Woolwich Medical Centre

Quality report

Greenhill
Woolwich
London
SE18 4BW

Date of inspection visit:
25 September 2019

Date of publication:
15 November 2019

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services, and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Chief Inspector's Summary

Woolwich Medical Centre is rated as good overall

The key questions are rated as:

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

We carried out an announced follow-up comprehensive inspection of Woolwich Medical Centre on 25 September 2019. This inspection included following up of requirements we made at the last inspection on the 27 November 2018 when the rating given for the practice was inadequate 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 was well-led, and leaders demonstrated they had the vision, passion and integrity to provide a patient-focused service that sought ways to develop and improve.
- An inclusive team approach was supported by all staff who valued the opportunities available to them to be part of a patient-centred service.
- There was an open and transparent approach to safety. An effective system was in place for managing significant events and staff knew how to report and record using this system.
- The assessment and management of risks was good and recognised as the responsibility of all staff.
- The arrangements for managing medicines, including obtaining, prescribing, recording, handling, storing, security and disposal minimised risks to patient safety. However, attention was needed to ensure prescriptions were appropriately accounted for. There was an effective approach to the monitoring of patients on high risk medicines.
- Staff were aware of current evidence-based guidance. They had received training and they were skilled and knowledgeable to deliver effective care and treatment.
- The practice worked collaboratively and shared best practice to promote better health outcomes for patients.
- There was evidence to demonstrate quality improvement was embedded in practice, including an annual programme of clinical audit used to drive improvements in patient outcomes.
- The practice proactively sought feedback from staff and patients which it acted on. Feedback showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.

- Information about services and how to complain was available.
- Staff were aware of the requirements of the duty of candour.

Notable Practice

- The practice has devised and implemented a shared care agreement that is used in conjunction with the Department of Community Mental Health. This ensures decisions about who should take responsibility for continuing care or treatment after initial diagnosis or assessment is based on the patient's best interests.

The Chief Inspector recommends:

- Ensure a system for the safe management of medicines is in place, namely accounting for prescriptions in line with Defence Primary Health Care (DPHC) policy.
- A system is in place to ensure the equipment used for providing care and treatment is safe, namely the checking of blood glucose equipment is complete.

Dr Rosie Benneyworth BM BS BMedSci MRCGP
Chief Inspector of Primary Medical Services and Integrated Care

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, a physiotherapist, a pharmacist and a nurse.

Background to Woolwich Medical Centre

Located just outside Woolwich Garrison, the medical centre occupies the ground floor of a two-storey building. The practice was part of a newly formed affiliation with two other larger London based practices. This main aim was to provide business resilience and to support each other at times of staffing shortages. This arrangement included weekly meetings together, some shared governance, with more in development and included access to SharePoint, a repository for service information, support with induction, group training and notably weekly mentorship for junior practice managers.

The practice 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 830 at the time of inspection. The age range of the population is 17 to 60 years. Dependants of personnel are not catered for at the medical centre and are signposted to local NHS GP services.

A Primary Care Rehabilitation Facility (PCRF) is co-located with the medical centre and provides a physiotherapy and rehabilitation service for service personnel only.

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 the largest unit in station. RAP staff can be deployed at any point. They included a full time Regimental Medical Officer (RMO), a registered (non-specialist) nurse and seven Combat Medical Technicians (referred to as medics). The second largest unit also provides two medics who can also be deployed at any stage, one of

these is currently away from work. 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.

The staff team

Position	Numbers
Senior Medical officer (SMO)	One - civilian
Administrators	one
Medical Officers (MO)	one Regimental Medical Officer (RMO) two supernumerary General Duties Medical officers (GDMO)
Nurse	one
Practice manager (military)	one
Physiotherapist (civilian locum)	one
Civilian practice nurses	one
Military practice nurses	one (currently on military duties)

Are services safe? | Good

We rated the practice as good 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 significant improvements had been made. Following our review of the evidence provided, the practice is rated as good for providing safe services.

