Newcastle Medical Centre

Albemarle Barracks, Near Harlow Hill, Newcastle upon Tyne NE15 0RF

Defence Medical Services Follow Up inspection

This report describes our judgement of the quality of care at Newcastle Medical Centre. It is based on a combination of what we found through information provided about the service, patient feedback and through interviews with staff and others connected with the service. We gathered evidence remotely in line with COVID-19 restrictions and guidance and undertook a short visit to the medical centre.

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

Contents

Summary

About this follow up inspection

We carried out this announced comprehensive follow up inspection on 28 and 30 June 2021. The report covers our findings in relation to the recommendations made and any additional improvements made since our last inspection.

We carried out a previous announced comprehensive inspection of Newcastle Medical Centre on 23 October 2019. The medical centre received an inadequate rating overall, with a rating of inadequate for the safe and well-led domains. The effective domain was rated as requires improvement and the caring and responsive domains were rated as good.

A copy of the previous inspection reports can be found at:

https://www.cqc.org.uk/sites/default/files/Newcastle_Medical_Centre_report_V5.pdf

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

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

At this inspection we found:

- A person centred culture was embedded to ensure patients received quality and compassionate care to meet their individual needs.
- Patients received effective care reflected in the timeliness of access to appointments, reviews and screening/vaccination data.
- The medical centre worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs.
- Multidisciplinary team meetings were held in the medical centre on a monthly basis, and care plans for complex patients drawn up jointly with other professionals to ensure the best care was provided.
- Although measures were in place to identify patients who were considered vulnerable, coding was not consistently applied to identify patients under the age of 18. Not all staff had completed the required safeguarding training.
- There was a safe system for the management of specimens and referrals.

- Medicines management was good except for one aspect in the management of Patient Group Directives (PGDs).
- To support assurance, the medical centre had full access to health and safety monitoring checks carried out by external partners. A range of risk assessments were in place for the medical centre.
- 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.
- Facilities and equipment at the medical centre were enough to treat patients and meet their needs.
- Staff were aware of the requirements of the duty of candour. Examples we reviewed showed the medical centre complied with these requirements.
- The medical centre had effective leadership although this was hindered by acute staff shortages. The leadership team were aware there were some shortfalls and had plans to address these. Staff worked well as a team and said they were well supported and included in discussions about the development of the service.

The Chief Inspector recommends:

- Ensure all patients deemed vulnerable have the correct coding applied on the clinical system (DMICP).
- All staff should be trained to the correct safeguarding level relevant to their role.
- Improve the infrastructure, facilities, cleaning arrangements and clinical waste management in line with the Health and Social Care Act 2008: ‘Code of practice on 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.
- The systems in place to accompany the safe use of acupuncture required improvement.
- The management of Patient Group Directives (PGDs) needed strengthening.
- Ensure that all staff can raise concerns and near misses through the ASER system.
- Develop the skills of staff to ensure they can carry out effective monitoring using DMICP.
- Safety within the PCRF should be reviewed and including a lone worker Standard Operating Procedure (SOP).
- Minor surgery outcomes to be audited.
- Formally review the need for the installation of a hearing loop.
- Up to date health promotion information should be made available in the waiting room.

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 inspector. The team comprised specialist advisors including a primary care doctor, a practice manager, a medical centre nurse, pharmacist, physiotherapist and an exercise rehabilitation instructor.

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 556 military personnel. 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 in the medical centre and provides personnel with a physiotherapy and rehabilitation service. The medical centre is open from 08:00 to 16:30 hours. 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

Doctors	One Senior Medical Officer (SMO)
Regimental Medical Officer (RMO)	One (unit asset non DPHC)
Practice manager	One
Nurses	One
Exercise Rehabilitation Instructors (ERI)	Three (unit assets non DPHC)
Physiotherapists	One
Administrators	Two

Pharmacy technicians	One
Medical Sergeant*	One (unit asset non DPHC)
Combat Medical Technicians* (CMTs)	Three (unit assets non DPHC)

*In the army, a medical Sergeant and CMT is a soldier who has received specialist training in field medicine. It is a unique role in the forces and their role is similar to that of a health care assistant in NHS GP medical centres but with a broader scope of medical centre.

Are services safe?

We rated the medical centre as requires improvement for providing safe services.

