Catterick ITC Medical Centre

Quality report

Scotton Road
Catterick Garrison
North Yorkshire
DL9 3PS

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14 January 2020

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9 April 2020

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	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Requires improvement
Are services responsive to people's needs?	Good
Are services well-led?	Requires improvement

Chief Inspector's Summary

This practice is rated as inadequate overall

The key questions are rated as:

Are services safe? – inadequate
Are services effective? – inadequate
Are services caring? – requires improvement
Are services responsive? – good
Are services well-led? - requires improvement

We carried out an announced comprehensive inspection of Catterick Infantry Training Centre (ITC) Medical Centre on 14 January 2020. 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:

- 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. Not all feedback received was formally reported.
- The practice had good lines of communication with the units and welfare team to ensure the wellbeing of recruits.
- Staffing levels at the practice were sufficient to meet the needs of the patient population.
- Effective medical cover was in place on weekdays between the times when the practice closed and NHS 111 commenced to provide medical cover.
- 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. Not all available and relevant data was being utilised to drive quality improvement.
- Systems to demonstrate effective staffing were underdeveloped. For example, mandated training could not be confirmed for all staff working at the practice.
- Governance systems, activities and working practices were not fully coherent or integrated.
- Information systems and processes to deliver safe treatment and care were underdeveloped including Read coding, 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 was compromised as not all clinicians used privacy screens/curtains when treating patients.

- 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 needed to be improved.
- Staff understood and adhered to the duty of candour principles.
- Effective arrangements were in place for infection prevention and control.

The Chief Inspector recommends:

- The practice should ensure the privacy and dignity of patients is maintained at all times. Where appropriate, patients should be routinely offered a chaperone.
- The management of governance systems, including the health governance workbook, should be strengthened to ensure all relevant information is captured to monitor service performance. The workbook should be kept up-to-date and available to staff so they have access to key governance information for their role.
- An audit of clinical records across all staff groups should be undertaken to identify the extent of inconsistencies with Read coding, the use of review templates, Rehab Guru exercise codes and discharge outcomes. Standard operating procedures should be developed to ensure appropriate coding, outcomes and templates are consistently used by clinicians. A programme of ongoing audit of clinical records should be established to ensure improvement with record keeping is maintained.
- The identification and development of standard operating procedures for all key activities for the practice
- The list of lead roles for the practice should be shared widely so all staff are aware of the roles and responsibilities of colleagues.
- The approach to quality improvement, including an integrated audit programme, should be developed so all staff groups participate in service improvement activity.
- The practice should ensure that staff complete the required mandated training. Furthermore, a training needs analysis should be undertaken and a training programme developed to ensure all staff have the correct skills and knowledge for their roles.
- An audit should be undertaken to determine the impact of direct access physiotherapy services.
- The arrangements for the identification and monitoring of patients prescribed high risk medicines should be revised so all patients prescribed these medicines are identified and monitored.
- The new patient registration process should be introduced in accordance with the Defence Primary Health Care (DPHC) guidance note.
- Arrangements should be made so the practice routinely receives recorded confirmation of the safety checks undertaken for the building and facilities.

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 primary care doctor, a practice nurse, two practice managers, a physiotherapist and a pharmacist. A physiotherapist and CQC administrator shadowed the inspection.

Background to Catterick ITC Medical Centre

Catterick ITC is part of the School of Infantry (SCHINF) which trains up to 26% of the army and provides trained infantry soldiers for all regiments of the Foot Guards, Line Infantry, Parachute Regiment and the Gurkhas.

Catterick ITC Medical Centre provides a routine primary care service to a patient population of approximately 5,008 including mostly army recruits and 888 permanent staff. At the time of the inspection there were 156 patients under the age of 18 and 31 over the age of 50.

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)	1
Civilian medical practitioners (CMP)	8 - 5.7 full time equivalents (2 full time, 6 part time, including 1 locum)
Senior nurse	1
Civilian practice nurses	5
Military practice nurses	1
Military practice manager	1
Civilian practice manager	1
Physiotherapists	7
Exercise rehabilitation instructors (ERI)	6
Pharmacy technicians	2
Administrative staff	4.5 full time equivalents
Combat medical technicians (medics)	15 - ITC assets

Are services safe? | Inadequate

We rated the practice as inadequate for providing safe services.

