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, and information given to us from the provider and patients.

### Ratings

<table>
<thead>
<tr>
<th>Overall rating for this service</th>
<th>Requires improvement</th>
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<tbody>
<tr>
<td>Are services safe?</td>
<td>Inadequate</td>
</tr>
<tr>
<td>Are services effective?</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Are services caring?</td>
<td>Good</td>
</tr>
<tr>
<td>Are services responsive to people’s needs?</td>
<td>Good</td>
</tr>
<tr>
<td>Are services well-led?</td>
<td>Requires improvement</td>
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Date of inspection visit: 2/5/2017  
Date of publication: 27/7/2017
Letter from the Chief Inspector of General Practice

We carried out an announced inspection at Northwood Headquarters Medical Centre on 2 May 2017. Overall, the practice is rated as requires improvement. Our key findings across all the areas we inspected were as follows:

- There was an open and transparent approach to patient safety and a system in place for reporting and recording significant events.
- Systems and processes to keep patients safe were not embedded at the practice; infection control and equipment testing required closer management. Other governance processes were not promoting patient safety as a priority.
- Data showed patient outcomes in some areas were lower compared to the national average. For example, the management and recall of hypertensive patients and blood pressure control in diabetic patients.
- There was no evidence of quality improvement in patient services. A lack of clinical audit meant the practice could not demonstrate how they compared their performance to other practices either locally or nationally, or how they ensured that improvements in patient outcomes had been delivered.
- Patients were positive about their interactions with staff and said they had been treated with compassion and dignity.
- Staff were aware of current evidence based guidance. Staff had received most of the mandatory training required to provide them with the skills and knowledge to deliver safe care and treatment. However they had not all received updated training specific to their role.
- Results from the patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available. The practice investigated and acted on complaints received.
- Feedback from the 40 comment cards we received showed patients found it easy to make an appointment with a GP and there was continuity of care when possible, with urgent appointments available the same day. Two less positive comments related to onward referral for other treatments and the lack of continuity of care between GPs during a particular period of time at the practice.
- The practice had good facilities and was equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed
showed the practice complied with these requirements.

- The practice had a clear leadership structure. However, governance arrangements were not embedded. This impacted on the safety and effectiveness of the practice. Performance was not being monitored in all areas.

**The Chief Inspector recommends:**

- All staff receive training to carry out their duties effectively, including training specific to their roles.
- A rolling programme of clinical improvement work to be established to ensure that the best outcomes possible are achieved for patients.
- Systems are put in place to identify any patients who are also carers and provide support and sign post as required. Clinicians use data available to identify patients requiring review of their conditions. Patients to be recalled at the earliest opportunity.
- Patients who are eligible to be invited to NHS health screening where appropriate.
- Systems are put in place to assure that all test results have been picked up and actioned from mailboxes of clinicians who no longer work at the practice.
- Systems are put in place for daily testing and maintenance of medical equipment.
- The management of infection control be improved to include the establishment of cleaning schedules and monitoring systems and to meet the requirements of The department of health national infection control guidance.
- Sharps bins to be assembled correctly and all clinical waste, including sharps to be disposed of without delay in accordance with The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 and also HTM 07-01.
- All prescription pads are to be be held securely.
- Medicines to be disposed of when no longer required.
- Leaders at the practice ensures good management of clinician times to deliver best use of resources.
- Formal governance arrangements including systems for assessing and monitoring risks and the quality of the service provision to be embedded and understood by all staff.

**Professor Steve Field (CBE FRCP FFPH FRCGP)**  
Chief Inspector of General Practice
### The five questions we ask and what we found

We always ask the following five questions of services.

