Hounslow Medical Centre

Quality report

Cavalry Barracks
Beavers Lane
Hounslow
Middlesex
TW4 6HD

Date of inspection visit:
10 March 2020

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13 May 2020

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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

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 a further announced follow up inspection on 17 June 2019. The practice was rated as inadequate overall, with a rating of inadequate for the key questions of safe, effective and well-led. Caring and responsive were rated as good.

A copy of the report from the previous inspections can be found at:

Hounslow Medical Centre, March 2018

https://www.cqc.org.uk/sites/default/files/20190808_hounslow_medical_centre_final_report.pdf

We carried out this announced follow up inspection on 10 March 2020. This report covers our findings in relation to the recommendations made and any additional findings made during the inspection.

This practice is rated as requires improvement overall.

The key questions are rated as:

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

We carried out an announced comprehensive inspection at Hounslow Medical Centre on 10 March 2020. 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 had strengthened systems to manage risks.
- The practice demonstrated an ethos of patient centred care.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- An effective system was in place for managing significant events and staff knew how to report and record using this system.

- Effective systems were in place for chronic disease management. However, refresher training was needed to ensure treatment was being delivered in line with current guidelines.
- Staff had developed links with military bases located nearby and support from the regional team had increased.
- The practice worked collaboratively and shared best practice to promote better health outcomes for patients.
- There was evidence to demonstrate quality improvement was being implemented with an annual programme of clinical audit for 2020.
- The practice proactively sought feedback from staff and patients which it acted on. Feedback showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- Equipment at the practice were sufficient to treat patients and meet their needs.
- Staff were aware of the requirements of the duty of candour.
- Patients found the appointment system easy to use and could access care when they needed it.

The Chief Inspector recommends:

- A review of safety arrangements to take account of medicines management policies and procedures. Ensure all staff have training relevant to their roles and include the need for including all relevant topics within induction.
- Improvement to the oversight of patients eligible for cervical screening.

Dr Rosie Benneyworth BM BS BMedSci MRCGP
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 primary care doctor, a practice nurse, a practice manage and a pharmacist.

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 300. Primary medical care is also provided to serving personnel from the Royal Military School of Music based two miles away at Kneller Hall barracks. The barracks were due to close in August 2020 with patients and staff to be relocated to Aldershot Garrison Medical Centre.

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
Regimental aid post[1] Medical Officer (RMO)	One
General Duties Medical Officer[2] (GDMO)	One
Practice Nurse	Two
Practice Manager	One military practice manager
Administrative support	One civilian medical administrator
Primary Care Rehabilitation Facility (PCRF) staff	The PCRF facility had been closed and services were provided from Aldershot. An outreach clinic is provided at Hounslow Medical Centre once a fortnight
Regimental aid post medics[3]	One Medical Sargeant (deployed) Five Combat Medical Technicians (CMTs) (deployed)
Contracted staff	One domestic staff

[1] Regimental Aid Posts (RAP) are front-line military medical staff posts attached to a military unit and are subject to deployment, often at short notice. When not deployed, RAP staff work in medical centres to update and maintain their clinical skills. They also have a focus on ensuring the occupational health requirements of unit personnel are up-to-date.

[2] A GDMO is a junior army doctor attached to a unit before commencing specialist Medical Officer training.

[3] In the army, a medic is a soldier who has received specialist training in field medicine. It is a unique role in the forces and their role is similar to that of a health care assistant in NHS GP practices but with a broader scope of practice.

Are services safe?	**Requires improvement**

We rated the practice as requires improvement for providing safe services.

Following our previous inspection, we rated the practice as inadequate for providing safe services. We found inconsistencies in processes to keep patients and staff safe including gaps in:

- safeguarding arrangements;
- infection prevention and control arrangements;
- emergency equipment and medicines;
- medicines management policies and procedures; and
- management of alerts.

At this inspection we found some of the recommendations we made had been actioned but there were still gaps. The practice is now rated as requires improvement for providing safe services.

