ITC Medical Centre Catterick

Scotton Road, Catterick Garrison, North Yorkshire, DL9 3PS

Defence Medical Services inspection report

This report describes our judgement of the quality of care at ITC Medical Centre Catterick. 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. We gathered evidence remotely in line with COVID-19 restrictions and guidance and undertook a short visit to the practice.

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

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SUMMARY OF INSPECTION

As a result of this inspection the 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 Infantry Training Centre (ITC) Medical Centre Catterick on 14 January 2020. The practice was rated as inadequate overall, with a rating of inadequate for the safe and effective key questions, requires improvement for the caring and well-led key questions and good for the responsive key question. A copy of the report from the previous inspection can be found at:

https://www.cqc.org.uk/sites/default/files/Catterick_ITC_Medical_report_9_April_2020.pdf

We carried out this announced follow up inspection on 8,9 and 15 June 2021. The inspection was carried out remotely on 8 and 9 June followed by a visit by the inspector on 15 June. This report covers our findings in relation to the recommendations made and any additional findings made during the inspection.

The CQC does not have the same statutory powers with regard to improvement action for the Defence Medical Services (DMS) under the Health and Social Care Act 2008, which also means that the DMS is not subject to CQC's enforcement powers. However, as the military healthcare Regulator, the Defence Medical Services Regulator (DMSR) has regulatory and enforcement powers over the DMS. DMSR is committed to improving patient and staff safety and will ensure implementation of the CQC's observations and recommendations.

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

At this inspection we found:

- The practice now received confirmation of the safety checks undertaken for the building and facilities.
- Effective arrangements were in place for infection prevention and control.
- Patient feedback about the service was positive. It showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.
- The practice had good lines of communication with the units and welfare team to ensure the wellbeing of recruits.
- The staffing establishment had been reviewed and practice staff thought the skills mix was adequate to meet the needs of the patient population.
- The practice had implemented a system to ensure that staff complete the required mandated training. A named lead had been appointed and a training programme developed to ensure all staff have the correct skills and knowledge for their roles.
- Effective medical cover was in place to cover the times when the practice was closed.
- Staff understood the Mental Capacity Act (2005) and how it applied in the context of the service they provided.
- Safe and effective processes were in place for the management of significant events and patient complaints.
- The outcome of clinical audit was used to improve patient outcomes. The practice had developed an integrated audit programme, designed so all staff groups participated in service improvement activity.
- Standard operating procedures had been developed to ensure appropriate coding, outcomes and templates are consistently used by clinicians. A programme of ongoing audit of clinical records had been established to ensure standards of record keeping are monitored.
- Governance systems, activities and working practices had been strengthened and better integrated. A list of lead roles for the practice was clearly displayed so staff were aware of the roles and responsibilities of colleagues.
- Information systems and processes to deliver safe treatment and care had been developed including Read coding (Read codes are a list of clinical terms to describe the care and treatment given to a patient), the use of review templates, the management of long-term conditions, audit of clinical record keeping, the new patient registration process and the management of referrals.
- The privacy and dignity of patients had improved with all clinicians using privacy screens/curtains when treating patients and the routine offer of a chaperone.
- The arrangements for managing medicines, including obtaining, prescribing, recording, handling, storing, security and disposal in the practice minimised risks to patient safety. The monitoring of high-risk medicines had been improved.
- Staff understood and adhered to the duty of candour principles.

The Chief Inspector recommends:

- Update the safeguarding policy to make reference to vulnerable adults, ensure appropriate alerts are in place on the patient records and that safeguarding training is in date for all staff.
- Further strengthen the high-risk medicine monitoring to ensure that a senior clinician maintains clinical oversight of the high risk medicine register.
- Improve the central alert handling process to ensure they are discussed at all appropriate meetings and include a record of actions taken.
- Further strengthen the monitoring of clinical records to include independent checks of staff members responsible for the reviewing of notes.
- Adapt standard operating procedures to make them specific to ITC Medical Centre Catterick.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

This inspection was undertaken by a CQC inspector and the inspection team comprised specialist advisors including two primary care doctors, a practice nurse, a practice manager, a physiotherapist and a pharmacist and a CQC inspection manager.

Background to ITC Medical Centre Catterick

ITC Catterick is part of the School of Infantry (SCHINF) which trains 24% of the army and provides trained infantry soldiers for all regiments of the Foot Guards, Line Infantry, Parachute Regiment and the Gurkhas.

ITC Medical Centre Catterick provides a routine primary care service to a patient population of approximately 5,000 including approximately 4,000 army recruits. At the time of the inspection there were 116 patients under the age of 18 and no patients over the age of 35.

The medical centre has a dispensary. A Primary Care Rehabilitation Facility (PCRF) is situated in the medical centre and provides a physiotherapy and rehabilitation service for patients.

Opening hours are from 07:00 to 16:30 hours Monday to Friday. From 16:30 to 18:30 access to medical cover is provided by the Garrison Medical Centre. From 18:30 weekdays and at weekends/public holidays an on call duty medic is available for advice in the first instance and patients can access NHS 111 if they need to consult with a doctor.

The practice was responsible for a 21-bedded inpatient facility (referred to as the MRS) located a short distance away. This facility has not been included as part of this inspection report.

