

Northolt Medical Centre

Quality report

RAF Northolt
Ruislip
Middlesex
HA4 6NG

Date of inspection visit:
6 December 2018

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6 February 2019

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information given to us by the practice and patient feedback about the service.

Ratings

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

Chief Inspector's Summary

This practice is rated as good overall

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

We carried out an announced comprehensive inspection of Northolt Medical Centre on 6 December 2018. Defence Medical Services (DMS) are not registered with the CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014 and are not required to be. Consequently, DMS services are not subject to inspection by the CQC and the CQC has no powers of enforcement. This inspection is one of a programme of inspections that the CQC will complete at the invitation of the Surgeon General in his role as the Defence Authority for healthcare and medical operational capability.

At this inspection we found:

- The practice was well-led and leaders demonstrated they had the vision, skill and capability to provide a patient-focused service.
- The practice understood the needs of the patient population and made changes to ensure patient needs were met.
- There was an open and transparent approach to safety. An effective system was in place for managing significant events and staff knew how to report and record using this system.
- The assessment and management of risks was comprehensive and recognised as the responsibility of all staff.
- Although we found some improvement was needed, overall the arrangements for managing medicines were safe. There was an effective approach to the monitoring of patients on high risk medicines.
- Staff were aware of current evidence based guidance. They had received training so they were skilled and knowledgeable to deliver effective care and treatment.
- The practice worked collaboratively and shared best practice to promote better health outcomes for patients.
- There was clear evidence to demonstrate quality improvement was embedded in practice, including an annual programme of clinical audit used to drive improvements in patient outcomes.
- The practice proactively sought feedback from staff and patients which it acted on. Feedback showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.

- Facilities and equipment at the practice were sufficient to treat patients and meet their needs.
- Staff were aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

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

- To enhance safety for patients, the practice acted to ensure drivers of military transport were subject to a DBS (Disclosure and Barring Service). As the cleaning team were mostly Nepalese, a Nepalese interpreter supported with the delivery of infection prevention and control (IPC) training for the team. IPC information was displayed in both Nepalese and English.
- The practice was proactive with meeting the specific needs of the patient population. A GP had completed a master's degree in performing arts medicine to better understand and treat injuries associated with the patient population of musicians. A musculoskeletal (MSK) injury trend audit led to the development of a bespoke screening tool and preventative measures for musicians and service personnel involved in high levels of parade work.
- The practice acted on feedback from patients to make improvements. For example, the practice introduced a confidentiality card request at reception. The patient could hold up the card indicating to the receptionist that they wished to speak to someone in private.
- The practice had processes to ensure the mental health needs of patients were being effectively met. These included a monthly clinical review of all patients referred to the Department of Community Mental Health and the provision of a community psychiatric nurse led outreach clinic twice a month. Feedback from patients clearly suggested the practice provided good mental health support and access to services.
- To reduce the high level of downgrading/sickness in one of the squadrons, the practice developed in conjunction with squadron leaders a bespoke sick chit that focussed on the work individuals could undertake rather than just being signed off work. This new approach showed an improvement in the numbers of service personnel unavailable for work.

The Chief Inspector recommends:

- A review of the arrangements for the management of medicines to ensure medicines are managed in accordance with operational policy.
- Clarifying the arrangements for home visits in patient information.

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

Our inspection team

Our inspection team was led by a CQC lead inspector. The team comprised specialist advisors including a GP, a practice nurse, a practice manager, physiotherapist and pharmacist.

Background to the Northolt Medical Centre

RAF Northolt supports both military and civilian aircraft and is home to units from all three of the armed services. The 32 (The Royal) Squadron and 63 Squadron RAF Regiment (Queens Colour Squadron) are based at the station, along with a large number of smaller units.

Based on the station, Northolt Medical Centre provides primary and emergency care to a practice population of 1501 patients. Service personnel make up 56% of the population with the remaining 44% comprising reservists, civilian staff and the dependants of service personnel. Due to the risks associated with a steady increase in the number of registered dependants, the practice was in the process of deregistering dependants who no longer met the recently revised eligibility criteria for registration.

