Newcastle Medical Centre

Albemarle Barracks, Near Harlow Hill, Newcastle upon Tyne NE15 0RF

Defence Medical Services Follow Up inspection

This report describes our judgement of the quality of care at Newcastle Medical Centre. It is based on a combination of what we found through information provided about the service, patient feedback and through telephone conversations with staff.

Overall rating for this service	**Good**	
Are services well-led?	**Good**	

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About this follow up inspection

We carried out an announced comprehensive inspection of Newcastle Medical Centre on 23 October 2019. The medical centre received an inadequate rating overall, with a rating of inadequate for the safe and well-led key questions. The effective key question was rated as requires improvement and the caring and responsive key questions were rated as good. We visited again on 28 and 30 June 2021 to carry out an announced comprehensive follow-up inspection. The medical centre received an overall rating of requires improvement, with a rating of requires improvement for the safe and well-led key questions. The effective, caring and responsive key questions were rated as good. We carried out a second announced comprehensive follow-up inspection on 22 September 2022. The medical centre received a good rating overall, with a rating of requires improvement for the well-led key question. The safe, effective, caring and responsive key questions were rated as good.

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

www.cqc.org.uk/dms

We carried out this announced follow-up inspection on 18 September 2023. The report covers our findings in relation to the recommendations made and any additional improvements implemented since our last inspection.

As a result of this inspection the practice is rated as good overall and good in the well-led key question.

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 within this report.

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.

At this inspection we found:

An increase in staffing levels and changes in working practices had resulted in a manageable workload for medical centre staff and a more effective coordination of care for patients.

Weekly clinical team meetings had been reinstated, standard operating procedures were now in place for the management of long-term conditions and patient recall systems were having a positive impact on patient care.

A programme of clinical audit and peer review had been implemented for all clinical staff. The medical centre had developed links with nearby military medical centres to provide resilience and opportunities to peer review one another's work.

The arrangements for data security and privacy had been improved to address issues highlighted at the previous inspection. In particular, the PCRF now managed issues around confidentiality when providing treatment in a shared facility.

Equipment within the PCRF was in-date for servicing and schedules for continual maintenance were in place.

The medical centre agreed to cease issuing repeat prescriptions for tick/borne encephalitis vaccines.

The line management arrangements currently in place for the practice manager were justified by the regional team and the collaborative leadership prevented any skill gaps.

The Chief Inspector recommends to the wider organisation:

Review the requirement of additional telephone lines to mitigate any risk in the event of an emergency situation.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

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

Our inspection team

The inspection was undertaken by a CQC inspector.

Background to Newcastle Medical Centre

Located in Albemarle Barracks, Newcastle Medical Centre provides routine primary care and occupational health care service to a patient population of 663 military personnel. Primary healthcare is provided to a 'sick at home' population in the North of England and an occupational service is provided to an approximate population of 1,500 reservists and 250 members of the University Officer training Corps. An occupational health service is also provided to military personnel at RAF Spadeadam and to Otterburn training camp where there can be significant numbers of visiting military personnel on exercise at any given time. A Primary Care Rehabilitation Facility (PCRF) is in the medical centre and

provides personnel with a physiotherapy and rehabilitation service. The medical centre is open from 08:00 to 16:30 hours. From 16:30 hours on weekdays emergency cover is provided by Catterick Medical Centre. From 18:00 hours midweek, weekends and public holidays patients can access emergency care through NHS 111.

The staff team

Doctors Locum doctor	One Senior Medical Officer (SMO) 30 hours per week (to provide cover in the absence of the RMO)
Regimental Medical Officer (RMO) General Duties Medical Officer (GDMO)	One (unit asset non-Defence Primary Health Care (DPHC), deployed) One
Practice manager	One
Nurses Band 5 Band 6	 One One
Exercise Rehabilitation Instructors (ERI)	Post vacant
Physiotherapists	One
Administrators	Two full-time Two part-time
Pharmacy technician	One
Medical Sergeant*	One (unit asset non DPHC)
Combat Medical Technicians* (CMTs)	Two (unit assets non DPHC)

*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 well-led?

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

At our previous inspection, we rated the medical centre as requiring improvement in well-led due to gaps in governance processes. At this inspection, we found that improvements had been made, facilitated by the return to established staffing levels.

Leadership, capacity and capability

The established posts of a second nurse and a third administrator had been filled and staff reported that this had alleviated the pressure of workload. In addition, the medical centre had reverted to offering a triage clinic to introduce a more effective and efficient management of clinical appointments. Weekly clinical meetings had been reinstated.

At the previous inspection, we highlighted that the line management of the practice manager by the physiotherapist was an unusual arrangement due to the skill set required. At this inspection, we contacted the Regional Clinical Director as this had not changed and the medical centre told us this was at the request of the regional team. We were told that this arrangement was in place because of the advantages of line management for civil service employees within Defence Medical Services at an appropriate grade outweighed the benefits of employment group specific management. The human resource issues of day to day management were the responsibility of the line manager but employment group specific support was provided by colleagues that included the SDO and the Area Manager and Operations Manager from the regional team. The line management for the exercise rehabilitation instructor (ERI) was now with the physiotherapist having previously been managed by the Senior Medical Officer.