<table>
<thead>
<tr>
<th>Are services safe?</th>
<th>Inadequate</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice is rated as inadequate for providing safe services. Patients were at risk of harm because effective systems were not in place or embedded to ensure the delivery of safe care and treatment.</td>
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<tr>
<td>• Staff understood their responsibilities to raise concerns, and to report incidents and near misses. When things went wrong reviews and investigations were carried out.</td>
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<tr>
<td>• Although risks to patients were assessed, the systems to address these risks were not embedded. For example in the management of staff training relevant to their role, safeguarding and chaperone training, electrical equipment maintenance and checks, infection control, and some aspects of medicines management. There was no risk assessment in place covering the system for dispensing medicines at the practice. There was no complete Hepatitis B register for staff in place.</td>
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<tr>
<td>• The contract in place for the disposal of sharps from the practice was not being managed.</td>
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<tr>
<td>• The lack of clear governance systems posed risks to patients. For example, we saw that some pathology test results requested by clinicians who had subsequently left the practice had not been checked to see whether further action for patients was necessary.</td>
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<table>
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<tr>
<th>Are services effective?</th>
<th>Requires improvement</th>
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<tbody>
<tr>
<td>The practice is rated as requires improvement for providing effective services.</td>
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<tr>
<td>• Data shared with us before inspection showed patient health care could be improved, for example, the recall of hypertensive patients to have a repeat blood pressure check was significantly below the NHS target and the Defence Primary Healthcare average. There was therefore scope to improve the management of patients with hypertension.</td>
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Northwood HQ Medical Centre Quality Report 2/5/2017
relation to audiometric hearing assessments, 72% of patients had an up to date assessment, compared to the DMS regional average of 91% and a national average of 88%. The number of patients who were up to date with their diphtheria vaccination was lower than regional and national averages. The tight control of blood pressure in diabetic patients was another area needing improvement.

- Knowledge of and reference to national guidelines was inconsistent. For example knowledge of shared care agreements was limited. (A shared care agreement outlines suggested ways in which the responsibilities for managing the prescribing of a medicine can be shared between the specialist and general practitioner. Sharing of care assumes communication between the specialist, GP and patient.)

- There was no rolling programme of clinical review work to drive improved outcomes for patients.

- Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients’ needs. We saw positive examples of physiotherapist involvement at the earliest stages to aid recovery of patients with musculoskeletal injuries.

- The practice could not demonstrate role-specific training, for example, for medics on how to use testing equipment correctly.

- The practice was unable to demonstrate that infection control was effectively managed. This was due to ineffective contractual arrangements with clinical waste collectors and lack of specific infection control training for the infection control lead. The standard of cleaning at the practice fell short of those required for a primary health care setting. There were no cleaning audits in place.

Are services caring?
The practice is rated as good for providing caring services.

- Data from the DMS patient experience survey showed patients gave positive feedback for all aspects of care.

- Information for patients about the services available was accessible.

- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

- We received 40 comment cards, thirty eight of which were all positive about the standard of care received. Two less positive comments related to onward referral for other treatments and the lack of continuity of care between GPs.
### Are services responsive?

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population.
- Patients commented they found it easy to make an appointment and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available. No complaints had been raised since October 2017 but there were processes in place to show how learning from complaints would be shared and managed with staff and other stakeholders.

### Are services well-led?

The practice is rated as requires improvement for providing well-led services.

- The practice had a vision to deliver quality care and promote good outcomes for patients.
- An overarching governance framework supported the delivery of the vision and good quality care. However, this did not include arrangements to monitor and improve quality, identify risk and to capture patients who required follow-up in a timely manner.
- There was a clear leadership structure and staff said they felt supported by management. We found evidence that the management structure did not provide sufficient oversight to enable the very best use of resources, and to provide assurance around key areas of work within the practice.
- The practice had policies and procedures to govern activity and held regular governance meetings. There were standing agenda items three of which were chronic diseases, infection control and quality improvement. However, there was no evidence to show this was managed effectively and coupled with the lack of clinical audit and improvement focus, made it difficult for the practice to showcase effective management and quality improvement.
- Staff had received inductions, annual performance reviews and attended staff meetings. Evidence from staff interviews indicated these interactions had failed to identify learning gaps for some staff.
- The provider was aware of the requirements of the duty of candour.
- The partners encouraged a culture of openness and honesty. The practice had systems to effectively manage safety incidents, to share information with staff and ensure appropriate action was taken.
- The practice had proactively sought feedback from patients, staff feedback was sought through more informal processes and staff felt they had a voice. No formal staff survey was undertaken.
Our inspection team

Our inspection team was led by a CQC inspector. The team included a second CQC inspector, a GP specialist adviser, a practice nurse specialist adviser, and a practice manager specialist adviser.

