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.

<table>
<thead>
<tr>
<th>Ratings</th>
<th>Overall rating for this service</th>
<th>Requires improvement</th>
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</thead>
<tbody>
<tr>
<td>Are services safe?</td>
<td></td>
<td>Inadequate</td>
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<tr>
<td>Are services effective?</td>
<td></td>
<td>Requires improvement</td>
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<tr>
<td>Are services caring?</td>
<td></td>
<td>Good</td>
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<tr>
<td>Are services responsive to people’s needs?</td>
<td></td>
<td>Good</td>
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<tr>
<td>Are services well-led?</td>
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<td>Requires improvement</td>
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Letter from the Chief Inspector of General Practice

We carried out an announced inspection at Woolwich Medical Centre on 18 January 2018. Overall, the practice is rated as requires improvement. Our key findings across all the areas we inspected were as follows:

- Staffing levels at the practice had been insufficient for a number of years with an over reliance on locum staff. There was no nurse working at the practice at the time of this inspection.
- With a female patient population of approximately 12% and the absence of a practice nurse, cytology was being outsourced to another defence medical centre.
- The arrangements for managing medicines, including obtaining, prescribing, recording, handling, storing, security and disposal in the practice minimised risks to patient safety.
- There was an effective process in place to monitor patients on high risk medicines.
- A system was in place for managing incidents and significant events. Staff were reluctant to report incidents so not all significant events had been reported and managed through the system.
- Infection prevention and control (IPC) measures at the practice were not sufficient. The IPC lead did not have the required training.
- Health and safety practices, and supporting processes, were underdeveloped. The lead for health and safety had not received training for the role.
- Arrangements for the management of clinical waste were not effective.
- Processes for identifying and monitoring vulnerable patients and patients who could be subject to safeguarding procedures were in place.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Mandated training for staff was not up to date, including safeguarding training.
- Clinical care for patients was person-centred and well managed. Patient feedback suggested the care was of a high standard.
- Effective medical cover was in place on weekdays between the times when the practice closed and NHS 111 commenced providing medical cover.
- The practice worked collaboratively and shared best practice to promote better health outcomes for patients.
- Quality improvement had been hampered by insufficient staffing levels. A programme of audit had recently been developed and all staff had been allocated an audit to complete. Quality initiatives had started and were based on population need.
• Staff had a good understanding of the Mental Capacity Act (2005) and how it applied in the context of the service they provided.

• Results from the Defence Medical Services 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.

• Patient feedback systems were in place for patients to provide their views about the service.

• Patients we spoke with said they found it easy to make an appointment and urgent appointments were available the same day.

• Staff said the service was well led and they felt engaged, supported and valued 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 privacy, dignity and confidentiality of patients was respected at the practice.

• Governance systems were underdeveloped.

The Chief Inspector recommends:

• A review of recruitment practices to ensure adequate staffing levels, staff competencies and skill mix are in place to meet patient population need.

• All staff receive training in significant event analysis and how to report events through the ASER system.

• A review of arrangements to ensure the practice complies with health and safety legislation and fire regulations.

• Review staff training to ensure staff are up-to-date with their mandated training, including safeguarding training at a level required for their role. Review role specific training to ensure staff are adequately trained to fulfil their role safely and effectively.

• Review the arrangements for infection prevention and control (IPC) to ensure it is in accordance with The Health and Social Care Act 2008 – Code of Practice on the prevention and control of infections and related guidance.

• Review how clinical waste is managed to ensure it complies with the Safe Management of Healthcare Waste Memorandum (HTM 07-01).

• Review the approach to risk management to ensure risk assessments and the risk register reflect the practice needs, are current and sufficiently detailed.

• Develop effective governance processes, including risk management systems and audit work to drive improvement.

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice
Summary of findings

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>
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<tbody>
<tr>
<td>The practice is rated as inadequate for providing safe services.</td>
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<tr>
<td>- A system was in place for reporting and recording significant events. Significant events were reviewed at team meetings so lessons were shared with the wider staff team. However, not all significant events had been reported through this system.</td>
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<td>- When things went wrong patients were engaged and received reasonable support, relevant information and an apology.</td>
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<tr>
<td>- Not all staff were trained to the appropriate level in child and adult safeguarding.</td>
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<tr>
<td>- Processes for identifying and monitoring vulnerable patients and patients who could be subject to safeguarding procedures were in place.</td>
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<tr>
<td>- Clinical risks to patients were assessed and well managed to minimise risks to patient safety. Patients on high risk medicines were closely monitored.</td>
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</tr>
<tr>
<td>- Infection prevention and control (IPC), health and safety and waste management arrangements at the practice were not sufficient.</td>
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</tr>
<tr>
<td>- Staffing levels at the practice had been insufficient for a number of years with an over reliance on locum staff. There was no practice nurse working at the practice at the time of this inspection.</td>
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<tr>
<td>- The practice had adequate arrangements to respond to emergencies and major incidents.</td>
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<tr>
<td>- Facilities and equipment at the practice were sufficient to treat patients and meet their needs.</td>
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<tr>
<td>- Patients could not be observed by staff in the waiting area in the event of a medical emergency.</td>
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Are services effective? Requires improvement
The practice is rated as requires improvement for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were above average.
- Practice staff assessed needs and delivered care in line with current evidence based guidance.
- Quality improvement had been hampered by insufficient staffing levels. A programme of audit had recently been developed and all staff had been allocated an audit to complete. Quality improvement initiatives had started and were based on population need.
- Standard operating procedures were either under review or were being developed to ensure they were current and reflected patient need.
- Patients were actively supported to live healthier lifestyles through a targeted and proactive approach to health promotion and wellbeing.
- All registered patient records had been summarised.
- Mandated staff training was not up-to-date and not all staff had received an induction and training specific to their role.
- There was evidence of appraisals for all staff.