The staff team at the time of the inspection

Position	**Numbers**
Senior Medical Officer (SMO)	one
Civilian medical practitioners (CMP)	six - four full time equivalents (two full time, four part time. One full-time position gapped (at interview stage)
Advanced nurse practitioner (ANP)	one
Civilian Unscheduled Care Practitioner (paramedic)	one
Civilian practice nurses	six (one band 6, five band 5)
Military practice nurse	one
Military practice manager	one
Civilian practice manager	one
Physiotherapists	six
Exercise rehabilitation instructors (ERI)	six
Pharmacy technicians	two
Administrative staff	nine (7.5 full time equivalents)
Combat medical technicians (medics)	16 - ITC assets

Are services safe?

We rated the practice as good for providing safe services.

Following our previous inspection, we rated the practice as inadequate for providing safe services. We found inconsistencies in processes to keep patients and staff safe including gaps in:

- training;
- recruitment checks;
- information to deliver safe care and treatment;
- management of high risk medicines and
- health and safety.

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

Safety systems and processes

Systems to keep patients safe and safeguarded from abuse had been strengthened.

- Measures were established to protect patients from abuse and neglect, including adult and child safeguarding policies. One of the doctor's was the safeguarding lead and maintained a vulnerable patient register for the practice. Reviewed in December 2020, the safeguarding policy included contact details for the local safeguarding team; it was displayed in the waiting room and all clinical areas. However, the policy referred to children and young people but did not include reference to vulnerable adults. The practice updated the policy. The safeguarding lead attended quarterly meetings with the local safeguarding team. There was a named doctor within the local children and adolescent mental health services (CAMHs) Team who provided a specialist link with the practice.
- Most staff had received safeguarding training and update training at a level appropriate to their role. Coding and alerts were used to highlight vulnerable patients on the electronic patient record system (referred to as DMICP). A safeguarding audit was undertaken in December 2020. There were two doctors who were out of date for level three training (expired in February 2021). One had been deployed since 2020 and one was waiting to enrol on a face to face course.
- Vulnerable patients were identified through the summarisation of patient records, patient assessment and through the unit health committee (UHC) meetings. Led by the units with representation from the medical centre, UHC meetings facilitate discussions about the needs of service personnel who are medically downgraded and those who are vulnerable. Each unit maintained a register of vulnerable personnel (referred to as VRM). The practice used the UHC as 'shadow clinics' and updated DMICP for individual patients following the meetings. Three patients identified as care leavers did not have the appropriate alert in place on their records. Alerts were added to the patients.

- A list of trained chaperones was held on the healthcare governance (HG) workbook. Practice administration staff had completed the training for their own understanding and clinical staff were used to chaperone. All trained staff had read the Defence Primary Healthcare (DPHC) chaperone policy and had completed a skills assessment. Chaperone posters were clearly displayed in clinical rooms and information was provided in the patient leaflet. The previous inspection visit highlighted that the PCRF team did not routinely offer patients the option of a chaperone. The policy was listed on the PCRF leaflet and a sign inside each cubicle advised that a chaperone was available on request. The most recent notes audit in the PCRF identified 100% achievement in using chaperone Read codes.
- 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. 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. A DBS check was overdue for two staff members. This had been requested and, the SMO had completed a risk assessment which supported the member of staff to continue working with patients and was on the practice risk register.
- Arrangements were in place to monitor the registration status of clinical staff with their regulatory body. Professional registrations were all in date and staff, including locums, had professional indemnity cover and had received the appropriate vaccinations for their role (all vaccinations were given as part of the onboarding process for doctors and nurses).
- There was an effective process to manage infection prevention and control (IPC), including a lead who had completed role specific training. The staff team were up to date with IPC training. A full IPC audit was undertaken each year and a monthly programme was used in between. For example, in May 2021, an audit had been completed on patient equipment both clinical and non-clinical. The IPC lead engaged with regional and national support forums. The PCRF undertook its own IPC audits.
- The practice provided minor surgery and the related standard operating procedure (SoP) took account of IPC. For PCRF clinicians practising acupuncture, arrangements were in place for the safe provision of this treatment, including a SoP that referenced national guidance and a consent form signed prior to any treatment. A specific acupuncture patient information leaflet was provided for patients, so they understood the process and any risks.
- Environmental cleaning was provided by an external contractor with two dedicated housekeepers for the practice. Cleaning schedules and monitoring arrangements were established, including a ‘tidy Friday’ checklist to ensure the premises were clean and tidy. Deep cleaning was carried out every six months. We identified no concerns with the cleanliness of the premises. As part of the COVID-19 response, cleaning of clinical rooms took place in between each patient.
- Clinical waste was bagged and tagged. The clinical waste contractors held the consignment notes although the practice could obtain copies on request. A quarterly waste audit was last carried out in April 2021. The audit score was 88%, actions on

non-compliance items had been included but the form required updating to show actions had been completed. For example, the audit identified that two of the rooms did not have a general waste bin.

Risks to patients

Systems to assess, monitor and manage risks to patient safety had been strengthened following the previous inspection.

