Catterick and Barrow Medical Group Practice

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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?	**Good**	

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Summary

About this follow up inspection

We carried out an initial announced comprehensive inspection at Catterick and Barrow Medical Group Practice on 16 May and 1 June 2023. We rated the service as good overall with a rating of requires improvement for the safe key question. The effective, caring, responsive and well-led key questions were rated as good. A copy of the previous report can be found at:

www.cqc.org.uk/dms

We carried out this announced focused follow up inspection on 4 September 2024. The report covers our findings in relation to the recommendations made and any additional improvements made since our last inspection.

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

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 CQC's observations and recommendations.

This inspection is one of a programme of inspections that 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:

- The provision of a welfare service at Barrow Medical Centre (BMC) had been reviewed and deemed sufficient. This would continue to be reviewed should the patient list size increase.
- Environmental cleaning arrangements had been reviewed, revised and updated to include regular deep cleans. The cleaning standards were found to be of a high standard and this was supported by patient feedback.
- Staffing levels at BMC had increased to facilitate more face-to-face appointments. This included the addition of a nurse and the planned introduction of a contracted civilian physiotherapist (under recruitment).
- Clinical governance around the total triage system had been strengthened and a sample review of consultations provided reassurance that the system was being used in a safe way.
- Medical equipment and gases were found to be consistently monitored, calibrated and stored appropriately.

- The summarising of patient notes was now clear of any backlog and effective systems were in place to process them in a timely way.
- Further improvements on minor issues were noted around the management of long-term conditions, audit and training.

The Chief Inspector recommends to Defence Primary Healthcare:

- Review the establishment of exercise rehabilitation instructor posts to ensure there is sufficient resource to follow best practice guidelines and effective rehabilitation pathways.

Dr Chris Dzikiti

Interim Chief Inspector of Healthcare

Our inspection team

The inspection team was led by a CQC inspector supported by a primary care doctor and a colleague from CQC.

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 6,200 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 is forecast to increase to 600 in future. The 2 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 based in the medical centre at CMC and provides personnel with a physiotherapy and rehabilitation service. The medical centre at CMC is open from 08:00 to 18:30 hours Monday to Friday. The opening hours at BMC are 08:00 to 16:00 hours Monday to Friday. On weekdays from 18:30 hours, 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	1 Senior Medical Officer (SMO) 6 civilian medical practitioners (CMPs) (5 part-time, 1 full-time, equivalent to 3.2 whole time equivalent) 1 General Duties Medical Officer (GDMO) 1 locum
Regimental Medical Officer (RMO)	1 (unit asset non DPHC)
Practice manager	1 (Group Practice Manager) 2 (1 at Catterick, 1 at Barrow) 1 Business Manager
Nurses	1 senior nurse (urgent care practitioner) 1 Band 6 civilian nurse 2 military nurses 2 civilian nurses 1 locum Regional nurse providing regular sessions at BMC 1 Band 6 nurse (part-time) at BMC 1 healthcare assistant
PCRF	9 physiotherapists 3 exercise rehabilitation instructors (ERIs)
Administrators	12
Pharmacy technicians	1
Combat Medical Technicians* (CMTs) Medical Assistants (MAs)	50 (DPHC assets, not unit) 3 (fleet assets based at Barrow)

*In the army, a 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 good for providing safe services.

Following our previous inspection, we rated the practice as requires improvement for providing safe services. We found shortfalls with:

- clinical oversight of the total triage system
- the provision of a welfare service at Barrow Medical Centre (BMC)
- summarising of patient notes
- cleaning arrangements for the clinical rooms used at BMC
- storage arrangements for medicines and medical gas to promote better safety and controlled access
- calibration of the blood glucose monitor
- overdue medication reviews on those patients on multiple medications
- risk assessments of products kept in the buildings that are potentially hazardous to health
- arrangements around confidentiality for patients being seen in the primary care rehabilitation facility (PCRF).