**Are services caring?**

The practice is rated as good for providing caring services.

- Patients were treated with compassion, dignity and respect, and were involved in decisions about their care and treatment.
- The patient experience survey showed that patients were satisfied with the care and attitude of staff at the practice.
- Information for patients about the service was available and accessible. It was also available in other languages to meet the needs of the patient population.
- Systems were in place to maintain patient and information confidentiality.
- We received 48 comment cards and interviewed three patients. All of the feedback was positive about the standard of care received.
- Interpretors were available for patients if they required this service.
### Are services responsive?

The practice is rated as good for providing responsive services.

- Patients found it easy to make an appointment and urgent appointments were available the same day.
- Telephone consultations could be provided as an alternative to visiting the practice.
- Effective medical cover was in place on weekdays between the times when the practice closed and NHS 111 commenced providing medical cover.
- Physiotherapists were employed at the practice. All referrals to this service were made by the doctors and the average waiting time for an appointment was less than one week.

### Are services well-led?

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

- The practice had a vision and strategy to deliver high quality care and promote good outcomes for patients.
- Governance systems, including risk management and audit, were underdeveloped due to inadequate staffing levels and inconsistent leadership over a number of years.
- Staff described how consistent leadership over recent months had led to more structure and stability. They felt engaged, supported and valued in the workplace.
- Regular practice and multi-disciplinary team meetings took place, which supported effective communication and shared learning within the team.
- The practice was aware of and complied with the requirements of the duty of candour. A culture of openness and honesty was promoted at the practice.
- The practice sought feedback from staff and patients, which it acted on.
Our inspection team

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

Background to Woolwich Medical Centre

Located just outside Woolwich Garrison, the medical centre occupies the ground floor of a two storey building. The centre provides routine primary care to service personnel, some of whom are subject to operational deployment at any time. Comprising two major units and 12 minor and reserve units, the patient list was approximately 900 at the time of inspection. The age range of the population was from 17 years upwards. Approximately 12% of the population was female. Dependants of personnel are not catered for at the medical centre and are signposted to a number of local NHS GP services.

In addition to routine doctor services, the medical centre offers emergency appointments each day, occupational health, force preparation for deployment, access to cervical screening and course medicals. Smoking cessation, weight management, well-person checks and sexual health promotion are available. A physiotherapy team is located within the medical centre.

At the time of the inspection, the medical centre staff team comprised a full time Senior Medical Officer (SMO), a full time practice manager, a full time receptionist and a part time physiotherapist. A full time practice nurse was on maternity leave. Their post was not filled at the time of the inspection. Although not employed at the medical centre, the practice was supported by a Regimental Medical Officer and combat medical technicians who were attached to the two major units.

The medical centre was open from 07:30 to 16:30 Monday, Tuesday and Thursday (closed from 12:30 to 13:30), and Wednesday and Friday from 07:30 to 12:30. The arrangements for access to medical care outside of opening hours were outlined in the practice leaflet and directed patients to contact NHS 111 or to attend the Queen Elizabeth Hospital accident and emergency department. Shoulder cover was provided between the hours of 16:30 and 18:30 by RAF Northolt Medical Centre.

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 inspection on 18 January 2018. During the inspection we:

- Spoke with a range of staff including the SMO, two combat medical technicians (CMT), the practice manager, physiotherapist, locum civilian doctor providing cover that day and the receptionist.
- Spoke with three patients who were attending the practice during the inspection.
- Reviewed 48 comment cards completed by patients who shared their views and experiences of the service.
- Looked at information, including patient records and information the practice used to deliver care and treatment.
- Looked at information used to monitor the quality and safety of services.

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 an established system in place for reporting and managing significant events. Our findings show that not all incidents or events were appropriately reported and processed through this system.

- The senior medical officer (SMO) was the lead for risk, including significant events. The standardised Defence Medical Services (DMS) wide electronic system (referred to as ASER) used for the reporting, investigation and learning from significant events, incidents and near misses was not being used effectively. During the inspection we heard about incidents and events that met the criteria as a significant event but had not been reported through the system. The SMO advised us that staff were reluctant to report significant events and was working with the team to change this culture.

