Hounslow Medical Centre

Quality report

Cavalry Barracks
Beavers Lane
Hounslow
Middlesex
TW4 6HD

Date of inspection visit:
17 June 2019

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12 August 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, and information given to us by the practice and patients.

Ratings

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

Chief Inspector's Summary

We carried out an announced comprehensive inspection of Hounslow Medical Centre on 21 March 2018. The practice was rated as requires improvement overall, with a rating of requires improvement for the key questions of safe, effective and well-led. Caring and responsive were rated as good.

We carried out this announced follow up inspection on 17 June 2019. This report covers our findings in relation to the recommendations made and any additional findings made during the inspection.

A copy of the report from the first inspection can be found at:

Hounslow Medical Centre, March 2018

This practice is rated as inadequate overall.

The key questions are rated as:

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

We carried out an announced comprehensive inspection at Hounslow Medical Centre on 17 June 2019. Defence Medical Services (DMS) are not registered with the Care Quality Commission (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 systems to manage risk required strengthening.
- The practice demonstrated an ethos of patient centred care. However, systems and staffing levels did not always support the effective delivery of care.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Systems in place for chronic disease management were not effective.
- Clinical record keeping was detailed and clear. However, there was no system to monitor that care and treatment was delivered according to evidence-based guidelines.
- Patients found the appointment system easy to use and could access care when they needed it.
- A recent programme of quality improvement work was in place and was starting to deliver better outcomes for patients.

- Staff had developed links with military bases located nearby and support from the regional team had increased.
- There were insufficient clinical hours to provide effective clinical leadership. Further support was required from the regional team.

The Chief Inspector recommends:

- A comprehensive review of safety arrangements to take account of:
    - Safeguarding arrangements.
    - Infection prevention and control arrangements.
    - Emergency equipment and medicines.
    - Medicines management policies and procedures.
    - Management of alerts
- Introduce a structured patient recall system to include patients with long-term conditions and those eligible for health screening.
- A review of governance arrangements to take account of:
    - The sufficiency of current clinical leadership arrangements.
    - The processes for managing risks, issues and performance.

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Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

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

Background to Hounslow Medical Centre

Hounslow Medical Centre (MC) is located in Middlesex near London Heathrow airport. The MC is part of Ministry of Defence (MOD) Hounslow base. The treatment facility offers care to forces personnel. Dependants and children are registered with nearby NHS practices. At the time of inspection, the patient list was approximately 625.

In addition to routine GP services, occupational health, travel health and physiotherapy services are provided on site. Family planning advice is available, with referral onwards to NHS community services. Maternity and midwifery services are provided by NHS practices and community teams. Medicals offered include diving that are completed fortnightly by the visiting Senior Medical Officer (SMO).

The Centre is staffed by a combination of military and civilian staff. There are nine posts outlined in the table below:

Position	Numbers
Senior Medical Officer	Post Vacant Support provided by SMO from Aldershot who visits approximately once a fortnight
Civilian GP	1 locum GP
Practice Nurse	1 civilian nurse (Band 6)
Practice Manager	1 military practice manager
Administrative support	1 civilian medical administrator
Primary Care Rehabilitation Facility (PCRF) staff	1 physiotherapist (gapped) 1 locum physiotherapist (providing an average of five sessions weekly) 1 exercise rehabilitation instructor (ERI) (providing an average of 4 sessions a week)
Contracted staff	1 domestic staff

In addition, the medical centre is supported by regimental aid posts (RAPs). There are seven Combat Medical Technicians (CMTs) who rotate weekly and one Medical Sargeant. These staff are managed and trained by their regiment.

Are services safe? | Inadequate

We rated the practice as inadequate for providing safe services.

Safety systems and processes

The practice had systems intended to keep patients safe and safeguarded from abuse. However, we found gaps in some areas:

- The practice had safety policies including adult and child safeguarding policies which were communicated to staff. Staff received safety information for the practice as part of their induction and refresher training, named safeguarding leads were on boards displayed in the patient waiting area and the two consulting rooms and policies were accessible to all staff. Not all staff were clear on who was the safeguarding lead (there were no terms of reference or job descriptions that related to safeguarding roles) and the referral process in the adult

safeguarding policy did not make it clear who to go to for further guidance. Child safeguarding details were displayed on the wall, but there was no reference to adult safeguarding contacts.

