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 from our ongoing monitoring of data about services, and information given to us from the provider, patients, the public and other organisations.

### Ratings

<table>
<thead>
<tr>
<th>Overall rating for this service</th>
<th>Inadequate</th>
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<tr>
<td>Are services safe?</td>
<td>Inadequate</td>
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<tr>
<td>Are services effective?</td>
<td>Requires improvement</td>
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<tr>
<td>Are services caring?</td>
<td>Good</td>
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<tr>
<td>Are services responsive to people’s needs?</td>
<td>Good</td>
</tr>
<tr>
<td>Are services well-led?</td>
<td>Inadequate</td>
</tr>
</tbody>
</table>
Woolwich Medical Centre is rated as Inadequate overall

The key questions are rated as:

Are services safe? – Inadequate
Are services effective? – Requires Improvement
Are services caring? – Good
Are services responsive? – Good
Are services well-led? - Inadequate

We carried out an announced follow-up comprehensive inspection of Woolwich Medical Centre on 27 November 2018. This inspection included following up of requirements we made at the last inspection on the 18 January 2018 when the rating given for the practice was requires improvement overall.

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.

The overall findings from the inspection:

- The practice had some systems in place to minimise risks to patient safety. However, areas of governance and staff management required review to ensure the effectiveness of these systems. For example, systems in relation to the management of laboratory results, referrals to secondary care and maintenance of equipment.

- The arrangements for managing medicines, including emergency medicines was good. However, improvement was needed in the care of patients prescribed high risk medicines.

- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.

- Staff had received mandatory training. However, some had not received training to enable them to deliver effective care and treatment, specifically the administering of vaccines.

- Staff induction was not specific to the practice.

- Staff involved and treated patients with compassion, kindness, dignity and respect.

- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.

- Information about services and how to complain was available.

- Staffing levels at the practice were inadequate to meet the needs of the patient population

- There was a clear leadership structure and staff felt engaged, supported and valued by the Senior Medical Officer (SMO).

- Staff were aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.
• Effective governance of the practice was limited by the overburden of responsibilities given to the SMO and the lack of permanent staff.

The Chief Inspector recommends:

• Ensure risks to patients are assessed, the systems to address these risks be embedded. For example, in relation to the management of secondary care referrals and of pathology test results.
• A review of staffing levels and skill mix at the practice to ensure sufficient skill and expertise is available to meet the needs of the patient population.
• Ensure all equipment is fit for use.
• Ensure all staff are trained so they provide effective care.
• Comprehensive bespoke inductions to be provided so that extra resilience is built into staffing ratios.
• Ensure patient survey results are reviewed and acted upon in a timely way.
• Implement a safe system to manage patients who are prescribed high risk drugs, specifically the use of shared care protocols where appropriate.
• A review of formal governance arrangements including systems for assessing and monitoring risks and the quality of service provision. Arrangements should be embedded and understood by all staff.

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

Our inspection team
The team that inspected Woolwich Medical Centre included a CQC lead inspector, and a team of specialist advisors including a GP, a practice manager and a nurse specialist advisor.

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 845 at the time of inspection. The age range of the population was 17 to 60 years. Dependents 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 medical services, the medical centre offers emergency appointments each day, occupational health, force preparation for deployment, access to cervical screening and course medicinals. 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 there was a civilian Senior Medical Officer (SMO) was in post. In addition, there is a nurse, a locum practice manager and one member of administrative staff. There were two physiotherapists (one was a locum) and an Exercise Rehabilitation Instructor (ERI), also a locum, within the Primary Care Rehabilitation Facility.
Although not employed by the medical centre, the practice team was supported by Regimental Aid Post (RAP) staff employed by the Field Army and attached to two major units. RAP staff can be deployed at any point. They included a full time Regimental Medical Officer (RMO and eight Combat Medical Technicians (referred to as medics). A medic is trained to provide medical and trauma support 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.

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.

### Are services safe? Inadequate

We rated the practice as inadequate for providing safe services.

Following our previous inspection, we rated the practice as inadequate for providing safe services. We found gaps in systems and processes to keep patients safe, including systems for, the monitoring of patients deemed to be vulnerable, safeguarding, infection control, waste management and the management of significant events. Low staffing levels posed a risk to patients.

When we carried out this follow up inspection we found that some of the above recommendations had been made but were not fully embedded to ensure patient safety. Following our review of the evidence provided the practice is still rated as inadequate for providing safe services.