Safety systems and processes

Systems to keep patients safe and safeguarded from abuse needed to be 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 patients register for the practice. Reviewed in April 2019, the safeguarding policy included contact details for the local safeguarding team; it was displayed in the waiting room and all clinical areas.
- Staff 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 2019.
- 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 and shared communication about the needs of service personnel who are medically downgraded and those who were vulnerable. Each unit maintained a register of vulnerable personal (referred to as VRM). The practice used the UHC as 'shadow clinics' and updated DMICP for individual patients following the meetings.
- We were advised the SMO had provided the staff team with chaperone training. A record of chaperone training was not identified on the practice training log therefore the date the training took place and list of attendees was not made available as evidence during the inspection. We were provided with this evidence after the inspection. The PCRF team did not routinely offer patients the option of a chaperone. 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. A DBS check was overdue for one staff member. This had been requested and, in the interim, the SMO had completed a risk assessment which supported the member of staff to continue working with patients.
- Arrangements were in place to monitor the registration status of clinical staff with their regulatory body. All staff had professional indemnity cover and had received the appropriate vaccinations for their role.
- There was an effective process to manage infection prevention and control (IPC), including a lead who was experienced and skilled for the role. They had applied for link practitioner IPC training and this was awaiting approval at the time of the inspection. Not all of the staff team were up-to-date with IPC training. An IPC audit was undertaken each year. 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. 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. The medical centre had a deep clean

following the refurbishment which was completed in October 2019. We identified no concerns with the cleanliness of the premises.

- Clinical waste was bagged and tagged. The lead for clinical waste was not available during the inspection and staff we asked were unaware of the arrangements for managing consignment notes and the clinical waste log. After the inspection we were sent evidence to demonstrate consignment notes were retained. An annual waste audit was carried out in September 2019. The audit identified incorrect colour bags were in use and this had since been rectified. In addition, sharps disposal units for cytotoxic waste (sharps containing chemical toxins) had been requested as a result of the audit.

Risks to patients

Systems to assess, monitor and manage risks to patient safety needed to be strengthened.

- 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.
- A specific locum induction programme was developed in December 2019 to familiarise temporary staff with systems and processes. Prior to this, the generic induction for permanent staff was used. We noted induction records for locum staff had not always been fully completed and/or clearly recorded.
- 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 was available. Routine checks were in place to ensure the required kit and medicines were available and in-date.
- All the staff we spoke with confirmed they were in-date for the required medical emergency training. The staff database showed gaps in training for basic life support and anaphylaxis training so it was unclear whether training was up-to-date.
- Evidence was in place to show the SMO provided a training session on exercise collapse associated sickle trait, heat injuries and sepsis. In addition, the nurses maintained a separate spreadsheet which confirmed all nurses had completed sepsis training.

Information to deliver safe care and treatment

Information systems to deliver safe care and treatment to patients needed to be strengthened.

- We found inconsistencies in the use of Read codes and established there was not an agreed list of codes that clinicians could refer to.
- Monitoring or audit of clinician records was not consistently taking place for all clinician groups. A records audit had taken place for physiotherapy and ERI staff in 2019; actions identified had or were being addressed. One of the doctors recently reviewed the records for all doctors and planned to discuss the outcome at the next doctor's meeting. During the inspection we asked but were not provided with evidence to demonstrate an audit of nurses and medics clinical record keeping was undertaken. After the inspection we were sent an audit completed in 2015. There was no evidence provided to indicate an audit of nurses and medics records had been completed since then.
- Scrutiny and summary of recruits joining the practice was considered a priority and 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 which facilitates the summarisation process so nurses were using an alternative way to summarise the records for this staff group.
- Although the practice had not implemented the 'scan and task' protocol, a process was in place to ensure clinicians received hospital letters for review. Once reviewed, letters were scanned onto DMICP. Not all staff who needed to know were familiar with the process for the management and scanning of clinical documents. We were advised the process was not captured in a SoP. However, we were provided with evidence after the inspection to show scanning guidance was in place for the practice.
- 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).
- In addition, a book was maintained for the two-week referrals. We noted some referrals dating back to May 2019 which were not showing as completed on the register. Checks of individual DMICP records confirmed patients had received their appointment.
- 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 Army Recruiting and Initial Training Command (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. There was not a central point for monitoring the progress of internal referrals.
- There was not a formal process in place for referrals made by the PCRF, such as those to the Regional Rehabilitation Unit (RRU) or the Multidisciplinary Injury Assessment Clinic (MIAC). The referring physiotherapist monitored the referrals they made. This could present a gap in monitoring should the referrer be absent from the service.
- Although a SoP was not in place, the administrator had developed detailed 'desk notes' about the referrals process and these were accessible to other staff. We were provided with evidence that showed the practice was in the process of setting up a shared spreadsheet that brought all

