Catterick Garrison Medical Centre

Quality report

Building 19
Cambrai Lines
Munster Barracks
Catterick Garrison
DL9 3PZ

Date of inspection visit:
18 July 2019

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11 September 2019

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information given to us by the practice and patient feedback about the service.

Ratings

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

Chief Inspector's Summary

This practice is rated as good overall

The key questions are rated as:

Are services safe? – Good
Are services effective? – Good
Are services caring? – Good
Are services responsive? – Good
Are services well-led? - Good

We carried out an announced comprehensive inspection of Catterick Garrison Medical Centre on 18 July 2019. Defence Medical Services (DMS) are not registered with the CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014 and are not required to be. Consequently, DMS services are not subject to inspection by the CQC and the CQC has no powers of enforcement. This inspection is one of a programme of inspections that the CQC will complete at the invitation of the Surgeon General in his role as the Defence Authority for healthcare and medical operational capability.

At this inspection we found:

- The practice was well-led and leaders demonstrated they had the vision, passion and integrity to provide a patient-focused service that sought ways to develop and improve.
- An inclusive team approach was supported by all staff who valued the opportunities available to them to be part of a patient-centred service.
- There was an open and transparent approach to safety. An effective system was in place for managing significant events and staff knew how to report and record using this system.
- The assessment and management of risks was comprehensive, well embedded and recognised as the responsibility of all staff.
- The arrangements for managing medicines, including obtaining, prescribing, recording, handling, storing, security and disposal minimised risks to patient safety. There was an effective approach to the monitoring of patients on high risk medicines.
- Staff were aware of current evidence based guidance. They had received training so they were skilled and knowledgeable to deliver effective care and treatment.
- The practice worked collaboratively and shared best practice to promote better health outcomes for patients.
- There was evidence to demonstrate quality improvement was embedded in practice, including an annual programme of clinical audit used to drive improvements in patient outcomes.
- The practice proactively sought feedback from staff and patients which it acted on. Feedback showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.

- Equipment at the practice were sufficient to treat patients and meet their needs. The building was not suitable, particularly for rehabilitation. Staff had a workaround for this until the Catterick Integrated Care Centre project is completed in 2023.
- Staff were aware of the requirements of the duty of candour.

The Chief Inspector recommends:

- The process to manage high risk medicines is reviewed to ensure it is failsafe.
- Although the practice had measures in place to mitigate the IPC and confidentiality risks associated with the infrastructure of the PCRF (Primary Care Rehabilitation Facility), the DMS should ensure arrangements to move the PCRF to a more suitable environment progresses in accordance with the timeframes identified during the inspection.

Dr Rosie Benneyworth BM BS BMedSci MRCGP
Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

The inspection team was led by a CQC lead inspector**.** The team comprised specialist advisors including a GP, practice nurse, practice manager, physiotherapist, exercise rehabilitation instructor and pharmacist.

Background to the Catterick Garrison Medical Centre

Catterick Garrison Medical Centre provides a routine primary care service to a patient population of 5701 including service personnel, families and dependants. There were 466 registered patients under the age of 18 at the time of the inspection and 71 patients aged 50 to 65 with no patients above this upper age range. The practice also provides occupational health to service personnel only and supports personnel who are not in work due to illness and who live in North Yorkshire and County Durham (referred to as 'sick at home').

The medical centre is a dispensing practice and is staffed by three pharmacy technicians. A Primary Care Rehabilitation Facility (PCRF) is co-located with the medical centre and provides a physiotherapy and rehabilitation service for service personnel only.

The medical centre is open from 08:00 to 18:30 hours Monday to Friday. Outside of these hours, including weekends and bank holidays, cover is provided by NHS 111.

The staff team

Position	Numbers
Senior Medical Officer (SMO)	Vacant until 22/7/2019
Deputy SMO	One (acting as SMO)
Medical Officers (MO)	Seven (two deployed)
General Duties Medical Officer (GDMO)	One
Civilian medical practitioners (CMP)	Five (one full time; four part time)
Senior Nursing Officer (SNO)	Vacant until 22/7/2019
Deputy SNO	One (acting as SNO)
Practice sister	One
Civilian practice nurses	Two

Military practice nurses	Two
Health care assistant	One
Military practice manager	One
Civilian practice manager	One
Practice supervisor	One
Administrative staff	10
PCRF	One officer in command and 11 staff
Pharmacy technicians	Three

Are services safe?

Good

We rated the practice as good for providing safe services.

Safety systems and processes

Systems were established to keep patients safe and safeguarded from abuse.

