# London Central Medical Centre

Wellington Barracks, Petty France, SW1E 6HQ

## Defence Medical Services inspection report

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

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

# Contents

# Summary

## About this inspection

We carried out this announced comprehensive inspection on 13 January 2022.

**As a result of the inspection the practice is rated as good overall**

Are services safe? – requires improvement

Are services effective? – good

Are services caring – good

Are services responsive to people's needs? – good

Are services well-led? - good

The CQC does not have the same statutory powers with regard to improvement action for the Defence Medical Services (DMS) under the Health and Social Care Act 2008, which also means that the DMS is not subject to CQC's enforcement powers. However, as the military healthcare regulator, the Defence Medical Services Regulator (DMSR) has regulatory and enforcement powers over the DMS. DMSR is committed to improving patient and staff safety and will ensure implementation of the CQC's observations and recommendations.

This inspection is one of a programme of inspections the CQC will complete at the invitation of the DMSR in its role as the military healthcare regulator for the DMS.

**At this inspection we found:**

- The practice sought feedback from patients which it acted on. Feedback showed patients received appointments at a time that suited them and from staff that treated them with compassion, dignity and respect. They were involved in care and decisions about their treatment.
- The practice was well-led and the leadership team demonstrated they had the vision, capability and commitment to provide a patient-focused service and consistently sought ways to develop and improve.
- An inclusive whole-team approach was supported by all staff who worked collaboratively to provide a consistent and sustainable patient-centred service.
- Effective safeguarding arrangements were in place and the practice had good lines of communication with the units and welfare officers to ensure the wellbeing of service personnel.

- There was an ethos of education, training and workforce development, reflected in the diverse range of trainee placements and General Practice Education Committee (GPEC) accreditation.
- 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 arrangements for managing medicines, including obtaining, prescribing, recording, handling, storing, security and disposal minimised risks to patient safety. There was scope to improve the management of controlled drugs.
- The practice worked collaboratively with internal and external stakeholders, and shared best practice to promote better health outcomes for patients.
- Arrangements were in place to ensure information to deliver safe and effective care was appropriate. However, the process for the summarisation of patient care was not clear.
- The healthcare governance workbook was well-developed and captured a wide-range of information to illustrate how the practice was performing.
- Quality improvement activity was embedded in practice, including various approaches to monitor outputs and outcomes used to drive improvements in patient care.

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

- The practice led on a regional quality improvement project in response to an area of risk identified in a cohort of suspected COVID-19 patients reported to have a silent hypoxia (low oxygen levels). A standard operating procedure, clinical pathway and patient guide on how to use the pulse oximeter were developed. A patient tracker was used to monitor patients in the community with a pulse oximetry. Evidence of effectiveness was limited but early results subjectively suggested community pulse oximetry improved remote review of COVID-19 patients and mitigated risks presented by reported cases of ‘silent hypoxia’.
- The practice had introduced an emergency sanitary box to the female toilet for patients to access. This initiative had been raised as a quality improvement project (QIP). It had been discussed by the regional QIP team and escalated to Defence Primary Healthcare (DPHC) Headquarters (HQ) with a view to introducing an emergency sanitary box into all DPHC facilities as best practice.

**The Chief Inspector recommends:**

- A local protocol should be developed for the summarisation of clinical records so there is a clear understanding of the process.
- The process for managing internal referrals should be reviewed with a view to considering a central monitoring process in line with how external referrals are managed.

- The process for managing requested tests should be reviewed to ensure measures are in place for follow up if a patient fails to attend for a test.
- Review the risk register to ensure it is structured and managed in accordance with DPHC policy.
- Keep under review the impact of increased temperatures and the current building work on the health and safety of patients, staff and others who visit the building.
- Review the management of controlled drugs to ensure adherence with legislation and organisational policy.
- Monitor staffing capacity to determine the impact of reduced staff levels on the health and wellbeing of staff.

**Dr Rosie Benneyworth** BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

## Our inspection team

The inspection was led by a CQC inspector and a team of specialist advisors including a primary care doctor, a nurse, pharmacist, physiotherapist and practice manager.

## Background to London Central Medical Centre

Located in Wellington Barracks, London Central Medical Centre (LCMC) provides a primary healthcare, occupational health and Force Protection service to a wide range of tri-service units. The patient population of 2,333 includes a small number of patients under the age of 18.Thirty one per cent of the population is over the age of 45.

A dispensary and PCRF are located within the medical centre. The PCRF provides a physiotherapy and rehabilitation service.

The practice is open 08:00 - 12:30 and 13:30 – 16:30 hours Monday to Thursday, 08:00 – 12:30 on Wednesday and Friday. Emergency appointments can be accommodated in the afternoons when the practice is closed. From 16:30 until 18:30 medical cover is provided by Pirbright Medical Centre. From 18:30 midweek, weekends and bank holidays patients can access NHS 111.