- There was a system to highlight vulnerable patients on records and a risk register of vulnerable patients. Staff were alerted to a vulnerable patient by automated alerts from the electronic clinical operating system. Multidisciplinary team (MDT) meetings were used to discuss vulnerable patients. Although staff showed good awareness of vulnerable patients, minutes did not record any discussion and notes were not added to the patient record.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff had links with the London borough of Hounslow safeguarding team and knew contact details for the Multi-agency Safeguarding Hub (MASH). There had been some liaison with the welfare team but the GPs were yet to attend Unit Health Committee (UHC) meetings therefore an opportunity to get feedback on patients identified as vulnerable was being missed.
- Staff had received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns.
- Staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The availability of chaperones was notified throughout the medical centre.
- The practice manager carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. DBS checks were undertaken where required. However, in the absence of the practice manager there was no process to ensure checks were completed.
- The system to manage infection prevention and control (IPC) required strengthening. The nominated lead had received bespoke training and an IPC audit had been undertaken in February 2019. However, the audit had not identified the PCRF area as non-compliant (there was no sink in the treatment room). IPC was a standing agenda item at practice meetings, however the meeting held on 16 May 2019 had no entries in this section and some tasks identified by the most recent audit had not been completed.
- There were systems for safely managing healthcare waste, an audit had been undertaken in May 2019 and no issues had arisen. The practice nurse was listed as the lead for waste management but had no terms of reference (TORs) for the role and a staff member without appropriate training was deputising. This was changed on the day of the inspection with the practice manager named as the deputy.
- There was a dedicated cleaner who worked sufficient hours for the size of the building. A daily check sheet showed which rooms had been cleaned. However, the cleaner was not working to any schedule, the daily checks were not being carried out against any set standard, the medical centre did not have sight of their cleaning contract and the cleaning supervisor did not complete assurance checks with the IPC lead. There had been a deep clean in February 2019 as a result of some building work, but deep cleans were not part of the cleaning contract (this was on the risk register).
- The practice had arrangements to ensure facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. However, there was no building specific fire risk assessment on display or hard wire electrical testing certificate available on the day. We were told that these were held by the unit.

Risks to patients

The systems to assess, monitor and manage risks to patient safety required strengthening.

- The overall staffing arrangements were adequate for the number of patients, however there was a reliance on support from locum staff and RAP medics. The centre relied on support from the regional team to manage staff absences and for responding to epidemics, sickness, holidays and busy periods. However, the nurse explained that they had only been able to take leave when the unit was on standown (closed for block leave) and tried to pre-plan the patients to be seen before or after their leave.
- There was an induction system for temporary medical centre staff. However, this was a generic document not tailored to their specific role, or to the practice itself.
- The practice was not suitably equipped to deal with medical emergencies. Staff had received some training, for example, in basic life support, but the requirements for emergency medicines had not been risk assessed and monitoring (ensuring key items were available and in date) was not effective. For example, there was no medication to treat suspected meningitis and no medication to treat severe low blood pressure. The adrenaline syringe had an expiry date of April 2019 and the blue needles and cannula had expiry dates of March 2019.
- There was no evidence of formal training on sepsis but administration staff had been given a guide to refer to. With the exception of the medic's room, posters detailing the signs of sepsis were not displayed in treatment rooms. There had been no formal training on the management of thermal injuries.

Information to deliver safe care and treatment

The processes to ensure staff had the information they needed to deliver safe care and treatment to patients were not fully effective.

- The recent DPHC new patient questionnaire had been implemented and 93% of summarising was up to date for the current list of registered patients.
- There was no systematic peer review of clinical notes, although there was evidence that the SMO had carried out reviews on GP consultations and no issues had been found. Although no issues were identified at the inspection, there was scope to ensure that notes made by the nurse and PCRF staff were periodically audited for quality assurance.
- There was a system in place to manage hospital letters and this showed who had read and actioned the letters for each patient.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- The system in place to govern referrals had recently been implemented. Appointment letters were handed to the patient in the consultation via ERS (electronic referral system). The practice had developed referral letter spreadsheets for routine referrals and urgent referrals, however, we saw four referrals that had not been included. The practice confirmed the day after the inspection that the four referrals were made internally from the physiotherapist to the ERI and would be captured by searches on DMICP.
- Sample testing results were entered onto a register allowing them to be tracked. However, the system was not being used effectively. We found three results that had not been filed and this included an abnormal result from 24 May 2019 which had not been actioned until 13 June 2019.