Safety systems and processes

The practice had systems to keep patients safe and safeguarded from abuse.

- 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. This was supplemented by a one-page easy reference guide in all clinical rooms.
- Policies were accessible to all staff and 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 was 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 (UHC) which was attended by the SMO, chain of command and the welfare team. We spoke with two members of the welfare team who were both complimentary about the care and support the practice provided to vulnerable patients. They both were frequent visitors to the practice and said communication was good across all levels.
- The SMO, the chain of command and the welfare team held a register of all downgraded personnel assessed as unfit for duty. Monthly multi-disciplinary meetings were held and safeguarding issues were discussed and the SMO attended these meetings. All staff were up-to-date with safeguarding training at a level appropriate to their role.
- Clinical staff acted as chaperones and had received a Disclosure and Barring Service (DBS) check. The chaperone policy and notices were displayed advising patients of the service. Chaperone training has been conducted in September 2019 for all staff.
- 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 logged had alerts on their records.
- The full range of recruitment records for permanent staff was held centrally. 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.
- There was an effective process to manage infection prevention and control (IPC), including a lead member of staff for IPC who was appropriately trained for the role. The staff team was up-to-date with IPC training. The practice completed an annual IPC audit in September 2019 and included the PCRF.
- Environmental cleaning was provided by an external contractor. Cleaning schedules and monitoring arrangements were established, including cleaning before the practice opened and at lunchtime. A deep clean of the premises took place in August 2019. We identified no concerns with the cleanliness of the premises.
- A member of staff had the lead for the safe management of healthcare waste. Consignment notes were retained at the practice and an annual waste audit was carried out in September 2019.
- Measures were in place to ensure facilities were safe. Electrical safety checks were completed within the last 12 months and water safety checks were undertaken each month. The station fire officer was responsible for fire safety at the practice and carried out an annual risk assessment of

the building annually. Firefighting equipment tests were all in-date. Staff were up-to-date with fire safety training and were aware of the evacuation plan.

- Equipment was checked and maintained according to manufacturers' instructions. Testing of portable electrical appliances and medical equipment was undertaken in September 2019.

Risks to patients

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

- There were still some staffing gaps but this had significantly improved and ongoing recruitment was taking place. Bespoke locum induction was included in the practice induction pack; these were comprehensive and differed depending on how long the locum was employed for.
- There is one permanent practice nurse with the RAP nurse supporting them when the unit was not deployed. In staff absence, nurse support from the affiliated practices was available.
- The practice was equipped to deal with medical emergencies and all staff were suitably trained in emergency procedures, including staff trained in life support. An emergency kit, including a defibrillator, oxygen with masks and emergency medicines were accessible to staff in a secure area of the practice; all staff knew of its location. A first aid kit and accident book were available. Weekly and monthly checks were in place to ensure the required kit and medicines were available and in-date.
- Staff were up-to-date with the required training for medical emergencies. They participated in regular training relevant to emergency situations. We noted a display regarding emergency protocols in the emergency treatment room.
- All staff were also trained in the recognition and management of sepsis. Posters about sepsis were displayed throughout the practice.
- Equipment throughout the practice had been calibrated and checked in line with DPHC policy.

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. The care records we looked at on the electronic patient record system (referred to as DMICP) showed information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- We noted the physiotherapist administration list on DMICP had not been updated for several years so did not accurately reflect who was actively undergoing rehabilitation. We discussed this with the Regional Clinical Lead Physiotherapist and were assured the list would be updated.
- Referrals to other departments and external health care services, including urgent referrals, were managed by the SMO. Whenever possible the patient left the medical centre with an appointment made for them. If an appointment was not available based on patient availability then the administrator followed it up on behalf of the patient. Referrals were logged and monitored, and the administrators audited the referrals; the last audit took place in December 2018. For urgent two-week-wait referrals, patients left the practice with an appointment.
- A process was in place for the management of specimens, including the transport of specimens to the laboratory. A monthly results audit was completed as per DPHC policy. All results were reviewed by the doctor or other clinicians as required from group affiliation. A samples log was in place, but we noted some potential issues with patient identifiable information. We discussed this with the practice and they agreed to address this immediately.

