# Newcastle Medical Centre

## Quality report

Albemarle Barracks
Near Harlow Hill
Newcastle upon Tyne
NE15 0RF

Date of inspection visit:
23 October 2019

Date of publication:
27 January 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? | Requires improvement |
| Are services caring? | Good |
| Are services responsive to people's needs? | Good |
| Are services well-led? | Inadequate |

# Chief Inspector's Summary

**This practice is rated as inadequate overall**

The key questions are rated as:

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

We carried out an announced comprehensive inspection of Newcastle Medical Centre on 23 October 2019. Defence Medical Services (DMS) are not registered with the CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014 and are not required to be. Consequently, DMS services are not subject to inspection by the CQC and the CQC has no powers of enforcement. This inspection is one of a programme of inspections that the CQC will complete at the invitation of the Surgeon General in his role as the Defence Authority for healthcare and medical operational capability.

**At this inspection we found:**

- The practice proactively sought feedback from staff and patients which it acted on. Feedback showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment. Information about services and how to complain was available to patients.
- Patients found it easy to make an appointment and urgent appointments were available the same day.
- The local leadership team had the experience, vision and passion to deliver high-quality sustainable care but was hampered in achieving this by unresolved relationship issues within the practice. The team said they received good support from region.
- Communication processes to share information, review clinical practice and discuss governance matters were not fully effective. Minutes of meetings lacked structure to clearly illustrate actions to ensure non-attenders were fully informed of what was discussed and the actions agreed.
- The leadership team promoted inclusion and encouraged staff to participate in developing the service.
- There was an open and transparent approach to safety and risk. A system was in place for managing significant events and staff knew how to report and record using this system.
- Risks to the service were recognised by the leadership team. The main risks included limited resilience to cover for staff absences and the infrastructure, which was old, dated and not compliant with infection prevention and control standards.
- Arrangements for managing medicines, including obtaining, prescribing, recording, handling, storing, security and disposal were in place. Some improvement was required in how medicines were managed.

- Although national guidance was not a standing agenda item at meetings, staff were aware of current evidence-based guidance and this was reflected in the clinical records for patients, which were of a high standard.
- There was evidence to demonstrate quality improvement was embedded in practice, including an annual programme of clinical audit used to drive improvements in patient outcomes.
- Equipment at the practice was sufficient to treat patients and meet their needs. Improvement was required in how its servicing was being monitored.

**We identified the following notable practice, which had a positive impact on patient experience:**

Based on a recognised model for transforming health care, the practice piloted an alternative way to deliver clinical care more to efficiently accommodate increased demand. An audit of the pilot showed patients were satisfied with the change with a notable reduction in the number of clinician consultations for 2018. Force health protection statistics improved and there was a reduction in the number of additional recall appointments. The practice has continued to work to this new model of consultation. A further audit is scheduled for February 2020.

**The Chief Inspector recommends:**

- A review of governance structures so they are strengthened, embedded and understood by all staff. Although not exclusive, this should include formal communication processes, the clinical audit programme, the practice training programme, equipment management and the clinical review process for doctors.
- An adult safeguarding policy is developed for the practice that reflects local arrangements.
- Improving the infrastructure, facilities, cleaning arrangements and clinical waste management in line with the Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'.
- The regional team keeps staffing levels and additional staff roles under review to ensure there is clinical resilience in the system. Recruitment to vacant posts should be progressed in a timely way.
- Arrangements are put in place so the patient waiting area can be monitored at all times.
- The arrangements for the management of high risk medicines and Patient Specific Directions are strengthened.

**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 doctor, practice nurse, practice manager and physiotherapist.

## Background to Newcastle Medical Centre

Located in Albemarle Barracks, Newcastle Medical Centre provides routine primary care and occupational health care service to a patient population of 518 military personnel. The population comprises 380 personnel from the 3rd Regiment Royal Horse Artillery (3RHA), 22 units in the local area and a fluctuating 'sick at home' population from units around the country.

In addition, the medical centre provides an occupational service to an approximate population of 1,500 reservists and 250 officer cadets. An occupational health service is provided to military personnel at RAF Spadeadam and to Otterburn training camp where there can be 1,500 visiting military personnel on exercise at any given time.

A Primary Care Rehabilitation Facility (PCRF) is located in the medical centre and provides personnel with a physiotherapy and rehabilitation service. As there is no dispensary at the practice, a contract in in place with a local pharmacy.

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

**The staff team**

| Position | Numbers |
|---|---|
| Civilian Senior Medical Officer (SMO) | One |
| Regimental Medical Officer (RMO) | One |
| Civilian practice nurse | One |
| Civilian practice manager | One |
| Administrative staff | Two locums |
| PCRF | One civilian physiotherapist<br>One Exercise Rehabilitation Instructor (ERI) – appointment pending at the time of the inspection |
| Medical Sergeant | One |
| Combat Medical Technicians (medics) | Three |

## Are services safe?

## Inadequate

**We rated the practice as inadequate for providing safe services.**

**Safety systems and processes**

Systems were established to keep patients safe, including processes to safeguard patients from abuse. Improvement was needed to strengthen some of these systems.