- We noted since October 2017 that the significant events recorded were subject to analysis and lessons learnt identified. For example, numerous out-of-date items were found on the medical emergency trolley, despite a check of the trolley the previous day by clinical staff. As a result, the SMO revised the protocol and facilitated staff training. Managerial checks of the trolley were increased to be carried out by the SMO and practice manager. Meeting minutes showed that significant events were discussed at the monthly practice meetings and lessons learned shared with the wider staff team.

- A sentinel event had been raised through the ASER system and the SMO was actively involved with the unit and other military departments in undertaking a root cause analysis of this event.

- We reviewed safety records and national patient safety alerts, including the minutes of meetings where these were discussed. National patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) and the Department of Health Central Alerting System (CAS) were received to the group mail box, which was monitored daily. They were logged and staff said they were discussed at either the weekly diary meetings or practice meetings.

- When unintended or unexpected safety incidents happened, patients received reasonable support, truthful information, a verbal and written apology and were advised about any action taken to improve processes in order to prevent the same thing happening again. The SMO advised us that staff received a tutorial in relation to their responsibilities in relation to Duty of Candour.

Overview of safety systems and processes

Not all systems were effectively developed or consistently used to keep patients safe and
safeguarded from abuse.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Information was displayed and included contact details of designated safeguarding teams in the local area.

- An alert could be placed on a patient’s record to identify if they were vulnerable. The practice manager conducted searches to monitor the alerts. The SMO had a good working relationship with the welfare team and met informally with the welfare officer on a regular basis to discuss any concerns. The SMO also attended formal meetings with the unit commanders, which provided a forum to discuss the needs of vulnerable personnel. Registers of vulnerable personnel were held by each unit and discussed at the unit meetings. The practice did not have a formal register to log vulnerable patients. Shortly after the inspection the SMO confirmed a practice level register had been developed.

- The SMO was the lead member of staff for safeguarding. Their level three training in safeguarding had expired and the refresher training they were due to attend had been cancelled. They were awaiting a new date for this training.

- The staff we spoke with demonstrated they understood their responsibilities in relation to safeguarding. They had received training appropriate to their role regarding the safeguarding of children and vulnerable adults.

- Information was displayed advising patients that a chaperone was available if required. Staff who acted as chaperones were trained for the role and had 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.

- A system was in place for monitoring the progress of patient referrals to secondary care services. Any delays noted were followed up. In addition, a process was established for managing tests and/or samples to ensure results were received in a timely way.

- The practice manager was the lead for infection prevention and control (IPC). Besides the basic online mandatory IPC training, they had not undertaken any additional training to effectively fulfil the role of IPC lead. A Health Governance Assessment Visit (HGAV) by regional headquarters (RHQ) in December 2014 identified that an IPC audit had not been undertaken.

- Two IPC audits had been completed for the practice; one in November 2015 and one January 2018. The latter was undertaken by a practice manager from another medical centre with the required IPC training. It was incomplete as compliance outcome scores were not identified and an action plan to address the areas of deficit had not been developed. In the absence of these, we scrutinised the content of the audit and noted a number of areas that required action. For example, a formal IPC policy was not in place, no previous IPC audits had been undertaken, a deep clean had not taken place and the flushing of clinical taps was being undertaken annually rather than weekly.

- The IPC audit also identified that carpets in two clinical areas needed to be removed. We observed a number of large floor vents in clinical areas. Staff were not sure what the vents were for. We observed a build up dirt and debris on the ground inside the vents. The coved skirting was not flush with the wall in all clinical areas creating a trap for dirt. The SMO advised us that funding had been agreed to replace the flooring. No date had been identified for this work to start. There was a malodorous smell in the female staff changing room. This had been reported and investigated but no source for the smell was identified.

- A legionella risk assessment had been undertaken by an external company and was last reviewed in June 2015. The same company carried out safety checks of the water temperatures each month. Legionella is a term for a particular bacterium which can contaminate water
- Environmental cleaning was carried out by an external company twice a day. The practice was clean and tidy when we inspected. Environmental cleaning equipment was used and we observed that it was stored in accordance with national guidance.

- Arrangements for the management of waste, including clinical waste were not effective. The practice did not hold a copy of the waste management contract or consignment notes as they were retained by the external company responsible for the health and safety of the barracks. The practice manager said they had requested these documents on numerous occasions without success. Clinical waste was not stored in the correct receptacles and this had been identified in the IPC audit; the practice manager was following this up. A waste audit had not been undertaken at the practice.

- All single use items were stored appropriately and were within their expiry date. Specific equipment was cleaned daily and daily logs were completed. Spillage kits were available.

- Effective arrangements for managing medicines, including emergency medicines and vaccines, were established to keep patients safe. The SMO was the medicines management lead for the practice. Policy and procedures were in place, including arrangements for obtaining, prescribing, recording, handling, storing and the security of medicines. The practice did not have a dispensary.

- Prescription pads were securely stored and there were systems in place to monitor their use. In the absence of a practice nurse, the cold storage unit for vaccines was monitored twice a day by a combat medical technician (CMT) to ensure temperatures were within the correct parameters. A small back-up fridge was available in the event of the main fridge failing.