- A framework of regularly reviewed safety policies was in place and accessible to staff, including locum staff. Staff received safety information about the practice as part of their induction and refresher training.
- Measures were in place to protect patients from abuse and neglect, including adult and child safeguarding policies. The safeguarding policy was last reviewed in January 2019. Staff, including Regimental Aid Post (RAP) staff working at the practice, had received safeguarding training and update training at a level appropriate to their role. RAP staff are clinicians who are attached to units rather than employed to work directly at the medical centre.
- Doctors, nurses and the lead physiotherapist had completed level 3 training in adult and child safeguarding. A safeguarding lead and deputy were identified for the practice. Safeguarding arrangements and local contact details were displayed in clinical rooms for staff to access. An audit in January 2019 confirmed the practice was working in accordance with the safeguarding policy.
- Coding and alerts were used to highlight vulnerable patients. A vulnerable patients register was held on the electronic patient record system (referred to as DMICP) with eight adults and three children identified at the time of the inspection. Monthly meetings to discuss vulnerable children were held with the health visitor and school nurse. Patient records were updated during the meeting. One of the safeguarding leads attended three monthly meetings with the local safeguarding team in Northallerton. The needs of service personnel assessed as being vulnerable were discussed with the Welfare Officer at the monthly Unit Health Committee (UHC) meetings.
- Chaperone training was provided in June 2019 and a list of trained chaperones was available. Notices advising patients of the chaperone service were displayed in patient areas. Staff had been subject to safety checks to ensure they were suitable to work with young people and vulnerable adults.
- The full range of recruitment records for permanent staff was held centrally. However, the practice could demonstrate that relevant safety checks had taken place at the point of recruitment, including a Disclosure and Barring Service (DBS) check to ensure staff, including

locum staff, were suitable to work with vulnerable adults and young people. DBS checks were renewed every five years. Staff had received the appropriate vaccinations for their role.

- Arrangements were in place to monitor the registration status of clinical staff with their regulatory body. All staff had professional indemnity cover. Information was in place to confirm staff had received all the relevant vaccinations required for their role at the practice.
- There was an effective process to manage infection prevention and control (IPC), including a lead and deputy lead for IPC who was appropriately trained for the role. The staff team was up-to-date with IPC training. An independent IPC audit had been undertaken in June 2018 and no significant concerns had been identified. The practice completed an annual IPC audit in May 2019. The Primary Care Rehabilitation Facility (PCRF) infrastructure was not ideal to support good IPC practice. For example, a carpeted floor and no sink in one treatment area. Staff could use handwashing sinks in other treatment areas but it meant they had to walk through another treatment area to reach it. Interim measures were in place to mitigate the risks, such as the use of hand gel. A project was underway for the medical centre including the PCRF to move to a bespoke new building by 2023.
- Seven PCRF clinicians practised acupuncture and arrangements were in place for the safe provision of this treatment, including an acupuncture health screening assessment and patient information sheet. The acupuncture risk assessment was out-of-date for review by three months and the lead physiotherapist provided evidence shortly after the inspection to confirm it had been updated.
- A physiotherapist also provided corticosteroid injection treatment for inflamed and painful joints. A standard operating procedure (SoP) was in place to support this procedure, and also a SoP to manage a potential allergic response associated with injection treatment. The risk assessment for this treatment was out-of-date for review and the lead physiotherapist provided evidence shortly after the inspection to confirm it had been updated. In addition, we were provided with the updated risk assessment for cryotherapy; the use of cold treatment for injury management.
- Environmental cleaning was provided by an external contractor. Cleaning schedules and monitoring arrangements were established, including cleaning before the practice opened and at lunchtime. A deep clean of the premises took place in December 2018. We identified no concerns with the cleanliness of the premises.
- A member of staff had the lead for the safe management of healthcare waste. Consignment notes were retained at the practice and an annual waste audit was carried out in July 2019.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

- Staff we spoke with said staffing levels and skill mix was adequate to meet the needs of the patients. There was a mix of military and civilian staff. A locum induction programme was in place to familiarise temporary staff with systems and processes. The PCRF coordinated the recruitment of locums for the department, which could be more efficiently managed through the broader recruitment process for the practice.
- The practice was equipped to deal with medical emergencies and all staff were suitably trained in emergency procedures, including staff trained in life support. An emergency kit, including a defibrillator, oxygen with masks and emergency medicines were accessible to staff in a secure area of the practice; all staff knew of its location. A first aid kit and accident book was available. Weekly and monthly checks were in place to ensure the required kit and medicines were

available and in-date. On the day of the inspection, reception staff identified a patient was acutely unwell. They acted promptly and so the patient received medical care in a timely way.