- The SMO was the lead for adult and child safeguarding and the practice nurse deputised in the absence of the SMO. The practice did not have a local safeguarding policy so deferred to the Defence Primary Healthcare (DPHC) policy which was available to staff along with contact details for the six local authorities safeguarding teams. A children's safeguarding flowchart was displayed in clinical areas for staff to follow for reporting issues and an adult variant was available in the safeguarding folder as required.
- Clinicians had completed level 3 safeguarding training and non-clinical staff had received safeguarding training, including update training, at a level appropriate to their role.
- A local policy for the management of vulnerable patients was is in place. System alerts were used to readily identify these patients and a register was held on the electronic patient record system (referred to as DMICP); a system search conducted on 18 October 2019 identified 27

vulnerable patients. Patients were discussed at the weekly 'huddle' meeting. Although 'huddle' meeting minutes were maintained, it was not clear which patients had been discussed and whether any action was agreed. This level of detail was important to effectively inform staff who were unable to attend the meetings.

- The SMO attended the base welfare meetings, a forum to review the needs of vulnerable patients to ensure they were being effectively and safely supported. The RMO attended the Unit Health Committee (UHC) where the health and occupational needs of patients were discussed, including those identified as vulnerable.
- Staff had received chaperone training and a list of trained chaperones was available. Access to a chaperone was outlined in the practice leaflet and displayed in patient areas. A local chaperone policy was in place and a register of trained chaperones was maintained.
- 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 for permanent staff, including a Disclosure and Barring Service (DBS) check to ensure they were suitable to work with vulnerable adults and young people. DBS checks were renewed every five years.
- The DBS for a medic expired on 21 October 2019. DBS checks for Regimental Aid Posts (RAP) are the responsibility of the unit so the practice manager was following this up through the Chain of Command. A risk assessment identified the medic could continue to work in the medical centre and the matter was logged on the risk register. A RAP is a front-line military medical asset attached to a military unit. They can be deployed at short notice. When not deployed, RAP staff work in medical centres to update and maintain their skills. They also have a focus on ensuring the occupational health requirements of unit personnel are up-to-date. The RAP team working at Newcastle Medical Centre included the RMO, Medical Sergeant and the three medics. A medic is trained to provide medical support on various operations and exercises. In a medical centre setting, their role is similar to that of a health care assistant in NHS GP practices but with a broader scope of practice.
- Arrangements were in place to monitor the registration status of clinical staff with their regulatory body. All staff had professional indemnity cover. Information was in place to confirm staff had received the relevant vaccinations required for their role at the practice.
- A process was in place to manage infection prevention and control (IPC), including a lead for IPC who was suitably skilled and experienced for the role. All staff, with the exception of the RMO, were up-to-date with IPC training. The practice manager had sent the RMO regular reminders since their training expired in April 2019.
- The medical centre was subject to an IPC audit in September 2019 and a management action plan (MAP) was produced following the audit. Staff and the regional team identified the aging infrastructure, including fixtures and fittings, were not fully compliant with IPC standards. Concerns with the building were identified on the issues register. There was a lack of appropriate handwashing facilities in clinical rooms. This was added to the risk register in 2004 and the risk was identified as 'transferred'. For example, the taps in the PCRF did not facilitate appropriate handwashing. This has been identified through the IPC audit and a request had been submitted for replacement taps. The physiotherapist was providing injection therapy in the PCRF and they agreed to provide further injections in an alternative IPC-compliant clinical room until the taps were altered.
- Environmental cleaning was provided by an external contractor. We were advised checks of the effectiveness of cleaning were carried out but it was unclear who carried these out. This was important given the infrastructure was not IPC compliant. Furthermore, an environmental

deep clean was not included in the contract current and this had been added to the risk register in 2013. It had been mitigated by an informal agreement for regular increased cleaning each month in high risk areas.

- Healthcare waste was appropriately managed and disposed of. It was collected every four weeks. Consignment notes were retained at the practice but a waste log was not in place. An annual waste audit was carried out in April 2019.

**Risks to patients**

Systems to assess, monitor and manage risks to patient safety were established. Improvement was needed to strengthen some of these systems.