Background to Northwood HQ Medical Centre

Northwood HQ Medical Centre is the home to Permanent Joint Headquarters and is responsible for the support of UK Military Operations worldwide. The population at Northwood HQ is in excess of 1900 and this figure changes on a regular basis due to operational tempo. The personnel located at Northwood HQ are UK Military Tri-service – Army, Air Force and Navy - and members of foreign military organisations.

The nearest hospital is Watford General Hospital, Vicarage Road, Watford, WD18 0HB. Dependants are not cared for by Northwood HQ medical centre, who can access services provided by NHS GP practices. Outside of practice hours, a 24 hour NHS advice line is available by dialling 111.

Why we carried out this inspection

The Care Quality Commission (CQC) carried out this inspection as one of a programme of inspections at the invitation of the Surgeon General in his role as the Defence Authority for healthcare and medical operational capability. Defence Medical Services (DMS) are not required to register with CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. Consequently DMS services are not subject to inspection by CQC and CQC has no powers of enforcement. However, where CQC finds shortfalls in the quality of services during inspection, we will report them by making a recommendation for action to the Surgeon General’s office.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice. We carried out an announced visit on 2 May 2017. During our visit we:

- Spoke with a range of staff, including two GPs and a GP registrar, the practice manager, deputy practice manager, the dispenser, a practice nurse, a health care assistant (known as a medic), a physiotherapist and two administrative staff. We were able to speak with one patient who used the service.
- Reviewed comment cards where patients shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.
To get to the heart of patients’ experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people’s needs?
- Is it well-led?
Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events. Staff told us there was a clear process for reporting and recording incidents. A recording form was available on the practice computer system. Staff said there was an open, no blame culture and added that they were supported through this reporting process.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events had been discussed. The practice had carried out a thorough analysis of the significant events. We saw evidence that lessons had been shared and action was taken to improve safety in the practice. For example, a patient who required a repeat prescription for a chronic disease was initially refused but following concerns raised and an investigation this was found to be incorrect and that prescription should be given. Learning was taken from this and shared with all staff.

Overview of safety systems and processes

The practice had clearly defined systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient’s welfare. There was a lead member of staff for safeguarding.

- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs and the nurse had received training to level three. We noted that one member of staff required an update on safeguarding training.

- A notice in the waiting room advised patients that chaperones were available if required. None of the staff who acted as chaperones had received any training for the role. We were told that no official training was currently available; however no bespoke in house training had not been undertaken by the practice to ensure patient safety. We were told of an occasion when the member of staff had stood outside of the privacy curtain when an examination had taken place. However they had all received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

We observed the premises to be clean and tidy. However,
• There were no current cleaning schedules and monitoring systems in place. The cleaning schedule in the treatment room showed that the last recorded cleaning took place in 15 May 2011. The practice nurse was the infection prevention and control (IPC) clinical lead, who had received on line training. However there was no evidence of any update training.

• All areas (including clinical) had only a daily clean, including those areas used for minor operations. The date of the last deep clean was not known. The practice was not adhering to the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance.

• Gloves, aprons, hand soap and gel were available around the medical centre and stored appropriately.

• Hand washing and sharps injury posters were in all clinical areas.

• There was no up-to-date infection control audit, with the last one being undertaken in August 2013.

• There was no complete Hepatitis B register for staff in place. The practice nurse had started it but was reliant on the current staff providing their own evidence as all staff files were held centrally and located at another base.