Safe and appropriate use of medicines

The arrangements for managing medicines, including obtaining, prescribing, recording, handling, storing, security and disposal in the practice minimised risks to patient safety. However, there was scope for further improvement in two areas.

- 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.
- The regional pharmacist carried out regular medicines checks and audits, which the practice contributed to.
- Prescription forms were held securely in a locked room and prescriptions were fully accounted for. Prescription records were in a loose-leaf register which is contrary to DPHC procedure that requires a bound book for recording prescription forms.
- Blood glucose monitoring equipment was available, however, the strips used did not correspond with the batch that were open. There were no records of control tests being carried out to check functionality. This did not cause any harm to patients.
- 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.
- Patient Group Directions (PGD) had been developed to allow appropriately trained nurses to administer medicines in line with legislation. The PGDs were current and signed. Equally, Patient Specific Directions (PSD) were in place and signed by the prescriber to permit medics to vaccinate patients. Medics had completed vaccination training.
- A process was established for the management of and monitoring of patients prescribed high risk medicines (HRM). A register of HRM used at the practice was held on Sharepoint and all doctors had access to this. Alerts, coding, diary dates and monthly searches were used to identify and manage patients on HRM. Shared care agreements were in place for the patients that required them. These were stored and managed on DMICP, an electronic document management and storage system, which all clinicians had access to.

Track record on safety

The practice had a good safety record.

- Measures to ensure the safety of facilities and equipment were in place. The practice manager was the lead for health and safety. Electrical and gas safety were up-to-date. Arrangements were in place to check the safety of the water. A fire risk assessment of the building was undertaken annually. The fire system was tested each week. Staff were up-to-date with fire safety training and were aware of the evacuation plan.
- 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.

- Staff used the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events, incidents and near misses. All staff had electronic access to the system, including locum staff. Staff provided several varied examples of significant events confirming there was a culture of effectively reporting incidents. Significant events were discussed at practice meetings. An ASER tracker was in use. There were no ASERs on the system with outstanding actions. The tracker was reviewed weekly by the practice manager and monthly by the wider team. An audit had not been conducted but was seen on the audit calendar to be completed in the future. We noted no ASERS had been raised by the PCRF.
- The practice manager was responsible for managing medicine and safety alerts. The practice manager received alerts each day and any alerts were logged on a spreadsheet. Alerts were emailed to staff with a read receipt and any actions required were logged.

Are services effective? | Good

We rated the practice as good for providing effective services.

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.

When we carried out this follow up inspection we found significant improvements had been made.

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 diabetes.
- We saw many examples of collaborative working and sharing of best practice to promote better health outcomes for patients. For example,
    - Weekly diary meetings for all staff to attend, where 'hot topics' were discussed and shared.
    - Meetings and forums were held to share and discuss evidence-based guidance, including NICE and SIGN.
    - Patient Based Small Group Learning (PBSGL) was in place. This is where several practices voluntarily worked in small groups with one person as facilitator, meeting on a regular basis. They discussed real patient problems, and the strategies employed to solve these cases.
    - Shared GDMO clinics. A GDMO is a junior army doctor attached to a field unit before commencing higher specialist training.
    - Monthly practice meetings

- Weekly meetings with the physiotherapist and the SMO.

- Our review of PCRF patient records showed Rehab Guru, software for rehabilitation plans and outcomes, was used for exercise programmes for some patients. Paper exercise sheets were also used depending on therapist preference. There was scope to ensure equity of service by offering Rehab Guru to all patients that could benefit from it.
- The PCRF team referred to the Defence Rehabilitation website for best practice guidelines.

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.
- We found the care of patients with long term condition was good. For example, patients with diabetes, hypertension and asthma. The nurse was the lead for long term conditions management and managed the register. They carried out regular searches, recalling patients when appropriate. We looked at a selection of patient records and were assured that clinicians were consistent in how patients were reviewed. For example, clinicians used the same asthma review template.