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

Safety systems and processes

At the last inspection, there was no welfare service on the base at BMC. This was largely due to the very small patient list of 150 and that the establishment for a submarine crew would not normally include specific welfare workers as this function was carried out by their ‘Division’. Senior Naval Officers and patients (line managers) had 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. At this inspection, it was confirmed that the provision of welfare services continued to be a Royal Navy rather than Defence Primary Healthcare (DPHC) responsibility and reviews by the Royal Navy Executive since the last inspection, including as recently as August 2024, had concluded that the current provision was adequate. This remained under review and we were told would become an increasing focus as the patient list increased. Options to increase local provision included the establishment of a ‘Barrow Carers’ Forum’. Any issues at BMC were managed through the Chain of Command. The medical centre had the option to refer patients to the national welfare service (Royal Navy personnel family services) although this was not the preferred option as it was not face-to-face. Some 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.

Environmental cleaning continued to be provided by an external contractor and the medical centre buildings at both sites appeared to be clean with no issues were identified. Cleaning schedules now included regular deep cleaning. The cleaner signed a daily checklist and this was reviewed by the cleaning supervisor. The infection prevention and

control (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. This issue has been raised with the contractor but a resolution had yet to be found which will provide for site secure clinical cleaning. There remained no definitive solution to the provision of site secure clinical cleaning and the present regime continued to rely on the office standard cleaning contract provided by BAE augmented by a self-cleaning regime carried out by medical centre staff. To optimise the self-help clinical cleaning by staff, the following measures had been introduced:

- A structured cleaning schedule in accordance with the DPHC IPC Compendium (copy provided as evidence).
- A local working practice (LWP) for IPC at BMC which detailed the current mitigations and procedures to ensure that the facility was cleaned in accordance with the cleaning schedule (copy provided by the practice).
- A regular program of IPC training for all staff at BMC .

Patients from BMC spoke positively when asked their views on the standard of cleanliness.

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 Regimental Medical Officer posts were often gapped due to deployment without locum doctors available to provide backfill. Staff absences were managed by using departmental rotas with locum backfill requested to cover long-term gaps. Civilian medical practitioners could also draw on support from Infantry Training Centre (ITC) Catterick medical centre.

A key theme raised at the last inspection by patients at BMC 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. Since the last inspection, staff uplift at Barrow included a Band 6 nurse (2 days a week) and 3 leading medical assistants (full-time). A relationship had been developed with HMS Neptune where a submariner specialist doctor conducted quarterly visits and completed monthly occupational health clinics/reviews.

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, piloted at CMC, and now rolled out across DPHC. The combat medical technicians (CMTs) were involved in the initial triage of patients. Telephone consulting was considered a higher risk and would normally be conducted by doctors or advanced nurse practitioners. Close supervision was essential to ensure safety was maintained. On the day of the last inspection, 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 clinical 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.

Following the last inspection report, an internal review was undertaken to look at how total triage could be supported in accordance with emerging policy and existing regulations. The model that was developed following this review continued to see initial patient contact provided by suitably trained CMT's and primary healthcare nurses, but with immediate, 'in room' supervision provided by a nurse prescriber. Overarching 'reach back' support was now provided by the duty doctor for that day (always a trained GP). Immediate questions raised by those contacting patients were now initially reviewed by the supervising nurse practitioner with recourse to the duty doctor should this be required. The LWPs for supervision and monitoring triage clinics had been updated and detailed robust processes.

The revised process was audited initially in September 2023, looking at documentation and effectiveness. The audit was repeated in January 2024 and a further audit was performed in July 2024 focusing on the appropriateness and efficacy of referrals. The most recent audit demonstrated that appointments for doctors were appropriate, with evidence patients assessed by a CMT or nurse who needed more clinical input had been appropriately referred. Patients had been offered urgent appointments on the day or offered a routine appointment the following week. There was evidence to show any patient who could not be treated in a primary care practice was forwarded on the correct pathway. We reviewed total triage processes including audits and clinical notes to find that the clinical governance was effective.

At the last inspection, patients from BMC who needed physiotherapy highlighted that the length of time driving time could be counterproductive to their recovery from injury. 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. There was now a private contract for physiotherapy in place, patients could be referred into this service as normal. In addition, a business case had been approved for a permanent civil servant physiotherapy (16 hours per week) and this project had entered the recruitment stage.