In addition to routine primary care services, the practice provides occupational health care to service personnel, including force preparation, diving medicals and aviation medicals. Family planning advice is available. Maternity and midwifery are provided by NHS practices and community teams. Patients have access to medicines through the dispensary in the medical centre. A Primary Care Rehabilitation Facility (PCRF) is located on the premises, with physiotherapy and rehabilitation staff integrated within the medical centre.

The practice is open from 08:00 to 17:00 Monday to Wednesday and Friday; Thursday 08:00 to 12:00. Arrangements are in place on weekdays for access to medical cover when the practice closed and before NHS 111 is available.

Although the staffing establishment for the practice is 23, at the time of the inspection eight posts were vacant with four filled by locum staff. The staff team comprised a mix of full and part time civilian and military staff and included:

- A deputy (DSMO) was acting into the Senior Medical Officer (SMO) while the SMO was deployed. The DSMO was supported by a civilian GP and locum GP;
- Two practice nurses (one locum) and a health care assistant;
- A physiotherapist and a locum Exercise Rehabilitation Instructor (ERI);
- A locum pharmacy technician;
- A practice manager was responsible for the running of the practice supported by a deputy practice manager and a team of seven administrators. Some of the administrative team were medics. A medic is trained to provide medical support and airfield crash cover on various operations and exercises. In a medical centre setting, their role is similar to that of a health care assistant in NHS GP practices but with a broader scope of practice.

A Regional Clinical Director (RCD) assumed overall accountability for quality of care at the practice.

Are services safe?	Good
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We rated the practice as good for providing safe services.

Safety systems and processes

Clear systems to keep patients safe and safeguarded from abuse were in place.

- A framework of regularly reviewed safety policies was in place and accessible to staff, including locum staff. Staff received safety information about the practice as part of their induction and refresher training.
- Measures were in place to protect patients from abuse and neglect. Adult and child safeguarding policies were included in the staff handbook. Information about safeguarding, including contact numbers, was displayed throughout the building. All staff had received up-to-

date safeguarding training at a level appropriate to their role. All clinical staff had completed level 3 training. The SMO (DSMO in their absence) was the safeguarding lead and the civilian GP was the deputy.

- The initial registration identified new patients who were vulnerable or subject to formal safeguarding arrangements. Codes were used on the electronic patient record system (referred to as DMICP) to highlight these patients. Regular searches of DMICP were undertaken to inform the register of vulnerable patients.
- Vulnerable patients were discussed at the 'care and concern' monthly meetings, which were attended by all clinicians. Practice staff had developed good relationships with the welfare team that was located in the same building. The practice was represented at the monthly station welfare meetings where concerns about vulnerable patients were also discussed.
- All staff had received chaperone training and notices advising patients of the chaperone service were displayed in clinic doors. Staff had been subject to safety checks to ensure they were suitable to work with young people and vulnerable adults.
- The full range of recruitment records for permanent staff was held centrally. However, the practice 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, including locum staff, were suitable to work with vulnerable adults and young people. DBS checks were renewed every five years.
- Military transport for the station was sometimes used for patients. The practice identified that drivers were not DBS checked and had worked with the Station Commander to ensure drivers were subject to a DBS check.
- Arrangements were in place to monitor the registration status of clinical staff with their regulatory body. All staff had professional indemnity cover. Information was in place to confirm staff had received all the relevant vaccinations required for their role at the practice.
- There was an effective process to manage infection prevention and control (IPC). The locum nurse was the temporary IPC lead while the regular lead IPC nurse was deployed. Both nurses were suitably trained for the role. An annual IPC audit had taken place.
- Environmental cleaning was provided by an external contractor. The cleaning staff team were mostly Nepalese so the practice manager had arranged for cleaning signs to be displayed in both Nepalese and English. The cleaning team had received infection prevention and control training in Nepalese through the use of a translator. Cleaning schedules and monitoring arrangements were established. A six-monthly deep clean of the practice was included in the contract.
- Systems were in place for the safe management of healthcare waste. Consignment notes were retained at the practice and an annual last waste audit was carried out.
- Measures to ensure the safety of facilities and equipment were managed by the station environmental health technician. Electrical safety checks were completed within the last 12 months. Water safety measures were undertaken each week and checks each month. A fire risk assessment of the building was undertaken annually. Firefighting equipment tests were current. Staff were up-to-date with fire safety training and were aware of the evacuation plan.
- Equipment was checked and maintained according to manufacturers' instructions. Testing of portable electrical appliances and medical equipment was in-date.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