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

- safeguarding policy
- medicines management;
- Improving the infrastructure, facilities, cleaning arrangements and clinical waste management

At this inspection we found that some recommendations we previously made had been actioned. However, there were further areas that needed strengthening. Issues with the infrastructure remained the same but plans were in place for refurbishment in September 2021.

Safety systems and processes

- Improvements had been made to the adult safeguarding policies. The medical centre worked to the Defence Primary Care Healthcare (DPHC) Tri-Service safeguarding policies. A local safeguarding standard operating procedure (SOP) was in place and it included references to children, vulnerable adults and the elderly. It also included links to Unit Welfare Officers and local safeguarding teams. Staff interviewed during the assurance audit were fully aware of the policy, including how to report a safeguarding concern.
- The status of safeguarding and vulnerable patients was discussed at the monthly meetings with the welfare officer. In addition, the needs of vulnerable patients were discussed at the Unit Health Committee (UHC) meetings. We spoke with the Welfare Officer for the camp who told us they provided a welfare service to military personnel and dependents for matters such as home sickness, domestic abuse, sexual assault, self-harm, mental health, housing issues etc. They confirmed they had a good relationship with the medical centre and communication between the two was good.
- The SMO was the safeguarding lead with the medical centre nurse acting as his deputy. The SMO and ERI were trained to level 3. The practice nurse was only level 2 trained but this was being addressed with further training in the next few weeks to represent her role as the deputy.
- The team made weekly contact with all military personnel considered vulnerable. The team had a network of contacts with internal and local services such as the Multi-agency Safeguarding Hub (MASH) team and Sexual Assault Centre (SAC).
- The medical centre worked closely with Department of Community Mental Health (DCMH) and the army and unit welfare services.
- We were advised that coding was applied to clinical records to identify patients considered vulnerable. A monthly search of DMICP (electronic patient record system)

was undertaken to ensure the register of vulnerable patients and patients under the age of 18 was current. When we reviewed the vulnerable patient DMICP search we saw two clinical records that did not have the appropriate alerts in place. This meant that external clinicians accessing the patient records on DMICP may not know the patient was vulnerable.

- Staff acted as chaperones at the medical centre. Chaperone training had been conducted last in May 2021.There were lists of trained chaperones displayed in the clinical rooms and reception. There was a chaperone policy/SOP in place.
- The full range of recruitment records for permanent staff was held centrally. However, the medical centre could demonstrate that relevant safety checks had taken place for the majority of staff, at the point of recruitment, including a Disclosure and Barring Service (DBS) check to ensure staff were suitable to work with vulnerable adults and young people.
- Staff were up to date with their Hepatitis B vaccination and there was a Hepatitis B register available to view.
- A process was in place to manage infection prevention and control (IPC). The current IPC lead was the permanent medical centre nurse who was currently on maternity leave, they were appropriately trained and completed an IPC audit prior to maternity leave in May 2021. The current locum nurse has completed mandatory IPC training and was sufficiently experienced to carry out this role in their absence.
- Following the IPC audit a management action plan (MAP) was produced. Staff and the regional team identified the ageing infrastructure, including fixtures and fittings, were not fully compliant with IPC standards. Concerns with the building were identified on the issues register. Most of the non-compliance areas required infrastructure works which will be included in the building re-furbishment. These works had been delayed due to Covid-19 and are now scheduled for September 2021.
- Environmental cleaning was provided by an external contractor. The medical centre manager conducted a series of checks each Friday which were documented, and copies retained, this included cleaning monitoring to ensure cleaner check sheets had been completed and that the medical centre appeared to be clean. The cleaning contract did not include a deep clean but on the first Friday of each month a team of cleaning staff completed a higher level clean of the clinical areas over the lunch period. This included moving furniture to prevent build up in restricted areas.
- Healthcare waste was appropriately managed and disposed of. It was collected every four weeks. Consignment notes were retained at the medical centre, but a waste log was not in place. An annual waste audit was carried out in February 2021.
- Clinical waste was held in a lockable skip adjacent to the Medical Centre although this was not secured to the building and was not located in a lockable waste store.
- The medical centre had a Covid-19 SOP in place. Triage was in place to prevent symptomatic patients entering the building and appropriate emergency responses were in place.
- The audit log demonstrated a detailed summary of all IPC related audits. These were programmed, well-constructed, captured performance and recorded actions for improvement. The actions were clearly identifiable and included realistic deadlines.