At the last inspection, PCRF gym areas did not provide the appropriate space for the patient list size. Staff were having to use gym space at the 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. We found additional capacity for the PCRF at Catterick had been achieved with additional gymnasium space identified and inspected by the Officer in Command physiotherapist at Catterick. This provided more capacity to deliver rehabilitation classes. However, exercise rehabilitation instructor (ERI) established posts were 1 short for the patient list size (based on DPHC policy). This meant that although patients were seeing physiotherapists in a timely way but when ready to see an ERI to continue the rehabilitation pathway, there was often a delay, sometimes up to 1 month, before an ERI appointment was available. ERIs were seeing as a minimum the number of patients per day as specified in the policy and were utilising group sessions as per policy. The impact was delays in patients progressing through the rehabilitation pathway and regaining

deployable status (often in addition to a lengthy wait to their surgery due to NHS waiting times).

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 regularly checked. Emergency training courses completed by staff online had been supplemented by face-to-face training delivered by the clinical team. We previously highlighted that the blood glucose monitor was giving readings out of range despite both the testing solution and test strips being in-date. The blood glucose monitor had been calibrated on the day of inspection and as per the current DPHC equipment directive, the medical centre was now using the Cardio Chek plus (a machine calibrated weekly by the nurses that measures blood glucose and lipids). Control readings were monitored by the duty nurse on a Monday and confirmed as correct and recorded as such. This record was in hard copy and was kept in the nurses' treatment room. We checked the records and found them to be complete.

Information to deliver safe care and treatment

The DPHC SOP was followed for the summarisation of patients' notes. However, at the last inspection, there was a backlog of patients' records (70%) awaiting the re-summarisation carried out every 3 years. Since the last inspection, the DPHC SOP for summarisation had been changed to 5 years. At this inspection we found that the total of notes up-to-date with summarising had gone from 27% to 83% (combined total for initial and 5 year if still within the practice) for serving personnel. For civilian patients, 98% of records were up-to-date with summarisation. The practice commented that this improvement had resulted in more early recognition of chronic disease e.g. working out the QRISK (an algorithm which calculates an individual's risk of having a hear t attack or stroke) and over 40s health checks.

A recent internal assurance inspection highlighted that there was a lack of LWP for the summarisation of patients notes. DPHC has a generic SOP for the scrutiny and summarising of notes, however, within the practice there was a lack of evidence to identify individuals' responsibilities for summarising. As a result of this feedback, it was agreed that an LWP would be developed, and an audit would be conducted to identify how many currently registered patients had up-to-date summaries in line with DPHC policy. This audit aimed to identify the percentage of notes which have not been summarised when a new patient registers with the practice and the percentage of patient notes which have not been summarised for over 5 years.

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 Senior Medical Officer (SMO) together with the doctor who was the lead for cancer performed audits to maintain clinical oversight. We highlighted at the last inspection that internal referrals were not monitored and these were added to the referral tracker on the day. These had now been added to the DPHC

tracker. The practice highlighted that the new NHS system meant that non-urgent referrals could not be tracked as the patient was contacted directly, not through the practice. A safety net was for the medical centre to be informed if the patient did not respond. Although potentially problematic for patients when deploying, this was an NHS initiative to reduce letters and therefore outside of DPHC policy and control.

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. Emailed results which were scanned or uploaded to the patient's DMICP record and the result tasked to the requesting clinician. At this inspection, the situation had not changed as CMC and BMC were not on the ICE system. However, a new sample tracker had been developed with automated RAG (red, amber, green) ratings that allowed a reviewing nurse to see at a glance what results were overdue. This was also reviewed monthly by the administration team. Audits were done quarterly and results reported to the laboratories. A nurse was allocated daily to go through the outstanding results and file those received. Clinicians could add to the tracker or send a task to the administration team for it to be added.

Safe and appropriate use of medicines

Requests for repeat prescriptions were managed in person or by email, in line with policy. A process was in place to update DMICP (electronic patient record) 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. At the last inspection, we reviewed patients on 4 or more medications and found 32 who were overdue a review. Following the inspection, an immediate response was made to contact the affected patients and ensure a medication review appointment was offered. To ensure this issue did not reoccur, an LWP was put in place and regular audits carried out. The last audit, completed July 2024, evidenced that over the past 6 months, the percentage of medication reviews completed remained consistently at 80%, dependent on the fluctuation in population. There continued to be systems in place to identify patients prior to review date and liaison with administration team to ensure appointments were made promptly. The LWP required prescribers to complete a template that ensured the review date was reflected both on the medication prescribed and on the prescribing screen. Through audit, it had been identified that some patients had had medication reviews but this had not been entered correctly onto the records. Opportunistically, prescribing clinicians reviewed medications and cancelled medication no longer being used. The nursing team when summarising registrations continued to check the prescribing screen and review repeat medications, if not in-date or not been dispensed for 12 months, a task would be raised to liaise with the SMO or prescribing doctor in order to maintain currency of medical records.