- Staff had mixed views on the sufficiency of clinical staffing levels. At the time of the inspection, we found staffing levels were appropriate to the size of the registered patient population. This was confirmed through discussions with the practice nurse and administrative staff who said staffing levels and skill mix were currently sufficient to meet the needs of the registered patients. Furthermore, feedback from patients indicated they received an appointment in a timely way. Recent staff absences had been effectively managed though vacant positions back filled with locums and active recruitment campaigns. The absence of an ERI was identified on the risk register in 2004. An ERI had been appointed in April 2019 but had not started in the role.
- The concern about clinical staffing levels was a potential risk for a number of reasons, including a fluctuating registered patient population and weak resilience in the system due to a reliance on one permanent doctor (the SMO), one physiotherapist and one practice nurse. The SMO highlighted that the registered patient population was low at the time of the inspection. In addition, it did not take into account the workload generated by service personnel who were not registered at the practice. They included a high level of reservists, service personnel on exercise at Otterburn training camp and the 'sick at home'; all of which the SMO advised was high for the region.
- The practice nurse highlighted that medicines management constituted a large portion of their work and the practice would benefit from the regular input of a pharmacy technician. Furthermore, the SMO also had additional responsibility for the clinical leadership and oversight of Boulmer Medical Centre.
- An induction for locum staff was in place and the two recently recruited locum administrative staff described a thorough induction. They also demonstrated a detailed understanding of DPHC systems and policies, including DMICP.
- The practice was equipped to deal with medical emergencies and all staff were suitably trained in emergency procedures, including training in life support. An emergency kit, including a defibrillator, oxygen with masks and emergency medicines were accessible to staff in a secure area of the practice; all staff knew of its location. A first aid kit and accident book was available. Monthly checks were carried out by the medics to ensure the required kit and medicines were available and in-date.
- Training in the management of emergency situations, was delivered separately to the RAP team and permanent DPHC staff. The RAP team were invited to training coordinated by the wider practice. The medics attended training if they were available and if it was relevant. The RMO provided the medics with additional training each week. This was a risk as the SMO did not have oversight of the quality of training being delivered by the RMO.
- Both teams were up-to-date with training in medical emergencies/basic life support, including the use of scenarios. Locum administrative staff had not received this training. They were still

within their induction period and training was scheduled to be delivered by the SMO on 31 October 2019. All staff had attended sepsis training. Posters about sepsis were displayed in the practice.

- The RMO had provided training for the RAP team on the management of thermal injuries in September 2019. DPHC staff had not been invited to this so the SMO had scheduled the same training for DPHC staff in December 2019.
- The waiting area could not be fully observed from the reception desk and this was identified on the risk register. A large fish tank in part contributed to this as it obscured the view from reception. The practice had considered options to facilitate observation of the waiting room. A decision was made to request a mirror and the practice manager confirmed they would submit a business case for this equipment.

**Information to deliver safe care and treatment**

Improvement was needed to strengthen information systems to ensure the delivery of safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The 13 clinical records we looked at on DMICP showed information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- Similar to the regional team governance visit in September 2019, we found there was no audit or review of doctors' clinical records. There was no process to formally review the clinical notes completed by medics; a task usually undertaken by the RMO and overseen by the SMO. The SMO regularly audited the practice nurse's and physiotherapist's clinical records.
- The new patient registration forms and health checks were used to facilitate the scrutiny and summarising of patients' records. The administrators updated new patient details on DMICP and then the practice nurse was responsible for updating the system once they had seen the patient for a new patient health check. We were advised all clinical records were up-to-date at the time of the inspection. A new process of triage also supported opportunistic scrutiny of records (discussed further under the effective domain).
- Staff described a regular loss of connectivity and/or screen freezing with DMICP, meaning clinics could be delayed. If this happened, the business resilience plan was followed and only emergency patients were treated. Doctors used pre-made packs to record written notes for emergency patients seen.
- An effective system was established for the management and monitoring of referrals to internal teams and external health care services, including urgent referrals. The administrative team managed a referral spreadsheet that was monitored each day and followed up on referrals if appointments were not offered in a timely way.
- Supported by a standard operating procedure (SoP), a system was in place which ensured samples were taken safely, appropriately logged out and logged in and results actioned by the appropriate clinician in a timely way.

**Safe and appropriate use of medicines**

The practice had systems for the appropriate and safe handling of medicines. Improvement was needed to strengthen some of the systems.

- Safe procedures were in place for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment. The SMO was the medicines management lead and practice nurse deputised in their absence.
- Dispensary stock was checked regularly. No controlled drugs (medicines liable to misuse) were held at the practice. Medication requiring refrigeration was monitored twice a day to ensure it was stored within the correct temperature range. Prescription forms were securely stored and their use monitored.
- Patient Group Directions (PGD) had been developed to permit the practice nurse to administer medicines in line with legislation; they were current and had been signed off by the SMO. A PGD audit had been completed by the SMO within the last 12 months. The physiotherapist worked to a Patient Specific Direction (PSD) for the provision of injection therapy. The process needed clarifying to ensure evidence was in place that the doctor had written the PSD and completed an appropriate assessment for the physiotherapist to administer the medicine.
- The regional governance team found during a visit in September 2019 that repeat prescriptions were not being effectively managed. This had been addressed by the practice as we found requests for repeat prescriptions were safely managed. A flow chart was available at reception to support the administrative team with the process. A system was in place to update DMICP if changes to a patient's medication was made by secondary care or an out-of-hours service.
- The doctors had access to the regional policy and guidance on high risk medicines (HRM). A register was not maintained of patients prescribed a HRM, although there was evidence that DMICP searches were undertaken. We completed our own search and identified one patient prescribed a HRM. The patient did not have an alert on DMICP and this was added during the inspection. Furthermore, the patient did not have a shared care agreement and we noted the SMO had written to the consultant recently requesting this.

