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

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<th>Service</th>
<th>Rating</th>
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<tr>
<td>Overall rating for this service</td>
<td>Good</td>
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<tr>
<td>Are services safe?</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Are services effective?</td>
<td>Good</td>
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<tr>
<td>Are services well-led?</td>
<td>Good</td>
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Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of Northwood HQ Medical Centre on 2 May 2017. The practice was rated as requires improvement overall, with a rating of requires improvement for the key questions of safe, effective and well led.

A copy of the report from our last comprehensive inspection can be found at:

http://www.cqc.org.uk/what-we-do/services-we-regulate/defence-medical-services#army

We carried out this announced follow up inspection on 10 July 2018. This report covers our findings in relation to the recommendations made and any additional improvements made since our last inspection.

Our key findings were as follows:

- All staff received mandatory training to carry out their duties effectively, with the exception of extended training for the infection prevention and control lead to fulfil their role effectively.

- A rolling programme of clinical improvement work was in place.

- Systems were in place to identify any patients who are also carers so that additional support could be offered, including signposting them to other services as required.

- Clinicians used data available to identify patients requiring a review of their conditions. Patients were recalled at the earliest opportunity, although this was hindered by the lack of clinical nurse time available. This included patients who were eligible for NHS health screening where appropriate.

- There was a failsafe system in place for the management of test results.

- Systems were in place for daily testing and maintenance of medical equipment.

- A new cleaning contract and funding had been put in place. This had not, however, made any improvement to the cleaning of the practice itself as cleaning staff were not trained to undertake the level of clinical cleaning required.

- Sharps bins were assembled correctly and all clinical waste, including sharps were 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 were held securely.

• Medicines were disposed of when no longer required.

• Formal governance arrangements including systems for assessing and monitoring risks and the quality of the service provision were embedded and understood by all staff.

The Chief Inspector Recommends

The management of infection prevention and control be improved to include the establishment of deep cleaning schedules and monitoring systems, and to meet the requirements of the Department of Health national infection control guidance.

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice
Our inspection team

The inspection was undertaken by a CQC inspector and a GP specialist advisor.

Background to Northwood HQ Medical Centre

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 changes. 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. Families and dependants are not registered at Northwood HQ medical centre but 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

To conduct this inspection, we contacted the practice manager and advised that we would be following up our findings of the inspection conducted in May 2017. We visited the practice on 10 July 2018.

As this was a follow-up inspection, we focused on the three key questions where improvements were required. We did not speak to patients as part of this review or use CQC comment cards to gather patient views of the service.
Are services safe? 
(for example, treatment is effective)

Our findings

Following our previous inspection on 2 May 2017, we rated the practice as inadequate for providing safe services. At that time we found that systems and processes to keep patients safe were not embedded; infection prevention and control and equipment testing required closer management. Other governance processes were not promoting patient safety as a priority.

Overview of safety systems and processes

The medical centre had undergone some improvement in cleanliness since the previous inspection. The introduction of a cleaning schedule in June 2018 and the introduction of a dedicated cleaner to the building were contributing factors to this improvement. However, the cleaning still required improvement.

- Although on the day of the inspection the medical centre appeared clean throughout, we saw infection control audits undertaken in December 2017 and June 2018 which identified areas of cleanliness which remained an issue, for example the cleaning of the floors and of clinical areas. The Senior Nursing Officer (SNO) and Practice Manager remained in regular contact with the contract cleaning company manager to identify any issues or concerns. A weekly cleaning feedback document was sent to both them and the Northwood Contract Management team. At the time of the inspection no deep cleaning had occurred for many years. A deep cleaning schedule commenced on 11 July 2018, the day following our follow-up inspection visit, with high risk areas taking priority. Investment in appropriate training and personnel by the cleaning contractor was required and had not happened.