We looked at a range of patient records and were assured that the care of patients with a mental illness and/or depressive symptoms was being effectively and safely managed, often in conjunction with the Department of Community Mental Health (DCMH). Appropriate templates were used to assess patients and ensure consistency when planning their care. This included a Shared Care Agreement newly developed by the practice which had been shared with DCMH. 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:

- 70% of patients had an audiometric assessment within the last two years. The SMO told us this was an area of improvement they were working on. They described how the patient population specific to Woolwich required more frequent audiometric testing and this was why the percentage was lower than required. This, coupled with lower staffing levels in the past, had made compliance difficult.

An audit calendar was in place that identified the audits to take place going forward. The PCRF was integrated in the wider audit programme for the practice. We saw a detailed audit calendar with repeat cycles evident on two. 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. We saw the PCRF had undertaken one audit in the past year.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- A generic and role-specific induction was in place for staff new to the practice. All permanent staff, including a recently inducted member of staff, described a comprehensive and supportive induction. This included supernumerary time and supervised practice. The physiotherapist was a locum and therefore structured appraisal did not occur. However, they described good relationships with senior physiotherapists at PCRF London who provided opportunities to discuss complex patients and peer review.
- There was one full time longstanding locum physiotherapist. We saw good links with the other two affiliated practices' PCRF departments. If the Woolwich physiotherapist was on annual leave for over a week then the other PCRF provided temporary cover for two days a week.
- The Woolwich PCRF should have had access to a full-time infantry Exercise Rehabilitation Instructor (ERI) but this ERI has been assigned by the unit to work in the main gym. This placed an extra strain on the physiotherapist. Referrals for support by the ERI were limited due to the ERI being used by the regiment to fulfil other roles. We found that this did hinder recovery but was out of the control of the medical centre leadership team.
- Mandated training was monitored and the practice staff team was in-date for all required training. A programme of ongoing development training was in place with in-house and external training sessions available to staff each week. Clinicians were also supported with continual professional development (CPD) and revalidation through protected time each week.
- A General Duties Medical Officer (GDMO) was working at the practice. There was a well laid out induction for the GDMO and also allocated tutorial time, and a weekly portfolio review with their supervisor.
- Regional meetings and forums were established for staff to link with professional colleagues in order to share idea and good practice. For example, nurses were supported to attend the regional nurse's forum to link with their colleagues.

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 standard policy that the patient found their own local care provider dependent on where they lived. Despite this we saw good communication between community health care professionals and the practice to ensure the patient had safe and consistent care.

- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment and this was usually done electronically.
- Clinical meetings to discuss patients were held each month between the physiotherapists and doctors. Patients referred to the PCRF were reviewed regularly, at the time of the inspection the waiting time for a routine follow-up appointment was seven days. PCRF staff referred patients to other clinics if it was deemed appropriate to their rehabilitation, such as weight management and smoking cessation.
- The clinical records we reviewed showed that appropriate staff, including those in different teams, services and organisations were involved in assessing, planning and delivering care and treatment.
- The SMO had set up a meeting, planned for November 2019, with the local NHS hospital's medical director to begin to build relationships, improve communication and explain the nuances of a military population.
- A Standard Operating procedure (SoP) was in place outlining the process to follow for patients leaving the military. Doctors provided patients transitioning from the military with a release medical. They also referred patients to the welfare team for support with the transition, and if appropriate to the Department of Community Mental Health (DCMH).

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.
- The nurse was the lead for sexual health and had completed the required training for the role (referred to as STIF). Information was available for patients requiring sexual health advice, including sign-posting to other services. Where appropriate, patients were referred to the local genitourinary clinic for screening. Condoms were available at the practice.
- Patients had access to appropriate health assessments and checks. Regular searches were undertaken for patients eligible for bowel and breast screening and appropriate action taken if patients met the criteria. DMICP checks alongside Open Exeter checks were undertaken to ensure patients meeting the national screening programme for cytology were recalled. Open Exeter is a national screening recall system that gives access to patient data so eligible patients can be invited to participate in the screening programme.
- The number of eligible women whose notes recorded that a cervical smear had been performed in the last three to five years was 560 which represented an achievement of 87%. The NHS target is 80%.