**Track record on safety**

The practice had a good safety record. Improvement was needed to strengthen some of the systems.

- The practice manager was the lead for health and safety and had completed training relevant to the role. They attended the health and safety (referred to as SHEF) meetings for the barracks.
- Risk assessments were in place for the building and had been reviewed and approved by the host unit safety officer. Electrical and gas safety checks were up-to-date. Arrangements were in place to check the safety of the water and a fire risk assessment of the building was undertaken annually. The fire system was tested each week. Staff were up-to-date with fire safety training and were aware of the evacuation plan.
- The testing of portable electrical appliances was in-date. We found some of the PCRF gym equipment was out of service. Once aware of this, the physiotherapist immediately removed the equipment from use and submitted a request for servicing. Removing this equipment from use did not impact on patient treatment care.
- An integral alarm was not fitted within the building and this has been mitigated by the supply of personal alarms located in every clinical room. We tested one of the alarms during the inspection and staff responded in a timely way.

**Lessons learned and improvements made**

The practice learned and made improvements when things went wrong. Improvement was needed to strengthen some of the systems.

- 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 reporting incidents. An ASER tracker was maintained and significant events reported were discussed at the weekly 'huddle' meeting. The minutes were not clear as to which significant events had been discussed, including any lessons learnt or action taken. The practice manager said they would revise the way this was recorded. Improving the recording of the minutes was important so staff not in attendance had access to clearly illustrated action points and lesson sharing.
- The practice manager and practice nurse 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 and were also discussed at practice meetings if appropriate. The meeting minutes were not clear which alerts were discussed.

| **Are services effective?** | **Requires improvement** |
|---|---|

**We rated the practice as requires improvement for providing effective services.**

**Effective needs assessment, care and treatment**

Processes to keep clinicians up to date with current evidence-based practice were in place. Improvement was needed to strengthen some of the processes and to ensure all clinical staff engaged in clinical discussions.

- Arrangements were in place to ensure staff had a forum to keep up-to-date with current practice and guidance. These included the weekly 'huddle' meeting, monthly practice meeting and daily clinical discussions. None of these forums included an agenda item to discuss national clinical guidance, including NICE (National Institute for Health and Care Excellence) and the Scottish Intercollegiate Guidelines Network (SIGN). We were advised the practice planned to implement NICE, SIGN & other national guidance discussions as a separate forum. The RAP team did not attend the practice meetings but were emailed the meeting minutes. The clinical meetings between the physiotherapist and the doctor required formalising.
- Despite these gaps, our review of clinical records demonstrated that all clinicians carried out assessments and provided care and treatment in line with national standards and guidance, supported by clear clinical pathways and protocols. The physiotherapist used Rehab Guru, software for rehabilitation plans and outcomes, for exercise programmes for patients. They also referred to the Defence Rehabilitation website for best practice guidance.
- Staff were kept abreast of clinical and medicines updates through the DPHC newsletter circulated to individual staff and to the practice each month. Participation with regional events and forums also provided an opportunity for clinicians to keep up-to-date. For example, the physiotherapist attended regional training and attended monthly regional meetings with other physiotherapists in the region and the practice nurse attended similar regional nursing events.

**Monitoring care and treatment**

The practice used data collected for the Quality and Outcomes Framework (QOF) to monitor outcomes for patients. QOF is a system intended to improve the quality of general practice and reward good practice. It is used across many NHS practices. The 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 or chronic conditions, including the recall of patients. The practice nurse maintained a spreadsheet which was cross-referenced with DMICP searches. This was reviewed each Friday.
- The numbers of patients with chronic conditions was low. For example, there were seven patients with high blood pressure and 10 with a diagnosis of asthma. All these patients were receiving appropriate treatment and care for their condition, and consistency was demonstrated in the way they were reviewed. For example, clinicians used the same asthma template when reviewing patients.
- Through review of clinical records and discussions with the doctors, we were assured that the care of patients with a mental illness and/or depressive symptoms was being effectively and safely managed, often in conjunction with the Department of Community Mental Health (DCMH). To maximise support for patients including timely access to support, the SMO had developed relationships with local mental health teams, including the crisis team. In addition, the SMO had established a clinical search for patients diagnosed with depression (including for over 180 days) and for patients prescribed common anti-depressants.
- 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 84% of patients.
- A lead member of staff and deputy were identified for audit, including clinical, non-clinical and system audit activity. A forward-planning audit calendar was under development at the time of the inspection. We looked at the audits undertaken since January 2018 and these were relevant to the patient population and undertaken as a quality improvement process to review clinical outcomes and ensure treatment/care was being provided in accordance national and local standards. For example, the SMO, in May 2019, completed an antibiotic prescribing audit for the previous six months; 17 patients had been prescribed antibiotics and no prescribing concerns were identified. During the same timeframe, the locum doctor conducted a prescribing audit for urinary infections, identifying that prescribing was compliant with national guidance. The physiotherapist had undertaken audits in relation to referral patterns including self-referrals, depression and demography of referrals.
- Minor surgery was a procedure offered at the practice and we found the practice was not working in accordance with the DPHC policy on the provision of minor surgery, including the completion of an annual minor surgery audit. Completed audits were discussed at the practice meetings. Evidence demonstrated the practice acted on the outcomes of audit to improve outcomes for patients.
- In September 2017, the practice manager took the lead on an ‘Appointment review project’. Between 2015 and 2017 there had been a gradual increase in clinician consultations (3,402 in 2015 to 5,808 in 2017) without any increase in clinician resources. The project aimed to evaluate the increased demand placed on the practice and look at patterns of appointments with a consideration to re-designing clinical provision based on the Virginia Mason Model