referrals together. This would provide a useful failsafe monitoring system, particularly as not all staff who needed to, understood the referral management process.

- 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 for managing, storing and disposal of medicines, including vaccines, medical gases, emergency medicines and equipment. The management of high-risk medicines needed to be strengthened.

- 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.
- We found the dispensary was well managed. All the medicines and equipment we checked were in date and fit for use. All 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 November 2019 following a recommendation from the regional pre-CQC inspection visit. The SMO advised us that they checked the 'doctor's bag' and kept a record of the checks.
- 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 also 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 was in the process of negotiating the 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 as 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. We were not provided with evidence that a PGD audit had taken place. After the inspection we were sent evidence to show a PGD audit had taken place in November 2019. This was not indicated on the practice audit log. Although Patient specific Directions (PSD) were not routinely used, we did see that a physiotherapist had administered an injection 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 November 2019. 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.
- Because of the low number of patients prescribed high risk medicines (HRM), patients received in-depth medicine reviews. A register was maintained of the patients prescribed HRMs. We looked at a range of patient's records and confirmed they were well managed with appropriate alerts used.
- 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. There was no evidence the dispensary had access to registration documents so they could update the medication record for these patients.

Track record on safety

Arrangements to ensure the safety of the premises and facilities needed to be strengthened.

- Arrangements for ensuring the safety of the building and facilities was coordinated at unit level. This information was not routinely shared so the practice had requested it from the Quarter Master with the most recent request email dated 17 December 2019. The practice had not received this information therefore we could not assure the checks for fire, water, gas, electrical and the building were up-to-date. A member of staff was the lead for equipment held at the practice. Although we were not provided with recorded evidence, the military practice manager confirmed equipment checks were up-to-date.
- A lead for health and safety was identified for the practice. A risk register and issues log was in place and these had recently been reviewed along with individual risk assessments. Records showed that not all staff were up-to-date with fire training.
- Although we were advised that products hazardous to health (referred to as COSHH) were not used clinically, the SMO confirmed after the inspection that COSHH products were used for minor surgery. In accordance with COSHH regulations, the SMO confirmed 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. We tested a personnel alarm during the inspection and staff responded in a timely way. Evidence was not in place to show regular testing of the alarm system took place. 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.

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, mental health training was provided for the staff team as a result of an ASER in relation to self-harm. Another example related to a secondary care consultant prescribing a treatment for a patient that was not appropriate. This led to the PCRF producing a list of appropriate consultants to refer to and that list had been shared with the doctors.
- 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. They were also discussed at the HoD, clinical and practice meetings.

Are services effective? | Inadequate

We rated the practice as inadequate 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.

- 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.

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 needed further development.

- 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). Undertaking searches using the population manager facility (referred to as ‘popman’) to identify and monitor patients with an LTC was not reliable. We found popman searches were inaccurate for asthma, diabetes, hypertension and other LTCs. The reliability of searches for patients with mental health needs was also affected as a search for patients with depression did not correlate with those on popman. We were advised doctors were not using the correct review templates resulting in inaccurate Read coding therefore unreliable popman searches. As an example, a patient was reviewed appropriately but the coding used identified a medication review rather than a review of their LTC. Furthermore, only 25% of patients with

diabetes had a recorded foot risk assessment which was not in accordance with NICE guidance on the prevention and management of diabetic foot problems.