### Safety systems and processes

The practice had systems to keep patients safe and safeguarded from abuse, but there was scope to improve them

- Measures were in place to protect patients from abuse and neglect. Adult and child safeguarding policies were available and took account of local arrangements. Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient’s welfare. The SMO confirmed that there were no children currently registered at the practice. However, the practice were aware of the duty of care to the children of serving personnel. Vulnerable patients were discussed with the chain of command at the Unit Health Committee which was attended by the SMO, chain of command and the welfare team. The SMO and the chain of command held a register of all injured (mental and physical) and downgraded personnel, which was also held by the welfare team. There were no routine meetings or discussion of vulnerable patients at practice level due to lone working and lack of permanent staff.

- The SMO was the safeguarding lead identified for the practice, but there were no deputising arrangements in place. They had received level 3 training relevant for the role, and all staff were up-to-date with safeguarding training at a level appropriate to their role. Clinical staff acted as chaperones, they had received a Disclosure and Barring Service (DBS) check. The chaperone policy and notices were displayed advising patients of the service.

- Measures were in place to highlight and monitor vulnerable patients, including the use of Read codes and application of alerts on electronic patient records. A central register of vulnerable
patients was maintained. We looked at the register and noted all patients had alerts on their records.

- 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 including a DBS check to ensure staff were suitable to work with vulnerable adults and young people. DBS checks were renewed every five years. They also monitored each clinical member of staff’s registration status with their regulatory body. All staff had professional indemnity cover. Information was in place to confirm staff had received the relevant vaccinations required for their role at the practice.

- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises were clean and tidy. There were cleaning schedules and monitoring systems in place. The designated infection and prevention and control (IPC) lead for Woolwich was the military nurse currently on secondment but due to be formally assigned to the practice in 2019. They are new to primary health care and have no specific IPC training other than the mandated IPC online modules. There was no listed deputy lead for infection prevention. However, we were informed following the inspection that in their absence this responsibility would be the responsibility of the medic.

- There was an IPC protocol and staff had received up to date training. Annual IPC audits had been previously undertaken in October 2018 which identified a significant number of issues that needed addressing. An action plan was in place and evidence showed this has been discussed in detail at a practice meeting in November 2018. It was noted that support could be accessed from a nearby base. Arrangements were in place for the safe management of healthcare, and systems for safely managing healthcare waste.

**Risks to patients**

There were systems in place to assess, monitor and manage risks to patient safety. However further improvement was needed.

- Varying staffing levels/skill, a reliance on locum staff and stretched clinical leadership meant governance systems were underdeveloped. The SMO remains in post, having provided consistency in the practice for one year. Unfortunately, this had been hampered by the RMOs absence resulting in a higher amount of work for the SMO to manage. Lead roles relating to healthcare governance were all undertaken by the SMO but no deputies were in place.

- The practice was not well staffed with key gaps such as nursing staff and The Regimental Medical Officer (RMO). The RMO was covered by a locum however the nursing posts were vacant and not filled. The practice told us that the locum practice manager was being replaced with a permanent member of staff within the next two weeks which would provide the practice some consistency. The practice was unable to fully utilise the military medics as they did not always know which medics were available and seldom had an awareness of the unit’s forecast of events. The PCRF was managed by one permanent member of staff who worked alongside one locum physio and one locum ERI (the ERI was leaving in January 2019 leaving the post vacant). Following the inspection, we were advised by the practice that a military Exercise Rehabilitation Officer (ERI) would be in post in January 2019. However, they would only be supervising rehabilitation for one of the two major units at Woolwich, still leaving significant gaps in staffing.

- The practice had an induction pack which covered mandatory and role specific induction for all clinical and administrative staff and locums. It was noted that safeguarding was not covered until week five onwards in the local induction. The practice manager acknowledged this needed to be
changed to capture this within the first week before the clinician began to see patients. The locum induction pack was generic and was not specific to the practice, for example detailed direction on local safeguarding referral processes was required.

- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. For example, they had received medical emergency training in the last 12 months for the care of head injuries. The SMO had also been out and visited the troops in their barracks to highlight the risks and emergency actions to take.

- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Staff, including reception staff, had received awareness training in identifying and managing patients with severe infections, such as sepsis.