Safe and appropriate use of medicines

The practice systems for appropriate and safe handling of medicines required improvement. There was no clear lead for medicines management.

- The systems for managing and storing medicines, including vaccines, medical gases, and emergency medicines and equipment needed strengthening to ensure patient safety and to provide an effective audit trail. The practice had not carried out an appropriate risk assessment to identify medicines that it should stock. The probe from the thermometer used to monitor fridge temperatures was not being used correctly to ensure accurate readings. The destruction of controlled drugs (CDs) was not carried out in accordance with guidance issued by The Royal Pharmaceutical Society. The practice kept prescription stationery securely. However, the tracking system for prescription pads was not fully effective. A prescription pad of unserialised and unaccounted prescriptions was found in the CD cabinet, there was an online record but no bound record book for tracking.
- Written procedures in medicines management were in place but there was no record of staff having reviewed them and the SOPs were not seen to be governing activity. For example, the management of stock was not per the SOP.
- Staff had access to British National Formulary (BNF) and prescribing formulary. Staff prescribed, administered and supplied medicines to patients in line with legal requirements and current national guidance.
- We reviewed two patients who took disease-modifying anti-rheumatic drugs (DMARDs). One did not have a shared care protocol uploaded into their notes (the practice had made multiple attempts to obtain this from the hospital). We saw that both patients had been managed appropriately.
- Whilst the practice did not routinely hold stock of CDs, appropriate steps were not always taken for the monitoring of CDs (held awaiting collection). For example, the prescription forms used for prescribing CDs had only been checked once since the register started in 2015 (the regional pharmacist recorded a check in April 2019). There was no log of keys removed for access to the CD cabinet and no standard operating procedure (SOP) for access.
- Prescriptions were signed before medicines were dispensed and handed out to patients.
- A repeat prescription system was in place and followed by staff. Staff told us that a clinician was informed of any uncollected prescription but this was not documented on DMICP. Some practice staff accepted verbal requests for repeat prescriptions, including over the telephone, contrary to DPHC policy.
- PGDs (Patient Group Directions) and PSDs (Patient Specific Directions) were in use to allow non-prescribing staff to carry out vaccinations in a safe way. However, some PGDs were found to be out of date (December 2016). We were told some PGDs had recently been authorised but the practice was unable to provide evidence at the inspection. We were told PSDs were not used at the practice.
- The practice nurse was the only staff member able to order vaccines.

Track record on safety

The health and safety systems at the practice needed further development.

- A building risk assessment was not in place and DPHC Safety Health Environment and Fire (SHEF) documents that were mandated for display were absent. One of the regimental support

staff was the designated SHEF lead but had not completed formal risk or SHEF training. Applications had been submitted for the practice manager to attend health and safety training and a member of the regional team provided support and guidance. Mandated SHEF training for staff was shown as being 100% compliant.

- Patients in the waiting area were observed by practice staff and potential risk highlighted if someone suddenly became unwell.
- Each workstation had a personal alarm that could easily be overheard in the medical centre. There was a fixed alarm system in the PCRF building that sounded in the medical centre when activated. The system was checked weekly and a register of checks maintained.
- The practice confirmed that there were occasions when patients' records were unavailable due to system failure. However, staff stated that this was seldom for more than a few hours at a time. In the event of the system being down for a prolonged period of time, only patients with urgent requirements were seen and paper notes would be taken and later scanned on the electronic clinical system. These contingency steps was detailed in the business continuity plan.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong. However, the Automated Significant Event Record System (ASER) for managing significant events could be improved.