- Staff were up-to-date with the required training for medical emergencies. They participated in regular training relevant to emergency situations. Staff had recently received training in how to manage patients presenting with a suspected climatic injury. We noted a display regarding the management of pain for non-freezing cold injury was displayed in clinical areas. Staff were also trained in the recognition and management of sepsis. Posters about sepsis were displayed throughout the practice.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we looked at on DMICP showed information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- A process was established for scrutiny and summarising of patients' records and this was monitored by the practice manager. For civilians, the patient completed a registration form, which was checked by the receptionist and then passed to the nurses for further checks. Summarisation of service personnel was completed on DMICP. A summarisation audit had been undertaken. At the time of the inspection 90% of the patient records had been summarised.
- Staff described occasional loss of connectivity with DMICP, meaning clinics could be delayed. If this happened, the business resilience plan was followed and only emergency patients were treated. If needed, patients could be seen at the Infantry Training Medical Centre (referred to as ITC) located a short distance away in Catterick Garrison.
- Referrals to other departments and external health care services, including urgent referrals, were managed by two dedicated administrative staff. They responded to requests from the doctors and booked patient appointments through the NHS e-Referral service (e-RS). If an appointment was not available based on patient availability then the administrator followed it up on behalf of the patient. Referrals were logged and monitored and the administrators audited the referrals; the last audit took place in December 2018. For urgent two-week-wait referrals, patients left the practice with an appointment. Referrals made from the PCRF were not integrated with the wider referral tracking system for the practice. Physiotherapists monitored the referrals they made to the Regional Rehabilitation Unit (RRU) and other services.
- Reviewed in April 2019, a SoP was in place with the aim to ensure samples were taken safely, appropriately recorded on DMICP and results reviewed and actioned by the appropriate clinician within seven days. We found that samples and results were effectively managed in accordance with the SoP.

Safe and appropriate use of medicines

The practice had reliable systems for the appropriate and safe handling of medicines.

- A lead and deputy were identified as the subject matter experts for medicines management with the day-to-day management of medicines delegated to a pharmacy technicians. Safe procedures were in place for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment.
- Dispensary stock was checked regularly. Appropriate arrangements were established for the safety of controlled drugs (CD), including destruction of unused CDs. Medication requiring

refrigeration was monitored twice a day to ensure it was stored within the correct temperature range. Prescription forms were securely stored and their use monitored.

- An independent audit of nurse prescribers was carried out by the SMO and was next due in August 2019. Patient Group Directions (PGD) had been developed to allow appropriately trained nurses to administer medicines in line with legislation. The PGDs were current and signed. Equally, Patient Specific Directions (PSD) were in place and signed by the prescriber to permit medics to vaccinate patients. Medics had completed vaccination training. A medic is trained to provide medical support on various operations and exercises. In a medical centre setting, their role is similar to that of a health care assistant in NHS GP practices but with a broader scope of practice.
- Requests for repeat prescriptions were safely managed and no telephone requests were accepted. A repeat prescription book was maintained and monitored by the pharmacy technicians. A process was in place to update DMICP if changes to a patient's medication was made by secondary care or an out-of-hours service.
- A process was established for the management of and monitoring of patients prescribed high risk medicines (HRM). A register of HRM used at the practice was held on Sharepoint and all doctors had access to this. Alerts, coding, diary dates and monthly searches were used to identify and manage patients on HRM. Shared care agreements were in place for the patients that required them. These were stored and managed on DMICP, an electronic document management and storage system, which all clinicians had access to.
- There were 10 patients prescribed an HRM and we looked at a range of these records. We noted that a 'hospital only issue medicine' was not recorded in the patient's DMICP record. This is important to check for interactions between medicines. In addition, a test required for a patient prescribed an HRM was not recorded in DMICP. The doctor confirmed the test had been undertaken and updated the record accordingly.
- The management of medicines was subject to regular audit. For example, an antibiotic prescribing audit in July 2019 identified that a staff teaching session was needed with a re-audit in 4-6 months. An HRM audit was carried out in November 2018 and immediate action was taken to address shortfalls identified. A PGD audit was carried out in January 2019.

Track record on safety

The practice had a good safety record.