- The CMTs administered vaccines in pairs in accordance with a Patient Specific Direction (PSD) from the SMO. A PSD is a recorded prescriber instruction for a medicine for a named patient, including the dose, route and frequency.

- The regional pharmacist visited twice a year to audit prescribing patterns. No concerns had been raised from these audits. An effective system was in place to monitor patients on high risk medicines. There was just one patient prescribed a high risk medicine and effective arrangements were in place to manage this, including a line of communication between the SMO and the secondary care consultant. The patient was coded correctly to reflect the use of the medicine.

- The full range of recruitment records for permanent staff was held centrally. However, the practice manager could demonstrate that relevant safety checks had taken place at the point of recruitment, including a Disclosure and Barring Service (DBS) check to ensure staff were suitable to work with vulnerable adults and young people. DBS checks were renewed every five years. A system was in place to monitor each clinical member of staff’s registration status with their regulatory body. They confirmed all clinical staff had professional indemnity cover. Information was in place to confirm staff had received all the relevant vaccinations required for their role at the practice.

- Stable staffing levels and an appropriate skill/competency mix had been identified as a risk for a number of years. At the time of the inspection there was an insufficient and inconsistent range of clinical staff to meet population need. The practice nurse had been on maternity leave since July 2017. A locum nurse had been appointed but they were no longer working at the practice. The practice received clinical support from the RAP (Regimental Aid Post) team. A RAP is a front line military medical asset that is the property of a military unit. Staffing of a RAP can include a medical officer, nursing officer and CMTs. In the army a CMT is a soldier who has received specialist training in field medicine. It is a unique role in the forces and has greater scope than that of a health care assistant found in NHS GP practices. Because RAP personnel
are not employed by the medical centre then the practice has no control over their terms and conditions, including the hours they work. This can lead to unpredictable and inconsistent staffing levels.

**Monitoring risks to patients**

Some risk management processes needed to be developed and/or reviewed to minimise the risks to patients and others.

- Policies and procedures were in place in relation to the management of risks at the barracks, including a health and safety policy. The practice manager was identified as the lead for health and safety but they had not undertaken specific training for the role. There was no formal assessment in place for the medical centre that took account of health and safety, including staff training, risk assessments, equipment and the environment. Risk assessments specific to the medical centre, such as those in relation to lone working and document storage were either in the process of being developed or under review.

- A risk register was established for the practice and health and safety was a standard agenda item at the practice meetings. We noted it lacked information in relation to a detailed description of mitigation and/or control measures. Review dates for each risk were not identified.

- The fire safety risk assessment and quarterly checks were arranged by the station. Mandated fire training had been completed by all staff. We observed fire doors held open with door wedges throughout the inspection. There were no records in place to show if a fire drill had taken place.

- Staff were aware of their role in the reporting and management of incidents, including how to report in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). Such incidents were reported through the ASER reporting system.

- The station was responsible for the electrical and gas safety of the building. The last gas safety check took place in July 2017. The periodic electrical test was up-to-date. Portable electrical equipment was checked on a regular basis to ensure the equipment was safe to use.

- We noted that the layout of the practice meant not all patients in the waiting area could be observed by reception staff. Shortly after the inspection the practice manager confirmed a mirror had been installed in the waiting area so the waiting area could be observed from all angles. The lighting in clinical areas was not effective or safe as it was reactive to sunlight and could automatically switch on or off when a patient was receiving treatment. For example, it would automatically switch on when a clinician was undertaking a vision test and requiring a dark environment.

- Clinical equipment was checked in line with Defence Primary Health Care (DPHC) policy to ensure it was working properly. Equipment was checked six-monthly and the last check took place in January 2018.

- A triage system was in place for patients who presented without an appointment (sick parade). The CMTs undertook the triage and liaised with the SMO if needed. If a patient needed to be seen outside of sick parade then the practice reviewed the diary to see if appointments were available. Patients were always seen on the same day if their health need was assessed as urgent.

**Arrangements to deal with emergencies and major incidents**
The practice had arrangements in place to respond to emergencies and major incidents.

- There was an emergency alarm system installed at the practice and it was tested regularly to ensure it was in working order.

- A resuscitation trolley was in place and records confirmed it was checked monthly and all items were in-date. It included the appropriate equipment and emergency medicines as described in recognised guidance, including oxygen. The staff training records provided assurance that all staff received basic life support training on an annual basis.

- Reviewed in January 2018, the business continuity plan took account of major incidents, such as power failure or building damage. The plan included emergency contact numbers for staff. A copy of this plan was available in the practice manager’s office and in reception.
Are services effective?
(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in accordance with relevant and current evidence based guidance and standards.

- Doctors were aware of evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE). They received NICE and other guidance updates by email and through the monthly newsletters circulated to practices by the Defence Primary Health Care (DPHC) service. If appropriate the guidance was discussed at practice meetings.

- Doctors referred to NICE and the BNF (British National Formulary) page for chronic disease management. We were provided with a number of examples whereby NICE was taken into account in relation to treatment for patients. For example, in response to NICE hypertension guidelines the SMO provided training to the CMTs.