- The lead nurse was aware that patients with an LTC were being Read coded incorrectly so had set up a separate register to manage and record the recall. The practice had low numbers of patients with an 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. Despite this alternative management approach, we found it was not failsafe as there was a risk that patients with an LTC who were incorrectly Read coded would not be identified.
- We looked in detail at a range of patient records and, besides inconsistencies with the use of review templates and Read coding, we 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. The discharge measures were not always captured so no reliable evidence could be provided to demonstrate effectiveness in terms of patient outcomes. Patients records showed Rehab Guru, software for rehabilitation plans and outcomes, was routinely used to provide exercise rehabilitation programmes for patients. However, the Rehab Guru exercise codes were not included in the records which would add additional clarity and allow clinicians at other facilities to continue ongoing treatment in a seamless way.
- 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 83% 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 2019 included:
- incidence of PVL-staphylococcus aureus skin and soft tissue infection in Gurkha recruits;
    - high risk medicines prescribing, including the prescribing of sodium valproate (used to treat epilepsy and bi-polar disorders) in females with childbearing potential;
    - medics prescribing compliance with MIPs;
    - controlled drugs prescribing;
    - health surveillance of women in ground close combat (WGCC);
    - minor surgery (June 2017 to June 2019);
    - new patient health checks;
    - QRISK2 scores in the over-40s; and

- a resuscitation audit.

- Although the PCRF had completed a BCM (Body Composition Monitor) audit, we were provided with no evidence to show audit had been undertaken in relation to referral pathways or best practice guidance. The PCRF team maintained a database of injury statistics which was updated each month, including the type of injury and stage in training. Any spikes in injury were reported to the recruit training team. The next step would be for this data to be analysed and captured through audit to inform the effectiveness of treatment and care.
- Improvements as a result of audit were evident. For example, the PVL-staphylococcus aureus audit in the Gurkha population led to a new method of decolonisation and a change in antibiotics used. The re-audit showed a 75% reduction in the incidence of PVL. Minutes of meetings demonstrated that the outcome of audits were discussed at clinical, practice and governance meetings.

Effective staffing

Continuous learning and development was promoted for staff. Improvements were needed.

- The military practice manager was responsible for the induction of medics, the civilian practice manager for locum staff and the SMO for clinical staff. We found induction documentation was inconsistent with some induction packs incomplete. In addition, the induction identified on the staff database was for the unit rather than the medical centre. After the inspection we were sent evidence to show that a practice induction was in place and it took account of different staff roles.
- All staff we spoke with described a comprehensive induction. For example, two new clinical staff said they were effectively supported and mentored as part of their induction, including supernumerary time and supervised practice. We noted that improving the approach to induction was identified on the practice management action plan (MAP).
- 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. Although all staff we spoke with said they were current with mandated training, the training records did not reflect this. For example, there were gaps in training for equality and diversity, DMICP and health governance awareness. Not having an up-to-date record meant the leadership team did not have an overall view of the status of training for the staff team. The SMO produced a practice development plan for 2020 and strengthening the structure and monitoring of the training programme was identified as an area of development.
- Internal and external training sessions were available to staff each week. For example, one of the doctors provided training in July 2019 about skin conditions and a physiotherapist facilitated training on ankle and knee injuries in August 2019. We were not provided with evidence to show the attendance at these training sessions. After the inspection we were advised the senior nurse was the training lead and held the records for in-house training at the practice. Evidence to confirm attendance at training was also submitted.
- Clinicians were supported with continual professional development (CPD) and revalidation through protected time. Nursing staff provided good evidence of clinical supervision and CPD activity. There was not a formal peer review process in place for the ERIs or physio therapists. Regional meetings and forums were established for staff to link with professional colleagues in order to share idea and good practice.
- The SMO set up weekly clinical meetings in August 2019. The aim of these meetings was to support 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, then these patients were admitted to the inpatient facility until such time as accommodation was secured.

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.
- 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 alcohol awareness, non-freezing cold injuries and sepsis.
- The practice had a stand at the annual health and wellbeing fairs held on the base. Last year the PCRF team offered attendees a functional movement assessment followed by advice on stretching exercises based on the outcome scores of the assessment.
- 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 the recently established quarterly injury prevention working group.
- There was a member of staff identified as the lead for sexual health. Not all staff were aware of who the lead was. Although two of the nurses were trained in sexual health (referred to as

STIF), the training instructors delivered sexual health training to the recruits. Patients with sexual health needs were referred to the North Yorkshire sexual health service. Information was available for patients requiring sexual health advice, including sign-posting to other services.