- Equipment throughout the practice as in good order except for some pieces in the Primary Care Rehabilitation Facility (PCRF). We saw some equipment was out of use because it had not been serviced this included the treadmill and the machine used for icing injuries. There was only one plinth in use as we were told the other was being used within the practice to replace one that had been ripped. These items had been reported as needing attention.

- Electrical safety checks were undertaken in accordance with policy. Fire safety including a fire risk assessment, fire plan, firefighting equipment tests and fire drills were all in-date. Portable appliance and clinical equipment checks were up-to-date and records maintained.

- There was no failsafe or local policy in place for the management of specimens and test results. The military nurse printed off two sample request forms and maintained one copy in a folder and sent one with the specimens. This constituted the samples register. The nurse checked the folder weekly and removed the test requests that had been returned and recorded ‘as seen’ on the Defence Medical Capability Information Programme (DMICP). However, the nurse did not have access to Path Links. There was no policy in place to cover nurse absence and although it was suggested that the medics would assume the role, when questioned they were unaware of the process. The SMO was the only clinician currently at Woolwich who had access to path links, which presented a considerable risk should they have any planned or unplanned absence.

**Information to deliver safe care and treatment**

Staff did not always have 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 saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.

- There was no significant backlog in electronic summarising at the practice. We saw that now any new patients were asked to complete a proforma on arrival. The practice followed up any areas of concern, such as raised blood pressure.

- There was a system in place for referrals and hospital appointments. These were managed by the SMO as no other member of staff had the appropriate access to do so. Internal referrals to other DPHC providers were done by the administrator. Where secondary care referrals could not be done electronically they were faxed or posted. There was no referrals tracker in place. When appointments were received they were kept in a tray in the office until a patient was contacted and they collected it. The practice was unable to demonstrate if this had led to any patients that did not attend as no audit has been conducted and with no register it was difficult to ascertain. The referral/appointment policy currently being used was not failsafe and needed review as it referred to a tracker being used. Following the inspection, we were advised by the practice that a system had been developed to track all internal and external referrals.
Safe and appropriate use of medicines

There were arrangements in place for the management of medicines and vaccines. This included arrangements for obtaining, recording and handling of medicines. However, some areas were needing improvement:

- Woolwich Medical Centre was not a dispensing practice. Arrangements were in place to send all prescriptions to a local community pharmacy. These were fulfilled and returned to the practice for collection by patients within 48 hours. We were not made aware of any delays in patients receiving medication.
- The regional pharmacist carried out regular medicines checks and audits, which the practice contributed to.
- Blank prescription forms and pads were securely stored and there were systems to monitor their use. Records showed that staff recorded fridge and room temperatures; this made sure medicines were stored at the appropriate temperature. Staff were aware of the procedure to follow in the event of a fridge failure.
- The practice did not hold any controlled drugs (medicines that require extra checks and special storage because of their potential misuse).
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.
- PSDs (Patient Specific Directions) were in use to allow non-prescribing staff to carry out vaccinations in a safe way. Staff had received training, they were however, awaiting authorisation by the SMO in accordance with policy as they were new to primary healthcare and were not fully trained in all aspects normally expected of a practice nurse in primary care setting. They were not operating under PSDs in the meantime.
- High risk medicines were not managed effectively. We saw one patient who was prescribed these and there was no shared care agreement in place. We saw they had received regular blood tests but there were no failsafe recalls routinely used on the clinical system to alert clinicians that blood tests were required to monitor effectiveness.
- We reviewed safety records and national patient safety alerts, including the minutes of meetings where these were discussed. The Medicines and Healthcare Products Regulatory Agency (MHRA) alerts were viewed by the practice manager and disseminated to the appropriate member of staff. All alerts were checked against equipment registers and DMICP patient records/stock reports. For example, the prescribing of Sodium valproate which is an anticonvulsant medicine used to treat epilepsy in adults and children.

Track record on safety

The practice had a good safety record.

- The SMO was the lead for health and safety. Risk assessments pertinent to the practice were in place including patient handling, needle stick injury, lifting and handling and lone working.
- There was an alarm system in the practice and PCRF staff had individual alarms to summon assistance in the event of an emergency.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.
• There was an electronic organisational-wide system (referred to as ASER) for recording and acting on significant events, incidents and near misses. The SMO was the lead for the process and all staff had access to the system.

• Significant events and other incidents were investigated with a route cause analysis undertaken to determine what went wrong. We saw minutes of meetings that showed significant events were discussed at the practice healthcare governance meetings.