Management, monitoring and improving outcomes for people

In the absence of a practice nurse, the SMO assumed the lead for the management of long term conditions. 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. It is used across many 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 provides a useful way of measuring this for DMS. Because the numbers of patients with long term conditions are often significantly lower at DMS practices, we are not using NHS data as a comparator.

The practice provided the following examples of patient outcomes data to us from their computer system on the day of the inspection.

- There were no patients registered at the practice with diabetes.
- There were 12 patients recorded as having high blood pressure. We reviewed the treatment and care offered to these patients and found that current NICE guidance had been followed. 80% had their blood pressure recorded in the past nine months. Of these patients with hypertension, nine had a blood pressure reading of 150/90 or less.

- The number of patients with long term physical or mental health conditions, who smoke and whose notes contained a record that smoking cessation advice or referral to a specialist service had been offered within the previous 15 months, was 88 which is 73% of the smoking patient population. The NHS target for this indicator is 90%. The absence of a consistent practice nurse
meant the practice was not in a position to deliver smoking cessation to patients.

- There were 14 patients with a diagnosis of asthma. We reviewed the treatment and care offered to these patients and found that current NICE guidance had been followed. Of these, 11 had received an asthma review in the preceding 12 months which included an assessment of asthma control using the 3 Royal College of Physicians questions.

- There were eight patients with a new diagnosis of depression in last 12 months. All had been reviewed within 10 to 35 days of the date of diagnosis.

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 instance of audiometric hearing assessment was above average compared to 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 July 2017 showed:

- 98% of patients had a record of audiometric assessment, compared to 96% regionally within DMS and 99% for DPHC nationally.

- 98% of patients’ audiometric assessments were in date (within the last two years) compared to 96% and 86.3% for DPHC nationally.

The SMO advised us that quality improvement, including clinical audit was underdeveloped at the practice due to a significant shortage of staff and the on-going reliance on locum clinical staff. We had access to the audit database, which showed gaps in the clinical audit programme. Since the SMO took up post in September 2017 audit activity had started. First cycle audits completed were identified as follows:

- A cervical screening audit was undertaken in October 2017 involving a review of patient records to ensure a cervical smear was in-date, a recall date identified and the correct coding was used. This audit was undertaken as a priority as one sub unit of Woolwich Garrison has a female population of over 50%, which the SMO described as particularly high for the military. In the absence of a practice nurse, cytology was being undertaken by another defence medical centre. The SMO had put measures in place, including regular checks and searches, to minimise the risk of patients being missed. Even with these failsafes, the SMO deemed it appropriate for the outsourcing of cytology to remain on the risk register.

- A hypertension audit was completed in December 2017 which sought to identify patients whose blood pressure exceeded 140/90. Patient records were reviewed to ensure appropriate follow up, coding and/or investigation were undertaken. In the absence of a practice nurse, the SMO provided the guidelines and training for the CMTs to ensure they were monitoring and managing blood pressure correctly. We spoke with two CMTs and they clearly understood the guidelines for monitoring and managing blood pressure.

- The regional pharmacist carried out six-monthly prescribing audits to ensure adherence to the prescribing formulary. The SMO confirmed there was no off-licence prescribing.

- The SMO understood the patient profile and was in the early stages of developing two quality improvement initiatives based on population need. The practice provided a service to the King’s Troop, Royal Horse Artillery unit so the practice managed a large number of horse-related injuries. The SMO had met with a select group of the patient population to provide advice and guidance on working with horses in order to reduce the number of injuries. Because of the high female population, the SMO was focussed on addressing female health. They had met with a specific population group to provide information and advice on CASH (Contraception and Sexual Health).
Monitoring arrangements were in place to check that standard operating procedures (SoP) continued to meet the needs of the practice and its patients. The SMO had reviewed the local protocols/SoPs and identified a number that needed to be developed. These included over 40s and over 50s health checks, cervical screening and a new patient checks.

The CAF internal quality assurance tool was used to monitor safety and performance. The CAF was formally introduced in September 2009 and since that time has been the standard healthcare governance assurance tool utilised by DMS practices to assure the standards of health care delivery within DMS. The current CAF we were provided with (undated) showed areas of partial compliance for Domain 2 (clinical effectiveness) in relation to audit and staffing (fit for role). This was similar to our findings.

Effective staffing

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

Although the practice had a generic induction programme for all newly appointed permanent staff, work was in progress to include a role-specific induction programme for staff. We were not provided with evidence to show that an induction pack had been completed for all staff, including locum staff.

The practice manager monitored the status of staff mandatory training and updates were provided at practice meetings. Not all staff were up-to-date with their training and this was in relation to the RAP staff who were providing health care support to the practice. The practice manager had been following up the training deficits in the RAP mandatory training requirements with the unit commanders.

Relevant competency checks were undertaken before staff engaged in practice or a procedure that was new to them. The CMTs were undertaking additional tasks in the absence of a practice nurse. They described how the SMO provided training and guidelines for each task and monitored their performance to ensure they were safe. For example, CMTs administered vaccines and had received specific training including an assessment of competence.