(VMM) of transforming health care.1 The VMM model is a patient-centred framework that seeks to improve quality and safety of patient care whilst stream-lining delivery.

- Results from the review project showed the emergency clinic (referred to as sick parade) was frequently oversubscribed with non-emergency patients seeking a quick appointment and patients from external units, such as Otterburn Training Camp, presenting with injuries as a result of exercise/training activity. For a three-month trial period sick parade was disbanded and a 'flow station' introduced. Patients presenting at sick parade were triaged by a medic working to a specific algorithm or flowchart. Not only was the patient's immediate need addressed but the medic also checked whether the patient was outstanding for vaccinations, audiology, repeat prescriptions, a medicine review, chronic disease review and receipt of test results. Based on this assessment, the patient was then referred on from triage to see the relevant clinician(s).
- The practice manager carried out an audit of the new arrangements from January to April 2018 to determine the impact of the trial and seek patient feedback. Findings showed patients were happy with the triage system and that it worked well. In particular, patients commented on the "one-stop-shop" approach and that "less appointments were needed". There was a notable reduction in the number of clinician consultations (3,717 for year 2018). In addition, there was an improvement in force health protection statistics and a reduction in consultations for additional recall appointments. With some revisions following the audit, the practice has continued to work to this new model of consultation. A further audit is scheduled for February 2020.

[1]Kenney, C, 2012. Transforming Health Care: Virginia Mason Medical Centre's Pursuit of the Perfect Patient Experience. 1. Productivity Press.

**Effective staffing**

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

- A generic induction programme was in place that involved role specific elements for clinical staff including medics. Detailed role-specific induction packs were also in place for clinical roles. The most recently recruited member of staff could demonstrate they had undergone the induction programme, including supernumerary time and supervised practice.
- Mandated training delivered to both the RAP and DPHC teams was monitored by the practice manager. The staff team was in-date for required training; any training gaps could be explained, accounted for or were being followed up. Clinicians had received specialist training to support with meeting the needs of the patient population, such as training in aviation medicine, boxing and diving medicals.
- A programme of ongoing in-house development training was in place with training sessions available to staff twice a month. The practice manager kept a record of the training. Clinicians were also supported with continual professional development (CPD) and revalidation through protected time.
- With the exception of doctors, a process of peer review was established for clinicians. The SMO facilitated supervision with the practice nurse. In addition, regional meetings and forums were established for staff to link with professional colleagues in order to share ideas and good practice.

**Coordinating care and treatment**

Staff worked 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 local health and social care organisations. For example, the physiotherapist had an effective communication link with the physical training (PT) staff for the unit and they used PT prescription cards to good effect. Prescription cards are the mechanism by which PCRF staff inform PT staff of appropriate exercises for injured soldiers. Furthermore, good links were established with the Clinical Commissioning Group, sexual health team, local mental health services and substance misuse service.
- The RMO and physiotherapist attended the main Unit Health Committee (UHC) meeting each month at which the health, occupational and rehabilitation needs of patients were discussed, including patients who had been downgraded. The SMO received UHC meeting minutes and entries of decisions regarding individual patients were available to the SMO on DMICP.
- Doctors provided patients transitioning from the military with a release medical. A summary letter was completed for the receiving GP. This summary was more detailed if patients had complex needs. Patients could be referred to the welfare team for support with the transition. Patients were also signposted to SSAFA, a UK not-for-profit organisation providing welfare and support for serving personnel in the British Forces, veterans and military families.