- From September 2017 it was identified the staffing level was not safe for patients, mainly due to a steady increase in the numbers of dependants registering at the practice. There had been no uplift in staff numbers to meet demand. The increase was linked to specific units spending the majority of their working career at the station, such as bands and cartography units. Staffing levels were also compromised because of deployment, long term sickness and welfare issues. The associated risks had been raised as significant events and included on the risk register. A well-managed plan was in place to reduce the number of dependants registered at the practice.
- At the time of the inspection there were staffing gaps and this was being managed mainly through the use of locum staff. To minimise risks associated with continuity, a detailed induction process was in place for locum staff to ensure they were familiar with systems and ways of working in Defence Primary Health Care (DPHC). This included an induction pack, ensuring relevant training was completed and competency checks if required.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. An emergency kit, including a defibrillator, oxygen with adult/child masks and emergency medicines were accessible to staff in a secure area of the practice; all staff knew of its location. A first aid kit and accident book was available. Routine checks were in place to ensure the required kit and medicines were available and in-date. The treatment room lacked an appropriate warning notice to identify that medical gases were stored in the room. The practice manager confirmed shortly after the inspection that appropriate hazard signage was displayed on crash room door where cylinders were located.
- Staff were up-to-date with the required training for medical emergencies. They participated in regular training simulation exercises for emergency situations often in conjunction with the station fire service. Specific training relevant to occupational risk included the management of burns and spinal injuries. The recognition and management of possible sepsis had been discussed as a team. A traffic light system for identifying the risk of sepsis was displayed in each of the clinical rooms.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we looked at on DMICP showed information needed to deliver safe care and treatment was available to relevant staff in an accessible way. A process was established for scrutiny and summarising of patients' records. There was no significant backlog as 97% of clinical records had been summarised. Staff advised us that the records of civilian patients were prioritised for summarisation. Arrangements were in place for peer review of locum GP consultations and prescribing patterns.
- Staff described occasional loss of connectivity with DMICP but said this did not have a significant impact on patient care. If this happened, the business resilience plan was followed and urgent appointments only were offered. There were four WiFi docking stations in the building which could be used during power outages.
- A dedicated member of the administrative team was responsible for the management of referrals, including internal referrals and those to external secondary care services. A referral

tracker was in place that included a traffic light system to identify if the status of a referral needed to be checked. Urgent referrals were followed up after two weeks.

- A process was in place for the management of specimens, including the transport of specimens to the laboratory and the use of Lablinks to manage test results. There had been a number of errors with Lablinks, including requests not being actioned and results not received. The errors had been raised as significant events and added to the risk register. When an error occurred, the internal protocol was followed to ensure the safe management of specimens. The nursing team monitored results and forwarded them to the GP for action.

Safe and appropriate use of medicines

The practice had systems to support the safe handling of medicines. Improvement was needed to strengthen some of these systems.