- Staff we spoke with said staffing levels were adequate to meet the needs of the patient population, including a mix of military and civilian staff. We found there was a good clinical skill mix. For example, the practice had the expertise to deliver women's health programmes, dermatology and occupational health.
- All staff including locums were required to complete an extensive induction programme which contained elements that were role specific. In addition, all permanent staff had a site induction recorded on the staff database. At the last inspection we noted induction records for locum staff had not always been fully completed and/or clearly recorded. At this inspection, we found records were complete and staff spoke positively when asked about their induction.
- The practice was equipped to deal with medical emergencies. All staff were aware of where and how to access the medical emergency trolley. The emergency kit, including a defibrillator, oxygen with masks and emergency medicines. A first aid kit and accident book were available. Routine checks were in place to ensure the required kit and medicines were available and in-date.
- We previously found that the staff database showed gaps in training for basic life support (BLS) and anaphylaxis training. The practice evidenced that all staff were now in date with BLS, automated external defibrillator (AED) and anaphylaxis training.
- Training sessions were in place to make staff aware of how to identify patients with severe infections. Sepsis training had been delivered in May 2021 and COVID-19 specific training had been delivered in September and November 2020.
- Adjustments in how services were delivered were made in response to the challenges posed by COVID-19. Consultations had been made available through email and video link. The dispensing area had been moved outside of the medical centre into the large foyer that allowed for social distancing to be maintained and screens provided a barrier. Sick parade had been adjusted from face to face into a remote virtual clinic where patients were triaged and only asked to come in person if deemed essential by a clinician. Personal protective equipment (PPE) was available and extended to medics who accompanied units when on exercise. Sanitiser was available for staff and patients at the entrance and throughout the building. Cleaning of clinical rooms took place after each patient and a risk assessment had been completed. Measures taken as a result of the risk assessment included regular opening of windows to improve ventilation and a limiting of numbers in communal areas.
- Two of the three areas where physical activity was conducted were temperature controlled following the installation of an air climate control system. The third area had a duty physiotherapist that checked the temperature. If too hot, windows and doors

could be opened to aid air flow. If the temperature remained too high then training would cease. If the temperature was too low, it was at the discretion of the officer in charge or clinical lead to decide whether to close the department. Wet-bulb globe temperature (WBGT-used to determine appropriate exposure levels to high temperatures) updates were sent every 15 minutes or when close to exceeding the Army Recruiting and Initial Training Command (ARITC) training levels.

Information to deliver safe care and treatment

Information systems to deliver safe care and treatment to patients had been strengthened.

- Inconsistencies in the use of Read codes had been addressed and improvements made. There was a more consistent use of clinical templates and an agreed list of codes that clinicians could utilise.
- Audit of clinical records were now consistently taking place for all clinician groups. However, there was scope to ensure that the clinical records for all clinicians were audited independently.
- Scrutiny and summary of patient records belonging to recruits joining the practice was considered a priority. A reliable process was in place to ensure there were no delays with recruits commencing their training. The practice was reliant on a timely receipt of patients' records from their NHS primary care practice, and similarly for international recruits. A workaround process put in place by the SMO for any delayed transfer of international records was working well.
- We were advised by the nursing team that summarisation of records for permanent staff was up to date. The practice had not introduced the new patient registration form so nurses were using an alternative way to summarise the records for this staff group. The practice had a two page summary and the processes involved in enlistment covered all areas included in the new patient registration form. This had been agreed by DPHC.
- The previous inspection highlighted that the practice had not implemented the 'scan and task' protocol, a process to ensure clinicians received hospital letters for review. We found the practice had updated the SoP and now followed the DMICP protocol for scanning and tasking hospital letters.
- Staff described occasional loss of connectivity with DMICP, meaning clinics could be delayed. If this happened the business continuity plan was followed, and only emergency patients seen. If needed, patients could see a doctor at Catterick Garrison Medical Centre a short distance from the practice.
- There was a dedicated administrator for managing referrals with a second administrator who was familiar with and had access to systems to cover for any absences. The practice used the e-Referral System (e-RS) to manage referrals to the NHS, including the urgent two-week referrals. Doctors provided a letter for the administrator and also sent a DMICP task. The administrator checked the status of the e-RS twice a day. The practice was informed by the hospital if patients failed to attend for their appointment. This was annotated in the patient's clinical record and a request made for the patient to make an appointment with their doctor. If appropriate, failure to

attend an appointment was raised at the UHC (recruits consent at the start of their training for healthcare matters to be discussed with the Unit Commander).

- If there were any delays with NHS referrals, then recruits could be referred to the private healthcare sector. This method of referral was approved, funded and coordinated through the ARITC, and recorded in the patient's clinical record. The administrator maintained a log of referrals made via ARITC that included the date of referral and date of appointment.
- Internal referrals, such as those to the Department of Community Mental Health (DCMH) and Regional Rehabilitation Unit (RRU), were made directly by clinicians. Referrals to the Regional Occupational Health Team (ROHT) were made by clinicians and monitored separately by another administrator. The process had been improved with the implementation of a spreadsheet that brought all referrals together. This shared document provided a failsafe monitoring system.
- The PCRF had implemented a tracking system that included all referrals and was accessible by all medical centre staff. This tracker included referrals made to the RRU and the Multidisciplinary Injury Assessment Clinic (MIAC).
- We found specimens and results were effectively managed. A system was in place to ensure samples were taken safely, appropriately recorded on DMICP and results reviewed and actioned in a timely way by the appropriate clinician.

Safe and appropriate use of medicines

Processes for managing medicines were appropriate and safe. This included arrangements for managing, storing and disposal of medicines, including vaccines, medical gases, emergency medicines and equipment.