- There was a system and policy for recording and acting on significant events and incidents. Staff had received training in using the system and understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so and had spoken with staff about lowering the threshold for reporting incidents.
- There were systems for reviewing and investigating when things went wrong. Most staff had access to the significant event reporting system and understood how to use it. The process relied on staff accessing the ASER tracker and there was no evidence to show discussion took place around all significant events. Making use of the 'lessons learned' function would widen learning across the practice team. The locum physiotherapist had not been given access to the ASER system.
- There was a system for receiving and acting on safety alerts. However, two Medicines and Healthcare products Regulatory Agency (MHRA) alerts from June 2019 had not been added to the register suggesting no action had been taken. Two Central Alerting System (CAS alerts) from May 2019 were seen unopened in the nurse's inbox suggesting they had not been actioned.
- Staff had access to the significant event reporting system and understood how to use it.

Are services effective?	**Inadequate**

We rated the practice as inadequate for providing effective services.

Effective needs assessment, care and treatment

- Clinicians were aware of relevant and current evidence-based guidance and standards, including National Institute for Health and Care Excellence (NICE) evidence-based practice guidelines and these were being followed to deliver care and treatment that met patients'

needs. However, there was no evidence of guidelines having been discussed at clinical meetings.

- The Defence Primary Health Care (DPHC) team produced a newsletter that was circulated to clinicians providing further information and a summary of relevant safety updates.

Monitoring care and treatment

The practice used information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice. It is used across many NHS practices. The Defence Medical Services (DMS) have a responsibility to deliver the same quality of care as patients expect in the NHS. The QOF provides a useful way of measuring this for DMS). Because the numbers of patients with long-term conditions are often significantly lower at DPHC practices, we are not using NHS data as a comparator.

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

- There were three patients on the diabetic register. We reviewed the treatment and care offered to these patients and found that none of these diabetic patients had been recalled for a review in the last 12 months.
- There were two patients recorded as having high blood pressure. These patients had not been recalled for their blood pressure to be taken in the past nine months.
- There were three patients with a diagnosis of asthma. They had not attended or been recalled for an asthma review in the preceding 12 months and their smoking status had not been captured.
- The practice had no patients on the mental health register and two patients diagnosed with depression. There was no structured review carried out on patients with depression in the last 12 months.
- The practice reviewed its antibiotic prescribing so was proactively supporting good antimicrobial stewardship in line with local and national guidance. The last audit was undertaken in May 2019.

Service personnel may encounter damaging noise sources throughout their career. It is therefore important that service personnel undertake an audiometric hearing assessment on a regular basis (every two years). Data from May 2019 showed:

- 100% of patients had a record of audiometric assessment.
- 82% of patients' audiometric assessments were in date (within the last two years).

There was evidence of quality improvement work including clinical audit and this had led to improved outcomes for some patients:

- An internal quality assurance tool, the Defence Medical Services (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. When we reviewed the CAF, we saw that a number of areas had been

highlighted, as requiring further work and the practice had a plan in place to action these issues.

- A programme of clinical audit had recently been implemented. This included an audit on foot care started by a GP in June 2019. However, it was too early to record the outcomes from audit work carried out.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. However, there was scope for improvement in staff development .

- The practice understood the learning needs of staff, however protected time and training was not always made available to meet them. Up to date records of skills, qualifications and training were maintained but some courses had not been completed by the nurse due to time constraints; for example, courses in asthma and diabetes management.
- The practice provided staff with an induction process and appraisals. However, the induction programme for the nurse was not role specific and clinical supervision was only provided quarterly.
- The practice nurse was appropriately qualified and their competence was assessed. The role included immunisation and the nurse had received specific training and could demonstrate how they stayed up to date. Further courses completed by the nurse covered infection prevention control and sexual health and a cervical cytology course was planned for September 2019. However, diabetes and asthma courses had been requested but were yet to be planned.
- The practice was resourceful in reaching out to external sources for support. For example, the nursing staff had developed links with the community outreach programme and the local sexual health service.
- The efficiency of the ERI was hampered by a lack of working space and no computer terminal. This had been raised to the battalion as it was the responsibility of the unit to provide working space and a terminal to the ERI.

Coordinating care and treatment

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

- The practice met with welfare teams to discuss vulnerable patients and their dependents.
- Links had been developed with NHS providers, for example; the local sexual health service.