Safety systems and processes

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

- 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. Staff were clear on who was the safeguarding lead and deputy, terms of reference reflected safeguarding roles and the referral process was included in the adult safeguarding policies detailing who to go to for further guidance. Child and adult safeguarding contact details were displayed and accessible to all staff. All clinicians were safeguarding level 3 trained and other staff had competed training appropriate to their role.
- 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. Staff showed good awareness of vulnerable patients, and since the last inspection, minutes of discussion were being recorded and notes were added to the patient record.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. The RMO had re-established links with the local Clinical Commissioning Group (CCG) to share and coordinate concerns. Staff had links with the London borough of Hounslow safeguarding team and knew contact details for the Multi-agency Safeguarding Hub (MASH). Liaison with the welfare team had improved with the RMO attending Unit Health Committee (UHC) meetings.
- 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. In the absence of the practice manager the checks were completed by the RMO.

- The system to manage infection prevention and control (IPC) had improved since the last inspection. The nominated lead had received bespoke training and an IPC audit had been undertaken in January 2020. The audit showed the facilities to be compliant with a compliance score of 89%. No serious issues had been identified and an action plan, drawn up as a result of the audit, demonstrated that areas of improvement had been addressed.
- There were systems for safely managing healthcare waste, an audit had been undertaken in January 2020 and no issues had arisen. The practice nurse was listed as the lead for waste management, this was reflected in the terms of reference (TORs). The practice manager was the named 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. Cleaning schedules had been implemented and the checks were now being carried out against a set standard. Monthly meetings with the cleaning supervisor were used to discuss any issues and review the cleaning contract. The contract included an annual deep clean with the last one carried out in January 2020.
- The practice had tightened up on arrangements to ensure facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. Since the last inspection, the building specific fire risk assessment was now on display and the practice had obtained copies of the hard wire electrical testing certificate and gas certificate from the unit. These were both current and in date.

Risks to patients

The systems to assess, monitor and manage risks to patient safety had been strengthened.

- The overall staffing arrangements were adequate for the number of patients. The staffing levels had increased since the last inspection and the RMO had provided continuity with clinical leadership since September 2019. The nurse had been given extra support with the addition of a regular locum. The practice population had decreased significantly with approximately half of the population having been deployed.
- There was an induction system for temporary medical centre staff. This had previously been a generic document but was now tailored to their specific role.
- 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 was available. Weekly and monthly checks were in place to ensure the required kit and medicines were available and in-date. In addition the RMO carried out ad hoc checks of the emergency trolley.
- The practice staff had completed formal training on sepsis and climatic injuries. Administration staff had been given a guide to refer to. In addition, the RMO had introduced simulation training to familiarise staff on how to deal with an emergency situation.
- Staff were familiar with organisational guidance issued in relation to the Covid-19 virus. The practice had placed prominent notices at the entrance to advise patients of the symptoms and appropriate actions to take. There had been no potential cases of patients showing symptoms but the medical centre staff understood what to look out for and how to respond.

Information to deliver safe care and treatment

Processes had been strengthened since the last inspection to ensure staff had the information they needed to deliver safe care and treatment.

- The recent Defence Primary Healthcare (DPHC) new patient questionnaire had been implemented and 99% of summarising was up to date for the current list of registered patients.
- At the last inspection there was no systematic peer review of clinical notes. At this inspection we found that a structured programme had been introduced with formal peer reviews of all clinicians taking place at least once every four months and when returning from block leave. In addition, the SMO and practice nurse reviewed the notes for medics daily.
- 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.
- There was an effective system in place to govern referrals. Appointment letters were handed to the patient in the consultation via ERS (electronic referral system). The practice monitored referral letter spreadsheets for routine referrals and urgent referrals. The monitoring of the spreadsheet was built into the business continuity plan and arrangements for access were in place with Aldershot Medical Centre.
- Sample testing results were entered onto a database allowing them to be tracked. We found the system was being used effectively and results had been actioned and filed in a timely manner.

Safe and appropriate use of medicines

The RMO had taken on the lead on medicines management and we found improved systems for appropriate and safe handling of medicines. However, we identified some areas which required further improvement.