• Three sharps bins in the medical centre were found to be not securely assembled and therefore unsecure on closure throughout the medical centre.

• There were no waste management records, registers or consignment vouchers. There was no system seen for the management of the clinical waste. We found four, five litre buckets which were full of used sharps, but had not been collected. Two of these were not securely closed, presenting risk to the person removing or moving them.

There were arrangements in place for managing medicines, including emergency medicines and vaccines (including obtaining, prescribing, recording, handling, storing, security and disposal). However, some improvement was needed.

• Alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) were received into the practice by the dispenser, who circulated these to all staff. We looked at the most recent alerts and saw that the practice had shared them with staff and that no actions were required.

• There were no failsafe procedures for the review of high risk medicines. For example the monitoring of disease modifying anti rheumatic medicines which were initiated by secondary care. The practice said they took bloods regularly, checked the results, gave short prescriptions and put alerts on the clinical system but no system of formal recall or management was in place.

• Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred.

• The regional pharmacist was scheduled to carry out two monthly medicines checks but we did not see evidence of this or of audits to ensure prescribing was in line with best practice guidelines for safe prescribing.

• There was no risk assessment in place to assure the system for dispensing medicines at the practice and to mitigate risk. There was no ‘second checker’ in place. This meant patients would receive their prescription from the GP, and give it to the dispenser who would issue the required medicines. However, controlled drugs were checked with the GP prior to dispensing. The dispenser was not medically trained but had completed an NVQ II in dispensing.

• Blank prescription forms and pads were securely stored throughout the practice with the
exception of one room which was left unlocked when not attended. There were systems in place to monitor their use.

- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Some of these required review and signature by the incoming lead GP.

- The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had procedures to manage them safely. There were also arrangements for the destruction of controlled drugs.

- Records showed fridge temperature checks were carried out which ensured medicines were stored at the appropriate temperature. However, staff were not aware of the procedure to follow in the event of a fridge failure. We saw medicines stored in the fridge that were not used by the practice, for example children’s vaccines and prescriptions for individual patients that were over six months old that had not been collected and had not been disposed of.

- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date. The regional pharmacist visited every two months. We were told they audited the stock levels, prescription processing and dealt with any queries.

- It was unclear how effectively medicines were managed within the dispensary at the practice. The dispenser working on the day of inspection told us they performed a date check on stock monthly, and a full stock take annually. This staff member had been in post for 18 months. We noted there was a large bin in the dispensary, which was three quarters full of medicines. When asked we were told these were unused medicines for disposal. The dispenser we spoke with could not provide any paperwork detailing stock checks were performed.

- Where medicines prescribed were not held in stock, patients could send their prescription to a community pharmacy to be fulfilled. When we investigated this, we found an example of a patient waiting over one week for a medicine prescribed by a hospital consultant. We brought this to the attention of the practice manager in feedback at the end of the inspection day. We were told that instances such as this should be brought to their attention so they could authorise sending the prescription to a community pharmacy for fulfilment. This indicated that communication across the practice, and following of established protocol was not embedded. We also noted that the practice closed on Wednesday afternoon for staff meetings and training. The dispenser was only requested to attend these important communication meetings once a month.

- Recruitment checks had been undertaken on civilian staff prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

**Monitoring risks to patients**

There were procedures for assessing, monitoring and managing risks to patient and staff safety. However, not all were up to date.

- There was a health and safety policy available.

- The practice had an up to date fire risk assessment and carried out regular fire drills. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff should help patients vacate the premises.
Not all electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order. For example, the blood glucose monitoring machine in the “snatch bag” had never been control tested.

There was a portable air conditioning unit which was last used in 2016. Records showed it was last serviced in 2013.

The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients’ needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients.

When we reviewed the management of call and recall of patients, we found nursing time available was more than sufficient to meet patients’ needs, but that the management of the nursing clinics required attention.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements to respond to emergencies and major incidents.