- The SMO was identified as the lead for medicines with one of the pharmacy technicians as the deputy lead. The day-to-day management of medicines was delegated to the two pharmacy technicians. This was reflected in the terms of reference.
- We found the dispensary was well managed. All the medicines and equipment we checked were in date and fit for use. Prescription pads were stored and managed safely by the dispensary. DMICP records were used as a routine method to check medicine stocks, including vaccines. Two full physical stock checks took place each year.
- Controlled drugs (medicines with a potential for misuse) and the keys to controlled drugs (CD) stocks were held securely. CDs were checked each month with a quarterly check also taking place. 'Loaned' CDs to the emergency trolley and doctor's 'grab bag' were checked against the 'loan card'. SoPs were in place for access to dispensary CDs and the doctor's 'grab bag' out-of-hours. A CD audit was carried out in January 2021 and no issues were found.
- The practice dealt with a large volume of vaccines so there were five fridges in the dispensary store, one in each treatment room and a small storage fridge if the dispensary was closed. Fridges were secure and data loggers in each fridge were used to monitor the temperatures. A cold chain SoP was in place and a SoP in the event of a

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

- Green bins were used to dispose of medicines and these were regularly collected. The practice had a contract to secure purple-lid bins for cytotoxic waste, such as live vaccines.
- Requests for repeat prescriptions were safely managed and no telephone requests were accepted. Clear directions were available to patients about requesting repeat prescriptions. A process was in place to update patient's records if any changes were made by secondary or out-of-hours services. A DMICP code was used to identify uncollected prescriptions. If it was an antibiotic, then the prescriber was alerted.
- Defence Patient Group Directions (PGD) were in use to allow nurses to supply and administer medicines in line with legislation and safely. PGDs were appropriately managed, staff had received training and had been authorised by the SMO. DMICP templates were used to record PGD use and batch numbers could be tracked back to individuals through a local process put in place between the nursing team and the dispensary. A PGD audit had taken place in January 2021. Patient specific Directions (PSD) were only used by a physiotherapist who administered injections in accordance with a PSD.
- The medics worked to MIPs (medics issuing protocols), which were signed off and kept in the dispensary. A MIPs audit had been undertaken in December 2020. Medics had their own cupboard containing over labelled medicines. The stock was checked twice a day against the DMICP stock list. This meant pharmacy technicians could cross reference with the dispensary stock checks and medicines issued to patients. Spot checks of the medics stock were carried out by the pharmacy technicians. Medics were not administering vaccines.
- Historically, the practice experienced low numbers of patients who were prescribed high risk medicines (HRM), and patients received in-depth medicine reviews. A register was maintained of the patients prescribed HRMs although at the time of inspection, there were no patients on the register. We looked at a range of historic patient's records and confirmed they were well managed with appropriate alerts used and regular monitoring took place in between medicine reviews. However, we found one patient with no alert who had moved to another practice. This was actioned on the day of inspection.
- Previously, DMICP searches were conducted for HRMs dispensed by the practice (rather than a patient population search), which meant only patients who had their medication issued through the dispensary would be captured. There was a risk that patients registering with the practice who were already prescribed an HRM would not be identified until they requested a repeat prescription. The process had been strengthened with the implantation of monthly searches against a list of high risk medicines. There were no patients on high risk medicines at the time of inspection.

Track record on safety

Arrangements to ensure the safety of the premises and facilities had been strengthened.

- Arrangements for ensuring the safety of the building and facilities was coordinated at unit level. This information was not routinely shared but was available on request from the Quarter Master (QM). The QM had provided the practice with written assurance that all checks were in date. These included checks for fire, water, gas and electric.
- A member of staff was the lead for equipment held at the practice, equipment checks were up to date.
- A lead for health and safety was identified for the practice. A risk register and issues log were in place and these had recently been reviewed along with individual risk assessments. The risk assessments included review dates and a record of actions taken. The risk register included assessments for both clinical and non-clinal risks.
- At the previous inspection, records showed that not all staff were up to date with fire training. We found that training had been amalgamated under health and safety (that included fire safety training as one of the modules), records showed that all staff had completed the module or had dates planned on the training specific calendar (a calendar of completed and planned training dates that was updated weekly).
- Products hazardous to health (referred to as COSHH) were used for minor surgery. In accordance with COSHH regulations, data sheets, risk assessments and a log of COSHH products were stored securely in the treatment room.
- With the exception of the PCRF, an alarm system was available in clinical areas to summon support in the event of an emergency. All, staff, including PCRF staff, had personal alarms. A SoP on responding to a panic alarm was in place. Testing of the alarm system took place weekly. A CCTV monitor with a live feed to the reception staff was used to monitor activity in the waiting area. A lone working policy was in place and it was reviewed in August 2019. The layout of the PCRF allowed verbal alarms to be effective in the event of an emergency. The reception desk was within audible distance and staff told us it was always manned.

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. These examples were confirmed through the ASER log and the action taken. Minutes of meetings demonstrated significant events were discussed at the heads of department (HoD) and practice meetings.
- Lessons learnt and improvements were made as a result of significant events. For example, a review of a patient with raised blood pressure resulted in an audit on all patients with hypertension and increased resilience through shared patient recall responsibilities. ASERs were discussed at the weekly HoD meeting and summarised at the practice meeting when appropriate. In addition, ASERs were raised at the weekly doctor's meeting and at the monthly clinical meetings and monthly nurses' meeting when appropriate.