**Helping patients to live healthier lives**

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

- Clinical records showed that staff encouraged and supported patients to be involved in monitoring and managing their health. Staff also discussed changes to care or treatment with patients as necessary.
- The practice nurse was 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 and an information folder were available in patient areas. At the time of the inspection there was information about the management of common infections, alcohol, smoking, healthy eating, sexual harassment, mental health and sepsis.
- There was no nominated lead for sexual health as the practice referred patients to local NHS sexual health services. The SMO had received training in sexual health (referred to as STIF) in 2003. The practice nurse was trained in the C Card Scheme to provide sexual health advice to patients. Condoms and chlamydia kits were available at the practice.
- Patients had access to appropriate health assessments and checks. Searches of DMICP were undertaken for patients eligible for the national screening programmes and appropriate action taken if patients met the criteria. Ninety-seven per cent of eligible female patients had participated in the national cervical screening programme.
- 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:

- 93% of patients were recorded as being up to date with vaccination against diphtheria.
- 93.5% of patients were recorded as being up to date with vaccination against polio.
- 92% of patients were recorded as being up to date with vaccination against hepatitis B.
- 92% of patients were recorded as being up to date with vaccination against hepatitis A.
- 93% of patients were recorded as being up to date with vaccination against tetanus.
- 93.2% of patients were recorded as being up to date with vaccination against MMR.
- 98.7% of patients were recorded as being up to date with vaccination against meningitis.

**Consent to care and treatment**

The practice did not always follow the guidance on obtaining consent to care and treatment.

- We found that written consent had not been obtained for two patients who received minor surgery two years ago. The SMO advised us that the DPHC policy had been revised and strengthened in relation to consent and minor surgery since then. The physiotherapist had a consent form for acupuncture and injection therapy which was used for all patients receiving these treatments. A consent audit had not been undertaken.
- Staff had a good understanding of the Mental Capacity Act (2005) and how it could apply to their patient population group. Although not recorded, the clinicians we spoke with told us the SMO had provided training on this subject matter.

| **Are services caring?** | Good |
|---|---|

**We rated the practice as good for caring.**

**Kindness, respect and compassion**

Staff supported patients in a kind and respectful way.

- Throughout the inspection we observed staff were courteous and respectful to patients arriving for their appointments.
- Results and comments from the September 2019 patient experience survey showed patients were happy with how they were treated. For example, all patients (30 respondents) were satisfied with their care and treatment. The two patients we spoke with and the 23 CQC comment cards completed prior to the inspection were complimentary about the considerate and caring attitude of staff.
- 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. HIVE provided information about facilities available on the station and locally including civilian healthcare facilities.

**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.
- The patient experience survey showed all patients received sufficient information about their condition and were involved in decisions about their treatment options. The CQC patient

feedback cards indicated patients received information about their care to support them with making informed decisions.

- The practice proactively identified patients who were also carers, including through the new patient registration process. A register of carers was maintained and were five patients with a caring responsibility were identified. Alerts to highlight this were not used and were added to the patients' records during the inspection. Information for carers was outlined in the practice information leaflet and displayed in the patient waiting area.

**Privacy and dignity**

The practice respected patients' privacy and dignity.

- Screening was provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. Clinic room doors were closed during consultations.
- The layout of the reception area and waiting area meant that conversations between patients and reception would unlikely be overheard. If patients wished to discuss sensitive issues or appeared distressed at reception they were offered a private room to discuss their needs.
- The practice could not always facilitate patients who wished to see a clinician of a specific gender so patients could be directed to an alternative medical centre or PCRF if needed.

## 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 the patient population. For example, clinics could be organised to accommodate short notice deployments and additional audiometry clinics were held due to nature of the unit and exposure to loud noise.
- The patient experience survey indicated that all respondents would recommend the practice to family and friends. The two patients we spoke with said the practice was accommodating with meeting their appointment needs.
- An access audit as defined in the Equality Act 2010 was completed for the premises in July 2019. The building was old, dated and did not lend itself to ease of access for patients with a disability. The practice had made as much reasonable adjustment as possible. Concerns identified from the access audit had been added to the risk register and requests submitted for work to be undertaken to improvements.
- Equality and diversity information and posters were displayed, including the unit equality and diversity representatives contact details. All staff had completed the mandated equality and diversity training.

**Timely access to care and treatment**

Patients' needs were met in a timely way.

- The practice accommodated patients with an emergency need and staff advised us that no patients were turned away and would be seen on the same day. Routine appointments could

with a doctor could be accommodated within two or three days. Same day appointments were available with the practice nurse.