The practice is part of the London DPHC affiliation which meant the practice worked closely with Woolwich and Hyde Park medical centres. This arrangement is referred to as ‘the affiliation’ throughout the report.

## The staff team

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| Medical team | Senior Medical Officer (SMO)<br>Civilian deputy Senior Medical Officer (DSMO)<br>Two Civilian Medical Practitioners (CMP) – one vacancy |
| Nursing team | Two civilian Band 6 practice nurses<br>Civilian health care assistant (HCA) |
| Practice management | Two practice manager (one civilian and one military) |
| Administration team | Two E1 administrators |
| Dispensary | Pharmacy technician |
| PCRF team | OC PCRF – deployed with locum cover in place<br>Band 7 physiotherapist<br>Three Band 6 physiotherapists<br>One administrator<br>Exercise rehabilitation instructors (ERI) – vacant until February |
| Trainee placement | GP ST3<br>GP ST2<br>General Duties Medical Officer (GDMO)<br>Two medics* - one vacant post |

*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?

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

## Safety systems and processes

- The children and vulnerable adults safeguarding standard operating procedure (SOP) was last reviewed in January 2022 and took account of both organisational and external local policy. The safeguarding SOP and referral process details were displayed in all rooms throughout the practice. Staff we spoke with were aware of the SOP and how to report a concern. Both designated safeguarding leads for the practice had completed level 3 safeguarding training. All other staff had completed training at a level appropriate to their role.
- Regular DMICP (patient electronic system) searches were undertaken to ensure the vulnerable patients register was up-to-date. There were 18 patients on the register and a random check of DMICP records showed appropriate alerts were on the records. A colour coded process was applied to the register to indicate the level of risk for each patient. Vulnerable patients were identified through summarisation of patient records, when they registered at the practice, during the patient health check and by the Welfare Officers. Each vulnerable patient was assigned a named doctor and offered timely appointments.
- The practice had an effective relationship with the Welfare Officers for the units, including open access to two-way referral of potentially vulnerable patients. In addition to informal communication, monthly meetings were held to review patients of concern and the four Welfare Officers attended the meeting on a rotational basis. We were provided with examples of when the practice, in conjunction with the Welfare Officer, went over and above what was required of them to support vulnerable patients.
- The chaperone policy was last reviewed in May 2021 and the staff team received chaperone training in March 2021. Overall, the patient records we looked at confirmed patients were offered a chaperone in the appropriate circumstances. Chaperone notices were displayed in reception and all clinical rooms. Reception staff asked patients if a chaperone was required at the point of booking an appointment if there was an intimate procedure involved.
- The full range of recruitment records for permanent staff was held centrally. The practice could demonstrate that relevant safety checks had taken place at the point of recruitment, including a Disclosure and Barring Service (DBS) check to ensure staff, including locum staff, were suitable to work with vulnerable adults and young people. DBS checks were renewed in accordance with organisational policy. Two of the administrative team had not had a check as they were employed prior to the requirement to hold a DBS and had been advised by Regional Headquarters (RHQ) they did not need to apply for a DBS under legacy rights. A process was in place to monitor the professional registration and immunisation status of clinical staff.
- A suitable qualified and experienced infection prevention and control (IPC) lead was identified for the practice. They were also the IPC lead for the region. Annual

mandatory IPC audits were undertaken with sufficiently high compliance achieved not to merit additional audits.

- Defence Primary Healthcare (DPHC) guidance was being followed in relation to COVID-19. Patients were screened via an intercom system before entering the medical centre. Information was displayed about minimising the spread of the virus including the requirement for patients to wear a mask. A sufficient supply of personal protective equipment (PPE) including masks, aprons and hand gel were available. The team received PPE and resuscitation of the COVID-19 patient training in April 2020.
- The premises was cleaned twice a day in line with the cleaning contract. Room doors were colour coded to identify the cleaning requirement and reference lists were in place for designated 'hot' rooms such as treatment room and toilets. A six monthly deep clean was scheduled and it last took place in December 2021. The healthcare assistant carried out daily checks of the standard of cleaning and the cleaning records. The practice regularly carried out checks of the premises in conjunction with the contract provider.
- Safe arrangements were in place for the management of clinical waste including a waste log and consignment notes. Waste was stored securely. An annual waste audit was carried out in December 2021 as part of the IPC audit.