- The pharmacy technicians recorded near misses and interventions. Dispensing and prescribing errors were recorded as ASERs.
- The pharmacy technicians were responsible for managing medicine and safety alerts. The system was checked for alerts each day and any alerts logged on a spreadsheet. Alerts were emailed to staff with a read receipt. Staff told us that they were also discussed at the HoD, clinical and practice meetings. However, we identified that not all Central Alerting System (CAS) alerts had been discussed at practice meetings and the link to the alert could be added to agenda to strengthen the process.

Are services effective?

We rated the practice as good for providing effective services.

Following our previous inspection, we rated the practice as inadequate for providing effective services. We found inconsistencies in processes to ensure effective services for patients including gaps in:

- the management of chronic conditions;
- quality improvement activity (QIA) in the PCRF;
- training and
- peer review (PCRF only);

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

Effective needs assessment, care and treatment

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

- Processes were in place to support staff with keeping 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 clinical meetings. They were also discussed at the health governance, HoD, practice and departmental meetings if appropriate.
- Staff were also kept informed of clinical and medicines updates through the DPHC newsletter circulated to staff each month.
- The PCRF team referred to the Defence Rehabilitation website for best practice guidance. We reviewed DMICP notes to find all had the musculoskeletal (MSK) outcome completed and the Read codes were correct.

Monitoring care and treatment

The practice undertook quality improvement work to review the effectiveness and appropriateness of the care provided. The approach to quality improvement had been developed since the previous inspection.

- Data collected for the Quality and Outcomes Framework (QOF) was used 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 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.

- The practice nurse was the lead for the management of patients with long term conditions (LTC). The population manager facility (referred to as 'popman') was used to identify and monitor patients with an LTC. In addition, there was evidence that the practice managed LTCs with supplementary searches to capture those with a missed diagnosis. For example, high blood pressure readings that had not been followed up.
- The practice had low numbers of patients with a LTC so the nurse provided us with an overview of the current status for each patient, including the action taken if patients failed to respond to recall letters.
- 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. Patients presenting with a mild to moderate anxiety or low mood were assessed in accordance with the pathway and treated initially at the practice (step 1) or referred to the DCMH if their clinical need was assessed as greater than what step 1 could provide. An out-of-hours suicide and deliberate self-harm risk assessment had been developed for the on-call medic assessing patients when the practice was closed. This was supported by guidance on the action to be taken depending of the risk level identified.
- The PCRF used the musculoskeletal health questionnaire (MSK-HQ) for initial patient assessments with patients issued appropriate measures based on their injury. A review of patient notes highlighted that record keeping had improved. The discharge measures were now captured and Read coding was consistent and accurate. Patients records showed documented exercise rehabilitation programmes for patients.
- 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 85% of patients.
- The practice used clinical audit to monitor and systematically review clinical outcomes to ensure treatment and care was being provided in accordance national and local standards. One of the doctor's was the lead for clinical audit. An audit tracker was established for the practice which captured audits from 2013. We noted clinical audit was focussed on the needs of the patient population, took account of national guidance, action to be taken and identified a timeframe for a repeat audit. Audits undertaken in 2020/21 included:
    - high risk medicines prescribing, including the prescribing of sodium valproate (used to treat epilepsy and bi-polar disorders) in females with childbearing potential;
    - concussion;
    - controlled drugs prescribing;
    - health surveillance of women in ground close combat (WGCC);
    - minor surgery (August 2019 to August 2021);
    - hypothyroidism;
    - adherence to Medics' primary healthcare protocols; and

  - emergency contraception.

- The PCRF has their own audit plan for the year on their HG workbook. This linked with the medical centre's audit log. The PCRF has started looking at audits on referral pathways and with treatment provided in accordance with best practice guidelines. For example, an audit completed around the magnetic resonance imaging (MRI) referral pathway. Improvements as a result of audit were evident. For example, an audit on patients presenting with lower back pain led to a set of recommendations designed to produce improved measurement of outcomes. Minutes of meetings demonstrated that the outcome of audits were discussed at clinical, practice and governance meetings.

Effective staffing

Continuous learning and development were promoted for staff. Improvements had been made following the previous inspection.

- We previously found induction documentation was inconsistent and that some induction packs were incomplete. In addition, the induction identified on the staff database was for the unit rather than the medical centre. At this inspection, we found that all staff including locums had completed a comprehensive practice induction which took account of different staff roles. In addition, permanent staff had a site induction.
- Staff we spoke with described a comprehensive induction. For example, two new administration staff said they were effectively supported and mentored as part of their induction, including the shadowing of an experienced staff member until confident to carry out tasks.
- Mandated training was monitored by the practice manager. Staff were sent an email each month reminding them of training they needed to complete and a link to the training. Compliance in mandatory training was to a good standard.
- Internal and external training sessions were available to staff each week. For example, the civilian practice manager had completed the DPHC practice manager's course and the military practice manager had completed a diploma in healthcare management.
- Clinicians were supported with continual professional development (CPD) and revalidation through protected time. Nursing staff provided good evidence of clinical supervision and CPD activity. The practice had implemented a formal peer review process for the ERIs and physiotherapists. Regional meetings and forums were established for staff to link with professional colleagues in order to share idea and good practice.
- Weekly clinical meetings supported staff with clinical, academic and reflective practice. We noted from the minutes that the meetings were well attended, covered a range of topics and included actions to promote up-to-date clinical practice.