<table>
<thead>
<tr>
<th>Are services effective?</th>
<th>Requires Improvement</th>
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<tbody>
<tr>
<td>We rated the practice as requires Improvement for providing effective services.</td>
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</tr>
<tr>
<td>Following our previous inspection, we rated the practice as requires improvement for providing effective services. This was due to the audit programme being limited and staff not having updated training or induction.</td>
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<tr>
<td>When we carried out this follow up inspection we found that, whilst there was some improvement, there was scope for further actions to be taken to improve outcomes for patients.</td>
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<tr>
<td>Following our review of the evidence provided, the practice is still rated as requires improvement for providing effective services.</td>
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**Effective needs assessment, care and treatment**

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

• The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from National Institute for Health and Care Excellence (NICE) and used this information to deliver care and treatment that met patients’ needs. We saw evidence which showed there were processes in place to review updates, discuss these with clinical colleagues to ensure evidence-based best practice was updated in line with amendments. Audits were undertaken stemming from NICE recommendations, for example, for the management of hypertension (raised blood pressure).

• We saw many examples of collaborative working and sharing of best practice to promote better health outcomes for patients. For example, the practice held weekly diary meetings for all staff to attend, whereby ‘hot topics’ were discussed and shared, for example meningitis.

**Monitoring care and treatment**

The practice had a good chronic disease management plan in place managed by the SMO. Patients were recalled appropriately and patients received effective, individually personalised care.

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.

Information used to monitor performance and the delivery of quality care was not always accurate and useful. Staff told us that they were aware of inconsistent use of Read codes and clinical templates and they understood how this could lead to inconsistent delivery of care for patients. The
practice provided the following patient outcomes data to us from their computer system on the day of the inspection:

- There were no diabetic patients.
- There were 10 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. All had a record for their blood pressure in the past nine months. Of these patients with hypertension, seven had a blood pressure reading of 150/90 or less.
- There were 15 patients with a diagnosis of asthma. Eleven 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. Of the remaining four, two were identified as not having asthma and two had previously had childhood asthma.
- There were 66 patients being treated with depressive symptoms which included everything from low mood to stress related disorders and clinical depression. The system showed that 41 patients had been referred to the Defence Community Mental Health (DCMH) in the last 12 months. This facility was in the same building as the medical centre and the practice had established good formal and informal links with them.

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). Data we were provided with for the practice showed:

- 61.5% of patients had an audiometric assessment within the last two years.

No explanation was given to this low number although low staffing levels would significantly affect this. Following the inspection, we were advised by the practice that the number had improved and was now 88%.

The RAP medics attached to the practice were responsible for ensuring the force were healthy and fully combat capable. They maintained spreadsheets and liaised with the unit chain of command for recall of patients to ensure they had received their vaccinations, medicals etc. The practice was not involved and did not have oversight of recall procedures to ensure it was being done effectively. The practice staff looked after planning of the smaller units and reserves.

All audits were currently undertaken by the SMO. An audit calendar was in place that identified the audits to take place going forward. Clinical audits undertaken for the practice included: an asthma audit, long term condition audit, prescribing audit and notes audit. The hypertension audit had resulted in the development of an a new policy in the management of raised blood pressure by medics. In a number of audits it showed that QOF indicators were being met and although they required monitoring there was no requirement for change.

We did not see any audits carried out by the PCRF. We did see some data collection with regard to patients that had not attended their appointments (DNA), however nothing had been done with this information.

**Effective staffing**

Evidence reviewed showed that not all staff had the skills and knowledge to deliver effective care and treatment.
• The nurse administering vaccines had not received any immunisation training, we were told that they had found the appropriate course and had booked a place but funding from the Region had not been agreed in time for the nurse to attend.

• Medics administering vaccines had not received an annual immunisation and vaccination training update in the past two years.

• Staff had access to one-to-one meetings, appraisal, coaching and mentoring, clinical supervision and support for revalidation. Clinical staff were given protected time for professional development and evaluation of their clinical work. The SMO regularly reviewed medics consultations and gave support and guidance.

• 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 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.

• This included care and risk assessments, care plans, medical records and investigations.

• Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients’ needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. However, due to the geographical location of the practice links to other practices and community teams was difficult. For example, when a patient required midwifery services it was local policy that the patient found their own local care provider dependent on where they lived. The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment this was usually done electronically via email.