- The practice informed us that no staff were currently providing acupuncture to patients. Acupuncture was historically undertaken by physiotherapy staff. Whilst there was no physiotherapist working at the medical centre at the time of the inspection the appropriate acupuncture SOP, risk assessment, patient information leaflet and written consent form were in place ready for the next clinician to uphold. We noted these were only in paper copy and not electronic.
- Although the SOP was in place, the written consent form for acupuncture was not always evident in DMICP records and there was no mention of air traffic controllers/aircrew on the consent form – (they should not control/fly for 12 hours post treatment).
- No acupuncture audit has been completed and no Read code (Read codes are a list of clinical terms to describe the care and treatment given to a patient) was used to identify records to enable an audit to take place.

Risks to patients

- Staff reported that current staffing levels were inadequate to meet the needs of the patient population. The Regimental Aid Post (RAP) staff were largely unavailable to support the delivery of primary healthcare due to unit commitments. The civilian SMO was the only doctor at the medical centre whilst the Regimental Medical Officer (RMO) was deployed, there was a permanent locum doctor available when needed. The physiotherapist post was vacant although currently being recruited for. At the time of the inspection there was no locum in place although one was scheduled to start the following week. The Band 6 nurse was on maternity leave and the locum nurse was scheduled to take leave and there was no cover in place for their planned absence. One of the administrative staff was on long term sick leave. At the time of the inspection the SMO was in discussion with the Regional Headquarters (RHQ) about a possible temporary closure of the facility due to poor staffing levels and increased clinical risk.
- The current locum nurse has been in post since March 2021 and came from a varied nursing background, they were currently upskilling in some of their Primary Care skills. They provided a safe service, but the effectiveness was reduced due to omissions in some aspects of their training. These areas included the ability to carry out DMICP searches and the management of some of the long-term conditions. In these areas the SMO took primacy, but this could be more appropriately devolved. It is understood that the previous permanent nurse undertook this activity. Distance support from the nearest medical centre was available and they were assisting with the cytology searches and administration. We noted that the SMO, pharmacy technician and PCRF staff were supportive and made themselves available to provide guidance and information when needed.
- At the last inspection the practice nurse highlighted that medicine management constituted a large proportion of their work and the practice would benefit from having a pharmacy technician in post. A pharmacy technician has now been employed and showed good understanding and management of medicines.

- Arrangements were in place to check and monitor the stock levels and expiry dates of emergency medicines. We saw evidence to show that an appropriately equipped medical emergency kit and trolley were in place and were regularly checked.
- The staff team was suitably trained in emergency procedures, including basic life support, sepsis and anaphylaxis.
- Improvements had been made to the layout in the waiting room so that patients could be seen whilst waiting.

Information to deliver safe care and treatment

- A process was established to ensure summarisation of patients' notes. Scrutinising was carried out opportunistically and when carrying out medication reviews.
- A peer review programme of clinicians' DMICP consultation records was undertaken in 2020 using a consistent methodology. We looked at a selection of these reviews and noted gaps in recording had been identified. We saw a peer review programme of nursing notes had been completed with high compliance found. Recommended actions were concise and provided enough depth to inform change if required. We reviewed 10 sets of nursing notes and they were of good quality.
- Co-ordinated by the administration team, an effective central system was in place for the management of both internal and external referrals.
- A good process was in place for the management of specimens. A record was maintained of all samples sent so when results were returned, they could be tracked, and any missing results identified.

Safe and appropriate use of medicines

The medical centre had systems in place for the safe handling of medicines. However, some improvement was still required to make them fully safe.

- Arrangements were established for the safe management of controlled drugs (CD), including destruction of unused CDs. We saw that monthly and quarterly checks were completed.
- Emergency medicines were easily accessible to staff in a secure area of the medical centre and all staff knew of their location.
- Medication requiring refrigeration was monitored twice a day to ensure it was stored within the correct temperature range.
- All staff who administered vaccines had received the immunisation training as well as the mandatory anaphylaxis training.
- All prescription pads were stored securely.
- Patient Group Directions (PGD) had been signed off to allow appropriately trained staff to administer medicines in line with legislation. The PGDs were current but were signed off incorrectly in that the authoriser had signed off on the authorisation sheet PGDs that

were listed as expired. Medicines that had been supplied or administered under PGDs were in date.