- All clinical rooms had an alarm which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children’s masks.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.
Are services effective? (for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients’ needs. The practice monitored that these guidelines were followed, used risk assessment tools, and peer reviewed clinical records in occasional meetings.

Management, monitoring and improving outcomes for people

The practice used information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice. The system is used to measure some aspects of performance in NHS practices. The Defence Medical Services (DMS) have a responsibility to deliver the same quality of care as patients expect in the NHS. The QOF provided a useful way of measuring this for DMS).

QOF results from 2016, which were benchmarked against NHS targets for the year 2011/12 showed:

- There were 168 patients at Northwood eligible for cytology; The NHS England target for cytology in 2011/12 was 80%. By December 2016 the practice achieved 86%. This was also above the average achievement for Defence Primary Healthcare (DPHC) which was 80% by December 2016.

- The 2011/12 NHS England target for thyroid function tests in patients with hyperthyroidism was 90%. By December 2016 the practice achieved 100%, following a dip to approximately 82% in June 2016. This was above the average achievement for DPHC which was approximately 96% in 2016.

Information from the Force Protection Dashboard, which uses statistics and data collected from military primary health care facilities, was also used to gauge performance. Data from the Force Protection Dashboard showed that management of audiometric hearing assessment was below average for DMS practices regionally and nationally. 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). Data from December 2016 showed 1988 patients were registered as requiring an audiometric assessment data below shows:
• At Northwood practice 96% of patients had a record of audiometric assessment, compared to 99% regionally within Defence Medical Services (DMS) and 99% for DPHC nationally.

• At Northwood practice, 72% of patients’ audiometric assessment was in date (within the last two years) compared to 91% regionally within DMS and 88% for DPHC nationally.

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. The data below from December 2016 provides vaccination data for patients using Northwood practice.

• 99.5% of patients at Northwood practice had a record of vaccination against diphtheria, compared to 100% regionally within DMS and 100% for DPHC nationally.

Data for vaccinations against measles, mumps and rubella (MMR) combined showed:

• There were 601 patients who had a record of vaccination against MMR. 29% of patients at Northwood practice had a record of vaccination against MMR, compared to 57% regionally within DMS and 60% for DPHC nationally.

Data held on other vaccinations issued showed:

• 98% of patients at Northwood practice had a record of vaccination against Hepatitis B, compared to 99% regionally within DMS and 99% for DPHC nationally.

• 100% of patients at Northwood practice had a record of vaccination against Tetanus, compared to 100% regionally within DMS and 100% for DPHC nationally.

• 99% of patients at Northwood practice had a record of vaccination against Typhoid, compared to 92% regionally within DMS and 91% for DPHC nationally.

• Data from QOF performance for six key indicators reported against, up to December 2016, which were benchmarked against the NHS targets set for 2011/12, showed there were 10 patients registered at Northwood with diabetes.

• The percentage of patients with diabetes whose last measured total cholesterol (within the preceding 15 months) was 5mmol/l or less was approximately 67%, compared to the NHS target of 70% and the achievement of approximately 67% for DPHC nationally.

• The percentage of patients with diabetes in whom the last blood pressure reading (measured in the last 15 months) was 150/90 or less was 70%, compared to the NHS target of 72%, and the achievement of 87% for DPHC nationally.

• The percentage of patients with diabetes, in whom the last blood pressure reading (measured in the last 15 months) was 140/80 or less, was 39%, compared to the NHS target of 60%, and the achievement of 53% nationally for DPHC.

• There were 1491 patients recorded as having high blood pressure. The percentage of patients with hypertension in whom there is a record of their blood pressure in the past nine months was 70%, compared to the NHS target of 90% and the achievement of 86% for DPHC nationally.

• The percentage of patients with hypertension in whom the last blood pressure (measured in the previous nine months) was 150/90 or less was 49%, compared to the NHS target of 70%, and the achievement of 67% for DPHC nationally.