Protected time was allocated each week for training and continual professional development (CPD). Staff received role-specific training where appropriate. Peer review and CPD opportunities were available for doctors in the form of internal and external events. For example, the SMO and doctors attended a clinical meeting with all DPHC doctors in the Central London area on a two weekly basis.

Doctors had received training regarding the application of 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 who acted as chaperones had received training.

The learning and support 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

There were well managed systems in place to ensure effective coordination of patient care.

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. The DMICP system was used for managing patient records. Read coding, a system used to support clinical coding of patient details, including diagnosis, was used by all clinical staff with access to patient records. The sample of anonymised patient notes we looked at was of a very high standard. Notes included risk assessments, care plans, consultation records and investigation/test results. There was an appropriate summary screen of patients’ health needs on DMICP.

- Multi-disciplinary (MDT) meetings took place on a monthly basis with the chain of command and involved representatives from the practice, including the rehabilitation team. These meetings looked specifically at the health and fitness of service personnel, including the patient sick list. In addition, quarterly unit health committee meetings were also established and they had a broader remit, such as participation of the welfare team. The SMO attended these meetings.

- When patients moved or were deployed their medical records were transferred electronically. Summarisation of records was the responsibility of the practice nurse. In the absence of the practice nurse, the RAP nursing officer had been undertaking the summarisation, including a review of Read codes. Read codes, are the standard clinical terminology system used in NHS medical practices in the UK. They provide a standard vocabulary for clinicians to record patient diagnoses, treatment and procedures.

- The practice had a pro-active approach to monitoring the status of vaccinations. A monthly search of DMCIP was undertaken by the CMTs to assess the status of force protection. Any outliers in terms of vaccinations were reported to unit commanders each month. They were also discussed at the unit health committee meetings, which the SMO attended.

- We found the practice managed information from other services in an efficient way. For example, any external correspondence, such as NHS 111 feedback, laboratory results and secondary care letters were scanned onto the system and sent to the doctor to review and code accordingly.

- The administrator was the dedicated lead for managing and monitoring the progress of referrals to secondary care services. The referrals register was checked weekly and any delays followed up. Equally, laboratory samples sent were logged and checked and results followed up if not received in a timely way.

Consent to care and treatment

Staff sought patient 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 (MCA) 2005. Where a patient’s mental capacity to consent to care or treatment was unclear, the clinician assessed the patient’s capacity.

Supporting patients to live healthier lives

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

- New patients were subject to checks and screening for lifestyle behaviours such as smoking and alcohol use. Family history was taken into account as part of the screening process.

- In the absence of a practice nurse, one of the CMTs was identified as the health promotion lead. They ensured health promotion material and displays were up-to-date at the practice and
coordinated the involvement of the practice at station-led health promotion fairs. The SMO told us a specific women’s health fair was planned given the high female population. Patients were directed to local NHS services for family planning and sexual health advice.

- Patients had access to appropriate health assessments and checks. Searches were undertaken for patients aged 50 to 64 years who were entitled to breast screening. The practice also engaged with all national screening programmes and had a mechanism to ensure that eligible patients were referred into the bowel cancer or abdominal aortic aneurysm (AAA) screening programs. There were no patients identified who were eligible for these screening programmes at the time of our inspection.

- The number of women aged 25 to 49 and 50 to 64 whose notes recorded that a cervical smear had been performed in the last three to five years was 49 out of 60 eligible women. This represented an achievement of 89%. The NHS target was 80%.

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, polio and measles, mumps and rubella. The data below from September 2017 provides vaccination data for patients using this practice:

- 93% of patients were recorded as being up to date with vaccination against diphtheria compared to 93% regionally and 95% for DPHC nationally.

- 93% of patients were recorded as being up to date with vaccination against polio compared to 93% regionally and 95% for DPHC nationally.

- 79% of patients were recorded as being up to date with vaccination against Hepatitis B compared to 74% regionally and 83% for DPHC nationally.

- 84% of patients were recorded as being up to date with vaccination against Hepatitis A, compared to 91% regionally and 94.5% for DPHC nationally.

- 93% of patients were recorded as being up to date with vaccination against Tetanus, compared to 93% regionally and 100% for DPHC nationally.

- 91% of patients were recorded as being up to date with vaccination against Typhoid, compared to 53% for DPHC nationally. A regional figure was not recorded.
Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

- Clinic room doors were closed during consultations. Curtains were provided in clinic rooms to maintain patients’ privacy and dignity during examinations, investigations and treatments.

- The layout of the reception area and the seats in the waiting area meant that conversations between patients and reception could not be easily overheard. A radio was playing in the background to aid privacy of conversations. If patients wanted to discuss sensitive issues or appeared distressed practice staff could offer them a private room to discuss their needs.

- A lowered counter was available at the reception for wheelchair users along with a hearing loop should the need arise. An accessible toilet was available in the building. Guidance was in place about how staff could access a translator should the need arise. A room could be made available for baby changing and/or breastfeeding.

- A suggestion box for patients to leave feedback was located in the waiting area. Patients also were given the opportunity to participate in the patient experience survey.