- Requests for repeat prescriptions were managed in person or by email, in line with policy. A process was in place to update DMICP if changes to a patient's medication was made by secondary care or an out-of-hours service.
- We saw evidence to show that patients medicines were reviewed regularly. The doctor's notes in DMICP were comprehensive.
- Processes for the management of high-risk medicines had improved. At the last inspection we saw no register was held. At this inspection we saw a process was established for the management of and monitoring of patients prescribed high risk medicines (HRM). The register of HRMs used at the medical centre was held on DMCIP and all doctors and relevant clinicians had access to this. We looked at a sample of patient records, we saw that all had been coded or had shared care agreements in place.

Track record on safety

- Measures to ensure the safety of facilities and equipment were in place. Electrical and gas safety checks were up to date. Water safety measures were regularly carried out with a legionella inspection undertaken in April 2020. A fire risk assessment of the building was undertaken annually. Firefighting equipment tests were current. Staff were up to date with fire safety training and were aware of the evacuation plan.
- A system for logging and monitoring the servicing of all clinical/non-clinical equipment was established, this included equipment in the PCRF.
- Although poor staffing levels in the medical centre were identified as their biggest risk, we were unable to see evidence of this on the risk registers shown to us on the day. Since the inspection the medical centre has provided evidence to show staffing levels had been identified on the up to date version of the risk register.
- The station major incident plan, dated March 2013, was held in the medical centre, and there was no role for the medical centre within it. The business resilience plan was reviewed in December 2020 and covered all key areas.
- The medical centre did not have a fixed alarm system but all clinical rooms within the main medical centre had handheld alarms in place. The alarms were last tested in 2020 and there was an SOP in place covering the use and response to an alarm being activated. Within the PCRF there were handheld alarms available but there was no lone working SOP in place.
- A COVID-19 risk assessment had been completed for the medical centre along with risk assessments for individual staff. The medical centre had developed an SOP in relation to COVID-19 and the use of personal protective equipment (PPE). The medical centre manager advised that this was regularly discussed with the staff team.
- Staff had the information they needed to deliver safe care and treatment to patients most of the time. If there is an unplanned DMICP outage, the medical centre would attempt to use laptops and Wi-Fi if it was a server issue. The SMO recently purchased

boosters for the WI-FIs to make connectivity easier. If DMICP could not be accessed at all, they would reduce to emergency patients only and packs of manual forms such as prescriptions were held in preparation of an outage. Although the clinics for the next day were not routinely printed, the practice manager at a nearby base (Boulmer) had access to Newcastle Medical Centres DMICP to provide information if required.

Lessons learned and improvements made

- All staff except for the locum nurse had access to the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events and incidents. The staff database showed that all staff had completed ASER training.
- From interviews with staff and evidence provided, it was clear there was a culture of reporting incidents from those staff able to access the system. Both clinical and non-clinical staff gave examples of incidents reported through the ASER system including the improvements made as a result of the outcome of investigations. An ASER log was maintained on the Healthcare Governance Workbook (HGW, a system that brings together a comprehensive range of governance activities) including any changes made.
- A system was in place for managing patient safety alerts. All alerts were received into the Group mailbox and forwarded to the pharmacy technician for action. There was a register on Sharepoint which detailed the alert and the action taken by the medical centre in response; the register was up to date. Safety alerts were a standing item on the agenda at the medical centre meetings.

Are services effective?

We rated the medical centre as good for providing effective services.

Following our previous inspection, we rated the medical centre as requires improvement for providing effective services. We found inconsistencies in processes for providing effective services including gaps in:

- the arrangements in place to ensure all staff had a forum to keep up to date with current medical centre and guidance;
- The arrangements for obtaining consent.

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

Effective needs assessment, care and treatment

- Improvements had been made to the arrangements in place to ensure staff had a forum to keep up to date with current medical centre and guidance. These included the weekly 'huddle' meeting, monthly medical centre meeting and daily clinical discussions. 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).
- 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 ERI used Rehab Guru, software for rehabilitation plans and outcomes, for exercise programmes for patients. They also referred to the Defence Rehabilitation website for best medical centre guidance.
- Staff were kept abreast of clinical and medicines updates through the DPHC newsletter circulated to individual staff and to the medical centre each month. Participation with regional events and forums also provided an opportunity for clinicians to keep up to date although this had been temporarily halted due to Covid restrictions.