## Risks to patients

- The practice had vacant positions including for two administrators and one recent vacancy for a civilian medical practitioner (CMP). Whilst patient access was not impacted, doctors highlighted this had meant reducing administrative time to complete clinical reports and governance activities in order to support increased clinical time. The eConsult system (remote consultations) accounted for approximately 5% of all consultations and had slightly increased demand. The primary care rehabilitation facility (PCRF) was experiencing a shortage of staff but this deficit was being effectively managed.
- Clinicians reported there was a well-balanced skill mix within the team. All the CMPs had Military Aviation Medical Examiner (MAME) training and were diving medicine trained.
- An appropriately equipped medical emergency kit was in place. Risk assessments were in place to show emergency medicines not kept on the trolley were held in the dispensary. Both oxygen and pads for the automatic external defibrillator (AED) were in date. The oxygen and Entonox (pain relieving gas) cylinders were free standing. For safety reasons, we discussed with the pharmacy technician more secure storage alternatives. Daily and monthly recorded checks of the kit and emergency medicines were undertaken. We noted the dates for a small number of dressings had expired and highlighted this to staff during the inspection. All staff were suitably trained in emergency procedures, including basic life support, anaphylaxis and the use of an AED. Training incorporated scenario-based emergency situations. The team completed sepsis and thermal injuries training within the last year.
- The waiting areas could be observed at all times by reception staff.

## Information to deliver safe care and treatment

- In the event of a DMICP outage the practice accommodated emergency patients only and referred to the business continuity plan, which directed patients to the other practices within the affiliation. The practice had the option to use laptops if it was a fixed network outage. In addition, hard copies of forms were held to use for emergency patients in an outage which could be uploaded to DMICP at a later stage. Doctors highlighted that DMICP regularly froze mid Skype consultations which added to time pressures.
- Whilst it was evident summarisation of patients' records took place, we were unable to confirm the process including which staff summarised the records. A population management (referred to as Popman) search by the practice on 2 December 2021 and again on 2 January 2022 showed 95% of patient records were in-date for summary. The search we ran indicated 75% of records had been summarised.
- We reviewed a wide-range of patients' clinical records. Overall, the records were of good quality in terms of assessment, diagnosis, clinical coding and care delivery based on current evidence. There were a small number of exceptions where records lacked detail, were incomplete or treatment directions was not sufficient; we discussed our findings with the individual clinicians. This was similar to the findings of the record keeping audit carried out by one of the practice doctors in February 2021. The audit included record keeping for doctors, nurses and medics. The repeat audit in September 2021 showed improvements to record keeping. However, not all clinicians were aware that their record keeping had been reviewed as part of the audit and the outcome. In addition, the doctor who completed the audit also audited their own records. We discussed alternative approaches to record auditing to ensure objectivity for all clinicians. For PCRF staff, spot checks of records were undertaken and the actions identified followed up. A full notes audit was planned for February 2022.
- A process and guidance was in place for the management of external referrals with an administrator assigned to monitoring the progress of referrals. The referrals spreadsheet clearly highlighted the two-week-wait referrals. A similar system was not in place for internal referrals, such as those to the Regional Occupational Health Team (ROHT), Multidisciplinary Injury Assessment Clinic (MIAC), Regional Rehabilitation Unit (RRU) and Defence Community Mental Health (DCMH). The doctors and physiotherapists made and managed these referrals. Whilst there was no evidence of referrals being missed, not having a centralised system with oversight was a risk as there was no consistent way to monitor when referrals were accepted and to minimise the risk of patients being missed.
- An SOP was in place for the management of specimens. We found the process was well-managed and included the required failsafe measures in the event of missed specimens and non-availability of the requesting clinician. Results were documented in the patient's record and the patient contacted or an appointment booked to discuss results. However, we identified a potential risk in process as the responsibility lay with the patient to provide a sample or book in for a blood test. In these instances, there was no process to identify that a requested test had been followed though by the patient. In the event of a test to identify a chronic illness or based on red flag symptoms, the current process could lead to delay in treatment that is reliant on a test result.