It is important that military personnel have sufficient immunity against the risk of contracting certain diseases. The World Health Organisation sets a target of 95% for vaccination against diphtheria, tetanus, pertussis 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.
- 93 % of patients were recorded as being up to date with vaccination against polio.

- 93 % of patients were recorded as being up to date with vaccination against hepatitis B.
- 89 % of patients were recorded as being up to date with vaccination against hepatitis A.
- 93 % of patients were recorded as being up to date with vaccination against tetanus.
- 78 % of patients were recorded as being up to date with vaccination against typhoid.
- 92% of patients were recorded as being up to date with MMR.

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 doctor or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

Are services caring? | Good

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.
- We received 43 CQC comment cards. All were entirely complimentary about the care they received.
- The practice had a board located in the waiting room named "The Tree of Learning". This 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.
- Across the affiliation the clinician mix was adequate. If patients preferred to see a male GP they could make an appointment at one of the other practices.

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.
- The Patient Experience Survey showed 98% of patients were involved in decisions about their care. Feedback on the CQC patient feedback cards highlighted that patients received information about their treatment to support them with making informed decisions about their treatment and care.
- 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.

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.

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

- 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 were referred to a local NHS service for family planning and sexual health advice.
- The Patient Experience Survey indicated that 96% of respondents would recommend the practice to family and friends.
- An access audit as defined in the Equality Act 2010 was completed for the premises in September 2019. There was level access throughout.
- Arrangements were in place for patients to access NHS 111 when the practice was closed, including emergency care. Shoulder cover was provided between the hours of 16:30 and 18:30 by RAF Northolt Medical Centre.

Timely access to care and treatment

Patients' needs were met in a timely way.

- The practice accommodated patients with an emergency need and staff advised us that no patients were turned away and would be seen on the same day. Routine appointments could be accommodated within 10 days.

- Arrangements were in place for patients to access NHS 111 when the practice was closed, including emergency care.
- Home visits and telephone consultations were available and were advertised in the patient information leaflet.
- Direct access physiotherapy (DAP) service had recently been put in place for patients. Patients prioritised as urgent were given the next available appointment. On the day of the inspection, patients requiring a routine physiotherapy initial assessment were seen within three working days.
- The PCRF shared information with the Regional Rehabilitation Unit (RRU) and referrals were made as required. When referrals were made to the Multidisciplinary Injury Assessment Clinic (MIAC) patients were seen within three weeks.

Listening and learning from concerns and complaints

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

- Information was displayed in the waiting area, outlined in the practice leaflet to help patients understand the complaints process. The complaints procedure was displayed in clinical rooms for staff to access.
- The practice manager was the designated responsible person who handled all complaints. Complaints were managed in accordance with the DPHC complaints policy and procedure. Both written and verbal complaints were recorded and linked to the health governance workbook.
- There were two complaints made during the period 2018/19 with no theme identified. We reviewed these and found they had been well managed. A complaints audit was included in the audit calendar.

Are services well-led? | Good

We rated the practice as good 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 being sufficiently developed to support effective performance.

When we carried out this inspection we found that significant work had been undertaken to ensure recommendations had been acted on.

Leadership capacity and capability

The leadership team had the experience, skills and drive to deliver high-quality sustainable care.

- The SMO and the practice team had worked extremely hard to improve standards and drive quality improvement throughout all aspects of the practice, this was to be commended.
- On the day of inspection, we saw a practice that was well-led. The leaders not only demonstrated managerial experience, capacity and capability, it was clear they had vision, passion with a focus on providing the best possible service for their patients.
- Staff spoke highly of how the practice was led. They said managers demonstrated a collaborative approach to leading the practice and supporting staff. The regional management team worked

closely with the staff team. We spoke with the Commanding Officer of the garrison and with the Lieutenant Colonel of one of the regiments; both spoke highly of the practice, its leadership and of the good quality of care provided for the patients.