- The systems for managing and storing medicines, including vaccines, medical gases, and emergency medicines and equipment had been strengthened to ensure patient safety and to provide an effective audit trail.
- The practice had carried out an appropriate risk assessment to identify medicines that it should stock for use in an emergency.
- The practice stored prescription stationery securely and the tracking system for prescription pads was now fully effective. All stock had been accounted for by the regional pharmacist. The serialised stock balance for the standard military prescription forms was rectified on the day.
- Written procedures in medicines management were in place. However, there was no record of staff having read them and they were not always seen to be governing activity. For example, the management of stock was not per the standard operating procedure (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 but we saw this had been requested. We saw that both patients had been managed appropriately.

- Whilst the practice did not routinely hold stock of CDs, appropriate steps were taken for the monitoring of CDs (held awaiting collection). For example, there was a log of keys removed for access to the CD cabinet and a standard operating procedure (SOP) was available online.
- Prescriptions were signed before medicines were dispensed and handed out to patients.
- The repeat prescription system in place was now effective. Staff told us that a clinician was informed of any uncollected prescriptions and this was now documented on the clinical operating system (known as DMICP). The practice administrator monitored the uncollected prescriptions and those awaiting collection were followed up with a telephone call to the patient.
- There was no monitoring of off-label (a licensed medicine where the license does not cover the indication for which the medicine is being prescribed) prescribing and patients were not provided with information on why they were being prescribed.
- PGDs (Patient Group 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 (signed by the previous doctor). This was rectified on the day. The audit of PGDs from March 2020 was yet to be completed. We were told PSDs were no longer used at the practice.
- The practice nurse was still the only staff member able to order vaccines. Therefore when the nurse is absent, the practice would be unable to order additional stock.

Track record on safety

The health and safety systems at the practice had been developed.

- A building risk assessment was now available and DPHC Safety Health Environment and Fire (SHEF) documents that were mandated for display were in place. Applications had been submitted for the practice manager to attend health and safety training but this had been held up by lack of funding. As a workaround, 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.
- 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 were detailed in the business continuity plan.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong. Since the last inspection, the practice had improved the utilisation of the Automated Significant Event Record System (ASER) for managing significant events.

- 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.
- There were systems for reviewing and investigating when things went wrong. All staff had access to the significant event reporting system and understood how to use it.

- At the previous inspection, we found the process for shared learning relied on staff accessing the ASER tracker and there was no evidence to show discussion took place around all significant events. At this inspection, we found the practice now made use of the 'lessons learned' function that had widened learning across the practice team. The practice analysed the data to identify and act on trends in ASER reporting. For example, there was a trend related to the supply of medicines from the outsourced pharmacy. This had been escaled to regional management and subsequently onto the contract holders. As a result, the pharmacy was contacted to say that all deliveries should be in a sealed box to protect patient confidentiality. Snap checks of the crash trolley had been introduced following out of date medicines found by the regional pharmacist.
- The practice had strengthened the system for receiving and acting on safety alerts. Alerts were received into a group email box that was accessible to all clinicians. There was a flow chart and an SOP for the management of alerts. This included read receipts from each clinician to acknowledge receipt by email. The practice manager was the responsible individual and was deputised by the RMO. We checked two recent alerts and found they had been received and actioned appropriately.

Are services effective?	Requires improvement

We rated the practice as requires improvement for providing effective services.

Following our previous inspection, we rated the practice as inadequate for providing effective services. We found inconsistencies in processes for providing effective services including gaps in:

- the management of long-term conditions;
- the recall of patients eligible for health screening.

At this inspection we found some of the recommendations we made had been actioned but there were still some room for improvement. The practice is now rated as requires improvement for providing effective services.