## Safe and appropriate use of medicines

- The SMO was the lead for medicines management. The pharmacy technician (PT) oversaw the operational management of medicines. Both their terms of reference reflected this arrangement. The practice worked to DPHC medicine management SOPs.
- Patient Group Directions (PGD) were used to allow practice nurses to administer medicines in line with legislation. PGD training was in-date and nurses referred to the appropriate policy guidance. DMICP templates were used for PGD administration. We found gaps in PGD authorisation and this was rectified shortly after the inspection. A process was established to monitor PGDs and we were provided with a PGD audit completed after the inspection on 19 January. Patient specific directions (PSD) had not been used since June 2021. We noted gaps in how these historical PSDs had been managed and highlighted this during the inspection. Nurses had completed vaccination training.
- The temperature of the vaccine fridge was regularly monitored. The fridge did not meet updated pharmaceutical refrigeration standards The practice acted on this promptly by securing appropriate refrigerated storage shortly after the inspection. We highlighted at the time of the inspection that the treatment room fridge was not suitably secured as it was unlocked. Both the nurses and practice managers accepted vaccine deliveries. We checked the vaccines and they were in date. Expiry dates were recorded on DMICP and a monthly report indicated when items were due to expire. Appropriate arrangements were in place to monitor cold chain medicines if transfer to another location was required.
- Although an SOP was not in place, there was a consistent approach for the management of information about changes to a patient's medicines received from other services. Incoming correspondence, such as from out-of-hours services, hospital discharge letters and out-patient clinics was added to the patient's medication record and the doctor informed.
- The storage, receipt and issue of blank prescriptions was in accordance with the DPHC SOP. Although there was no running total, the serial numbers corresponded with the register. Repeat prescriptions were received by eConsult, email or by the patient completing the repeat prescription request form. The PT only dispensed prescriptions if they had been signed by the doctor. Our review of patients' records showed that medicines were appropriately prescribed, including the issuing of repeat prescriptions.
- A high risk medicines (HRM) register was maintained. One of the doctors was the lead for HRMs and a clinical meeting was held every two weeks to discuss patients prescribed HRMs. We reviewed four patients on HRMs and all had a shared care agreement in place, which outlined how the patients should be monitored.
- Controlled drugs (medicines with a potential for misuse) were held securely. Controlled drugs (CD) and accountable drugs registers, collection checks and destruction were in line with guidance. The CD keys were kept in a cupboard with digital access. Duplicate keys were not held in a sealed envelope in line with guidance. Due to a change of dispensary staff, the controlled drug (CD) and accountable drug monthly check was missing for July 2021. We noted instances of alterations made on the CD and accountable drug registers and highlighted to the practice that any corrections must be

clarified, dated and signed by means of a footnote. Monthly and quarterly CD checks had not all been signed by the second checker. Some Schedule 3 accountable drugs had been dispensed but not double checked; this will be rectified when a second PT starts working at the practice in February 2022. The CD audit and annual declaration was due to be submitted before 31 March 2022. The audit was completed shortly after the inspection on 4 February 2022 and forwarded to the inspection team.

- Uncollected prescriptions were checked regularly by the PT. Any high-risk medicines, antibiotics or medicines used in the management of long-term conditions that were uncollected were brought to the attention of the doctors to follow up with patients.

## Track record on safety

- One of the practice managers was the lead for health and safety. A risk and retired risk register was in place, and also an issues and retired issues log. The risk register included the main risks for the practice and had been recently reviewed. Minutes of practice meetings confirmed the risk register was a standing agenda item. In accordance with DPHC guidance, the 'four T's' (transfer, tolerate, treat, terminate) had not been introduced to clearly indicate where and how risks were being managed.
- Reviewed in December 2021, the range of practice risk assessments covered both clinical and non-clinical risks including COSHH (substances hazardous to health) risk assessments. The practice did not have a lone working risk assessment as staff did not routinely lone work. Fire, gas and electrical checks were up to date.
- Evidence was provided to confirm portable appliance testing and a legionella risk assessment had been undertaken. The annual equipment audit (referred to as LEA) was undertaken in June 2021 and no recommendations were made. A MIAC clinic from Aldershot RRU was held in the PCRF and the equipment used belonged to the MIAC service. Evidence was provided via the RRU Aldershot healthcare governance workbook showing servicing history and ownership of the MIAC equipment.
- The practice was working to a COVID-19 risk assessment. The number of people accessing the building had been reduced, social distancing measures were in place, face coverings were mandated and the number of chairs in the waiting room had been reduced. There was signs about COVID-19 displayed, a protective screen at reception and an intercom at reception to carry out a COVID-19 screen with the patient. Hand sanitiser and sufficient supplies of PPE were available.
- There was a fixed alarm system in clinical areas which alerted staff in reception, including where the alarm was activated. Administrative staff and the practice managers had handheld alarms. Handheld alarms were also available for members of the PCRF team. Staff responded appropriately when we tested one of these alarms.
- There had been an historical issue with temperature control of the premises meaning at times the environment was uncomfortably hot. This issue had been escalated and was recorded on the risk register. Staff advised us they had logged temperatures in excess of 40 degrees for one month and over 35 degrees for three months in the summer of 2021. The increased temperatures were compounded by blacked out polythene covered windows, which allowed for no ventilation and regular loud drilling from

external building renovation (expected completion Spring 2022). To manage the heat, mobile air conditioning units and fans were in use throughout the premises. The business continuity plan had been activated in response to the heat with the MIAC clinics moved when necessary to an office with air conditioning.

- To manage the heat, mobile air conditioning units and fans were in use throughout the premises. The PCRF had developed strategies to counter the difficult working conditions. Wet Bulb Globe Temperature (used to indicate the likelihood of heat stress) peak readings for PCRF rehabilitation were recorded daily by the physical training gym staff.