- The SMO, the doctor, the physiotherapist and the practice nurse were all civilian staff and were able to promote consistent leadership. The practice manager was also protected from short notice deployments. This provided stability when planning for the future.
- 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 practice 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 in order to maximise their health and deliver fit personnel for operation".
- The aim of the practice was:
    - 'Woolwich Medical Centre will deliver a safe and effective primary healthcare service to military personnel in the UK in order to enhance and sustain the operation effectiveness of the Army.'
- On the day of the inspection, we found the practice was working to and achieving its aims. We spoke with the SMO who provided a detailed account of the vision and plans for the future. This included embedding the working relationships with the newly formed affiliation.

Culture

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

- An inclusive culture underpinned the approach of the practice. All staff had an equal voice, regardless of rank or grade.
- Staff described an open and transparent leadership style and said they would feel comfortable raising issues. They felt respected, supported and valued. Both formal and informal opportunities were in place so staff could contribute their views and ideas about how to develop the practice.
- Openness, honesty and transparency were demonstrated when things went wrong. A no-blame culture was evident; complaints and incidents were seen as opportunities to improve the service.
- Leaders clearly demonstrated that the needs and welfare of staff were priority. Staff were encouraged and supported to be the best they could be through training and developing their skills.
- The practice actively promoted equality and diversity, with a dedicated notice board to inform patients. All staff had received training in this area.

Governance arrangements

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

- The staffing structure was established with additional ongoing work being formalised with the group affiliation. There was a detailed list of roles and accountabilities seen. This was split between the affiliated practices with both lead roles and deputy roles, this allowed cross cover between the practices.
- Staffing levels remained slightly lower but in the main had been, or were in the process of, being addressed. A new practice nurse was employed three weeks previous to our inspection and was currently undergoing induction. An additional administration post had been advertised.
- The practice worked to the health governance (HG) workbook, a system that brings together a comprehensive range of governance activities, including the risk register, significant events tracker, lessons learnt log, training register, policies, meetings, quality improvement and audit. All staff had access to the workbook which provided links to meeting minutes, policies and other information.
- An effective range of communication streams were used at the practice. A schedule of regular meetings were well established.
- Audit was a routine method used to measure the effectiveness and success of clinical and administrative practice. An audit programme was established with clear evidence of action taken to change practice and improve the service for patients.
- 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 clear and effective processes for managing risks, issues and performance.

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

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- An internal quality assurance tool, the DMS Common Assurance Framework (CAF) was used to monitor safety and performance for the practice and included the PCRF. The DMS CAF was formally introduced in September 2009 and since that time has been the standard healthcare governance assurance tool utilised by DMS practices to assure the standards of health care delivery within DMS. The eCAF was reviewed monthly and the management Action Plan (MAP) was discussed in Healthcare Governance meetings.
- 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 (PPG) was in place to seek the views of patients. We saw evidence from PPG meeting minutes that patients had requested a rolling information presentation was added to the television the waiting area. This had been acknowledged and agreed and the practice was awaiting a larger television to facilitate this.
- 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 survey were undertaken quarterly.
- 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 mid-year 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 (WRVS). Several members of the Chain of Command including the Commanding Officer, padre, WRVS support worker and welfare worker visited during the inspection and all were highly complimentary about the staff at the practice and the care they provided to patients.

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 shared care agreement used to promote consistent care for those patients who also used the services of DCMH.
- The physiotherapist had analysed injury trends and as a result determined more knee cuffs were required to use with the ice therapy machine.
- Within the following month the physiotherapist and the SMO had plans to implement an assessment clinic for patients with complex pain; plans for starting this were seen with bookings already in the DMICP diary.