• The percentage of patients with long term physical or mental conditions, who smoke and whose notes contain a record that smoking cessation advice, or referral to a specialist service, (where available) had been offered within the previous 15 months was 60%, compared to the NHS target of 90% and the achievement of 70% for DPHC nationally.
From data provided, some groups of patients were particularly small, such as those requiring blood pressure monitoring due to diabetes. We saw that numbers of patients given in data, did not include figures on those patients excepted from checks or screening. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). Data provided to us did not explain which patients had been excepted.

The QOF data collection was not performed by the practice but was done centrally by Defence Statistics. There was no evidence that this was checked within the practice to ensure any exceptions were appropriate.

There was limited evidence of quality improvement including clinical audit:

- There had been four clinical audits commenced in the last two years, none of these were completed audits where the improvements made were implemented and monitored.
- The follow-up of patients whose test results showed their treatment regime may need adjusting, required greater attention. When we reviewed why patients had not been recalled as required, we found this was down to insufficiently managed recall systems rather than appointment availability and access.

**Effective staffing**

Evidence reviewed showed that not all staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- Staff had all received mandatory training in subjects such as fire, basic life support and infection control. However, the practice could not demonstrate how they ensured role-specific training and continual update training for relevant staff. For example, for those reviewing patients with long-term conditions there had been no disease specific training undertaken such as spirometry training or asthma update training. Some staff were undertaking checks of medical equipment but had not been trained to do so meaning the checks were not done adequately. We noted the work of the medic was overseen by the practice nurse, and the nurse was not adequately trained as an infection control lead.
- No staff were trained to chaperone although they did undertake these duties.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had 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 on line resources and discussion at practice meetings. However, there was currently only one nurse who could vaccinate, and there was a delay in vaccinating personnel. We were told this delay was up to three weeks. The practice nurse was responsible for checking vaccination competencies with all medics who have completed the two day immunisation and vaccination course. We were told the course was difficult to access and two other medics needed to attend. We were told that the medic, who had completed the theory part of the course six months ago, was yet to be signed off as competent. This presented as a further example of the work of the nurse not being effectively overseen and managed.
- We saw a machine used for hearing testing which staff used, however there were no records to
show that staff have been trained to use it.

- The medical centre was Yellow Fever registered and the practice nurse was up to date with training for this.

- The practice nurse maintained their own continual professional development. The practice nurse had initiated a clinical supervision group with other local units who met every three months to discuss topics of interest and best practice. The practice manager organised mandatory training and the practice nurse managed their own nursing update training. We were told there was no issue with being released for courses and or updates. The practice nurse was responsible for the treatment room medic. No documented evidence of any clinical supervision was available. The medic assessed all “fresh cases”. We noted that there was no peer review to discuss choices and treatments the medic may have pursued with basic triaged cases. This lack of competency assessment constituted a significant gap in clinical oversight.

- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. All staff had received an appraisal within the last 12 months.

**Coordinating patient care and information sharing**

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice’s patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.

- The practice shared relevant information with other services in a timely way, for example when referring patients to other services. We spoke with the administrator who undertook the booking of follow on appointments for patients including those that were required to have appointments made within two weeks of seeing their GP. There was a good system in place which enabled the patient to have their appointment made immediately after seeing their GP. There were also fail safe checks after the appointment by the administrator to ensure the patient had attended their appointment and a follow up letter had been received.

- 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, with patients’ consent, using a shared care record. However, knowledge of shared care agreements was limited. (A shared care agreement outlines suggested ways in which the responsibilities for managing the prescribing of a medicine can be shared between the specialist and general practitioner. Sharing of care assumes communication between the specialist, GP and patient.)

**Consent to care and treatment**

Staff sought patients’ consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and
- Guidance, including the Mental Capacity Act 2005.

- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

**Supporting patients to live healthier lives**

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.