- We had the opportunity to speak with three patients during the inspection. They told us they were satisfied with the care provided by the practice and said they were treated with dignity and respect. All told us they could get an appointment when they needed one.

- Results from the September 2017 Patient Experience Survey showed patients valued the care at the practice. From a sample of 27 patients:
  - Twenty four patients said they would recommend the practice to friends, family and colleagues.
  - Twenty six patients said their privacy and dignity was respected at all times.
  - Twenty six patients said staff were helpful and friendly.

- We did not receive any comparator data from Defence Medical Services to set out alongside the above data. We received 48 completed comment cards prior to the inspection and feedback about treatment and care was very complimentary. Patients said that they felt involved in decision making about the care and treatment they received. Comments indicated that patients felt listened to and supported by staff, and they had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

Care planning and involvement in decisions about care and treatment
• The feedback provided by patients indicated that clinical staff took the time to explain their condition or injury and treatment plan.

• Data received form the latest DMS patient experience survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. From a sample of 27 patients:
  o Twenty five patients said clinicians listened to them and took on board their comments.
  o Twenty four patients said they were involved in decisions regarding their care.

Patient and carer support to cope emotionally with treatment

• Patient information leaflets and notices were available in the patient waiting area, which advised patients about how to access a number of organisations. We saw that information that was relevant to the patient demographic was prominently displayed and accessible.

• Measures were in place to support with identifying patients who were carers. At the time of our inspection there were no patients registered who had caring responsibilities.

A representative from the practice attended station welfare meetings with the chain of command on a regular basis. The meeting was also attended by the welfare team and the support for patients with caring needs could be discussed at these meetings.
Are services responsive to people’s needs?  (for example, to feedback)

Good

Our findings

Responding to and meeting people’s needs

- A range of services were available to patients. These were either available at the practice or patients were signposted to other services. Over 40’s health screening, audiology screening, physiotherapy and travel advice were provided. Patients requiring cytology were referred to another local defence medical centre. Patients were referred to a local NHS service for family planning and sexual health advice.

- Access to a doctor was good for patients; most patients were seen within 48 hours of requesting an appointment. Patients could have 15 minute appointments. If needed, patients could book a double appointment of 30 minutes with the doctor. Telephone consultations were available if the patient requested that option.

- No male doctors worked at the practice (unless locum cover) so if patients wished to see a male then they would be signposted to another defence medical centre.

- All referrals to the rehabilitation team were made by the doctors and the average waiting time for an appointment was less than one week.

Access to the service

- The medical centre was open from 07:30 to 16:30 Monday, Tuesday and Thursday (closed from 12:30 to 13:30), and Wednesday and Friday from 07:30 to 12:30.

- The arrangements for access to medical care outside of opening hours were outlined in the practice leaflet and directed patients to contact NHS 111 or to attend the Queen Elizabeth Hospital accident and emergency department.

- Shoulder cover was provided between the hours of 16:30 and 18:30 by RAF Northolt Medical Centre.

- Extended hours were not available due to the staffing levels and reliance on locum staff.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- The practice manager was the designated responsible person who handled all complaints in the practice. They and the staff team adhered to the DPHC’s established policy on the management of complaints.

- Information was available in the waiting area to support patients’ understanding of the
complaints system. How to make a complaint was summarised in the practice leaflet.

- We spoke with three patients who told us that they would feel comfortable with making a complaint and knew how to complain if the need arose.
- There had been no formal complaints since 2015. A process was not in place for recording verbal complaints and the SMO had addressed this.
- Staff advised us that if there was any learning from complaints then this would be shared at the practice meetings. Complaints were audited through the CAF.
Are services well-led?
(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Requires improvement

Our findings

Vision and strategy

- The practice was working to the following DPHC mission statement:
  - “To deliver a unified, safe, efficient and accountable primary healthcare service for entitled personnel to maximise their health and deliver personnel medically fit for operations.”

- The practice had been without consistent clinical leadership for at least five years prior to the SMO taking up post in September 2017. In January 2018 the SMO produced a management plan for the practice with the aim to set direction, clarify priorities and define the governance structure. Alongside this, the SMO and practice manager worked together and developed an improvement plan for the practice that took account of both clinical and non-clinical matters. The areas identified for improvement correlate with our findings from the inspection.

- Both the SMO and practice manager were open and transparent with the inspection team about the current limitations of the service, the improvements made and the improvements needed. Throughout the inspection they demonstrated a cogent commitment to improving the service for their patients.

Governance arrangements

The overarching governance framework was under review to support the delivery of the strategy and the recently defined management plan.

- Varying staffing levels/skill, a reliance on locum staff and inconsistent clinical leadership meant governance systems were underdeveloped. This was compounded by the practice manager having received an inadequate induction and limited access to training, support and mentorship for the role. We found that the absence of these supportive measures had a direct impact on how risk was managed, particularly in relation to health and safety. The SMO provided evidence to demonstrate that in October 2017 they raised the matter to Regional Headquarters (RHQ) requesting training and mentorship for the practice manager. The SMO was also addressing other staffing issues identified in relation to clinical competence.