## Lessons learned and improvements made

- Significant events (SE) and incidents were reported through the electronic organisational-wide system (referred to as ASER). All staff had a log-in to the ASER system to report SE and incidents. Part 2A ASER access was held by SMO, OC PCRF, Band 7 physiotherapist and both practice managers. The practice did not maintain an ASER log and this was identified on the latest healthcare governance assurance visit (HGAV). Although the practice managers highlighted that SEs were managed via the ASER system, patterns and themes were not as easily identified without a log. Minutes of the monthly healthcare governance (HCG) meetings confirmed SEs were discussed including lessons learnt. Staff provided several examples of SEs including themes of SEs and the action taken to minimise reoccurrence.
- The pharmacy technician (PT) was responsible for managing patient safety alerts and checked the Medicines and Healthcare products Regulatory Agency (MHRA) website daily for updates. Since the inspection, the PT had subscribed to the MHRA to receive medicine alerts. Several alerts had not been recorded on the alerts register. Once we made the practice aware of this, the register was updated. Practice meeting minutes showed that alerts were discussed with the team. Staff were also made aware of any new alerts at the Monday morning meeting.
- A search was recently set up to identify patients prescribed valproate (medicine to treat epilepsy and bipolar disorder). It included all patients and was revised during the inspection to search for female patients to check pregnancy prevention information for women able to have children.

# Are services effective?

**We rated the practice as good for providing effective services.**

## Effective needs assessment, care and treatment

- Processes were in place to support clinical staff to keep up to date with developments in clinical care including NICE (National Institute for Health and Care Excellence) guidance, the Scottish Intercollegiate Guidelines Network (SIGN), clinical pathways, current legislation, standards and other practice guidance. Clinical updates was a standing agenda item at the fortnightly clinical meetings, which also provided the opportunity to discuss patient care, including those with complex needs. General Duties Medical Officers (GDMO) on placement at the practice had the task of producing a quarterly clinical care update report.
- Best practice guidance updates relevant to the PCRF were monitored and logged. PCRF staff were familiar with Department of Defence Rehabilitation Guidance and provided examples of treatment provided based on evidence-based guidelines and care pathways. The PCRF used Rehab Guru (software for rehabilitation exercise therapy) and, if appropriate, this was documented in the clinical records we looked at.
- The use of the rehabilitation master template and Musculoskeletal health Questionnaire (MSK-HQ) scores were detailed on all initial assessments we looked at. Examples of additional patient reported outcome measures (PROM) were recorded where appropriate.

## Monitoring care and treatment

- We were advised that COVID-19 had a significant impact on chronic disease management as the patient population was dispersed all over the country so follow up had been a challenge. The practice had implemented measures, such as patients taking their own blood pressure readings. Despite this challenge, we found that effective systems were in place to ensure patients with a chronic disease were well managed. Doctor and nurse leads were identified for each chronic condition to ensure consistency of care. The nurses took the lead with recalling patients for checks.
- A chronic disease register (CDR) was established. The nurses used different systems to collate data to ensure all patients with a chronic disease were identified on the CDR. The systems were checked at least monthly to ensure the relevant data was captured. Both nurses were aware of each other's system and how it worked. The systems were subject to a six monthly audit.
- Our DMICP search for chronic diseases produced the following data:
    - Of the 12 patients with a diagnosis of diabetes, eight (73%) had a blood pressure reading of 150/90 or less. Seven (58%) had a cholesterol of 5mmol/l or less.

  - Of the 91 patients with high blood pressure, 65 (76%) had a record of a blood pressure check within the last 12 months.
  - Of the 41 patients with a diagnosis of asthma, 56% had been reviewed in the last 12 months.
  - These figures were consistent with other local DPHC practices where patients were working from home outside of London. The practice was working towards meeting the national targets.