• Clinical meetings to discuss patients were held each month between the physiotherapists and doctors. Patients referred to the PCRF were reviewed every two to four weeks. PCRF staff referred patients to other clinics if it was deemed appropriate to their rehabilitation, such as weight management and smoking cessation.

• The SMO attended Unit Health Committee (UHC) meetings to update unit commanders on medically downgraded patients. In addition to UHC meetings, the SMO attended welfare meetings where the needs of vulnerable patients, including patients with mental health needs were discussed.

Supporting patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

• Records showed, and patient feedback confirmed, 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.
Cervical smears were referred to either the nearest military medical centre or local sexual health service. However, the nurse had a clear understanding of the cytology administration and patients received their invitations and results at the appropriate time.

Patients had access to appropriate health assessments and checks. Routine searches were undertaken to identify for patients eligible for bowel and breast screening.

It is important that military personnel have sufficient immunity against the risk of contracting certain diseases. The World Health Organisation sets a target of 95% for vaccination against diphtheria, tetanus, pertussis and polio and measles, mumps and rubella. The following illustrates the current 2018 vaccination data for the practice patient population:

- 93% of patients were recorded as being up to date with vaccination against diphtheria.
- 95% of patients were recorded as being up to date with vaccination against hepatitis B.
- 96% of patients were recorded as being up to date with vaccination against hepatitis A.
- 70% of patients were recorded as being up to date with vaccination against typhoid.

The typhoid vaccine has a lower uptake than other vaccinations. Current guidance state DMS practices should offer the typhoid vaccination to personnel before deployment and not to routinely vaccinate the whole population.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- Where a patient’s mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient’s capacity and recorded the outcome of the assessment.

<table>
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<th>Are services caring?</th>
<th>Good</th>
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We rated the practice as good for caring.

Kindness, 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.
- 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, these results were not available for us during this inspection.
- The practice had a board located in the waiting room named “The Tree of Learning”. his was an opportunity for patients to add comments onto the tree about the care they received. We saw patients were highly complementary about the staff and the care they received.

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

- An interpretation service was available for patients who did not have English as a first language and all staff we spoke with were aware of how to access it.
- Processes were in place to identify patients who also had a caring responsibility so that additional support or healthcare could be offered if needed. The new joiner’s registration form included a question about caring responsibilities. Alerts could be used on DMICP to identify carers. At the time of the inspection there was only one carer identified at the practice.

Privacy and dignity
The practice respects the privacy and dignity of patients.

- 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.
- The PCRF utilised one room for two patient consultations, a curtain separated both areas meaning patients could be overheard. There were radios in each area to try and muffle conversations.

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<th>Are services responsive to people’s needs?</th>
<th>Good</th>
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We rated the practice as good for providing responsive services.

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. Direct Access to physiotherapy had not yet been introduced.

Timely access to care and treatment

- 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.
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. There had been no formal complaints since 2015.
- 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.

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<tr>
<th>Are services well-led?</th>
<th>Inadequate</th>
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We rated the practice as inadequate for providing a well-led service.

Following our previous inspection, we rated the practice as requires improvement for providing well-led services. This was due to some governance structures not sufficiently developed to support effective performance.

When we carried out this follow up inspection we found that little work had been undertaken to ensure recommendations had been acted on, however, further work was needed to allow the practice to provide safe and effective care. Following our review of the evidence provided, the practice is rated as inadequate for providing well-led services.

Leadership capacity and capability

We found the management team had the experience, skills and tenacity to deliver good care. However staffing levels remain a risk.

- The current leadership capacity is provided by the civilian SMO and locum practice manager and they share the key leadership responsibilities. The main responsibilities within in the practice fell to the SMO, there were no deputies for cross coverage and resilience in the event of absence from the practice. The RMO provides deputy leadership when working but is currently absent.
- The team did not feel supported by the regional HQ despite being co-located in Woolwich. A review of the CAF was 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. The Practice was dependent on DPHC Regional Headquarters who conduct the HGAV visits. On discussion with DPHC the Practice was due to have an HGAV January 2017 but due to regional staffing levels the programme was put on hold. Members of the Regional team had visited the practice many times since January 2018 to offer some support, however little actual improvement has been seen.
- Staff told us the SMO was approachable and always took the time to listen to all members of staff. There was a meetings programme in place and the practice held regular whole team meetings.
- Staff said they felt respected, valued and supported. The SMO encouraged all members of staff to identify opportunities to improve the service delivered by the practice.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of
services must follow when things go wrong with care and treatment). This included support training for all staff on communicating with patients about notifiable safety incidents. The leaders encouraged a culture of openness and honesty.