Monitoring care and treatment

- Long-Term Conditions (LTCs) was currently managed by the locum nurse. However much of the administration and updating was carried out by the SMO. The SOPs outlining the management and monitoring arrangements for LTCs were in place. We looked at seven sets of patients' notes, they were comprehensive and in good order. Regular searches took place that demonstrated a thorough system consistent with good medical practice. The medical centre provided us with the following data:
    - The small numbers of patients on both the hypertension and diabetic registers were regularly monitored in accordance with best medical practice guidance. Processes were in place to identify and monitor patients at risk of developing diabetes, including through over 40s health checks.

  - Patients with a diagnosis of asthma had received an asthma review in the preceding 12 months.
  - Audiology statistics showed 68% of patients had received an audiometric assessment within the last two years. This number was reduced due to the impact of the pandemic and in line with DPHC policy.

- 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.
- We looked at the clinical records of patients currently receiving support from the PCRF. We saw that it took a holistic view of patients, including mood, sleep and lifestyle. Patients could be signposted to different outside agencies for further support and advice. We saw a simple yet effective example whereby a patient was sent home as they had not slept; recognising that rest and recovery is a priority for effective rehabilitation.
- We saw that referrals to the Regional Rehabilitation Units were made promptly with minimal wait time for the patient.
- An audit calendar was in place. We looked at the audits undertaken since January 2020, they included;
  - Antibiotic prescribing
  - Histopathology
  - Consent to minor surgery
- These audits tended to be more of a review style, for example, building a search, checking the patient records and implementing change, these were not written up formally to demonstrate improvements in outcomes for patients on a rolling basis.
- The doctor performs some minor surgery procedures, mostly skin tag, mole, cyst removals and cryotherapy. To date an audit has not been performed.
- The PCRF had undertaken a notes audit and a consent audit but there had been no clinical audits undertaken by the PCRF within the past two years, mostly due to lack of a permanent physiotherapist being in post.

Effective staffing

- The medical centre has implemented the DPHC induction programme which included role specific elements. The medical centre has enhanced the DPHC induction programme to include elements specific to Newcastle Medical Centre and had included links to relevant documents for reference.

- Locum staff completed the DPHC induction programme and we saw evidence of a completed induction programme for the current locum nurse.
- The SMO kept themselves updated with different training and was Military Aviation Medicine trained (MAME) in support of the air traffic controllers who work at RAF Spadeadam.
- The medical centre had a training calendar. At the last inspection there were concerns raised as the medical centre had no oversite of the training needs of the regimental staff working there. At this inspection we saw there was a record of mandatory training and compliance was good across the medical centre team except for one CMT that had been deployed since January 2021. The medical centre manager monitored compliance and discussed required training activity in the huddle meeting and included training links in the meeting minutes. Time was available to staff every Wednesday afternoon to complete mandatory training.
- All staff had received a yearly appraisal. We saw GP peer review had taken place in January 2021. There was no evidence of a physiotherapist or CMT notes audit or peer review, but this was due to lack of a physiotherapist and irregular CMT presence in the medical centre. The medical centre manager had implemented a programme of one to one interview between the SMO and clinical staff; allocating time on DMICP on Wednesday afternoons but she was not assured that these review sessions were utilised.
- The medical centre could demonstrate how it ensured role-specific training and updating for relevant staff. For example, for nurses and doctors on consent and Gillick competence (Gillick is a term used in medical law to decide whether a child under 16 years of age is able to consent to his or her own medical treatment, without the need for parental permission or knowledge).
- Staff administering vaccines had received specific training which included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to online resources and discussion at nurses' meetings.

Coordinating care and treatment

- The SMO attended the UHC meetings at which the health and care of vulnerable and downgraded patients was reviewed. The SMO had forged good safeguarding links with community teams.
- The PCRF communicated well with the medical centre both in person and electronically, they told us this worked well.
- For patients leaving the military, pre-release and final medicals were offered. During the pre-release phase the patient received an examination and a medication review. A summary print-out was provided for the patient to give to the receiving doctor, and a letter if the patient was mid-way through an episode of care. A structured mental health questionnaire was also completed.
- Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing

care and treatment. This included when patients moved between services, including when they were referred or after they were discharged from hospital. Information was shared between services and we saw that a full copy of findings from investigations and any further treatment requirements were sent to the medical centre to update the patient's records. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with more complex needs.