- The SMO (DSMO in their absence) was the medicines management lead with the day-to-day management of medicines delegated to a locum pharmacy technician supported by two medics
- Although appropriate arrangements were established for the safe management of accountable and controlled drugs (medicines with a potential for misuse), we found a topical medicine was not managed and stored as an accountable drug in accordance with organisational policy. Immediately after the inspection the practice manager confirmed the medicine had been moved to the controlled drug cupboard and was being managed as an accountable drug. Furthermore, archived prescriptions were retrieved to aid accounting.
- Processes were in place to ensure the stock of medicines was managed effectively. The temperatures of the medication fridges were checked and recorded each day to ensure medicines were stored within the correct temperature range. The fridge in the nurse's treatment room was not lockable. Although the treatment room door was locked out-of-hours, shortly after the inspection the practice manager confirmed measures had been put in place to secure the fridge when the treatment room was unattended.
- The ambient temperature of the nurse's treatment room was not being monitored. The practice manager confirmed shortly after the inspections that temperatures were being recorded.
- The monitors to check blood glucose levels were not the correct ones. The practice manager confirmed shortly after the inspection that the correct glucose monitors had been ordered.
- A record of prescription forms received was in place and were loose leaf which is contrary to DPHC procedure that requires a bound book for recording prescription forms. Although the record of supply and receipt were on separate pages, which made accounting difficult, we determined that prescriptions were correct and accounted for.
- Changes made to a patient's medicines by out-of-hours and secondary care services were followed up appropriately. Patient Group Directions (PGD) had been developed to allow nurses to administer medicines in line with legislation. These were authorised in September 2018. PGDs were monitored by the SMO. We noted that one of the nurses had completed the PGD training but had not completed the required in-house assessment.
- A high-risk medicines list was in place and alerts were used to identify patients prescribed these medicines. A register was maintained and searches undertaken to ensure the register was up-to-date. We checked the records for five patients prescribed a high-risk drug and appropriate monitoring of their health was taking place. Shared care agreements with secondary care services were not in place for all patients. The practice had an audit trail to

demonstrate they had tried unsuccessfully to obtain these agreements with the local NHS Trust.

Track record on safety

The practice had a good safety record.

- A lead for health and safety was identified and they were suitably trained for the role. Safety processes for the practice were monitored and reviewed, which provided a clear, accurate and current picture that led to safety improvements. Risk assessments pertinent to the practice in place, including those for hazardous substances, operating electrical equipment and lone working.
- Panic alarms were installed in clinical rooms and were tested regularly.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff used the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events, incidents and near misses. All staff had electronic access to the system, including locum staff. Staff provided several examples of significant events they had raised demonstrating there was a culture of effectively reporting incidents. A monthly ASER and audit meeting was held to review significant events and undertake a root cause analysis. The ASER system was also used to report good practice and quality improvement initiatives.
- The pharmacy technician was responsible for managing medicine and safety alerts. They checked for alerts twice a day. Alerts were emailed to staff and discussed at the practice and clinical meetings.

Are services effective?	Good
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We rated the practice as good for providing effective services.

Effective needs assessment, care and treatment

The practice had processes to keep clinicians up to date with current evidence-based practice.

Clinical staff assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. NICE (National Institute for Health and Care Excellence) and other practice guidance was a standing agenda item at the weekly clinical meetings open to attendance by all clinicians. For example, the NICE updates for Primary Care from August and September 2018 was discussed at the October meeting. At this meeting clinical case discussions were also a standing agenda item.

Monitoring care and treatment

The practice used data collected for the Quality and Outcomes Framework (QOF) to monitor outcomes for patients. QOF is a system intended to improve the quality of general practice and reward good practice. It is used across many NHS practices. The 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.

We were provided with the following patient outcomes data during the inspection:

- Six patients were on the diabetic register. Four patients had a last measured total cholesterol of 5mmol/l or less which is an indicator of positive cholesterol control. All six patients had a last blood pressure reading of 150/90 or less.
- Thirty-one patients were recorded as having high blood pressure. Twenty-nine were eligible for blood pressure value checks. Of those, 25 had a BP recorded of 150/90 or less. We discussed the remaining four patients and were satisfied with how their care was being managed.
- Twenty-three patients had a diagnosis of asthma. Nineteen of these patients had an asthma review in the preceding 12 months which included an assessment of asthma control using the three Royal College of Physicians questions. We discussed the remaining four patients and were satisfied with how their care was being managed.

A GP was identified as the lead for chronic disease management and one of the nurses managed the chronic disease register. They carried out regular searches, recalling patients when appropriate. We looked at a selection of patient records and were assured that clinicians were consistent in how patients were reviewed. For example, clinicians used the same asthma review template.

A chronic disease and palliative care meeting was held monthly. The minutes from October 2018 showed the chronic disease register was reviewed for each condition and action taken as appropriate, such as letters sent to patients for reviews or rectifying coding errors. Patients on the cancer register were also reviewed.