Helping patients to live healthier lives

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

- Patients at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.
- All new patients were asked to complete a proforma on arrival. Notes were scrutinised by administration staff and then reviewed by the nurse and GP.
- The practice offered basic sexual health advice and referred on to local clinics in the community for more comprehensive services including family planning. The practice nurse was

the appointed lead in the practice for sexual health and had completed the Sexually Transmitted Infection Foundation (STIF) core foundation and STIF-Plus 2015 courses.

- We were not assured that all patients had access to appropriate health assessments and checks. No searches had been undertaken for all patients aged 50 to 64 years who were entitled to breast screening since the Regimental Medical Officer (RMO) had left in April 2019. Following the inspection, the practice confirmed that there was no eligible women registered who were entitled to breast screening.
- The number of women aged 25 to 49 and 50 to 64 whose notes recorded that a cervical smear had been performed in the last three to five years was 12 out of 18 eligible women. This represented an achievement of 67%. The NHS target was 80%. The practice nurse was due to complete training for cervical cytology in September 2019, patients were directed to a nearby base (the low uptake rates were in part down to the transient eligible population, predominantly phase 2 trainees).
- NHS health check screening was provided for the practice population of 90 patients aged 40 or above and. However, the last patient recall was done in May 2018.
- 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. The data below from May 2019 provides vaccination data for patients using this practice:
    - 90% of patients were recorded as being up to date with vaccination against diphtheria. No regional or national comparative data was available.
    - 90% of patients were recorded as being up to date with vaccination against polio. No regional or national comparative data was available.
    - 73% of patients were recorded as being up to date with vaccination against Hepatitis B. No regional or national comparative data was available.
    - 81% of patients were recorded as being up to date with vaccination against Hepatitis A. No regional or national comparative data was available.
    - 90% of patients were recorded as being up to date with vaccination against Tetanus. No regional or national comparative data was available.

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. However, no training had been offered and no information regarding the core principles of the Mental Capacity Act were displayed.
- Verbal consent was recorded on the consultation notes.

Are services caring?	Good

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- A poster in the waiting area advised patients a private room would be made available should they want to have a private conversation or to discuss sensitive issues.
- We received 23 patient Care Quality Commission comment cards in total. Of these, 22 were entirely positive about the service experienced.
- A range of information was available to patients to support their welfare. Information at the entrance to the practice had names and photographs of the welfare service team and the duty telephone number.

Involvement in decisions about care and treatment

- The clinicians and staff at the practice demonstrated that they recognised when people attending the medical centre required extra guidance in making decisions about their care. Staff demonstrated how they gauged the level of understanding of patients, avoided overly technical explanations of diagnoses and treatment and encouraged and empowered young patients to make decisions based on sound guidance and clinical facts.
- Interpretation services were available for patients who did not have English as a first language and staff knew how to access them. A poster, in different languages and displayed in the reception area, advised patients of the service.
- The Choose and Book service had been implemented and was used to support patient choice as appropriate. (Choose and Book is a national electronic referral service which gives patients the choice of date and time for their first outpatient appointment in a hospital).
- Data received from the patient experience survey (11 questionnaires completed in May 2019) showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example:
    - 64% said that they felt involved in decisions regarding their care (27% said that this question did not apply to them).
    - 55% said that they would recommend the service to family and friends (45% said that the question did not apply: this is often because military personnel know that their family and friends would not be entitled to register at a military medical centre).

The data presented by the practice was not benchmarked against regional and national averages for DMS, or against the previous year's performance.

- Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of organisations. We saw that information that was age appropriate and relevant to the patient demographic was prominently displayed and accessible.
- The practice acted in a compassionate way toward any patient that had to be discharged on health grounds. We saw that the practice reassured patients and signposted to personnel within the military who could guide them through the exit process and transition to NHS care and other support functions.
- Practice staff told us that they proactively identified patients who were also carers and that a code was added to their records in order to make them identifiable so that extra support or

healthcare could be offered as required. A paper slip was available in the reception area so carers could make themselves known discreetly.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect. However, rehabilitation sessions were not segregated from the main gym activity.
- The seating in the reception area was set back from the hatch to improve confidentiality of conversations at reception. A radio provided background noise and seating was a short distance away from the desk. A poster advised patients that a room would be provided should a confidential conversation be requested.
- Doors were closed during consultations and conversations could not be overheard.