Helping patients to live healthier lives

- The medical centre nurse was the lead for health promotion and had had the appropriate training and experience in this field. We saw information leaflets about sexual disease (Chlamydia), antibiotics and the flu jab in the waiting area, leaflets were minimal in line with the fragmentary orders issued during the pandemic. Whilst we are aware of the orders given, we saw little evidence of laminated displays offering good health promotion advice and information. There was information for staff in clinical areas for example information about sepsis and anaphylaxis.
- The SMO also had the appropriate sexual health training and provided sexual health support and advise. Patients were signposted to local sexual health services for procedures not undertaken at the medical centre.
- Cytology is currently carried out by the nurses at Boulmer Medical Centre.
- Regular searches were undertaken to identify patients who required screening for bowel, breast and abdominal aortic aneurysm in line with national programmes. At the time of the inspection there were no patients identified that met the criteria for bowel screening.
- An effective process was in place to recall patients for their vaccinations. As a result of the COVID-19 pandemic and in accordance with DPHC FragO, routine immunisations were ceased, and remain so to date. Only operationally essential vaccinations were administered. This will have had an effect on the vaccination statistics, and figures should be considered with this in mind.

Vaccination statistics were identified as follows:

- 61% of patients were in-date for vaccination against polio.
- 82% of patients were in-date for vaccination against hepatitis B.
- 70% of patients were in-date for vaccination against hepatitis A.
- 61% of patients were in-date for vaccination against tetanus.
- 72% of patients were in-date for vaccination against MMR.
- 61% of patients were recorded as being up to date with vaccination against diphtheria.

Consent to care and treatment

- At the last inspection we saw the practice did not always follow the guidance on gaining consent, at this inspection we saw that improvements had been made. Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw evidence that showed consent for minor surgical procedures was obtained and coded appropriately on DMICP.
- Clinicians had a good understanding of the Mental Capacity Act (2005) and how it would apply to the population group. They had received training in mental capacity.

Are services caring?

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- We were unable to collate responses from patients using Care Quality Commission paper comment cards in order to comply with COVID-19 restrictions. However, we did speak with one patient whilst at the medical centre. This conversation was very positive about the service experienced. The patient praised the efficient way they had been helped as they were new to the area. We also observed staff being courteous and respectful to patients on the telephone.
- 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

- Patients identified with a caring responsibility were captured on a DMICP register, it included what had been discussed at the monthly practice/clinical meeting and any actions identified.
- We were advised patients usually identified themselves as a carer through the new patient registration form or when the Unit Welfare Officer shared this information with the medical centre. Alerts were added to all registered carers and they were offered flexibility with appointments.
- Staff explained that they occasionally saw patients who spoke English as a second language. They could access a translation service if they needed it. Staff told us about a recent instance where ‘The Big Word’ was used to provide a translation service during consultation.

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 medical centre 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?

Responding to and meeting people's needs

- The medical centre identified that the system referred to as 'sick parade', was delaying patients with appointments being seen (sick parade is when a patient turns up and waits to be seen without an appointment). The medical centre team decided to implement an appointment only system where patients were reviewed by a medic where they would also review Force health protection status and conduct audios and routine vaccinations whilst also addressing the condition for which they attended. This reduced the number of attendances, improved health protection and was popular with the patients. An audit showed improvement in prevented clinics overrunning and staff being overwhelmed.
- An access audit as defined in the Equality Act 2010 had been completed for the premises in October 2020.
- No hearing induction loop was in available on the premises. The practice assured us that this was currently not needed but no formal audit or search had been undertaken to clarify this.
- In response to restrictions associated with COVID-19, the first point of access for patients had moved to e-Consults with most consultations undertaken in this way. E-Consults were triaged by the duty doctor and actioned during the same session in which they were received. Dependant on the patient's clinical need, the option of a telephone or face-to-face appointment or e-mail reply could be offered.
- Telephone requests were added to a doctor's routine clinic as appropriate. Same day appointments were available. Patients under 18 were unable to access E-Consult so were advised to contact the medical centre by telephone to ensure they were triaged early and appropriately.
- Physiotherapy could be sought via the doctor or by a direct access physiotherapy (DAP) service available through self-referral. Patients were booked into telephone triage slots as referred patients. Routine and follow up physiotherapy appointments were available the following week as there was no physiotherapist in post access until then. An appointment was available within two working days to see an ERI. If a referral was urgent then patients could be seen at a nearby base instead.