- Measures to ensure the safety of facilities and equipment were in place. The practice manager and deputy were the leads for health and safety. Electrical and gas safety were up-to-date. Arrangements were in place to check the safety of the water. A fire risk assessment of the building was undertaken annually. The fire system was tested each week. Staff were up-to-date with fire safety training and were aware of the evacuation plan.
- Safety processes for the practice were monitored and reviewed, which provided a clear and current picture that led to safety improvements. Risk assessments pertinent to the practice were in place and they had been reviewed in March 2019. Safety data sheets were in place for hazardous substances. The station lead for health and safety carried out an annual assessment and the next was due in September 2019. Equipment checks, including the testing of portable electrical appliances were in-date. The PCRF provided evidence that the equipment held at the various gyms used to treat patients had been serviced.
- An alarm system was available in clinical areas to summon support in the event of an emergency. CCTV was fitted in waiting rooms so reception could monitor these areas in the

event of a medical emergency. A lone working SoP was in place for the PCRF. A monitor with a live feed to the administration team was used to monitor patients in the PCRF waiting area.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff used the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events, incidents and near misses. All staff had electronic access to the system, including locum staff. Staff provided several varied examples of significant events confirming there was a culture of effectively reporting incidents. Significant events were discussed at the heads of department (HoD) meetings each week. They were also discussed and lessons learnt identified at the clinical, practice and PCRF meetings. Significant events were not closed until all actions had been completed. The ASER system was also used to report good practice and quality improvement initiatives.
- Improvements were made as a result of investigations into significant events. For example, a medicine was found in the toy box in the waiting area was reported as a significant event. Since then, the toy box is checked at the end of each day.
- The practice manager were responsible for managing medicine and safety alerts. The pharmacy technicians also received alerts which they actioned immediately. The system was checked for alerts each day and any alerts logged on a spreadsheet. Alerts were emailed to staff with a read receipt. They were also discussed at the HoD and practice meetings. An audit of the management of alerts carried out in June 2019 showed 92.3% of alerts were actioned within 24 hours showing improvement from previous audit.

Are services effective? | Good

We rated the practice as good for providing effective services.

Effective needs assessment, care and treatment

The practice had processes to keep clinicians up to date with current evidence-based practice.

- Patient records informed us that clinicians carried out assessments and provided care and treatment in line with national standards and guidance, supported by clear clinical pathways and protocols. Arrangements were established to ensure staff were up-to-date with current legislation, research and guidance, including NICE (National Institute for Health and Care Excellence) and the Scottish Intercollegiate Guidelines Network (SIGN). These were discussed at the weekly meetings for clinicians and, if relevant to the wider staff team, at the practice meetings and health care governance meetings. Staff were also kept informed of clinical and medicines updates through the Defence Primary Health Care (DPHC) newsletter circulated to staff each month.
- In addition to participating in the wider practice meetings, the PCRF team held two formal meetings each month to discuss current practice, share updates and peer discussion.
- Our review of PCRF patient records showed Rehab Guru, software for rehabilitation plans and outcomes, was used for exercise programmes for some patients. Paper exercise sheets were also used depending on therapist preference.
- The PCRF team referred to the Defence Rehabilitation website for best practice guidance. For example, ERIs used it for guidance on equipment management, training and best practice guidance.

- PCRF staff were involved in external working groups to establish best practice for lower back pain, persistent pain, thoracic outlet syndrome (compression of nerves or vessels from the lower neck to the armpit) and stress fractures. The PCRF was represented at the regional rehabilitation forum.

Monitoring care and treatment

The practice used data collected for the Quality and Outcomes Framework (QOF) to monitor outcomes for patients. QOF is a system intended to improve the quality of general practice and reward good practice. It is used across many NHS practices. The Defence Medical Services (DMS) have a responsibility to deliver the same quality of care as patients expect in the NHS. The QOF provides a useful way of measuring this for DMS. Because the numbers of patients with long term conditions are often significantly lower at DPHC practices, we are not using NHS data as a comparator.

- A lead doctor was identified for each long term condition with a lead nurse overseeing the management, including recall, of patients with long term conditions.
- We were provided with the following patient outcomes data during the inspection:
    - There were 14 patients on the diabetic register. For seven patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control.
    - For 12 patients with diabetes, the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.
    - There were 52 patients recorded as having high blood pressure. Forty patients had a record for their blood pressure taken in the past nine months. Forty-two patients had a blood pressure reading of 150/90 or less.
    - There were 79 patients with a diagnosis of asthma. Fifty-nine patients had an asthma review in the preceding 12 months which included an assessment of asthma control using the three Royal College of Physicians questions.
- The practice recognised that it was not meeting all the QOF targets, such as the recall target of 75% for diabetes, and were addressing this at the time of the inspection. Patients had been sent recall letters and further letters if no response was received. As a result, six patients were booked in for a review.
- We looked at a range of patient records and were assured that the care of patients with a mental illness and/or depressive symptoms was being effectively and safely managed, often in conjunction with the Department of Community Mental Health (DCMH). Appropriate templates were used to assess patients and plan their care.
- Information from the Force Protection Dashboard, which uses statistics and data collected from military primary health care facilities, was also used to gauge performance. Service personnel may encounter damaging noise sources throughout their career. It is therefore important that service personnel undertake an audiometric hearing assessment on a regular basis (every two years). Audiometric assessments were in date for 73% of patients. An audit conducted in June 2019 confirmed the practice was 100% compliant with completing the audiometry questionnaires prior to assessment.
- A patient database was used effectively to monitor injury trends and access to PCRF. It was used to share information with unit commanders at the UHC meetings. This supported units

to understand the specific injuries associated with the operational activity of the unit and thus explore ways to minimise injuries based on specific trends.