- Our review of records for patients with a chronic condition showed that assessment, diagnosis, clinical coding and investigations were appropriate. The relevant DMICP templates were consistently used. The practice also held a register for patients with a diagnosis of gout and the gout template was used.
- Step 1 of the DPHC mental health pathway was delivered by the doctors at the practice. Patients were also provided with a self-help guide, apps, links to websites and books to access. Patients could be referred to the Improving Access to Psychological Therapies (IAPT) programme for interventions when there was a trigger event without a diagnosis; often coded as 'workplace stress' or 'domestic stress'. The Welfare Officers had a key role with identifying and managing social triggers to minimise the development of mental health issues. The DCMH held a clinic at the medical centre so doctors had access to mental health practitioners for advice. The DCMH was also represented at the Unit Health Committee (UHC) meetings. Our review of patient records showed that patients received mental health care appropriate to their needs.
- Sixty five percent of patients were in-date for an audiometric assessment (within the last two years). This percentage was consistent with other DPHC practices. During COVID-19 routine audiometry had ceased in line the April 2020 DPHC directive. The practice had resumed audiometry as restrictions relaxed. Some audiology clinics were held in the evening due to noise from the external building work.
- A lead for audit was identified for the practice. An audit tracker and programme was in place which captured all quality improvement activity, including clinical audits, mandated audits and data searches. The range of clinical audits we looked at included osteoporosis (September 2021), antibiotic prescribing (July 2019), shared care agreements, diabetes and a cytology to monitor uptake during COVID-19. There was some variance in audit quality as a small number did not include an action plan or an indication as to whether the audit would be repeated. It was clear, though, that the majority of audits had led to improvements, such as in patient care and enhanced staff knowledge.
- PCRF staff demonstrated a detailed knowledge of the patient population with evidence of data collection, audit and action to improve injury management and the patient's wellbeing. Our review of patient records showed subjective and objective outcomes were identified particularly in relation to stress related or overload injury. There was evidence of long-standing data collection and actions to improve patient stress exposure during military training.
- The PCRF was also selected to trial both wearable integrated rehabilitation application (WIRA) and health and well-being data through a trial questionnaire as part of two separate human performance monitoring research streams.

- The practice led on a regional quality improvement project in June 2020 in response to an area of risk identified in a cohort of suspected COVID-19 patients reported to have a silent hypoxia (low oxygen levels) where patients were asymptomatic initially but deteriorated at a later point of the disease process. In addition, COVID-19 guidelines recommended the use of pulse oximetry during remote consultations by clinicians. The practice developed an SOP, clinical pathway and patient guide on how to use the pulse oximeter. A patient tracker was used to monitor patients with a pulse oximetry. There was limited evidence of effectiveness but early results subjectively suggested community pulse oximetry improved remote review of COVID-19 patients and mitigated risks presented by reported cases of 'silent hypoxia'.

## Effective staffing

- A formal induction programme was in place for new staff joining the practice and it included a role specific induction. Mandatory training was monitored by the civilian practice manager and the administrator for the PCRF. Staff were advised by email when their mandatory training was due with a link to the training course. Staff were given allocated time one afternoon each month to complete the training and also continuing professional development (CPD). Records showed staff were up-to-date with mandatory training.
- A programme of in-service training was in place and training was targeted to the needs of the patient population. For example, staff participated in a session which involved wearing specific service personnel uniforms to understand the impact uniforms can have on the person's health in terms of weight and heat generated.
- Staff were supported with role-specific training, including for lead roles. For example, the practice had completed IPC link practitioner training. The military practice manager had completed the DPHC practice manager course and had completed the required occupational health and safety training course.
- Clinicians described a range of opportunities to enhance their knowledge and skills. The practice participated in a quarterly Practice Based Small Group Learning (PBSGL) forum with the other medical centres in the affiliation to enhance learning and share developments in practice. For example, an update on the management of menopause was facilitated in November 2021. Clinicians indicated that access to CPD sessions from Guy's and St Thomas NHS Foundation Trust and Imperial College Healthcare NHS Trust benefitted them educationally and supported with networking with NHS colleagues. `

## Coordinating care and treatment

- Discussions with staff, supported by clinical records, confirmed the practice had a range of established links with internal services and departments, and with local NHS and social care services. Close working with other practices within the affiliation meant resources could be shared. Clinicians also had access to military secondary care consultant colleagues based in London.

- Links were established with the Westminster safeguarding team and social services. Staff described how their relationship with the Primary Care Network had been helpful with early access to COVID-19 vaccinations for vulnerable patients. Other services the practice could access included the British Legion Admiral Nurses, counselling services and Combat Stress. The practice, including the PCRF, was represented at the UHC meetings each week at which the care of vulnerable and downgraded patients was reviewed.
- For patients leaving the military, pre-release and final medicals were offered. The practice worked closely with the Personnel Recovery Unit, located in Wellington Barracks, to support the transition of patients who had been absent from work. During the pre-release phase, the patient received an examination and a medication review. A summary print-out of the patient's health needs was provided. For patients with complex needs moving to another medical centre, a summary letter was given to the receiving doctor. Patients were also made aware of the Veterans Health Service and, if appropriate, the Veterans Mental Health Transition, Intervention and Liaison Service (TILS).