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, with the DCMH and ambulance service. Referrals to the RRU were dealt with promptly.
- A doctor was nominated to represent at one of the UHC 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 troop physiotherapist, ERI and lead physiotherapist also attended the UHC meetings.
- The practice worked closely with the welfare team to support service personnel, including recruits, who had opted to leave the army. A leavers package was in place that included external organisations providing information and support with future employment, securing accommodation and benefit entitlements. The package included the provision of release medicals provided by the medical centre.
- The welfare team paid particular attention to recruits who joined the army from care services and potentially had no accommodation to return to. If this was the case, these patients would be catered for by the welfare teams in conjunction with the training teams.

Helping patients to live healthier lives

Staff supported 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.
- One of the medics 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.
- The practice had adjusted services to support the containment of COVID-19. For example, sick parade had become a virtual clinic. A SoP had been implemented detailed how to protect from infection and how to treat a patient on exercise with suspected COVID-19. Routine vaccinations had been deferred but essential immunisations were being given.
- Medics were aligned to different platoons and tailored activities to their needs. For example, Gurkhas commonly had skin complaints and one of the medical officers with an interest in dermatology produced information to advise them.

- Health promotion displays were available in patient areas. These were dated and refreshed in line with the strategy. At the time of the inspection, we saw there were displays about climatic injury, stress and mental awareness.
- The practice had a stand at the six monthly health and wellbeing fairs held on the base. However, there had not been a health fair since the previous inspection due to Covid-19.
- Two of the nurses were trained in sexual health (referred to as STIF), one acted as the lead. The nurses delivered sexual health training to the recruits. Patients with sexual health needs were referred to the North Yorkshire Sexual Health Service (appointments could be arranged within two days). Information was available for patients requiring sexual health advice, including signposting to other services. There was now a telephone advice service, clinicians could ring to arrange a clinical review for a patient which could, if required, be undertaken at the practice. Chlamydia screening packs and condoms packs were freely and readily available for the recruits from easily accessible locations within the practice.
- The practice had three patients who met the criteria for cervical cytology. Two of the three patients were up to date with screening with one planned. In line with DMS policy, all eligible patients were sent three invite letters and a disclaimer if they did not respond. The practice nurse conducted monthly searches and sent letters accordingly.
- 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. Unit commanders were responsible for ensuring their personnel kept up-to-date with vaccinations. Based on clinical records, the following illustrates the current vaccination data:
    - 89% of patients were recorded as in date for vaccination against diphtheria.
    - 89% of patients were recorded as in date for vaccination against polio.
    - 89% of patients were recorded as in date for vaccination against tetanus.
    - 77% of patients were recorded as in date for vaccination against hepatitis B.
    - 64% of patients were recorded as in date for vaccination against hepatitis A.
    - 100% of patients were recorded as in date for vaccination against MMR
    - 93% of patients were recorded as in date for vaccination against meningitis.

At the time of inspection, there had been a large intake and clinical searches viewed the following week evidenced that vaccinations were being administered in a timely manner.

- Recruits often arrived with no evidence of previous immunisations, so this patient group was offered childhood immunisations. Often there were delays with clinical notes arriving from overseas so immunisations were offered ahead of the notes to avoid delays with joining the military.
- Units were responsible for ensuring their personnel kept up to date with vaccinations. The practice worked collaboratively with Chain of Command to ensure all personnel requiring additional immunisations in line with operational requirements were identified

and vaccinated within an appropriate timeframe. Monthly searches were undertaken to recall patients for vaccinations.

- On leaving the Army, personnel underwent a release medical with the approach tailored to individual patient's needs. Attempts were made to book release medicals with the safeguarding lead. The welfare team were engaged throughout the process to ensure all issues were adequately addressed. Social workers were informed to ensure adequate accommodation and a safe care environment was available on leaving Catterick. Transition to National Health Service (NHS) services was managed to ensure continuity of care. In the absence of the safeguarding lead, the other doctors were aware of the considerations required when a recruit exits the Service. This was covered in the medical officer induction.

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. For example, the PCRF took written consent for acupuncture and injection therapy, and the minor surgery audit confirmed written patient consent was obtained. Staff were aware of the Gillick competence used to determine the capacity to consent in young people under the age of 18.
- Recruits signed a consent form at the start of their training permitting information to be shared with the unit commanders and for discussion at the UHC.
- Staff we spoke with were aware were aware of the principles of the Mental Capacity Act (2005), and how it could apply to their patient population.

Are services caring?

Following our previous inspection, we rated the practice as requires improvement for providing caring services because the arrangements for ensuring the privacy and dignity of patients needed improving.

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

We rated the practice as good for providing caring services.

Kindness, respect and compassion

Staff supported patients in a kind and respectful way.

- Results from the May 2021 Patient Experience Survey (30 respondents) showed 100% of patients would recommend the medical centre to their friends and family. We asked for patient feedback as part of the inspection but had no response. The PCRF carried out a patient survey in September/October 2020. Twenty patients responded and all were satisfied with how staff treated them.
- The Ministry of Defence produced a quarterly Recruit Training Survey Phase 1 report designed to monitor each centre for newly recruited personnel. The latest report from June 2021 highlighted that patient ratings for the medical care provided at ITC Medical Centre Catterick had risen from 69% in quarter three to 80% in quarter four.
- An information network known as HIVE was available to all patients. This provided a range of information to patients who had relocated to the base and surrounding area. The Garrison HIVE provided information about facilities available on the camp and locally, including civilian healthcare facilities.
- A practice information leaflet was available to ensure patients were clear about the facilities available including key members of the practice team, contact numbers, opening times and clinics provided.