**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.

**Culture**

The practice had a culture of good quality sustainable care.

- Staff stated they felt respected, supported and valued.
- The practice focused on the needs of patients.
- 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.

**Governance arrangements**

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

- Staffing levels and skill mix at the practice remained an issue. The SMO was the lead for all key areas of practice. The practice relied on locum staff due to permanent staff vacancies. Administration and nursing posts remained vacant. The practice was still working on updating or generating their local policies from their management action plan stemming from the last CQC inspection in January 2018. More work was required, as an example they have no local safeguarding policy or standard operating procedures (SOP) for locum GP awareness, no sample recording/tracking policy, no test results/Path Links policy and the referral SOP was not being followed as it was out of date.

- The audit programme had improved the previous inspection although most audits were those mandated by DPHC such as the infection control audit. All audits were done by the SMO and were within cycle one. No administrative staff or medics were involved in the audit process.

- The SMO is the only current permanent member of staff who actively uses the electronic referral/choose and book system due to lack of ability to generate smart access cards. This issue was further compounding the SMO workload as all electronic referrals were having to be done by
them and not deferred to the administrative staff to facilitate. The current locum had a smart card but it was not being used.

• There was a positive approach to meetings, including clinical and practice meetings. Minutes of meetings demonstrated that lessons learned from significant events, complaints and other investigations led to change and improvement in practice.

• Assessments were in place for managing risks. Regular risk register meetings were taking place between the practice manager and the SMO, where the risk was discussed and review/actions recorded. Risks were followed through to closure or passed to Regional HQ. They were also discussed during the Healthcare Governance Practice Meeting.

• 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.

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

• An understanding of the performance of the practice was maintained on a basic level amongst staff. Practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice. The SMO monitored achievement against clinical indicators in QOF and reported if there were areas which required focus.

Managing risks, issues and performance

There were some clear and effective processes for managing many risks, issues and performance. However, we identified some areas where improvement was required.

• There were gaps in processes to identify, understand, monitor and address current and future risks including risks to patient safety.

• Staffing levels throughout the practice were not adequate to ensure patient safety.

Appropriate and accurate information

The practice did not always have appropriate and accurate information.

• An understanding of the performance of the practice was maintained. The SMO used the Common Assessment Framework (CAF) as an effective governance tool. The practice had yet to transfer to the new eCAF and had been given an extended completion deadline in early 2019. The CAF was reviewed by management groups but not as a whole team/practice. The practice had put in place a management action plan following the last CQC inspection visit and had made good progress with improvements within their own capabilities considering the limited staffing available to them. We were told the local DPHC regional HQ had offered little support or engaged with this process of improvement.

• 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 because systems and processes were not fully failsafe to effectively monitor and manage patient’s referrals and laboratory results.

• Information used to monitor performance was not always accurate. Staff told us that they were aware of inconsistent use of Read codes and clinical templates and they understood how this could lead to inconsistent delivery of care for patients. The SMO had introduced a quick guide to Read Codes for all staff to refer to. Some permanent staff had received training in the use of ‘Population Manager’ which is a clinical search facility. However, locum staff had not.
There were good arrangements at the medical centre in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. This extended to the PCRF.

Engagement with patients, the public, staff and external partners

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

- 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.
- The Tree of Learning had been established in the practice to provide an opportunity for patients to feedback about the care they received.
- Patient experience surveys were undertaken quarterly although no results of the most recent survey were available.
- Staff were encouraged to feed into various practice meetings. The senior management team military/civilian operated an open-door policy. Staff were encouraged to have two-way discussion on midyear appraisals, peer reviews and annual reports.
- We saw good evidence of engagement with the Chain of Command, welfare and other DPHC specialist services. The practice had very good links with the Army Welfare Service and the Women’s Royal Voluntary Service.

Continuous improvement and innovation

- The practice has worked hard to improve following the last inspection. They had produced a management action plan which they have been working through. We saw examples of the practice focussing on continuous learning and improvement. For example, the introduction of a meeting structure ensuring all staff are engaged with the practice ethos and development.