- Quality improvement, including clinical audit, was clearly embedded in practice and seen as the responsibility of all staff. The PCRF was integrated in the wider audit programme for the practice. A lead for audit was identified and an audit programme was established for 2019. All audit activity from 2015 was logged on the health governance workbook, clearly showing that audits were regularly repeated. The audits we looked at showed the practice acted on the outcomes to improve the service. For example, an audit for back pain disability in June 2019 identified the standard was not being met so an action plan was developed. Furthermore, a third repeat audit (July 2019) to determine if standards were being met by using validated Patient Reported Outcome Measures (PROMS) showed that PROMS was starting to embed in the practice of PCRF clinicians. A gout audit in January 2019 identified that patients were being lost to follow up. As a result, a lead clinician was identified to manage the care of patients diagnosed with gout.
- Completed by the PCRF, a sleep audit showed a strong link between a lack of sleep and increased injury risk. Results were fed back to the unit commander with a recommendation that soldiers be educated in the importance of sufficient sleep. The PCRF was also involved in clinical trial of 'My recovery App' for low back pain exercise delivery.
- Delivery of rehabilitation was limited by the infrastructure as there was minimal gym space in the PCRF which meant the facility could only deliver very basic exercise demonstration. The Regional Rehabilitation Unit (RRU) gym and garrison gym were used as an alternative.

Effective staffing

Continuous learning and development was promoted for staff. The staff database was monitored by the practice manager to ensure staff were up-to-date with training and development.

- A generic and role-specific induction was in place for new staff to the practice. All staff, including a recently inducted member of staff, described a comprehensive and supportive induction. This included supernumerary time and supervised practice.
- Mandated training was monitored and the staff team was in-date for all required training. A programme of ongoing development training was in place with in-house and external training sessions available to staff each week. Clinicians were also supported with continual professional development (CPD) and revalidation through protected time each week.
- A General Duties Medical Officer (GDMO) was working at the practice. A GDMO is a junior army doctor attached to a field unit before commencing higher specialist training. There was a well laid out induction for the GDMO and also allocated tutorial time and a weekly portfolio review with their supervisor.
- A process of clinical supervision was in place for PCRF staff and a supervision log was maintained. A SoP was in place for PCRF staff and it covered protected time of up to five days each year for goal specific training in accordance with individual staff objectives.
- Regional meetings and forums were established for staff to link with professional colleagues in order to share idea and good practice. For example, nurses were supported to attend the regional nurse's forum to link with their colleagues.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- The clinical records we reviewed showed appropriate staff, including those in different teams, services and organisations were involved in assessing, planning and delivering care and treatment.
- The practice had developed good working relationships both internally and with health and social care organisations. For example, monthly meetings were held with the health visitor and school nurse. One of the doctors was the lead for networking with the local Commissioning Care Group (CCG) and participated in a CCG-led CPD group and a nurse attended cytology meetings coordinated by the CCG.
- A doctor was nominated to represent at one of the various UHCs and welfare meetings to discuss the occupational health needs of the units, the needs of patients who were medically downgraded and those who were vulnerable. The PCRF was also represented at these meetings.
- PCRF staff visited the units to advise on injury prevention and also to provide training to physical training instructors (PTI).
- A SoP was in place outlining the process to follow for patients leaving the military. Doctors provided patients transitioning from the military with a release medical. They also referred patients to the welfare team for support with the transition, and if appropriate to the Department of Community Mental Health (DCMH). Patients were signposted to SSAFA, a UK charity providing welfare and support for serving personnel in the British Army, veterans and military families.

Helping patients to live healthier lives

Staff were proactive and sought options to support patients to live healthier lives.