Are services responsive to people's needs? | Good

We rated the practice as good for providing responsive services

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example, the practice was promoting and providing information on vaccinations at the time of the inspection in readiness for a pending deployment.
- The practice had completed an access audit as defined in the Equality Act 2010 using a bespoke audit tool Services were provided on the ground floor and there was an accessible toilet in the building.
- The practice stated that they would not make a home visit unless in the case of an emergency, and any request would be reviewed individually. This was detailed in the practice leaflet.
- Where military personnel were signed off from work for health reasons, the medical centre ensured that line managers were informed about any downgraded activities for safety reasons. This ensured that Chain of Command had a clear idea of which tasks personnel could safely undertake.

Timely access to care and treatment

- Access to routine appointments was good. A patient who rang in on the day of our inspection could have accessed a same day appointment with a GP or a nurse. Any patient who did not attend was contacted by email and any repeat occurrence reported to the practice manager.
- Patients needing to access the PCRF could not self-refer and the wait time was approximately five days (the key performance indicator or KPI in DMS is 10 days). The practice had made the decision not to allow patients to self-refer to maintain assurance and consistency when using a locum physiotherapist.
- Outside of routine clinic hours, shoulder cover was provided by Sandhurst Medical Centre. From 18:30 hours, patients were diverted to the NHS 111 service. If the practice closed for an afternoon for training purposes, patients could still access a GP in an emergency. In this way, the practice ensured that patients could directly access a GP between the hours of 08:00 and

18:30, in line with DPHC's arrangement with NHS England. For military specific medical queries, patients were signposted to the duty medic through the Guardroom.

- There was clear instruction in the waiting area and in the practice leaflet advising patients of the nearest accident and emergency (A&E department), located in West Middlesex University Hospital.
- Results from the practice's patient experience survey showed that patient satisfaction levels with access to care and treatment were generally high. For example:
    - 73% of patients said that they could access an appointment at a convenient time (27% said this question was not applicable to them).
    - 64% of patients said that the medical centre listened to their comments, complaints and compliments (27% said this question was not applicable to them).
    - The majority of comments made in the 23 CQC comments cards were positive. Three cards contained mixed reviews. Two of these patients mentioned waiting to be seen.

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.

- Defence Primary Health Care had an established policy and the practice adhered to this.
- The practice manager was the designated responsible person who handled all complaints in the practice. Verbal complaints were recorded and managed through the same process as written complaints.
- We saw that information was available to help patients understand the complaints system.
- We reviewed one complaint that had been submitted by a patient in the past 12 months. A patient had travelled to a community pharmacy to collect a medicine having been told it was in stock to find that it had been issued to another patient. The patient received an apology and additional training was arranged for staff at the pharmacy to improve the process for dealing with military prescriptions.
- There were processes in place to share learning from complaints. The monthly healthcare governance meeting had complaints as a standing agenda item and audits were carried out annually to review for any themes and trends. Each complaint had an audit attached that detailed how the issue was resolved.

Are services well-led?	Inadequate

We rated the practice as inadequate for providing a well-led service.

Leadership capacity and capability

Evidence gained during the inspection highlighted a lack of clinical leadership at the practice. The SMO visited once a fortnight and prioritised the completion of medicals. The locum GP did not have additional responsibilities so many of the systems implemented lacked the monitoring and clinical oversight required to ensure effectiveness. Staff we spoke with were not always clear on individual's responsibilities. The lack of clinical leadership impacted on the nurse who was frequently the 'go to' person but had not got protected time or had role specific training. The RMO

left in 2019 following planned paternity and annual leave that had previously been postponed to allow the locum medical officer to bed in. The continued absence was due to long planned resettlement and terminal leave on leaving the Military. The issues still needing addressing were:

- Clinical leadership roles needed clarification. For example; safeguarding lead, medicines management lead and audit lead. The terms of reference (TOR) and job descriptions needed updating.
- Protected time and role specific training was not sufficient to support staff in leadership roles.
- Systems and processes lacked the clinical oversight to be effective.
- The demands on the practice nurse impacted on their capacity to carry out their role.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care. However, some work was required in order to achieve this.