- The physiotherapist could provide urgent, routine and follow-physiotherapy appointments within one day. The SMO advised us that the wait for specialist medicals was minimal and these could often be accommodated on the same day.
- Non-attendance at appointments was monitored and the non-attendance rate was displayed in the patient waiting area.
- There was confusion about access to medical cover between 16:30 and 18:30 (referred to as shoulder cover) and before patients could access the NHS 111 service. Staff advised us shoulder cover was not available. The operations manager, who attended the inspection, confirmed that shoulder cover was provided by Catterick Medical Centre. Following this confirmation, the practice manager updated the practice information leaflet, answer phone message and signage on the front door was updated to reflect the change.
- Telephone consultations were available with clinicians. Home visits were not offered due to the small size of the clinical team. This had been added to the risk register in 2018. Staff were unaware of the new DPHC SoP regarding home visits. In response, the practice manager updated the practice policy during the inspection. They updated the practice information leaflet immediately after the inspection, which advised patients a home visit could be arranged depending on the availability of a doctor.
- A direct access physiotherapy (DAP) service was in place. A DAP audit was completed in July 2018 to determine trends and establish a baseline. The audit showed that just over 50% of patients were self-referrals. The requirement for a patient to have a previous appointment with a clinician had been reduced by just over 50%. A re-audit was planned for November 2019.

**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 and outlined in the practice leaflet to support patients with understanding the complaints process. The complaints procedure was displayed in clinical rooms for staff to access.
- The practice manager was the designated responsible person who handled all complaints. Complaints were managed in accordance with the DPHC complaints policy and procedure. Both written and verbal complaints were recorded on the complaints register.
- Any complaints and lessons learnt were discussed at the practice meetings. Changes to practice were made if appropriate and used to improve the patient experience. The complaints register showed no complaints had been were received since August 2018.

| **Are services well-led?** | Inadequate |
|---|---|

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

**Leadership capacity and capability**

The SMO and practice manager were the leaders for the practice and they had the experience and drive to deliver high-quality sustainable care. Achieving this was limited because of a division within the team.

- The SMO, practice manager, practice nurse and physiotherapist were civilians employed by the DPHC. This arrangement provided consistency for the practice especially as the RAP team was subject to deployment, including short notice deployment.
- We found evidence to confirm the team was not working effectively. Efforts to address this had been made by the leadership team, including escalation to the regional team. However, at the time of this inspection the matter remained unresolved. CQC have escalated the issue to the Defence Medical Services Regulator (DSMR).
- Although the SMO was overall responsible for the practice, the RAP team, managed by the RMO, were disengaged from many of the routine governance processes within the practice. For example, the RAP team did not routinely participate in the practice training programme, rather organised their own training. This meant the SMO, as clinical lead, had no oversight of the quality and consistency of training the RAP team received.
- Furthermore, the RAP team did not attend practice or clinical governance meetings. When available, the RAP team attended the weekly informal 'huddle' meetings, introduced to improve communication at the practice. Non-attendance at formal meetings meant the RAP team's understanding of practice governance processes and any change to these processes was limited.
- When reviewing the ASER tracker we noted a theme of significant events raised by DPHC staff regarding the relationship issues and fragmented communication within the team. For example, in August 2018 a significant event was raised as the RAP team was running separate clinics from those being provided at the medical centre. To improve communication, the team collectively developed a protocol for the management of force protection and clinical need in relation to deployments. Staff said this was working well.
- Communication between the doctors was not effective, which posed a risk to the provision of safe and effective care for patients. For example, the RMO attended the UHC meetings but there was no formal feedback mechanism in place for the RMO to inform the SMO of the outcome of these meetings. Furthermore, there was no clinical/peer review between the two doctors.
- The SMO and practice manager were clearly focussed on improving the service to provide the best possible service for their patients and make the best use of the limited clinical resources. This was reflected in the positive impact from the re-design of the sick parade clinic.
- DPHC staff spoke highly of the leadership team. They said the SMO and practice manager embraced change and demonstrated a collaborative approach to leading the practice and supporting staff. Furthermore, the team said they were well supported by the regional team even though they felt more could have been done to resolve the division within the team.

**Vision and strategy**

The practice worked to the DPHC vision of:

> *'Safe practice – by design'*

The aim of Newcastle Medical Centre was to:

> *'Deliver safe, effective, responsive and compassionate primary care; in support of the operational requirements of our PAR [population at risk]'*

- We found there were potential risks to delivering safe and effective care due to the division within the team.

**Culture**

The leadership team was inclusive and all staff were treated equally.

- DPHC staff described an open and transparent leadership style and said they would feel comfortable raising issues with the SMO and practice manager. They felt respected, supported and valued. Both formal and informal opportunities were in place so staff could contribute their views and ideas about how to develop the practice.
- The leadership team clearly demonstrated a patient-centred focus. Staff understood the specific needs of the patient population and tailored the service to meet those needs.
- Openness, honesty and transparency were demonstrated when things went wrong. A no-blame culture was evident; patient feedback and incidents were seen as opportunities to improve the service.
- The practice had systems to ensure compliance with the requirements of the duty of candour, including giving those affected reasonable support, information and a verbal and written apology. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.
- Leaders clearly demonstrated that the needs and welfare of staff were priority. Staff were encouraged and supported to be the best they could be through training and developing their skills. Supervision and appraisal was in place for all staff.

**Governance arrangements**

There was an overarching governance framework in place to support the delivery of good quality care. Improvement was needed to strengthen some of the systems.