Since the last CQC inspection, the medical gas storage facility has undergone an overhaul both in terms of maintaining standards of tidiness and cleanliness and through instituting a program of regular inspections by the new Military Practice Manager. As a result, these improved standards had been maintained and the storage facility now met both the

mandated and expected standards. We received copies of the medical gas risk assessments carried out since the last inspection.

Track record on safety

At the last inspection, there was no evidence provided of Control of Substances Hazardous to Health (COSHH) risk assessments. The practice confirmed that they had started work to address this issue and in advance of this inspection, provided evidence that COSHH assessments had all been completed in July 2024.

Are services effective?

We rated the practice as good for providing effective services.

Although the effective key question was rated good at the previous inspection, we had highlighted minor issues and found improvements had been made. These included:

- the requirement for a consistent approach with the management of long-term conditions
- lack of clarity and cohesion of the audit calendar
- improvements with the induction and training.

At this inspection we found these had been actioned.

Monitoring care and treatment

Long-term conditions (LTCs) management was led by 2 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 a 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 (SOP) in place for the management of LTCs that outlined the monitoring arrangements. The SOP for CMC had previously conflicted with that for Barrow Medical Centre (BMC). A local working policy was now in place for the group practice and anything site specific was included as an annex.

Although an audit calendar was in place at the last inspection, it was not clear which 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. At this inspection we found that legacy audits had been archived and a new audit calendar had been implemented to include site specific audits where applicable, for example, infection, prevention and control audits.

The healthcare governance workbook (HcG Wb) had continued to be developed as a combined document. A third practice, Infantry Training Centre (ITC), Catterick was also being integrated as part of the group practice and the HcG Wb was being further developed to bring this into line. SharePoint was used as a one stop shop with links to read only documents to ensure there was a controlled single version of current documents.

The staff training database was populated by the Group Practice Manager, ASER logs were combined but separated out to be site specific. Meetings were integrated and facilities provided so BMC staff could dial in. Face-to-face meetings would mean having to shut BMC down temporarily so full practice face-to-face meetings were seen as more cost than benefit. However, individual staff members from Barrow had attended CMC for regional and refresher training sessions. The Regional Nurse Advisor attended Barrow twice a month for 2 days to deliver both clinical care and clinical assurance.

The audit programme was combined with site specific elements where required and rationalised to account for Defence Primary Healthcare (DPHC) mandated, internal, local need and professional interest as per the DPHC classifications. This was consolidated to a single page and colour coded to give clear visibility on completed, pending and overdue audits.

Patient recalls were managed through a single spreadsheet and recall was a centralised function managed from Catterick. Alerts were centrally managed through the pharmacy technician at Catterick ITC. Emails were sent out to nominated individuals at each medical centre who were responsible for reporting back and confirming that actions had been taken. The responsible individual would then add this to the spreadsheet. Patient feedback was coordinated and remained site specific to identify any local issues or themes.

A new automated texting system had been introduced. This was used for targeting messaging such as flu vaccinations and total triage. This utilised the web based system to send messages and removed the need to manually send out invites and appointment reminders.

Effective staffing

We had previously highlighted that the induction programme did not include key information on local policies and processes that would be particularly helpful for locum staff. A briefing, normally with the Senior Medical Officer (SMO), had been introduced to the induction programme to allow for information to be provided on local services, instruction on how to access them and any limitations such as wait times for a speciality.

Staff had previously voiced frustration over funding for courses. In particular within the nursing team. Although this has not affected patient care, it had an impact on individuals being able to remain their competency, for example ear irrigation. Staff said this had improved with additional funding secured and a £250 individual allowance for staff to use for training in a specific interest. The SMO reported that no funding for training had been refused in the last 12 months. An additional underwater specialist doctor had been trained as the single specialist was a Regimental Medical Officer (likely to be regularly deployed) and there was 1 unit that carried out occupational diving.