- Clinical records showed that staff encouraged and supported patients to be involved in monitoring and managing their health. Staff also discussed changes to care or treatment with patients as necessary.
- The health care assistant had the lead for health promotion. The health promotion strategy was underpinned by national priorities and initiatives to improve the population's health including, stop smoking campaigns and tackling obesity. It also took account of the patient population need and seasonal variation impacting health.
- Health promotion displays were available in patient areas. These were dated and refreshed in line with the strategy. At the time of the inspection there were displays about hepatitis A, managing hay fever and sepsis.
- Health fairs were held on the base unit gymnasiums and the practice was represented by the nurses.
- A mental health information display was available for patients that took into account well being and mindfulness. It included details about websites patients could access for further information.
- One of the doctors was the lead for sexual health and had completed the required training for the role (referred to as STIF). Information was available for patients requiring sexual health advice, including sign-posting to other services. Where appropriate patients were referred to local genitourinary clinic for screening. Condoms were available at the practice. In the foyer, information about local sexual health pathways was displayed for patients.

- Patients had access to appropriate health assessments and checks. Regular searches were undertaken for patients eligible for bowel and breast screening and appropriate action taken if patients met the criteria. DMICP checks alongside Open Exeter checks were undertaken to ensure patients meeting the national screening programme for cytology were recalled. Open Exeter is a national screening recall system that gives access to patient data so eligible patients can be invited to participate in the screening programme.
- It was noted by staff that not all children had received immunisations appropriate to their age group so an audit of childhood immunisations was undertaken in June 2019. It identified that 78.2% of the child population had coverage for childhood immunisations. Age group three to five years was identified as having the highest number out-of-date at 11.9%. An action plan was developed following this audit including a recall programme, building new searches and childhood immunisation health promotion displays. A repeat audit was planned for September 2019.

It is important that military personnel have sufficient immunity against the risk of contracting certain diseases. The World Health Organisation sets a target of 95% for vaccination against diphtheria, tetanus, pertussis and polio and measles, mumps and rubella. Based on clinical records, the following illustrates the current vaccination data for military patients:

- 93% of patients were recorded as being up to date with vaccination against diphtheria.
- 93% of patients were recorded as being up to date with vaccination against polio.
- 93% of patients were recorded as being up to date with vaccination against hepatitis B.
- 91% of patients were recorded as being up to date with vaccination against hepatitis A.
- 93% of patients were recorded as being up to date with vaccination against tetanus.
- 91% of patients were recorded as being up to date with vaccination against typhoid.
- 96% of patients were recorded as being up to date with vaccination against MMR.
- 96% of patients were recorded as being up to date with vaccination against meningitis.

The unit commanders were responsible for ensuring their personnel kept up-to-date with vaccinations. They appropriately did this through the Joint Personnel Administration (JPA) system. The practice carried out an assurance check.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making. This included the PCRF who took written consent for treatments such as acupuncture and injection therapy.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. Staff we spoke with were aware of the Mental Capacity Act (2005) and how it could apply to their practice. Further training regarding mental capacity was due to take place in August 2019.
- Monitoring the process for seeking consent was undertaken through an annual audit with the most recent conducted in June 2019. The audit found that record keeping regarding consent needed to improve so a training session was delivered to staff.

Are services caring?	Good

We rated the practice as good for caring.

Kindness, respect and compassion

Staff supported patients in a kind and respectful way.

- Throughout the inspection we observed staff were courteous and respectful to patients arriving for their appointments.
- Results and comments from the February 2019 Patient Experience Survey (30 respondents) showed patients were happy with how they were treated. The three patients we spoke with and the 18 CQC comment cards completed prior to the inspection were very complimentary about the friendly, considerate and caring attitude of staff.
- The practice had an information network available to all members of the service community, known as HIVE. This provided a range of information to patients who had relocated to the base and surrounding area. Information included what was available from the local unit and from civilian facilities, including healthcare facilities.
- The practice had a concise information booklet to ensure patients were clear about the facilities available including key members of the practice team, contact numbers, opening times and clinics provided.
- The practice maintained a log of 'excellent patient care. Examples of when the practice went 'the extra mile' included:
    - A member of staff collected a prescription from Darlington and delivered it to the patient in Hartlepool. The patient was a wheelchair user so this saved them the inconvenience of travelling to Catterick again.
    - A member of staff took a patient's medicine to their home (with consent) as they needed it due to moving continent but were unable to call into the practice for childcare reasons.
    - A patient needed an urgent vaccination late on a Friday afternoon and a clinician stayed late to facilitate this.
    - A patient's prescription had to be outsourced to a local pharmacy. To avoid a delay with taking the medicine, a member of staff collected the prescription for the patient.

Involvement in decisions about care and treatment

Staff supported patients to be involved in decisions about their care.