Effective needs assessment, care and treatment

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

- 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. Since the last inspection processes had been strengthened to ensure clinical staff were kept up-to-date with evidence-based guidance and standards, including guidance from the National Institute for Health and Care Excellence (NICE) and the Scottish Intercollegiate Guidelines Network (SIGN). Relevant guidance was a standing agenda item at the monthly healthcare governance meetings. For example, meeting minutes from January 2020 showed guidance discussed included cannabis-based medicinal products and the management of fever in under-5s.
- In addition, clinical updates were discussed at the departmental meetings and the four weekly nurses meetings. The practice also received the DPHC newsletter that included NICE and medicines management 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 a small number of patients on the diabetic register. We reviewed the treatment and care offered to these patients and found that they had been recalled and had attended for a review in the last 12 months.
- There were a small number of patients recorded as having high blood pressure. All these patients had been recalled for their blood pressure to be taken in the past nine months and had a blood pressure of 150/90 or less which is an indicator of positive control.
- There was a small number of patients with a diagnosis of asthma. All had been recalled and had attended for an asthma review in the preceding 12 months and their smoking status had been captured.
- The practice had a small number of patients on the mental health register and no patients diagnosed with depression. There were care plans in place and there were regular reviews carried out with the welfare team.
- 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 January 2020.
- Information from the Force Protection Dashboard, which uses statistics and data collected from military primary health care facilities, was also used to gauge performance. Service personnel may encounter damaging noise sources throughout their career. It is therefore important that service personnel undertake an audiometric hearing assessment on a regular basis (every two years). Audiometric assessments were in date for 100% of patients had an assessment in the last two years. A total of 66 patients were due for a follow up appointment but all were deployed. The clinical records we looked at showed audiometric assessments were appropriately undertaken and recorded in accordance with the Hearing Conservation Programme.
- A structured programme of clinical audit for 2020 was in place. However, it was too early to record the outcomes from audit work carried out. For example, a gout prescribing audit completed in November 2019 identified a small number of patients prescribed medication and only half had been appropriately monitored. The audit findings were discussed at an audit meeting and a repeat cycle was planned in May 2020.

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 professional development courses had not been completed by the nurse; for example, in asthma and diabetes management. The practice had contacted DPHC to request this and in the interim, the nurse had completed some online training.
- The practice provided staff with an induction process and appraisals. The induction programme was now role specific and a structured programme of clinical supervision was in place.
- 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, sexual health and a cervical cytology course.
- 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.

Coordinating care and treatment

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

- The practice had established strong links and met regularly 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. Prominently displayed notice boards were used to target specific health promotion; for example, 'World Sleep Day', 'Stop Smoking Day', sexual health and mental health.
- All new patients were asked to complete a proforma on arrival. Notes were scrutinised by administration staff and then reviewed by the nurse and doctor.
- 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 assured that all patients now had access to appropriate health assessments and checks. Searches had been undertaken for all patients aged 50 to 64 years who were entitled to breast, bowel and Aortic (AAA) screening. The practice maintained a tracker to provide an updated status, all eligible patients were in date or had been invited for 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 11 out of 22 eligible women. This represented an achievement of 50%. The NHS target was 80%. The practice nurse was in date with training for cervical cytology, patients were directed to a nearby base (the low uptake rates were in part down to the transient eligible population. All 11 patients who were overdue a test had been written to and invited to attend. The oversight of patients who do not attend could be improved with access to Open Exeter and better communication with Public Health on the

status of patients screened. The practice told us that oversight was maintained from Aldershot Garrison Medical Centre.

- NHS health check screening was provided for the practice population of 75 patients aged 40 or above and. All had received an invite and 10 checks had been completed. The practice planned to send out follow-up letters to those who had not attended.

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

- 97% of patients were recorded as being up to date with vaccination against diphtheria.
- 97% of patients were recorded as being up to date with vaccination against polio.
- 98% of patients were recorded as being up to date with vaccination against hepatitis B.
- 97% of patients were recorded as being up to date with vaccination against hepatitis A.
- 97% of patients were recorded as being up to date with vaccination against tetanus.
- 99% of patients were recorded as being up to date with vaccination against yellow fever.
- 99% of patients were recorded as being up to date with vaccination against MMR.
- 100% of patients were recorded as being up to date with vaccination against meningitis.

The unit commanders were responsible for ensuring their personnel kept up-to-date with vaccinations. They appropriately did this through the Joint Personnel Administration (JPA) system. The practice carried out an assurance check.