In response to a breakdown in communication with the Department of Community Mental Health (DCMH) that placed a patient at risk, a register was developed of patients referred to the DCMH. Each month one of the GPs reviewed the clinical records for all patients on the register to ensure the practice was updated on treatment, care and any new risks. The GPs referred patients to the outreach clinic held twice a month at the practice facilitated by a community psychiatric nurse (CPN) from the DCMH. Feedback from patient interviews and through the CQC comment cards issued prior to the inspection, clearly suggested that patients felt the practice provided good support and access to mental health services.

We looked at a range of patient records and were assured that the care of patients with a mental illness and/or depressive symptoms was being effectively and safely managed.

Information from the Force Protection Dashboard, which uses statistics and data collected from military primary health care facilities, was also used to gauge performance. Service personnel may encounter damaging noise sources throughout their career. It is therefore important that service personnel undertake an audiometric hearing assessment on a regular basis (every two years). Audiometric assessments were in date for 97% of patients.

Audit was clearly embedded in practice and seen as the responsibility of all staff. A comprehensive programme of audit was in place that took account of population need and highlighted the audit activity for each department, such as the PCRf and nursing team. The programme identified the auditor, initial or repeat audit, date the audit was presented to the team and review timeframe.

Where appropriate, audit referenced organisational and/or national best practice. Examples of audits undertaken included: clinical recall; learning disabilities; unfit handling live arms; appointment waiting times; antibiotics; locum doctor prescribing habits; repeat medicines

prescribing; cytology; thrombocytosis (raised platelets in the blood); results handling; high risk medicines; QOF; thyroid and PCRf treatment process. The monthly ASER and audit meeting provided staff with the opportunity to present their audits to the wider team.

There was evidence that audit resulted in the practice being reviewed and changes made if necessary. For example, a prescribing audit identified that shared care agreements were not in place for all patients. This led to the formal requests being made to secondary care clinicians. Furthermore, a PCRf led musculoskeletal (MSK) injury trend audit identified the most common MSK injuries for three of the units. The audit highlighted injury types to high risk patient populations. A screening tool was developed as a direct result of the findings from the audit, with the aim to enable a more reproducible and more effective assessment of the patients at risk. This demonstrated an effective and efficient quality and improvement initiative.

Effective staffing

Continuous learning and development was promoted at the practice.

- All staff had received a generic and role-specific induction when they took up post at the practice. Mandated training was monitored and the staff team was in-date for all required training. Competency checks were undertaken where appropriate. Role-specific training was encouraged, such as additional training for the IPC lead.
- We found that the physiotherapist did not have a required qualification (referred to as MAME) to assess aircrew without an initial assessment being carried by the GP. The practice manager confirmed shortly after the inspection that the physiotherapist had applied for the next MAME course.
- The Regional Rehabilitation Unit (RRU) undertook advisory visits to the PCRf to monitor the performance of and support for Exercise Rehabilitation Instructors (ERI).
- All staff had an identified workplace supervisor and had access to one-to-one meetings, mentoring and support for revalidation. Clinical staff were given protected time for professional development.
- Regional meetings and forums were established for staff to link with professional colleagues in order to share idea and good practice. For example, nurses were encouraged to attend the regional nurse's forum and was established and the nurses could attend this to link with their colleagues and share ideas.
- Peer review was in place for the nursing team, provided by the regional nurse. Peer review took place on an ad hoc basis for PCRf staff and was not documented. It was not in place for GPs and shortly after the inspection, the practice manager confirmed peer review had been scheduled for the doctors with formal quarterly sessions to commence in January 2019.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- The deregistration of patients who were dependants was being handled well in conjunction with the Station Commander and Clinical Commissioning Group (CCG). A structured handover process was in place for transferring patients to local NHS practices.