## Helping patients to live healthier lives

- A lead and deputy for health promotion were identified for the practice. The health promotion lead for the affiliation circulated information to the practices within the group. It was clear from the patient records we looked at that promoting optimal health was routine, particularly in relation to smoking cessation. The PCRF team was proactive with health promotion and asked lifestyle questions regarding smoking, lifestyle, sleep and mood. Health promotion information displayed in the practice was based on the national public health promotion programme and the needs of the patient population. It was refreshed regularly. Information to promote the uptake of smear tests and also information about testicular cancer was displayed in the patient toilet.
- A lead and deputy were identified for sexual health and both had completed the required training (referred to as STIF) for the role. Patients could be referred to both internal and external specialist sexual health services. One of the nurses had the lead for pregnancy and the role involved ensuring that pre and post-partum pregnant women maintained engagement with the practice when on maternity leave.
- A process was in place to identify and monitor patients eligible for health screening. Regular searches were undertaken for bowel (25 patients identified), breast (18 patients identified) and abdominal aortic aneurysm screening (no patients identified) in line with national programmes. The number of eligible women whose notes recorded that a cervical smear had been performed in the last 3-5 years was 261 which represented an achievement of 96%. The NHS target was 80%.
- During COVID-19 routine vaccinations ceased in line the April 2020 DPHC directive. The practice had resumed the vaccination programme as restrictions relaxed. The vaccination statistics were identified as follows:

- 88% of patients were in-date for vaccination against diphtheria.
- 88% of patients were in-date for vaccination against polio.
- 88% of patients were in-date for vaccination against hepatitis B.
- 95% of patients were in-date for vaccination against hepatitis A.
- 88% of patients were in-date for vaccination against tetanus.
- 99% of patients were in-date for vaccination against MMR (measles, mumps and rubella).
- 99% of patients were in-date for vaccination against meningitis.

## Consent to care and treatment

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making. They had a good understanding of the Mental Capacity Act (2005) and how it would apply to the patient population. Consent and the offer of a chaperone was appropriately recorded in the clinical records we looked at. The record keeping audit from February 2021 identified some gaps, so staff had been provided with training, including training in mental capacity.
- Supported by an SOP, the PCRF provided an acupuncture service. Consent was taken via standard written forms and then indicated on the medical notes by ticking the consent box on the rehabilitation master template.

# Are services caring?

**We rated the practice as good for providing caring services.**

## Kindness, respect and compassion

- The most recent patient feedback survey carried out by the practice (19 respondents) indicated staff treated patients with kindness, respect and compassion. The six patients we interviewed as part of the inspection shared this view. No patients responded to the DMSR patient satisfaction survey which complemented this inspection.
- An information network (known as HIVE) based at Wellington Barracks was available to members of the service community and provided a range of information to patients who had relocated to the base and surrounding area. Contact details for the Army Welfare service was available in the waiting room.
- Clinicians provided several examples of compassionate patient-centred care provided by the practice, including the provision of a pop-up clinic to facilitate vaccinations for those in a critical role unable to access routine care. We also heard of about how a care package was provided through the Clinical Commissioning Group for a patient with complex needs. The practice provided a sanitary emergency box in the female toilets.

## Involvement in decisions about care and treatment

- The respondents to the patient feedback survey and the patients we interviewed said they were involved with decision making and planning their care. Our review of patient records confirmed this.
- A carers lead was identified. Carers were identified through the patient registration process, clinical code searches, poster campaigns, positive questioning during consultations, summarisation and the new patient health checks. Carers were offered longer appointments if they needed it. The last carers search was run in January 22 and 28 carers were identified. Display screen information about access to support for carers was available in the waiting room.
- The PCRF appropriately used light duties prescriptions, including adaptations to manage the specialist equestrian population. Downgrade maintenance physical therapy and reconditioning physical therapy prescriptions were occasionally used.
- An interpretation service was available for patients who did not have English as a first language. Information was available in Nepalese for medical centre workers whose first language was not English.

## Privacy and dignity

- All sources of patient feedback confirmed that the privacy and dignity of patients was respected. Consultations took place in clinic rooms with the door closed. Headphone sets were used for telephone consultations. There were privacy curtains in all clinical rooms. Information was available advising patients they could speak with a member of staff in private if required. Staff had completed the Defence Information Management Passport training which incorporated the Caldicott principles. The practice could accommodate patients if they wished to see a clinician of a specific gender.

# Are services responsive to people's needs?

**We rated the practice as good for providing caring services.**

## Responding to and meeting people's needs

- Staff provided several examples of how the service has responded to meet patient need. Although the introduction of eConsult enabled shift workers and those that work remotely to access care more easily, feedback indicated it was not effective for ceremonial staff who had no access to mobile phones at work. For this reason, the practice re-introduced an emergency clinic (referred to sick parade). The practice also provided on-site vaccination clinics for a specific cohort of service personnel.
- The PCRF had developed bespoke programmes to support patients at risk of occupational musculoskeletal (MSK) injury, such as the farriers at Hyde Park and the Grenadier Guard musicians
- Furthermore, the practice responded positively to patient feedback. For example, the time of appointments were changed to take into account school timings and London traffic. In addition, the practice emailed carers rather than texting in response to feedback.
- An Equality Access Audit for the medical centre and PCRF was completed in December 2021 and all areas on non-compliance had been addressed. The building was accessible for people with mobility needs including a lift and accessible toilets. A hearing loop had been ordered.