- All areas (including clinical) had only a basic daily clean (by cleaners), including those areas used for minor operations. Clinicians also cleaned their own areas to compensate for this. In addition, the practice had not undertaken a minor surgery outcomes audit, as recommended by NICE (The National Institute for Health and Care Excellence). Following the inspection, the practice notified us that an audit had been undertaken and no issues had been identified.

- 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 a complete Hepatitis B register for staff in place.

- Sharps bins in the medical centre were found to be securely assembled and checked by two members of staff.
• There were waste management records, registers and consignment notes in place. There was an effective system in place for the management of the clinical waste.

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

• There were failsafe procedures in place 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 took bloods regularly, checked the results, gave short prescriptions and put alerts on the clinical system and we saw a system of formal recall and 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 carried out medicine checks every two months to ensure prescribing was in line with best practice guidelines for safe prescribing.

• There was a risk assessment in place to assure the system for dispensing medicines at the practice and to mitigate risk. The regional pharmacist had confirmed that the dispenser was competent to dispense alone. 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. If a patient was prescribed controlled drugs, these were checked with the GP prior to dispensing. The dispenser was not medically trained but had completed an NVQ three in dispensing.

• Blank prescription forms and pads were securely stored throughout the practice.

• Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. All had been reviewed and signed.

• 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. Staff were aware of the procedure to follow in the event of a fridge failure.

Monitoring risks to patients
There were procedures for assessing, monitoring and managing risks to patient and staff safety.

• All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
Are services effective?  
(for example, treatment is effective)

Our findings

Following our previous inspection on 2 May 2017, we rated the practice as requires improvement for providing effective services. At that time, data showed that patient health care could be improved for example for the recall of patients with hypertension. Not all staff could demonstrate they had received role specific training. There was no clear audit programme in place. When we carried out this follow up inspection we found that all of the above recommendations had been acted on. Following our review of the evidence provided, the practice is now rated as good for providing effective services.

Effective needs assessment, care and treatment

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

- Clinical staff were aware of evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. Staff referred to this information to deliver care and treatment that met patients’ needs. They described how updates on NICE and medicines management were outlined in a newsletter circulated to clinical staff by the Defence Primary Health Care (DPHC) each month and was a standard agenda item at the monthly practice meeting.

- Clinical staff met weekly to discuss NICE guidance. Every week a different member of staff chose a topic to research and then discussed with the wider staff team. Every month the team also had a specialist speaker visit to discuss current guidance, for example most recently talks were given on bowel conditions and ear, nose and throat care.

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. 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 DPHC practices, we are not using NHS data as a comparator.

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

- There were nine patients on the diabetic register. We reviewed the treatment and care offered to these patients and found that current NICE guidance had been followed. For 67% of these diabetic patients, the last measured total cholesterol was 5mmol/l or less. For 89% of these diabetic patients, the last blood pressure reading was 150/90 or less.
• There were 64 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. 85% had a record for their blood pressure being monitored in the past nine months. Of these patients with hypertension, approximately 77% had a blood pressure reading of 150/90 or less. This showed significant improvement from the last inspection.

• There were 21 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, 75% had had an asthma review in the preceding 12 months which included an assessment of asthma control using the 3 Royal College of Physicians questions.

Whilst every effort has been made by the practice to source another practice nurse to assist the SNO with routine duties, the position remained vacant and had significant impact on the services offered by the medical centre. Four significant events had been raised by the practice highlighting staffing issues to Regional Headquarters. The vacancy had an adverse effect on the wellbeing of remaining staff. At the time of this inspection the waiting times for audiometric testing were 21 days wait for audiometric testing and 40% of personnel out of date.

Clinicians used data available to identify patients requiring review of their conditions. Patients were recalled at the earliest opportunity, although this was hindered by the lack of clinical nurse time available. This included patients who are eligible for NHS health screening where appropriate. Every month a search was undertaken for patients who were eligible for health checks such as breast screening, bowel screening and Abdominal Aortic Aneurysm screening (AAA). We saw that patients had been referred as necessary.