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. Recruits from Nepal and commonwealth countries were patients of the practice so staff were familiar with the interpretation service and provided examples of when it was used. The welfare officer advised us that overseas recruits were allocated a sponsor from their unit who provided support with attending appointments, including translation.
- The Patient Experience Survey showed 97% of patients felt that they were involved in decisions about their care.

- A carers register was in place. Patients with a caring role were identified through the summarisation process and through the UHC meetings. Carers were highlighted on the clinical system and staff were aware of the need to be flexible with appointments for carers. All patients with caring responsibilities were offered the annual flu vaccine. Support services were advised through engagements with the unit healthcare meetings and welfare. Information for carers was included in the patient information leaflet.

Privacy and dignity

The arrangements for ensuring the privacy and dignity of patients had been improved.

- Privacy screening was provided in doctors', nurses' and medics' consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. Clinic room doors were closed during consultations.
- Patients attending the PCRF were treated in a large open room with approximately 10 curtained cubicles. At the previous inspection, we observed treatment of multiple patients in the department simultaneously with no curtains closed. At this inspection we observed curtains were closed around all cubicles where patients were receiving treatment. Staff told us that this had become routine practice,
- The layout of the reception area and waiting area meant that conversations between patients and reception could not be overheard. A sign at reception requested that patients wait until they were called forward to the reception desk. If patients wished to discuss sensitive issues or appeared distressed at reception, they were offered a private room to discuss their needs.
- The practice could facilitate patients who wished to see a clinician of a specific gender.

Are services responsive to people's needs?

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 and clinics were organised to meet the needs of specific population groups. For example, specific emergency clinics (referred to as sick parade) were in place for recruits at a time that did not disrupt their training. In addition, smoking cessation and dedicated vaccination clinics were held weekly for recruits.
- An access audit as defined in the Equality Act 2010 was completed for the premises in December 2020. Numerous issues were identified from the audit, added to the risk register when appropriate, and reported to the Quartermaster (QM). A meeting was held with the QM and an action plan produced to address and monitor progress with the issues found.
- The practice lead for diversity and inclusion had attended additional training for this role. They also attended diversity and inclusion meetings at unit and national level. A diversity board was available in reception and it was up-to-dated with any new information.
- Practice staff considered the cultural and religious beliefs of patients, for example, when assessing their capacity.

Timely access to care and treatment

Patients' needs were met in a timely way.

- The practice accommodated patients with an emergency need on the day they presented at the practice. Routine appointments with a doctor could be facilitated within two days and nurses had capacity to see a patient on the same day. A routine physiotherapy new patient appointment was arranged within three days, a follow up physiotherapy appointment within two days and we were told urgent appointments would be accommodated on the same day.
- Although not outlined in the practice information leaflet, telephone consultations with a doctor could be organised. The practice leaflet confirmed home visits were available with requests for a home visits triaged by the duty doctor.
- The Garrison Medical Centre provided medical cover when the practice closed at 16:30. From 18:30 during the week, weekends and public holidays the duty medic triaged patients and signposted them to NHS 111 if appropriate. The practice provided a service on bank holidays for emergency appointments only.

- A direct access physiotherapy (DAP) service was in place for permanent staff who were patients but not recruits. The practice worked to the DMS policy for recruits, which dictated that recruits should be referred to physiotherapy. Patients using DAP were seen the next day in most instances. The PCRF carried out annual audits to monitor the usage of DAP. The last audit carried out in August 2020 highlighted 23% used the DAP service.

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.
- Both the military and civilian practice managers were the designated responsible persons for the management of complaints. The practice managed complaints in accordance with DMS policy. Both written and verbal complaints were recorded and linked to the health governance workbook. There was only one complaint recorded in 2021. We noted it was effectively managed and well documented.

Are services well-led?

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

Following our previous inspection, we rated the practice as requires improvement for providing well-led services. We identified shortfalls in leadership capability and governance arrangements.

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

Leadership, capacity and capability

The practice had historically experienced a lack of continuity with leadership. Since the loss of permanent staff in July 2020 and the arrival of a new SMO in August 2020, the practice has benefited from a period of stability both within the senior management team and the wider practice team.

- The practice management believed there was both breadth of knowledge and skills within the team to deliver safe and effective healthcare. The team contained a broad range of skill sets including an unscheduled care practitioner who had paramedic qualifications which brought additional knowledge to the team and provided training opportunities.
- There were two practice managers, one military and one civilian which ensured continuity in leadership. One of the full time civilian medical practitioners (CMPs) provided cover for the SMO during gaps in military leadership and the nursing and PCRF teams contained a large civilian element which again provided continuity.
- All staff spoke highly of the leadership of the practice. They reported feeling supported, informed and included by the leadership team.
- The regional management team worked closely with the staff team.

Vision and strategy

The practice worked to the recently revised DPHC mission statement of:

> “Provide and commission safe and effective healthcare which meets the needs of the patient and chain of command in order to contribute to fighting power.”