The practice nurse kept an audit of the practice’s uptake for the cervical screening programme (2016); 52 patients attended for a cervical smear. None of the samples taken were rejected as inadequate.Staff had received training and update training. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Patients had access to some appropriate health assessments and checks but there were gaps in the system. Health checks for new patients and breast cancer checks took place. A monthly search was undertaken for all patients aged 50-64 years who would be entitled to breast screening and an appointment sent to them. However, the practice did not engage with all national screening programmes and had no mechanism to ensure that eligible patients were referred into the bowel cancer or abdominal aortic aneurysm (AAA) screening programs.
Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same gender.
- There was an accessible toilet in the waiting area.
- Baby changing facilities were available.

We received 40 comment cards, 38 of which were all positive about the standard of care received. Patients said they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect. Two less positive comments related to onward referral for other treatments and the lack of continuity of care between GPs.

We spoke with one patient. They told us they were satisfied with the care provided by the practice and said they were able to get an appointment when needed. Data received from the Defence Medical Services patient experience survey (February 2017) showed results from 54 returned surveys-

- 100% of patients that this applied to said the GP was satisfactory, good or very good at listening to them.
- 100% of patients that this applied to said they agreed or strongly agreed that they had confidence in the ability of the staffs' ability to provide care.
- 100% of patients that this applied to said they were treated with dignity and respect.
- 100% of patients that this applied to said they found the receptionists at the practice helpful.

This data was in relation to Northwood and we were not provided with any comparative data for us to use as a benchmark against.
Care planning and involvement in decisions about care and treatment

Patients commented in feedback provided on CQC comment cards that they felt involved in decision making about the care and treatment they received. They commented that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

Results from the DMS Patient Survey Experience showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example:

- 100% of patients that this applied to said the explanation given by the healthcare practitioner was good or very good.
- 100% of patients that this applied to said the health care practitioner was satisfactory, good or very good at involving them in decisions about their care.

The practice provided facilities to help patients be involved in decisions about their care:

- The practice dealt with patients from approximately 29 different countries and many of these patients did not have English as a first language.
- Staff told us that interpreter services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in reception.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients the choice of date and time for their first outpatient appointment in a hospital). This was undertaken with the patient so that they left the practice with their appointment time.

Patient and carer support to cope emotionally with treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations.
Are services responsive to people’s needs?  
(for example, to feedback)

Our findings

Responding to and meeting people’s needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- Patients were able to have 15 minute appointments with the GP and up to 30 minute appointments with the practice nurse.
- Same day appointments were available for those patients with medical problems that required it.
- Patients were able to receive travel vaccines when required. The practice was a yellow fever centre.
- Two physiotherapists were employed within the medical centre. In addition there was an exercise rehabilitation instructor who conducted classes in both the medical centre and in the gymnasium next door. All referrals to this service were made by the GPs and the average waiting time for an appointment was less than one week.
- There were accessible facilities, which included interpreter services when required.
- Transport for patients to hospital appointments was available if needed.
- Eye care and spectacles vouchers were available to service personnel from the medical centre.

Access to the service

The practice was open from Monday to Friday, between the hours of 8am and 6pm on a Monday, 8am to 4.30pm on Tuesday and Thursday and 8.30 to 12.30 on Wednesday and Fridays. A walk in ‘fresh case’ clinic was available between 8am and 8.30am every weekday.

No extended hours were offered. However, a GP was available to take telephone calls between the hours of 4.30pm and 6.30pm for routine calls, after the practice had closed and before the NHS 111 service could be used. Details of how patients could access the GP when the practice was closed were displayed on a sign outside of the practice and through the base helpline. Details of the 111 out of hours service was also displayed on the outer doors of the medical centre and in the practice leaflet.

Results from the DMS Patient Survey Experience showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example:
- 100% of patients that this applied to said their appointment was at a convenient time.
- 51% of patients said that their appointment was on time, 43% said they waited less than 15 minutes, 4% waited between 15-30 minutes and 2% waited more than 30 minutes.
- 98% of patients said they were satisfied with their access to routine care, 2% said they were not.

Patients told us on the day of the inspection that they were able to get appointments when they needed them.