- The SMO role until September 2017 had been fulfilled by a series of locums. At the time of the inspection there was no nurse cover at the practice. The SMO had put measures in place to manage this and mitigate risk, including the outsourcing of cytology. CMTs were undertaking some nursing role duties under the supervision of the SMO.

- Although staff were aware of their own roles and accountability, not all staff had a copy of their job description and/or terms of reference. An allocation of responsibilities/lead roles was in place. Due to insufficient staff there were numerous gaps in the assignment of lead roles.
• The practice used the CAF as a governance tool to monitor the safety and quality of the service. The CAF showed numerous areas of partial compliance across all domains. Our findings correlate with those of the CAF, demonstrating it was being used effectively at practice level to monitor the service. An update in the form of a progress report on the CAF was submitted to RHQ each quarter.

• A review of the CAF is undertaken by RHQ every two years and is referred to as a Health Governance Assurance Visit (HGAV). The last HGAV for the practice took place in December 2014 and identified some of the concerns we found, particularly the over reliance on locum staff. The practice was not issued with a management action plan despite a recommendation that a further HGAV visit should take place in June 2015. This visit did not happen even though a new practice manager took up post in January 2015.

• There was evidence from minutes of practice meetings and discussions with staff that lessons learned from significant events and other investigations led to change and improvement in practice. However, we did find that there was under reporting of incidents and events. The SMO was aware of this and was working with the staff team to dispel any anxieties about reporting.

• There were no health care governance meetings in place. The SMO had plans to implement these once sufficient and consistent clinical staffing was established.

• Assessments were in place for managing risks. Some risk assessments were in the process of being reviewed or developed. The risk register was underdeveloped as it lacked detail and clear timeframes for review.

• Policies from the national framework were implemented and were available to all staff. These were updated and reviewed regularly. Staff confirmed they were familiar with policies and other protocols and used them in the delivery of high quality care.

• Clinical and administrative audit was underdeveloped. In the last three months a list of proposed audits had been produced. All staff have been given training in how to conduct an audit and allocated at least one audit to complete with timelines.

• Effective measures were in place to manage performance by staff. We were provided with an example illustrating how the SMO had identified concerns/risks with practice and had managed it in an efficient and effective way to ensure patient safety.

• Robust systems were in place to monitor patient safety updates and alerts sent by the Medicines & Healthcare products Regulatory Agency (MRHA).

Leadership and culture

• Staff said they felt respected, valued and supported, and their views were listened to when exploring ideas on how to improve the service. Staff told us the SMO and practice manager were visible, approachable and always took the time to listen to all members of staff. They felt involved and engaged in how the practice was run.

• Staff highlighted that since the recent appointment of a consistent SMO the practice was more structured and communication processes had been improved. For example, a weekly diary meeting for all staff had been introduced each Monday at 12:00. This aim of the meeting was to confirm staff availability for at least the following four weeks and to provide an opportunity to bring to the attention of all staff urgent issues ahead of the next practice meeting. Furthermore, a weekly 30 minute ‘hot topic’ training session had been introduced for all clinicians each Monday morning at 11:30.

• Practice meetings were held each month and were used as an additional governance communication tool. Minutes took account of matters such as performance indicators, health
and safety, staff training, complaints and audit. Minutes were available for practice staff to view.

- Systems were in place to ensure compliance with the requirements of the duty of candour and all staff had a good understanding of what this meant and their responsibilities in relation to the requirements. Duty of candour is a legal requirement services must follow when things go wrong with care and treatment. The practice had systems to ensure that when things went wrong with care and treatment, the practice gave patients reasonable support, information and a verbal and written apology.

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

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

- Patient surveys and from any individual patient feedback received.
- The suggestion box available in the waiting area for patients to leave feedback.
- A patient participation group or similar type of collective forum was not established to seek the views of patients.
- Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

**Continuous improvement**

The following improvements had been made to the service since October 2017:

- Clinical audit had only recently started to happen and an audit programme had been developed. Although a limited number of audits had been undertaken, they showed that changes had been made to improve patient care. For example, the cervical smear invitation system had been audited and a new process put into place.
- To address potential Caldicott breaches the small waiting area outside the clinical rooms was moved. In addition, all clinical letters awaiting review by doctors had been relocated to the practice manager’s office.
- A ‘Personality Board’ with photographs of medical centre staff has been displayed in the waiting area so patients can identify key personnel and their role.
- An In/Out board has been put in reception to indicate which staff members are in the building.
- Clinical letters were coded by doctors to aid linking letters with consultations/ health needs when they were being scanned on to patient records.
- In the absence of a nurse, a CMT has been nominated as health promotion lead to ensure that all notice boards were regularly updated.
- A Standard Operating Procedure (SOP) file had been developed to ensure consistent treatment was given by all clinicians in areas such as weight management, raised blood pressure, abnormal urine dipsticks and abnormal blood results. A head injury protocol has been developed to ensure consistent information was given to patients by all staff.
- A quarterly practice newsletter with information for patients was in the process of being developed and was due to be circulated in March 2018.
- All staff were being encouraged to record verbal complaints and compliments, not just written
ones.