- There was a clear staffing structure in place and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. Terms of reference (ToR) were in place to support job roles, including staff who had lead roles for specific areas.
- The practice worked to the health governance (HG) workbook, a system that brings together a comprehensive range of governance activities, including the risk register, significant events tracker, lessons learnt log, training register, policies, meetings, quality improvement and audit. Staff had access to the workbook which provided links to meeting minutes, policies and other information.
- Communication streams, such as the schedule of regular meetings were not fully effective. Although meeting minutes were maintained and circulated, they needed further development in terms of structure so staff not in attendance had access to clear information about what was discussed and agreed. National guidance, such as NICE, was not a standard agenda item at any of the meetings.
- Audit was a method used to measure the effectiveness of clinical and administrative practice. However, the audit programme was undeveloped as some key audits were missing, such as a minor surgery and a consent audit. Although an audit spreadsheet was in place with links to individual audits, there were gaps in recording audit recommendations and impact, the audit cycle and audit review date.
- The practice was subject to a regional governance visit in September 2019. The leadership team had been responsive to the findings and actioned many of the recommendations made, such as the of a forward-planning audit programme.

**Managing risks, issues and performance**

Processes were in place to identify, understand, monitor and address current and future risks including risks to patient safety.

- The practice manager maintained an active risk register which they reviewed each month. They were aware of the new DPHC risk SoP and the requirement to complete risk forms when transferring risks to region and or the Chain of Command.
- Processes were in place to monitor national and local safety alerts, incidents, and complaints.
- The leadership team was mindful of risks to the service. The main risks identified were staffing levels/recruitment and the infrastructure. During the inspection, the SMO referred frequently to a lack of resilience in the service, given the size of the service including the number of units and large reserve population. This risk was added to the risk register in 2004. The team was stretched further when the RMO made changes in 2018 to role of the medics within the practice. These changes placed additional work on the administrative team. A related near miss occurred which led to a significant event being raised.
- The SMO referred to a paper produced in 2014 that provided performance indictors to identify projected staffing levels to meet the patient population. Using the indicators, the SMO identified a shortfall in the number of doctors to provide a safe and effective service for the practice population, including both registered and non-registered patients. We saw evidence that these findings were emailed to the regional team in August 2018. The SMO was advised to submit a business case for an uplift in staffing. The business case was submitted in 2019 and we were advised no action had been taken at the time of the inspection.
- Strategies were in place to ensure sufficient clinical cover was in place. For example, the SMO coordinated their annual leave around the availability of the RMO. If the practice nurse was on leave then no nurse cover was available. All efforts were made to fill vacant posts so patient care was not compromised. Securing a locum doctor could be a challenge and this was added to the risk register in 2017. We noted there was a significant delay in the recently recruited ERI taking up post.
- The SMO was keen to ensure staff were multi-skilled. For example, a business case had been submitted for the practice nurse to undertake a prescribing course. Clinical staff advised us that the practice would benefit from regular input from a pharmacy technician.
- A system was in place to monitor performance target indicators. In particular the system took account of medicals, vaccinations, child health, cytology, summarising and non-attendance rates.
- A business continuity plan was in place and staff were familiar with the content. It was reviewed in May 2019.
- Procedures were in place for managing poor performance of DPHC staff. RAP staff were outside of the DPHC management structure so any concerns with their performance was raised with the regional team.

**Appropriate and accurate information**

The practice acted on appropriate and accurate information.

- The regional governance visit in September 2019 identified the eCAF was not being used. The eCAF was in use when we inspected the practice and all staff had access to it. It was reviewed

by the whole team each month. There were four outstanding actions active on the eCAF management action plan (MAP).

- The eCAF (Common Assurance Framework) is an internal quality assurance tool. The 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 defence healthcare.

**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. Although not displayed for patients to see, a patient experience survey was undertaken throughout the year. In addition, patients could leave feedback via through the suggestion box. The practice acted on patient feedback. For example, the location of the audiometry room was changed in response to feedback which suggested the booths were extremely hot.
- One patient participation group (PPG) had been held but discontinued as the participants had been ordered to attend. The practice was looking to develop a stronger social media platform and presence to seek patient feedback. It was awaiting access to a WIFI network in the barracks.
- A process of 360 feedback has been completed by the SMO and physiotherapist. Plans were established to continue with this and complete the process with all DPHC staff.
- Good and effective links were established with internal and external organisations including the welfare team, RRU, the DCMH, local NHS services and social services.

**Continuous improvement and innovation**

The SMO was the quality improvement lead and staff had been provided with quality improvement training. It was evident the practice team looked at ways to improve the service; both for the patient experience and to make best use of its limited resources. This was evident through the significant investment in the re-design of sick parade based on the Virginia Mason Model, which incorporated patient feedback as a measure when reviewing the impact of the change. In addition, the management of deployments protocol was identified as a quality improvement project (QIP). All QIPs were recorded on the HG workbook. The practice completed a biannual quality improvement report.