The practice had developed their own mission statement:

> “The ITC Medical Centre will provide a safe, effective, caring and responsive practice for patients within the Infantry Training Centre in order to maximise their individual health and well-being and support ITC’s mission to produce operationally effective personnel for the Field Army.”

Plans were in place to develop a Catterick Integrated Care Centre (CICC) by 2024. The aim of the CICC is to provide an integrated approach to care provision with defence primary care, local NHS primary care, social care and third sector organisations working together in a purpose-built health and well-being facility. In the lead up to the CICC project, the practice had developed good links with the Garrison Medical Centre. The ANP, nurse lead and unscheduled care practitioner provided a foundation for the development of the CICC (Catterick Integrated Care Centre) through exchange working.

Culture

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

- All staff we spoke with said the management took an interest in them, so they felt included and valued regardless of rank or grade. This inclusion was promoted through informal discussions, the introduction of more structured meetings and departmental visits.
- Cross-departmental integration provided staff with a wider understanding of how the practice worked. Both formal and informal opportunities were in place so staff could contribute their views and ideas about how to develop the practice.
- Staff understood the specific needs population and tailored the service to meet those needs. In particular, staff were mindful of the potential vulnerability of recruits and worked closely with the units and welfare team to ensure recruits were well supported.
- 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.

Governance arrangements

The responsibilities, roles and systems of accountability to support good governance and management had been strengthened. Since the assignment of the new SMO, leadership was noted to have improved. The list of leads within the practice was displayed outside the practice manager's office and had also been emailed to all staff. Most positions had deputies assigned. Staff we questioned believed that the staffing structure and levels were adequate to meet the needs of the patients. It was noted that during surge periods the practice could be stretched but managed to cope.

- The practice worked to the health governance workbook, a system designed to bring 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. We identified the workbook planned to be developed further and to include the wider staff team and to further strengthen the system.

- Lead roles for staff were identified and had been extended to capture all day-to-day tasks and activities. Staff we spoke with were clear on their own roles and the responsibilities of colleagues.
- A full range of practice SoPs covering all key areas of practice activity was now in place. However, some of the SoPs were generic DPHC documents that had not been tailored to the practice and some required further development. For example, the safeguarding policy did not refer to vulnerable adults and there was no SoP for providing support to carers.
- There was an established set of meetings both formal and informal that supported communication and engagement processes. For example, clinical meetings took place on the last Wednesday each month and a full practice meeting took place every six to eight weeks. Staff we spoke with said the practice meeting was valuable for sharing information relevant to their role. However, navigation through minutes was not always straightforward. For example, minutes from the last clinical meeting was numbered and did not include a topic or title and those from the HoD meeting were listed by department not subject matter making it difficult to identify what had been covered.
- The leadership team carried out spot visits/inspections to each department.

Managing risks, issues and performance

Processes for managing risks, issues and performance had been strengthened.

- The practice had reviewed and updated its risks in line with the latest DPHC guidance. There was a practice-wide risk register and issues log in place with evidence of two risks transferred to the regional team. The risk assessments for the practice were linked to the risk register.
- A reliable process was now established to monitor the performance of clinical staff. We identified that this could be further improved by auditing the auditors.
- The leadership team had oversight of national and local safety alerts, incidents, and complaints.
- Audit was a routine method used to measure the effectiveness and success of clinical and administrative practice. An extensive audit programme was established for 2021. There was clear evidence that clinical audits undertaken had led to positive change.
- A business continuity plan was in place for the practice and a major incident plan for the garrison.

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. There was evidence that the practice acted on feedback from patients. For example, the introduction of chairs outside the immunisation rooms as some patients fed back that they felt faint prior to having immunisations.
- Good and effective links with internal and external organisations were established, including with the welfare team, RRU and the DCMH. In particular, there were strong relationships with infantry training team.
- A civilian medical practitioner was a lead on the local medical committee (LMC) and was clinical lead for South Tees Clinical Commissioning Group (CCG). Staff told us that these links were used to strengthen engagement with local NHS and civilian agencies. For example, staff spoke of strong links with the local safeguarding team, the north Yorkshire Tuberculosis Team and local mental health and sexual health teams.

Continuous improvement and innovation

The practice maintained a quality improvement log on the health governance workbook. This had been developed since the last inspection with improved records around areas of good practice entered onto a quality improvement log. The quality improvement log had captured the following:

- The review of all letters returned from secondary care to ensure they met the two week timeline set by the local trust. The review found seven per cent did not arrive back within this timeframe and this was fed back to the trust.
- A DMICP template produced to align practice between medical officers (MOs) which resulted in incidence of disease. This was now included in new clinical inductions.

The Practice had an extensive quality improvement project (QIP) register which all staff could populate and was a standard agenda item at practice meetings. QIPs were also communicated to DPHC Regional Headquarters. There was a good examples of quality improvement that included:

- Enabling outreach remote X-ray services on site for patients with latent tuberculosis that required regular chest imagery.

- The administration team rotated through all administrative roles to ensure they were omnicompetent and able to cover staff absences; this project was planned to be developed further to include the PCRF administration team.
- A review of Vitamin D in the management of stress fractures which included the engagement with external agencies and resulted in a practice SoP.
- The PCRF provided an injury prevention brief to new unit course instructors to ensure they understand injury risk factors and management to reduce the risk for recruits. The PCRF also participated in a quarterly injury prevention working group.