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 (MCA) 2005. At the last inspection, we found that staff had not received MCA training. Training had now been completed by the majority of staff in November 2019. The practice had added an 'at a glance' guide to the staff noticeboard that provided information regarding the core principles of the Mental Capacity Act.
- Verbal consent was recorded on the consultation notes.

Are services caring?	Good

We rated the practice as good for caring.

Following our previous inspection, we rated the practice as good for providing caring services. At this inspection we continued to rate the practice as good for providing caring services.

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.

- Posters displayed throughout the waiting area asked patients to respect confidentiality at the reception desk.
- We received 18 patient Care Quality Commission comment cards in total. All completed comment cards were entirely positive about the service experienced and complimented the practice staff on providing an excellent service.
- 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 contact details that included 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 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 (15 questionnaires completed in January and February 2020) showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example:
    - 93% said that they felt involved in decisions regarding their care (7% said that this question did not apply to them).
    - 14% said that they would recommend the service to family and friends (86% 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 benchmarked against regional and national averages for DMS, or against the previous year's performance. However, the comparable data was not available to us due to confidentiality.

- 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. For example, there were dedicated noticeboards to promote sexual health and mental health services and patient information.
- 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. Privacy curtains or screens were in clinical all clinical rooms.
- 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 designated room was available for confidential conversations.
- 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

Following our previous inspection, we rated the practice as good for providing responsive services. At this inspection we continued to rate 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 coronavirus at the time of inspection.
- 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 urgent appointment with a doctor or a nurse. Routine appointments were available the next day. Any patient who did not attend were contacted by telephone and this was recorded on DMICP.
- The PCRF department had been transferred to Aldershot Garrison Medical Centre. Patients needing to access the PCRF could now self-refer and the wait time was approximately two days (the key performance indicator or KPI in DMS is 10 days). At the previous inspection, the

practice had made the decision not to allow patients to self-refer to maintain assurance and consistency when using a locum physiotherapist.

- Medical support, referred to as 'shoulder cover', was provided by Sandhurst Medical Centre from 16:30 to 18:30 hours Monday to Thursday and from 12:30 to 18:30 on a Friday. Patients could obtain clinical advice over the telephone or attend a booked appointment in person. Outside of these hours, patients were diverted to the NHS 111 service. In this way, the practice ensured that patients could directly access a doctor between the hours of 08:00 and 18:30, in line with DPHC's arrangement with NHS England.
- If the practice closed for an afternoon for training purposes, patients could still access a doctor in an emergency. 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. The nearest walk-in centre also detailed in the practice leaflet was approximately four miles away at Teddington Memorial 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:
    - 93% of patients said that they could access an appointment at a convenient time (7% said this question was not applicable to them).
    - 100% of patients said that the medical centre listened to their comments, complaints and compliments.

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.

- DPHC had an established policy for managing complaints 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. This included a form and instructions on how to make a complaint.
- There had been no verbal or written complaints submitted by a patient since the last inspection. In the same time period, the practice had recorded five verbal compliments made in relation to the service provided.
- 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?	Good

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

Following our previous inspection, we rated the practice as inadequate for providing well-led services. We found inconsistencies in processes for providing well-led services and recommended a review of governance arrangements to take account of:

- The sufficiency of current clinical leadership arrangements.
- The processes for managing risks, issues and performance.

At this inspection we found recommendations we made had been actioned. The practice is now rated as good for providing well-led services.

Leadership capacity and capability

At the last inspection we highlighted a lack of clinical leadership at the practice. In September 2019, an RMO was posted into the medical centre, and with support from a GDMO, there was clear evidence of improvement.

There were still some issues that needed addressing, however the practice clearly evidenced positive change.

- Leaders demonstrated the managerial experience and capability to address the issues. Clinical leadership roles had been implemented and staff understood their own responsibilities as well as those of colleagues.
- Protected time was provided to support staff in leadership roles.
- Systems and processes had been strengthened to improve clinical oversight and provide resilience. DPHC made the decision to not deploy the RMO in order to provide continuity of leadership.
- At the last inspection we highlighted the demands on the practice nurse impacted on their capacity to carry out their role. This had improved with the addition of an extra nurse and with division of responsibilities to provide increased resilience.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care. In spite of the imminent closure, the practice demonstrated significant progress towards achieving the strategy. However, some further improvements were required.