Governance arrangements

There had been an increase in audit activity now that permanent staff were in post. This included both clinical and administrative auditing. The practice was working towards completion of all Defence Primary Healthcare (DPHC) mandated programme and had included additional audits on opiate analgesia and zopiclone (a medicine used to aid sleep) usage.

Previously, we highlighted issues with data security when the physiotherapist used an online prescription application. The practice confirmed that this had ceased immediately after the inspection. The Primary Care Rehabilitation Facility (PCRF) was now conducting clinical audits which included a programme of review for clinical note taking.

The exercise rehabilitation instructor (ERI) notes we reviewed at the previous inspection did not have any use of Rehab Guru (software for rehabilitation prescription) for exercise programmes for patients. A review of PCRF notes highlighted that best practice guidance was referred to but not always followed, and, that there was scope to improve the written record to explain why specific exercises had been prescribed. Training had been provided to the ERI but they subsequently left. A programme of notes' audits was in place ready for

the new ERI, mentoring was to be provided and protected time was planned to allow reviews against best practice guidance.

Long-Term Conditions (LTCs) were managed by the nurse. With the nursing team at the established level, DPHC standard operating procedures (SOPs) outlining the management and monitoring arrangements for LTCs had been developed and were discussed at monthly meetings. An effective patient recall process was in place and we reviewed patients on the diabetes and hypertension registers to find that they were being seen in a timely manner.

At the previous inspection we found a peer review programme of clinicians' DMICP consultation records was in place. However, we saw a self-completed peer review programme of nursing notes and recommended that this be completed by another clinician. This had been actioned with the introduction of peer reviews between nursing staff through collaboration with Boulmer Medical Centre.

Audiology statistics showed 79% of patients had received an audiometric assessment within the last two years. This number had improved from 66% (at the previous inspection) due to the implementation of a patient recall system and completion of a catch up programme.

At the previous inspection we found that the tick-borne encephalitis vaccines were on repeat prescription as opposed to being on a vaccination diary recall. When not on the vaccination diary, they could be missed when searching for patients requiring vaccinations and thus not completing the course. The practice had reviewed and discussed the process and although planning to review again in the near future, had not changed the process. Staff felt that there system served them well and minimised administrative work. Although not contrary to any legislative requirement or DPHC policy, it is not best practice to prescribe any vaccine on a repeat prescription as a patient should not be able to request a vaccine. A diary entry should be automatically generated from the protocol used and the clinical staff member administering the first vaccine should make a follow-up appointment at the time. Following discussion with the Regional Clinical Director and Regional Pharmacist, the medical centre agreed to cease using repeat prescriptions for the vaccine. A Patient Group Directive was implemented and prescriptions were to be done for single dose of vaccines as needed.

Managing risks, issues and performance

A back-up power supply for the vaccine fridge was now in place to provide continuity in the event of an electricity outage.

Action had been taken following the recommendation we made to mitigate the potential risk with having only one phone line for the practice. We were told that this amounted to an additional handset which allowed clinicians to liaise with the emergency services in the event of an emergency. However, the medical centre still only had one phone line and told us they were continuing requests for a resolution.

At the previous inspection, we highlighted that no entries had been made onto the risk register by the PCRF despite confidentiality and privacy being a risk when providing

treatment in the unit gym. We were sent an updated PCRF risk assessment a few days after visiting and the risks associated with confidentiality had been added and mitigation implemented. In addition, an additional door into the physiotherapist's room had been requested and a privacy screen was being used on the laptop and mobile device by PCRF staff when seeing a patient in a public area.

The medical centre provided evidence to show that gym equipment in the PCRF treatment area was in-date for servicing. This had been completed in November 2022.

Environmental cleaning was provided by an external contractor and arrangements had improved since the previous inspection. The cleaning contract was owned and monitored by the quartermaster and a copy had now been provided to the medical centre. Medical centre staff confirmed to us that cleaning was now being carried out in clinical rooms without interrupting clinics (between the hours of 06:00 and 08:00 and at lunch time). Higher level cleaning was now being done consistently and an annual deep clean was included in the contract.

Legionella was identified in the water supply in November 2021. Whilst the system had been flushed and some ongoing testing had pursued, the medical centre staff team were not in receipt of clear information from the camp around which taps had been tested and what the result was. This posed a potential risk to staff and patients who could not be assured that the water they used was safe. After the inspection, the Regional Clinical Director informed us that the Regional Area Manager had visited and gained the appropriate assurance around legionella. In addition, an SOP had been developed by the medical centre to improve staff understanding and raise awareness. Testing was being carried out an recorded and links and been improved with the organisation responsible for testing and providing reports.