There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using public health information posters and they ensured a female sample taker was always available. 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 91%. The NHS target was 80%.

There was evidence of quality improvement including clinical audit:

An ongoing programme of clinical audit was in place and demonstrated a commitment to improving outcomes for patients at the practice. Twenty-three audits had been completed since May 2017. All clinicians were actively engaged with clinical audit and we saw some good examples of audit activity linked to NICE guidelines. For example, a two cycle audit on patients with Osteoporosis, and a two-cycle antifungal medicine audit. Other audits included diabetes and cancer care. Whilst we were encouraged to see the audit programme had improved, not all audits were meaningful. We discussed this with the practice who acknowledged this was work in progress.

Effective staffing

• The practice had an induction programme for all newly appointed staff including locum staff. This included topics such as safeguarding, infection prevention and control, fire safety, health and safety, information governance and Caldicott accountability. Staff had access to, and made use of, e-learning training modules and in-house training. Staff had all received mandatory training in subjects such as fire, basic life support and infection control. In addition,
staff had received role-specific training. Staff who acted as chaperones had received training which had been devised and delivered by the practice themselves.

- Staff administering vaccines and taking samples for the cervical screening programme had received specific training including an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes. The medical assistants (MA) and the SNO triage and ran urgent, on the day, clinics for patients. This was overseen informally by a GP daily if required, and more formally at a weekly one to one meeting between the GP and medic. Consultations and any concerns were addressed with further advice, support and training given if required.

- The SNO was the infection prevention and control clinical lead, who had received on-line mandatory training. However, they had not received any further advanced training to enable them to fully fulfil this role. We were told after the inspection that a place had been secured for this training in the Autumn.

- Staff received role specific training, for example when testing hearing, giving vaccinations and in the management of long term conditions.

- 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 care and treatment**

- 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.

- We found the practice shared relevant information with other services in a timely way. For example, one of the administrators was the dedicated lead for managing and monitoring the progress of referrals to secondary care services. They maintained and monitored referrals and were able to highlight when the patient had received an appointment.

- Discharge and hospital letters were received by the medical centre and there was a good system in place to ensure that a clinician reviewed and actioned these, this included an audit trail to record what had been done.

- A register was in place for samples sent to the laboratory. It was checked daily and any outstanding results were followed up.

- Letters from secondary care received at the practice were logged, dated, stamped and scanned onto the patient’s record by the administration team and the GP was made aware so that they may review them.
Are services well-led?
(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Good

Our findings
Following our previous inspection on 2 May 2017, we rated the practice as requires improvement for providing well led services. At that time we found:

- 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 demonstrating 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 prevention and 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.

- Test results were not 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.

When we carried out this follow up inspection, we found that most recommendations had been acted on. Whilst we were encouraged to see how hard the practice had worked to ensure compliance, two areas still needed improvement. The management of infection prevention and control and the limited availability of clinical nurse time. Whilst we saw that the management, including recall, of patients with long term conditions had significantly improved, the extra work to make those improvements coupled with the vacant clinical nurse post poses a risk to the sustainability of good recall management.

Governance arrangements
The practice had improved the overarching governance framework which had led to improvement of the care delivered.
• There were arrangements in place for managing medicines, including emergency medicines and vaccines (including obtaining, prescribing, recording, handling, storing, security and disposal).

• All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.

• Staff were up to date with mandatory training, with the exception of extended training for the infection control lead to fulfil their role effectively.

• A rolling programme of clinical improvement work was in place.

• Systems were in place to identify any patients who are also carers and provide support and sign post as required.

• There was a failsafe system in place for the management of test results.

• The management of infection control had improved as a new contract and funding had been put in place. This had not, however, changed or made any improvement to the cleaning of the practice itself.

• Sharps bins were assembled correctly and all clinical waste, including sharps are disposed of without delay in accordance with The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 and also HTM 07-01.