- The DPHC vision of ‘best, safe practice - by design’ had been adopted.
- The practice had their own mission statement which was ‘. Hounslow Medical Facility will deliver a unified, safe, efficient and accountable primary healthcare service for entitled personnel to maximise their health and to deliver personnel medically fit for operations’.

Culture

The practice leaders portrayed a determined and diligent approach, highlighted by the progress made in a short space of time and despite the planned closure of the barracks.

- Staff stated they felt respected and valued. We found a workforce that had clearly benefited from the additional support, in particular from the RMO and additional 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, areas for training in chronic disease management highlighted at the last inspection had not been completed.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training.

Governance arrangements

The practice had clarified responsibilities, roles and systems of accountability to support good governance and management.

- There had been an increase in regional support following the last CQC inspection in June 2019. This had resulted in a programme of improvement to strengthen the governance framework and staff spoke positively about the regional support provided.
- A rotating programme of meetings had been implemented in a protected time slot each Thursday morning. These included a practice meeting for all DPHC and regimental staff, a healthcare governance meeting for all staff, a clinical meeting for all clinical 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.
- Staff were now clear of the roles and accountabilities of colleagues including leadership for safeguarding and medicines management. However, the governance arrangements for medicines management needed further strengthening.
- Practice leaders had established a number of policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

The processes for managing risks, issues and performance had been strengthened.

- 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.
- The practice had implemented a framework to manage current and future performance.
- Practice leaders had timely oversight and consistently completed timely action in response to national safety alerts.
- A clinical audit programme had recently been implemented and repeat cycles were being used to monitor the 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 had been improved to manage potential risk should an emergency situation arise.

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. The information was being used to monitor performance and the delivery of quality care, for example, there was now a 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 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.

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. The views of patients were routinely sought in line with DMS policy and staff provided examples of changes this feedback had triggered.
- An understanding of the performance of the practice was maintained. The practice manager used the Common Assessment Framework (CAF) as an effective governance tool. A number of different meetings were held regularly. We saw that meetings were used for forward planning, for example, to ensure that the practice made best use of funding with limitations imposed due to the imminent closure. Staff regularly met together to learn from one another, discuss recent guidance changes and to review their approach in clinical settings.
- The information used to monitor performance and the delivery of quality care was accurate and useful. Staff had identified inconsistent use of Read codes and they understood how this could lead to inconsistent delivery of care for patients. Staff reported issues with using this search facility as they found it to be unreliable. In mitigation, staff had adopted corroborative ways of working by using patient registers which they routinely updated and cross checked.

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, patients had asked for health promotion activity and in response, the practice had organised a sexual health education session.
- The practice clearly displayed outcomes from patient feedback in the waiting area. A 'you said, we did' board was displayed in the patient waiting area. There were two examples displayed that showed how the practice had responded to patient feedback. Patients had asked for appointments with the PCRF to be available from the medical centre and a fortnightly outreach clinic from Aldershot PCRF had been introduced.
- 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).
- Attempts had been made to form a patient participation group and the practice manager had attended an open session at Kneller Hall where patients were invited to attend and give feedback. However there had been no uptake from patients.

Continuous improvement and innovation

There was evidence of significant efforts from the practice team to introduce new systems and processes to drive improvement. The practice had progressed with the framework developed to drive improvement. In addition, we saw specific areas of quality improvement work that included:

- Use of quick response (QR) codes (an image that works in the same way as a bar code) on the patient leaflet to provide information and a quick link to the patient survey.
- An electronic patient satisfaction survey which uploads the responses onto SharePoint (an intranet and content management system).
- Non-clinical audits were used to monitor quality improvement; for example, handwashing and pathology sample audits had been completed in 2020.
- An internal recognition award scheme had been introduced.