**Listening and learning from concerns and complaints**

- The practice had a system for handling complaints and concerns.
- Defence Primary Health Care had an established policy and the practice adhered to this. The practice manager was the designated responsible person who handled all complaints in the practice. We saw that a complaints log had been implemented in October 2016 when the new practice manager took up post and since then no complaints had been received by the practice. Prior to this there was no complaints information available.
- We saw that information was available to help patients understand the complaints system.
Are services well-led?  
(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Requires improvement

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Our findings

Vision and strategy

The practice had a vision to deliver quality care and promote good outcomes for patients.

- The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values. The mission statement was “This practice is committed to provide the highest quality primary care health service to entitled personnel in order to enhance and sustain operational effectiveness”.

- The practice had supporting business plans which reflected the vision and values and progress against this was monitored.

Governance arrangements

On the day of our inspection, we found the practice did not have appropriate governance arrangements in place to support the delivery of good quality care, for example:

- A comprehensive understanding of the performance of the practice was not maintained and consistently shared with staff.

- A programme of continuous clinical and internal audit was not used to monitor quality and to drive improvements.

- Clinical audits did not demonstrate quality improvement. For example, there had been four clinical audits undertaken within the year, none of which were completed audits where the improvements made were implemented and monitored.

- There were insufficient arrangements in place for identifying, recording and managing risks and issues, and for implementing mitigating actions. For example, patients were at risk of harm because systems and processes were not in place, to effectively monitor and manage infection control, deliver role specific staff training and competence checks, and to effectively manage the clinical sessions of the practice nurse to ensure best possible use of their time.

- There was no risk assessment in place to assure the safety of dispensing arrangements, there was no audit trail of stock checks in the dispensing area.

- Contractual arrangements provided insufficient cover for removal of sharps waste from the practice.

- Our findings on inspection indicated that the DMS Common Assurance Framework (CAF) was being used as a self-assessment tool by practice managers, adopting a policy checking approach, rather than using the CAF as a management interrogation tool to check the integrity and stability of safety measures, designed to reduce the risk of harm to staff and patients using the practice. The CAF document did not accurately reflect the areas within the practice that we
We looked at the procedures used by GPs that should ensure test results were reviewed daily. We noted there was no clear system in place to ensure that test results were looked at in a timely way and no set processes for reviewing blood results of absent doctors (through leave or having left the practice). Inboxes were found with un-actioned results for clinicians, dates of these results ranged from May to Sep 2016. One was for a positive swab result which meant the patient concerned may have benefitted from treatment. We saw evidence that some test results had been seen and not filed; others were not actioned.

Systems were in place to monitor equipment alerts sent by the Medicines & Healthcare products Regulatory Agency (MRHA).

We saw evidence from minutes of meetings that sufficient time was allowed for lessons to be learned and shared following significant events and complaints.

**Leadership and culture**

We found that although on the day of inspection the GPs and management of the practice told us they prioritised safe, high quality and compassionate care we found leadership arrangements were not effective enough to ensure safe and high quality care.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (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). The practice manager encouraged a culture of openness and honesty.

The practice gave affected people reasonable support, truthful information and a verbal and written apology. However the issues we found on the day inspection with regard to unseen test results had gone unseen by the practice and therefore patients had not been notified nor followed up.

There was a clear leadership structure and staff felt supported by management.

- The practice held and minuted a range of multi-disciplinary meetings including meetings with social workers to monitor vulnerable patients.
- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported.

**Seeking and acting on feedback from patients, and staff**

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- Patients through the patient experience survey.
- Through complaints and compliments received.
- There was no formal staff survey undertaken although feedback from staff was gained generally
through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues.

**Continuous improvement**

The practice was a training practice. The teaching and support was embedded. We spoke with the registrar who was there on the day, they spoke highly of the support and level of teaching they received. However the gaps in governance should be addressed immediately in order that GP registrars are familiar with ‘what good looks like’.