- The DPHC vision of 'best, safe practice - by design' had been adopted.
- The practice had their own vision which was 'this practice is committed to providing the highest quality primary care service, to all entitled personnel, in order to enhance and sustain operational effectiveness'.

Culture

The practice leaders portrayed a determined and diligent approach, highlighted by the progress made with limited capacity and in a short space of time.

- Staff stated they felt respected and valued. However, the significant demands on the practice nurse were highlighted on the day and there was no clear support in place. CMTs were scheduled to complete vaccination training to take some pressure off the nurse.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They could do this anonymously if they wished, but all staff we spoke with said that they were happy to raise issues directly with manager and leaders. They had confidence that these would be addressed and spoke of a no-blame culture within the practice.
- Appraisals were provided to staff annually. However, the demands on staff limited development opportunities.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training.

Governance arrangements

The practice did not have consolidated and clarified responsibilities, roles and systems of accountability to support good governance and management.

- There had been an increase in regional support following a Health Governance Assurance Visit (HGAV) in May 2019. This had resulted in a programme of improvement to strengthen the governance framework and staff spoke positively about the regional support provided. However, the speed of change made the implementation challenging.

- There was a monthly practice meeting that extended to include all staff. Minutes were made available to any staff member unable to attend.
- Joint working with the welfare team, SAFFA (The Armed Forces Charity), pastoral support and Chain of Command was interactive and led to co-ordinated person-centred care.
- The PCRF delivered rehabilitation services from a separate building. However, the audit programme for PCRF was limited (with the exception of IPC audits) and no notes audit had been undertaken.
- Staff were not always clear of the roles and accountabilities of colleagues including leadership for safeguarding and medicines management.
- Practice leaders had established a number of policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. However, these were not always in accordance with DPHC policy and were not always seen to be governing activity.

Managing risks, issues and performance

The processes for managing risks, issues and performance needed strengthening.

- There were some effective processes to identify, understand, monitor and address current and future risks including risks to patient safety. Staff told us that they would raise any issue with the practice manger and the threshold for what constituted a significant event had been lowered to encourage more reporting.
- The practice had plans to manage current and future performance. However, the large number of improvements targeted in a short time period required substantial support and training to become effective.
- Practice leaders did not have timely oversight and had not consistently completed timely action in response to national safety alerts.
- A clinical audit programme had recently been implemented and it was too soon to be seen as having a positive impact on quality of care and outcomes for patients.
- The practice had plans in place and had trained staff for major incidents. However, the emergency medicines and equipment arrangements were not effective and left patients at potential risk should an emergency situation arise.
- There had been no PCRF specific risk assessments carried out. For example, there was no assessment of the risks when performing acupuncture.

Appropriate and accurate information

The practice worked to ensure that it held appropriate and accurate information.

- Staff were competent in the use of 'Population Manager' which is a clinical search facility. However, the information was not being used to monitor performance and the delivery of quality care, for example, there was no structured approach to manage patients with long-term conditions.
- The practice used information from the CAF and HGAV to formulate an action plan to address areas of improvement.
- There were robust 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.

Engagement with patients, the public, staff and external partners

The practice involved patients, staff and internal partners to influence its services.

- Patients were approached to feed back their views on the way care was delivered to them. We saw that a recent survey had led to improved delivery of care to patients. For example, issues with the local pharmacy prescription services had been identified as a trend for patient complaint. The practice manager worked through a performance review with the pharmacy that resulted in an improved delivery service for patients.
- The practice clearly displayed outcomes from patient feedback in the waiting area.
- The practice was engaging with station commanders, welfare support services, local NHS services, local military services, DPHC and the Department of Community Mental Health (DCMH). There was scope for improvement with GP and nurse involvement in the UHC meetings. Both expressed an interest in attending.

Continuous improvement and innovation

There was evidence of significant efforts from the practice team to introduce new systems and processes to drive improvement. It was at an early stage of development so many of the systems needed to be improved through monitoring, however the framework developed evidenced some progress had been made.