- The practice had 47 patients who met the criteria for cervical cytology. Forty-two patients were up-to-date with screening. Five patients were either due for screening, overdue or were non-responders. 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 send 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 for military patients:
    - 99% of patients were recorded as in date for vaccination against diphtheria.
    - 95% of patients were recorded as in date for vaccination against hepatitis B.
    - 95% of patients were recorded as in date for vaccination against hepatitis A.
    - 96% of patients were recorded as in date for vaccination against MMR
    - 99% of patients were recorded as in date for vaccination against yellow fever.

We were not provided with the full range of vaccination data for patients

- Recruits from Nepal 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. All recruits were offered the flu vaccine.
- 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.

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?	Requires improvement

We rated the practice as requires improvement 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 from the 2019 Patient Experience Survey (372 respondents) showed 95.3% of patients would recommend the medical centre to their friends and family. The 44 CQC comment cards completed prior to the inspection were all very complimentary about the friendly, considerate and caring attitude of staff. We did not have the capacity to interview patients during the inspection. The PCRF carried out a patient survey in January/February 2019. Twenty patients responded and all were satisfied with how staff treated them.
- 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 91.5% 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.
- One of the doctors advised us that patients with a caring role were identified through the summarisation process and through the UHC meetings. At the time of the inspection the practice manager was unable to confirm if a carers register was in place. After the inspection, we received evidence to show a search for carers had been carried out and seven were identified. The practice was aware of the need to be flexible with appointments for carers and all were offered the flu vaccine.

Privacy and dignity

The arrangements for ensuring the privacy and dignity of patients needed improving.

- 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. We observed treatment of multiple patients in the department simultaneously with no curtains closed. Although there were signs to indicate patients could

ask for the curtains to be closed, recruits may not feel confident asking for this due to their youth and rank. Furthermore, infantry training is now open to women and several women had been treated in the department. Not using the privacy curtains was identified through the recent pre-CQC inspection visit but had not been addressed. Staff we spoke with felt not using curtains maintained an open working culture.

- 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? | 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 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 2019. Numerous issues were identified from the audit but an action plan to address them had not yet been developed.
- 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.

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 one day and nurses had capacity to see a patient on the same day. A routine physiotherapy new patient appointment was arranged within two days, a follow up physiotherapy appointment the next day and an urgent appointment within one day. Next day appointments were available with the ERI for routine and follow up appointments.
- 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.
- 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. We were advised the uptake for DAP was fairly low. In accordance with DPHC guidance, the PCRF introduced DAP 12 months ago. There was scope to undertake an audit to demonstrate the impact of the change in access.

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 since October 2018. We noted it was effectively managed to the satisfaction of the complainant.

Are services well-led?	Requires improvement

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

Leadership capacity and capability

The practice had historically experienced a lack of continuity with leadership. Since 2018 the practice has had three different SMOs.

- Since taking up post in August 2019, the SMO had identified a number of improvements that needed to be made to the service. These improvements were outlined in the practice development plan (PDP) for 2020. The SMO was due to leave the military in August 2020 so leadership beyond that date was identified as an area of development to ensure strong and competent leadership is sustained.
- The current military practice manager was appointed to a vacant post and they received a handover from the civilian practice manager. A deficit in skills and knowledge was identified in the PDP. It acknowledged staff responsible for the administration of governance systems required mentoring and support to ensure they develop the capability to maintain strong systems that underpin the delivery of safe and effective care for patients. Through the inspection process, we also identified this as an area of development.
- All staff spoke highly of the leadership of the practice since last August. They reported feeling supported, enthusiastic and motivated by the new SMO. An appreciation of having a ‘hands on’ SMO was echoed by all staff we spoke with.
- 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 SMO had developed the following mission statement for the practice:

  “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. A project board was established with a project director and area project manager identified. We had previously been provided with a detailed report about the project when we inspected the Garrison Medical Centre in July 2019.
- In the lead up to the CICC project, the SMO had produced a proposal for the two medical centres to start working together and sharing best practice.