Timely access to care and treatment

- The medical centre and dispensary were open Monday to Thursday 08:00-16:30 hours and on a Friday 08:00-16:00.
- Details of how patients could access the doctor when the medical centre was closed were available through the base helpline. Details of the NHS 111 out of hours service was in the medical centre leaflet.

Listening and learning from concerns and complaints

- The medical centre manager was the lead for complaints which were managed in accordance with the DPHC complaints policy and procedure. Written and verbal complaints were recorded and discussed at the medical centre meetings. A complaints audit had not been undertaken as there were only four complaints recorded. A trend analysis was outstanding on the risk register dated January 2021.
- The PCRF had no complaints recorded in the past 12 months.

Are services well-led?

We rated the medical centre as requires improvement for well-led.

Following our previous inspection, we rated the medical centre as inadequate for providing well-led services. We found inconsistencies in processes for providing well-led services Governance structures needed strengthening, embedding and to be understood by all staff. This included some formal communication processes, the clinical audit programme, the medical centre training programme, equipment management and the clinical review process for doctors

At this inspection we found that communication processes and governance had improved. The medical centre is now rated as requires improvement for providing well-led services.

Vision and strategy

- The medical centre worked to the DPHC vision of: ‘Safe medical centre – 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).

Leadership, capacity and capability

- The SMO and medical centre manager were the leaders for the medical centre, and they had the experience and drive to deliver good sustainable care. The leaders not only demonstrated managerial experience, capacity and capability, it was clear they had vision, passion with a focus on providing the best possible service for their patients. They clearly understood the medical centre priorities and demonstrated they had capability to drive service change for the benefit of patients.
- Staff told us there was an open culture within the medical centre and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Following the last inspection relationships with the Regimental Aid Post (RAP) team had improved. The SMO was overall responsible for the medical centre, the RAP team, managed by the RMO, were more engaged with the routine governance processes within the medical centre.
- Staff we spoke with told us that they enjoyed working at the medical centre and that the team approach was supportive. Most staff had worked from home during the pandemic combined with also providing on site services at the medical centre. Several staff had been deployed to assist with the national COVID response.

Culture

- Staff were consistent in their view that the medical centre was patient-centred in its focus.
- We heard from staff that the culture was inclusive with an open-door policy and everyone having an equal voice, regardless of rank or grade. All were familiar with the whistleblowing policy and said they would feel comfortable raising any concerns
- Processes were established 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. We were provided with examples of when duty of candour had been applied.

Governance arrangements

There was an overarching governance framework in place to support the delivery of good quality care.

- There was a clear staffing structure in place and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. Terms of reference (ToR) were in place to support job roles, including staff who had lead roles for specific areas.
- The medical centre worked to the health governance (HGW) workbook, a system that brings together a comprehensive range of governance activities, including 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. A limited programme of clinical and internal audit was in place.
- A comprehensive understanding of the performance of the medical centre was maintained. The SMO monitored achievement against clinical indicators and reported if there were areas which required focus.

Managing risks, issues and performance

- 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 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 enough clinical cover was in place. For example, the SMO coordinated their annual leave around the availability of the RMO. If the medical centre 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. A business case had again been raised for permission to be given to close the medical centre whilst staff are on leave as there was not enough cover.
- A system was in place to monitor performance target indicators. The system took account of medicals, vaccinations, child health, cytology, summarising and non-attendance. Risk to the service were recognised and logged on the risk register.
- Processes were in place to monitor national and local safety alerts and incidents, but these were underdeveloped and needed further work to ensure patient safety.
- Processes were in place for managing staff under-performance including external support for clinicians.

Appropriate and accurate information

- Quality and operational information was used to ensure and improve performance.
- There were arrangements at the medical centre in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. This extended to the PCRF.

Engagement with patients, the public, staff and external partners

- There were systems in place to encourage patients to provide feedback on the service and contribute to the development of the service. Due to COVID-19, options for patients to provide feedback while visiting the medical centre were limited. Patient experience surveys were uploaded directly to Governance Assurance Performance and Quality (GPAQ) with limited evidence for the practice to review. There were only 20 entries made between January and June 2021. Suggestions were largely unachievable such as tea and coffee in the waiting room.
- Good and effective links were established with internal and external organisations including the Welfare Officer, Regional Rehabilitation Unit (RRU), DCMH and local health services.

Continuous improvement and innovation

We identified that the medical centre had worked hard to continue to provide a good service over the last year despite many challenges, with staff clearly motivated to develop the service.