- To reduce the high level of downgrading in one of the squadrons, the practice worked with squadron leaders to develop a bespoke sick chit that focussed on the work individuals could undertake rather than just being downgraded and not available for work. The practice submitted this as a quality improvement project as the new approach had shown improvement in the numbers of service personnel unavailable for work.
- The clinical records we reviewed showed appropriate staff, including those in different teams, services and organisations were involved in assessing, planning and delivering care and treatment.
- The practice had developed good working relationships both internally and with health and social care organisations. The doctors and PCRf staff held meetings on a regular basis to discuss and monitor patients under the care of PCRf. The SMO and lead physiotherapist attended the Unit Health Committee (UHC) meetings held each month. These meetings reviewed the needs of patients who were medically downgraded and those who were vulnerable.
- The practice also worked closely with the Regional Rehabilitation Unit (RRU) and the DCMH, and had good links with the local midwifery service and health visiting team.

Helping patients to live healthier lives

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

- Clinical records showed that staff encouraged and supported patients to be involved in monitoring and managing their health. Staff also discussed changes to care or treatment with patients as necessary.
- The practice supported national priorities and initiatives to improve the population's health including, stop smoking campaigns and tackling obesity. A health promotion display board was available to patients and it was refreshed based on the annual health promotion calendar. At the time of the inspection it provided information about how to manage flu symptoms.
- A nurse was identified as the lead for sexual health and they had completed the required training for the role. Information was available for patients requiring sexual health advice, including sign-posting to other services.
- Patients had access to appropriate health assessments and checks. Routine searches were undertaken for patients eligible for bowel and breast screening and appropriate action taken if patients met the criteria.

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. Based on clinical records, the following illustrates the current 2018 vaccination data for military patients:

- 99% of patients were up to date with vaccination against diphtheria.
- 99% of patients were up to date with vaccination against polio.
- 100% of patients were up to date with vaccination against hepatitis B.
- 95% of patients were up to date with vaccination against hepatitis A.
- 99% of patients were up to date with vaccination against tetanus.
- 94% of patients were up to date with vaccination against typhoid.

- 99% of patients were up to date with vaccination against yellow fever.

Based on a population of 149, all childhood immunisations were up-to-date. Searches were undertaken each month to check the status of immunisations.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. The staff team received training regarding the Mental Capacity Act (2005) in August 2018.
- The practice monitored the process for seeking consent appropriately. Coding in relation to consent was used for all invasive procedures undertaken, including acupuncture.

Are services caring?	Good
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We rated the practice as good for caring.

Kindness, respect and compassion

Staff supported patients in a kind and respectful way.

- Throughout the inspection staff were courteous and respectful to patients arriving for their appointments.
- Results from the October 2018 Patient Experience Survey (59 respondents out of 60) showed all patients who responded to the specific question would recommend the practice to family and friends. The 45 CQC comment cards completed prior to the inspection were very complimentary about the caring attitude of staff.
- The practice had an information network available to all members of the service community, known as HIVE. This provided a range of information to patients who had relocated to the base and surrounding area. Information included what was available from the local unit and from civilian facilities, including healthcare facilities. The practice used the HIVE social media page to communicate with civilian patients.

Involvement in decisions about care and treatment

Staff supported patients to be involved in decisions about their care.

- Interpretation services were available for patients who did not have English as a first language. Notices were displayed in clinical areas and in reception informing patients this service was available. Resources had been developed to meet the communication needs of staff from minority groups and these resources could be made available for patients if needed. For example, staff notices were available in Nepalese.
- The Patient Experience Survey showed that 55 respondents felt involved in decisions about their care (one patient did not answer the question and three said the question was not applicable). Feedback on the CQC patient feedback cards highlighted that patients received information about their treatment to support them with making informed decisions about their treatment and care.
- The practice proactively identified patients who were also carers. There were processes in place to identify patients who had caring responsibilities, including the use of alerts, codes and

regular searches. Patients were asked at registration whether they had caring responsibilities. Fifteen adults and one young person were identified as having caring responsibilities. Where appropriate, their needs were discussed at the station welfare meetings each month.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. Clinic room doors were closed during consultations.
- The layout of the reception area and seating, in close proximity to the dispensary and dental reception, meant that conversations between patients and reception could be overheard. The practice had addressed this through the use of screens. A television was playing to minimise conversations being overheard.
- Based on feedback from the Patient Participation Group (PPG), the practice had introduced a confidentiality card request at reception. Without speaking, the patient could hold up a card indicating to the receptionist that they wished to speak to someone in private.
- If patients wished to discuss sensitive issues or appeared distressed at reception they were offered a private room to discuss their needs.
- The practice could facilitate patients who wished to see a GP of a specific gender.