Culture

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

- All staff we spoke with said the SMO 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 from the SMO. Staff said their subject matter expertise, particularly at the clinical meetings, was valued by the SMO.
- Although there was scope for further development, staff reported cross-departmental integration had improved in recent months. 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 needed to be strengthened.

- Structures, processes and systems to support good governance and management were not understood by all staff. 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 needed to be developed further and shared with the wider staff team to ensure all relevant staff had access to key governance information for their primary role. For example, we found gaps in the training record and audit log on the workbook. There was a disconnect between what staff told us and the governance records. In particular, this related to staff training. This meant securing reliable information during the inspection was piecemeal. To seek assurance about the safety of service provision for patients we needed to follow up on gaps and inconsistencies in evidence after the inspection.

- Although lead roles for staff were identified, these were high level leads based on six key components of governance, such as effectiveness and risk management. The list of lead roles was not sufficiently extensive to capture all day-to-day tasks or activities. After the inspection we were provided with a comprehensive list of leads and were advised this was in place at the point of the inspection. Not all staff we spoke with were clear about who held lead roles.
- A full range of practice SoPs covering all key areas of practice activity were not in place, including those related to the management of hospital letters, referrals, vulnerable patients and patients with a caring role.
- Since taking up post the SMO had improved communication and engagement processes. For example, clinical meetings had been set up to take place each month. Staff said these meetings were valuable for sharing information about clinical care and best practice. In addition, the leadership team carried out spot visits/inspections to each department.

Managing risks, issues and performance

Processes for managing risks, issues and performance needed to be 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 not established to monitor the performance of clinical staff. We were not provided with evidence to indicate the concerns we found with Read coding and DMICP review templates had been identified by the practice.
- 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 audit programme was established for 2020. There was clear evidence that clinical audits undertaken had led to positive change. Not all staff/departments were proactively involved in the audit programme. In addition, we were unable to ascertain if the inaccuracies with Read coding had an impact on the reliability and validity of clinical audit.
- 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.
- The practice had a pre-CQC inspection regional inspection in November 2019 and a significant number of improvements needed were identified across all domains. We were advised the finding of this inspection were being used to make improvements. For example, chaperone training had been delivered, searches undertaken for high risk medicines and an equality access audit had been completed. We were not provided with a detailed plan outlining how all improvements would be actioned.

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, PCRF told us changes were made to rehabilitation programmes based on patient feedback. In addition, heaters were purchased for the PCRF in response to patients commenting on the waiting room being cold. These patient comments and the action taken were not formally recorded. to provide evidence of this.
- We saw a large number of comment forms in the PCRF that had been completed by recruits; the vast majority were positive comments and compliments specifically mentioning positive experiences and treatment by staff members. This information had not been formally captured or analysed.
- 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 ARTIC for secondary care referrals to prevent any delays in treatment.

Continuous improvement and innovation

The new SMO had identified improvements that needed to be made to the service. Furthermore, the regional pre-CQC inspection visit identified improvements required across all five domains. There was evidence the practice was working to make the improvements identified. However, there was a way to go to ensure all improvements had been actioned.

The practice maintained a quality improvement log on the health governance workbook. This needed further development as we found areas of good practice that were not recorded on the log. The quality improvement log had captured the following:

- A significant reduction in the incidence of PVL-staphylococcus aureus following changes made as a result of the audit.
- The development of the out-of-hours suicide and deliberate self-harm guidance and risk assessment to support the on-call medics assessing patients when the practice was closed.

Quality improvement activity we identified but was not formally recorded or identified on the improvement log included:

- As a result of skill fade being identified, ERIs had a placement on the upper limb course at the RRU to ensure they were clinically up-to-date.
- Based on research undertaken by a physiotherapist researcher working in the PCRF, it was identified that patients were sustaining injuries due to over loading. Recommendations were made about loading. As a result of the findings, the delivery of physical training and impact of the ITC course was reviewed and modified demonstrating effect outside of the medical chain and for the wider army as a whole.
- Change needed was identified in response to the army's revision of fitness testing 12-18 months ago. A full review of the rehabilitation delivery was conducted and new protocols were developed, which included clear parameters for returning to training and the requirements

needed by the recruits depending on what stage of the course they were at. This change ensured the risk of re-injury was reduced significantly.