- Interpretation services were available for patients who did not have English as a first language and staff provided an example of when they recently used the service.
- The Patient Experience Survey showed 100% of patients were involved in decisions about their care. Feedback on the CQC patient feedback cards highlighted that patients received information about their treatment to support them with making informed decisions about their treatment and care.
- The practice proactively identified patients who were also carers. A SoP was in place to support the carer identification process. In addition, the practice information leaflet included a section inviting patients who were carers to identify themselves. A register of carers was maintained and it identified five patients with a caring responsibility.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Screening was provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. Clinic room doors were closed during consultations.
- The layout of the reception area and waiting area meant that conversations between patients and reception staff would unlikely be overheard. If patients wished to discuss sensitive issues or appeared distressed at reception, they were offered a private room to discuss their needs.
- The PCRF infrastructure risked breaching patient confidentiality as one clinical area was accessed through another. This was being addressed through the project to develop a Catterick Integrated Care Centre by March 2023. As an interim measure, the PCRF had signs displayed advising patients that it was a shared area and that a private room could be offered if required.
- The practice could facilitate patients who wished to see a GP of a specific gender. All the physiotherapists were female and ERIs male so a patient requesting a clinician of specific gender that could not be accommodated were referred to other PCRF in the garrison.

Are services responsive to people's needs? | Good

We rated the practice as good for providing responsive services.

Responding to and meeting people's needs

Services were organised and reviewed to meet patient needs and preferences where possible.

- Staff understood the needs of its population and tailored services in response to those needs. Appointments slots were organised to meet the needs of specific population groups. For example, and as a result of patient feedback, extra appointments were available for dependents, including children.
- Specific clinics were in place including vaccination, chronic disease, family planning and baby clinics.
- The Patient Experience Survey indicated that 97% of respondents would recommend the practice to family and friends. Comments submitted by patients included: "outstanding on a one-to-one service" and "friendly and helpful in (sic) the correct treatment path to take".
- An access audit as defined in the Equality Act 2010 was completed for the premises in June 2019. The building did not lend itself to ease of access for patients with a disability. The practice had made as much reasonable adjustment as possible. Clinic rooms were available on the ground floor. Notices in both waiting areas advised patients of where the accessible WC facilities were available on site. Five parking bays were allocated for patients with a disability. As these were being used by patients without a disability, the practice manager had contacted the guardroom to take action.
- Facilities were available for families, including a private room for breast feeding, baby changing facilities and a play area in both waiting areas.

Timely access to care and treatment

Patients' needs were met in a timely way.

- The practice accommodated patients with an emergency need and staff advised us that no patients were turned away and would be seen on the same day. Routine appointments could be accommodated within 10 days. Same day appointments were available for children. There

was a three to four week wait for medicals. If there was an urgent need for a medical that the practice was unable to accommodate, then the patient was referred to the other medical centre in the garrison.

- Non-attendance at appointments was monitored for the practice, including the PCRF. The non-attendance rate was 14.9% for June 2019. An audit of waiting times had been completed for a week timeframe in July 2019 and was displayed for patients.
- Arrangements were in place for patients to access NHS 111 when the practice was closed, including emergency care.
- Home visits and telephone consultations were available with clinicians.
- A direct access physiotherapy (DAP) service was in place for patients. Patients prioritised as urgent were given the next available appointment ideally within five working days and patients with a routine need were seen within 10 working days. The PCRF also allocated patients to an advice clinic if triage indicated they were likely to need just one session. This meant DAP patients and doctor referrals could all access the same appointments based solely on clinical need. This process worked well with access meeting demand.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information was displayed in the waiting area, outlined in the practice leaflet to help patients understand the complaints process. The complaints procedure was displayed in clinical rooms for staff to access.
- The civilian practice manager was the designated responsible person who handled all complaints. The practice manager took on this role in their absence. The practice managed complaints in accordance with the DPHC complaints policy and procedure. Both Written and verbal complaints were recorded and and linked to the health governance workbook.
- Any complaints were discussed at the clinical and/or practice meetings and lessons identified. Changes to practice were made if appropriate and used to improve the patient experience. For example, a complaint about the medic's reception desk not being staffed led to the development of a SoP to ensure a medic was always available at the desk.

Are services well-led?	Good

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

Leadership capacity and capability

The leadership team had the experience, skills and drive to deliver high-quality sustainable care.

- On the day of inspection, we saw a practice that was well-led. The leaders not only demonstrated managerial experience, capacity and capability, it was clear they had vision, passion with a focus on providing the best possible service for their patients.
- Staff spoke highly of how the practice was led. They said managers demonstrated a collaborative approach to leading the practice and supporting staff. The regional management team worked closely with the staff team.

Vision and strategy

Throughout the inspection it was clear staff were committed to providing and developing a service that embraced the mission and vision.

- The practice worked to the DPHC mission statement of:

  "Safe practice by design."

