a review date. We saw that some risks had been transferred to Regional and DPHC Headquarters. The registers were regularly reviewed. There was scope to clarify ownership of and optimal management of risks. Where risk ownership was shared across the Foundation College, PPP Infrastructure Management Limited and DPHC, it was not always clear which organisation held the levers for resolution implementation.

There were a range of risk assessments in place including both clinical and non-clinical risks. The assessments included lone working, sharps safety and health and safety; COSHH risk assessments were developed during the inspection. There were processes were in place to monitor national and local safety alerts, incidents, and complaints.

The Business Continuity Plan (BCP) had been reviewed and was exercised to ensure that staff knew what to do in an emergency. The BCP covered all the main risks to the service and included all three sites. The practice had a major incident plan which supported all units and had been agreed by unit commanders.

Staff who were not performing would be supported initially to identify any underlying cause and implement support structures. If performance did not improve then formal performance management processes, military or civilian, would be followed.

Appropriate and accurate information

The eCAF (Common Assurance Framework) commonly used in DPHC services to monitor performance is an internal quality assurance governance assurance tool to assure standards of health care delivery within defence healthcare. The practice used this to ensure quality outcomes.

Systems were in place that took account of data security standards to ensure the integrity and confidentiality of patient identifiable data, records and data management.

Engagement with patients, the public, staff and external partners

There were various options in place to encourage patients to provide feedback on the service and contribute to the development of the service. These included a patient experience survey and a suggestions box was available in the waiting room.

Changes had been made as a result of patient feedback and included improved menu for ward patients, access to mobile phones for inpatients and improved access to rehabilitation sessions.

The staff team stated that they felt well supported and had excellent communication streams with the Unit they supported. Welfare staff told us that their relationship with the medical centre team was positive and trusted. Communication channels with local NHS services, including local sexual health services and secondary care providers had been established and meant that patients could access the care that they needed locally.

Continuous improvement and innovation

The PCRF team recognised that Medial Tibial Stress Syndrome (MTSS) represented one of the top 5 most common MSK injuries seen at AFC(H) and so introduced some targeted work to ensure consistency of treatment and outcomes for patients. External training courses have been delivered to the PCRF team, including Tom Goom's 'Running Repairs,' which seeks to aid diagnosis of MTSS. A traffic-light system was adopted to categorise patients with regard to their individual recovery journey, doctor oversight of downgraded junior soldiers and implementation of a mini multidisciplinary injury assessment clinic (MIAC) to support patients through their rehabilitation pathway. Positive outcomes included more junior soldiers recovering more quickly.

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The nursing team had identified that prevalence of smoking amongst permanent staff was higher than that of the UK population and so designed a service improvement project (SIP) aimed to increase engagement with the existing Smoking Cessation Service (SCS). Whilst small, there was an increase in number of people engaging with the service and work will continue in support of patients quitting smoking.

The Foundation College had been able to fund a CAMHS (Child and Adolescent Mental Health Service) practitioner who had been working with the medical team for 18 months. The CAMHS practitioner provided early intervention, mostly around anxiety and depression. The RCADS (Revised Child Anxiety and Depression Scale: a screening tool

for depression and anxiety such as social anxiety and separation anxiety) was used to support junior soldiers. Swift access to this early intervention delivered dividends to young patients who benefitted from around 8 therapeutic sessions according to their need.

The team had worked with local NHS services to arrange direct access to the local fracture clinic at Harrogate District Hospital. This meant patients with a fracture diagnosed elsewhere (across all four UK nations or overseas for example whilst on leave, military exercise or adventurous training) could be reviewed directly by orthopaedics without having to reattend the local A&E.