Are services responsive to people's needs?	Good
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We rated the practice as good for providing responsive services.

Responding to and meeting people's needs

Services were organised and reviewed to meet patient needs and preferences where possible.

- The practice identified a rise in the registration of dependants was impacting on care, especially due to the numbers of patients with complex needs. Additional afternoon sessions were required to meet clinical demand at a cost to the occupational medical clinics. The registration criteria for the practice was reviewed resulting in a significant number of dependants no longer meeting the criteria. Vulnerable patients remained with the practice. Affected patients had been consulted with and seen individually if required. Support had been offered with registering at local NHS practices. The handover process was detailed, which was particularly key for patients deregistering who had complex needs or caring responsibilities.
- A deregistration register was maintained to ensure all patients were accounted for. It included the action taken and outcome of patients who appealed against being deregistration. Any appeals involved a clinical review by a doctor.
- Staff understood the needs of its population and tailored services in response to those needs. There was evidence of training based on population-need. For example, one of the doctors completed a master's degree in performing arts medicine to better understand and treat injuries associated with the patient population of musicians. All doctors were trained to carry out aviation and sports diving medicals.
- Breast feeding and baby changing facilities were available.
- An access audit as defined in the Equality Act 2010 had been completed for the premises and reasonable adjustments had been made to accommodate patients. A lift was available for access to the first floor. Disabled parking and accessible WC facilities were available.

Timely access to care and treatment

Patients' needs were met in a timely way.

- Patients with an emergency need were seen that day and the waiting time for a routine appointment was two to three days. Double appointments at either the request of the clinician or patient could be made. Every effort was made to provide a same day appointment for children.
- Non-attendance at appointments were monitored and displayed in the patient waiting area. For example, 33 patients failed to attend their appointment in December 2018.
- The practice leaflet identified that home visits were not available. The practice manager clarified that these were not advertised. However, home visits could be facilitated. If a patient contacted the practice requesting a home visit then a telephone assessment would be carried out by the nurse to determine the need for a home visit. Telephone consultations were available with GPs.
- At the time of the inspection the next available routine physiotherapy appointment was within seven working days, well under the target of 10 working days. ERI access was within two working days.
- A direct access physiotherapist service (DAPS) had been in place since September 2018. Although not yet formally reviewed, the physiotherapist indicated that access for patients had improved. Feedback from the PPG was praising of the DAPS.
- Arrangements were in place for patients to access primary care when the practice was closed, including emergency care. The Patient Experience Survey showed that 58 respondents out of 59 had received their appointment at a time that suited them.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information was available to help patients understand the complaints process. The practice managed complaints in accordance with the DPHC complaints policy and procedure. Both a complaints and compliments log was maintained.
- The practice manager was the designated responsible person who handled all complaints and the practice manager deputised in their absence. A record of complaints was maintained, including verbal complaints. Three complaints had been received in the last 12 months. They had been managed effectively and resolved to the satisfaction of the complainants.
- Any complaints were discussed at the practice meetings and lessons identified. Changes to practice were made if feasible and used to improve the patient experience. For example, changes were made to the referral system based on a patient complaint. This included identifying a dedicated member of staff for manage and monitor referrals.
- A suggestion box, forms and pens were located in the waiting area for patients to leave feedback.

Are services well-led?	Good
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We rated the practice as good for providing a well-led service.

Vision and strategy

The practice worked to a clearly defined mission statement and vision including the Defence Primary Health Care (DPHC) mission statement of:

“DPHC will deliver a unified, safe, efficient and accountable primary healthcare and dental care services for entitled personnel to maximise their health and to deliver personnel medically fit for operations.”

The mission statement for RAF Northolt was:

“To deliver air power in support of current and contingent operations globally, while developing commercial activity for Defence benefit and enabling our joint supported units to deliver their operational output.”

The vision for the practice was:

“To provide safe, holistic and high quality care to the eligible population.”