- The aims of the practice were:
  - To provide the highest quality of care to all patients regardless of their background.
  - To treat every patient holistically.
  - To continuously improve the quality of care by being a learning organisation and being open and honest.
- On the day of the inspection, we found the practice was working to and achieving its aims.
- We spoke with the operations manager who provided a detailed account of the vision and plans for the future. Central to this was a project to develop a Catterick Integrated Care Centre (CICC) in partnership with the NHS. This would mean bringing local health, social care and third sector organisations together in a purpose built health and well-being facility to provide holistic family support. Although funding had not yet been finalised, a project board was established with a project director and area project manager identified. We were provided with a detailed report that was presented to the project board in June 2019. It identified that the project would be completed by 2023.

Culture

The culture at the practice was inclusive and all staff were treated equally.

- An inclusive culture underpinned the approach of the practice. All staff had an equal voice, regardless of rank or grade.
- The PCRF was integrated with the wider practice, including an integration of governance systems. This integration could be enhanced further by managing PCRF patient referrals through the practice referral management process. Equally, the administration of PCRF locums could be more efficiently managed
- Staff described an open and transparent leadership style and said they would feel comfortable raising issues. They felt respected, supported and valued. Both formal and informal opportunities were in place so staff could contribute their views and ideas about how to develop the practice.
- The practice clearly demonstrated a patient-centred focus. Staff understood the specific needs population and tailored the service to meet those needs. For example, the practice was mindful of the vulnerability of service personnel, the injury prevention steering group and the healthy eating working group.
- Openness, honesty and transparency were demonstrated when things went wrong. A no-blame culture was evident; complaints and incidents were seen as opportunities to improve the service.
- The practice had systems 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.

- Leaders clearly demonstrated that the needs and welfare of staff were priority. Staff were encouraged and supported to be the best they could be through training and developing their skills. Supervision and appraisal was in place for all staff.
- The practice actively promoted equality and diversity and staff had received training in this area.

Governance arrangements

There was an effective overarching governance framework in place which supported the delivery of good quality care.

- There was a clear staffing structure in place and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. Terms of reference were in place to support job roles.
- The practice worked to the health governance (HG) workbook, a system that brings together a comprehensive range of governance activities, including the risk register, significant events tracker, lessons learnt log, training register, policies, meetings, quality improvement and audit. All staff had access to the workbook which provided links to meeting minutes, policies and other information.
- An effective range of communication streams were used at the practice. A schedule of regular practice, HoD and team specific meetings were well established.
- Audit was a routine method used to measure the effectiveness and success of clinical and administrative practice. A comprehensive audit programme was established with clear evidence of action taken to change practice and improve the service for patients.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- Risk to the service were well recognised, logged on the risk register and kept under scrutiny through regular review. There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety. Processes were in place to monitor national and local safety alerts, incidents, and complaints.
- A system was in place to monitor performance target indicators. In particular the system took account of medicals, vaccinations, child health, cytology, summarising and non-attendance rates.
- A business continuity plan was in place.
- Procedures were in place for managing poor performance. We were given an example of how a potential breach of confidentiality was effectively managed by the practice.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- An internal quality assurance tool, the DMS Common Assurance Framework (CAF) was used to monitor safety and performance for the practice and included the PCRF. The DMS CAF was formally introduced in September 2009 and since that time has been the standard healthcare governance assurance tool utilised by DMS practices to assure the standards of health care delivery within DMS.

Engagement with patients, the public, staff and external partners

The practice involved patients, staff and external partners to support high-quality sustainable services.

- There were various options in place to encourage patients to provide feedback on the service and contribute to the development of the service. A patient experience survey was undertaken throughout the year. In addition, patients could leave feedback via through the suggestion box. Patients were informed of the response to their feedback through a 'You said we did' display. For example, patient feedback requested that the dispensary accept cash payments. The practice responded by stating this had been escalated to regional headquarters.
- The practice was exploring options to develop a patient focus group.
- Good and effective links with internal and external organisations including the welfare team, RRU, the DCMH, local NHS services and social services.

Continuous improvement and innovation

Continuous improvement was embedded in the culture which was one of improving the health and wellbeing of the benefit of the patients. The practice maintained a quality improvement log on the HG workbook which was monitored monthly. We found that improvements were implemented based on the outcome of feedback about the service, complaints, audits and significant events.

Quality improvement activity we identified included:

- The logging and monitoring of the use of medicines off-licence.
- Development of an upper-limb rehabilitation class.
- Improvements to the medical emergency training, including the use of scenarios.
- Sleep audit to determine the impact lack of sleep may have on injury prevention.
- Identifying a lead for the management of gout.
- The health care assistant was mentoring the health care assistants in the medical regiments.