Throughout the inspection it was clear staff were committed to providing and developing a service that embraced the mission and vision.

Leadership capacity and capability

Despite a depleted leadership team (SMO deployed and the practice had been without a deputy practice manager for a long time), we saw a practice that was well led. The leaders demonstrated they had the experience and skills to deliver high-quality sustainable care. They clearly understood the practice priorities and demonstrated they had capability and tenacity to drive service change for the benefit of patients. As an example, the deregistering of civilian patients based on re-defined eligibility criteria was being managed in a systematic way and demonstrated effective change management skills.

Culture

The culture at the practice was inclusive and all staff were treated equally.

- Staff told us they felt respected, supported and valued. Staff described an integrative approach involving all staff supporting each other. Opportunities were in place so staff could contribute to discussions about how to run and develop the Practice.
- Staff we spoke with clearly demonstrated a patient-centred focus and they said this ethos was promoted by leaders and embedded in practice.
- The practice had systems to ensure compliance with the requirements of the duty of candour, including giving those affected reasonable support, information and a verbal and written apology. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. A duty of candour register was in place.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- The practice actively promoted equality and diversity and provided staff with the relevant training. Staff felt they were treated equally.
- There was a strong emphasis on the safety and well-being of all staff. For example, conflict resolution training had been provided following two incidents where staff had to manage abusive patients. Supervision and appraisal was in place for all staff.

Governance arrangements

An effective overarching governance framework in place which supported the delivery of good quality care.

- There was a clear staffing structure in place and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. Terms of reference were in place to support job roles. The regional management team worked closely with the practice.
- The practice worked to the health governance workbook, a system that brings together a comprehensive range of governance activities, including the risk register, significant events tracker, lessons learnt log, training register, policies, meetings, quality improvement and audit. All staff had access to the workbook which provided links to meeting minutes, policies and other information.
- An effective range of communication streams were used at the practice. A schedule of regular practice and department meetings were well established. Meetings included those for the practice, heads of department, junior ranks, multidisciplinary rehabilitation and health care governance.
- Audit was a routine method used to measure the effectiveness and success of clinical and administrative practice. A comprehensive audit programme was established with clear evidence of action taken to change practice and improve the service for patients.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- Risk to the service were well recognised, logged on the risk register and kept under scrutiny through regular review. There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety. Processes were in place to monitor national and local safety alerts, incidents, and complaints.
- A business continuity plan was in place. The plan for major incidents had recently been tested for the station.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- An internal quality assurance tool, the DMS Common Assurance Framework (CAF) was used to monitor safety and performance. The DMS 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 practice received a Health Governance Assessment Visit (HGAV) from the regional team in February 2018. The practice had completed the resulting actions identified in a management action plan (MAP)

Engagement with patients, the public, staff and external partners

The practice involved patients, staff and external partners to support high-quality sustainable services.

- There were various options in place to encourage patients to provide feedback on the service and contribute to the development of the service. A patient experience survey was undertaken throughout the year.
- A Patient Participation Group (PPG) had been set up and the first meeting was held at the beginning of November 2018. Seven patients attended the first meeting, the majority of whom

were service personnel. The meeting generated a discussion about communication, appointment access, continuity of staff and facilities.

- The practice had good and effective links with internal and external organisations including the Regional Rehabilitation Unit (RRU), the DCMH, CCG and local NHS primary care providers
- A process was in place for staff to provide feedback on the service. The results of a staff survey were produced in November 2018 and showed a high level of staff satisfaction with their working arrangements.

Continuous improvement and innovation

Seeking to continually improve the service was evident throughout the inspection. We found numerous examples of that improvements that had been made based on the outcome of feedback about the service, complaints, audits and significant events. These included:

- A review of the eligibility criteria for registration based on the needs of the service personnel and demands on the service.
- Introduction of patient confidentiality cards as a result of feedback through the PPG.
- One of the GPs specialising in performing arts medicine to support the needs of the patient population.
- Maximising the safety of patients by ensuring the drivers of military transport were subject to DBS safety checks.
- IPC notices displayed in Nepalese to support effective communication with the cleaning team.