## Timely access to care and treatment

- Patients were encouraged to use telephone consultations or eConsult. We were advised that this suited the patient population in London. Face-to-face appointments had been available throughout COVID-19 and patients were triaged before an appointment for symptoms.
- The duty doctor triaged eConsults in line with the practice's SOP/flowchart. Urgent appointments with a doctor and nurse could be accommodated on the same day and routine appointments for both within three days. The health care assistant could see a patient the next day. Patient feedback, including the patients we spoke with as part of the inspection, confirmed they received an appointment promptly and at their preferred time.
- The PCRF was meeting key performance indicators for service access. An urgent, routine and follow up physiotherapy appointment was available on the same day. Direct access to physiotherapy accounted for 40% of patient referrals. The PCRF had a process in place to triage eConsults. A MIAC clinic was held twice a week in the PCRF.

- Access to emergency out-of-hours cover midweek was provided by Pirbright Medical Centre from 16:30 hours until NHS 111 commenced at 18:30. Patients had access to NHS 111 at weekends and on public holidays.

## Listening and learning from concerns and complaints

- Both practice managers oversaw patient complaints, which were managed in accordance with the organisational complaints policy (JSP 950). A complaints log was maintained. It was unclear if verbal complaints were recorded. The practice confirmed after the inspection that the complaint log had been reviewed to ensure verbal complaints were captured. From discussions with staff it was clear complaints were effectively managed, discussed at the practice meetings (if appropriate) and lessons learnt shared.
- Patients were made aware of the complaints process through the practice information leaflet and information displayed in the waiting room. Patients we interviewed were aware of how to complain but said they had no reason to make a complaint about the service.

# Are services well-led?

**We rated the practice as good for providing caring services.**

## Leadership, capacity and capability

- Staff we spoke with described a service that was well-led by a leadership team who had the capacity and capability to deliver high-quality sustainable patient care. We found leaders were adaptable to ensure continuity of patient care. For example, the PCRF had experienced discontinuity in staffing levels and had taken action to minimise the impact on delivery of patient care. Staff told us the SMO recognised strengths in the team and promoted an open forum approach to encourage ideas and input from the whole team. In addition, staff advised us that risk management and governance of the service had improved since the SMO took up post.
- Although there had been less face-to-face visits from the regional team, leaders said there was good regional support through regular virtual meetings with the area manager and other leaders of practices within the affiliation.
- We acknowledged that the timing of the inspection during the Covid-19 Omicron wave had a significant impact on the team's ability to prepare for, and respond to, the inspection. One member of the management team was deployed on a military Aid to Civil Authorities (MACA) programme and several other staff were on high readiness to support the national COVID-19 booster vaccination effort.

## Vision and strategy

- The practice worked to the DPHC mission statement, identified as:

  "Provide and commission safe and effective healthcare which meets the needs of the patient and the chain of command."

- The practice had its own mission statement, stated as:

  "Deliver a patient centred service for Central London Personnel, in a practice that has a psychologically safe environment and culture for all staff, learners and educators."

- The needs of patients were considered with service planning and the introduction of service changes. For example, eConsult was beneficial to some patients but not others so the practice ensured all patients groups had equal service access.
- A practice objective for 2021 was to gain GPEC accreditation to become a training practice and this objective had been achieved. In 2022 there were plans to develop the London Defence Primary Healthcare affiliation to ensure efficiency of service provision.

## Culture

- It was clear from our interviews with patients, staff and the Welfare Officer that there was a patient-centred culture at the practice. This was particularly evident in the team's response, management and compassion for vulnerable patients.
- Staff described an inclusive and open-door culture with everyone having an equal voice, regardless of rank or grade. They said leaders listened to staff concerns and were proactive in addressing issues early before they escalated. 'White Space' activities were encouraged for reflection. Acknowledgement of staff contribution to the service was demonstrated through a Thank You Scheme and In Year Rewards. Staff were aware of how to the access the Employee Wellbeing Service.
- All staff said they would feel comfortable raising any concerns and were familiar with the whistleblowing policy. Staff were given the opportunity to speak out at meetings or had the option to approach one of the leaders or the area manager.
- The practice had systems to ensure compliance with the requirements of the duty of candour, including giving those affected reasonable support, information and a verbal and written apology. We were given examples of when duty of candour had been applied. 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.

## Governance arrangements

- The healthcare governance (HG) workbook was the overarching system used to bring together a range of governance activities, including the risk register, training register, SOPs, quality improvement activity (QIA) and complaints. A monthly HG meeting was held which all staff were invited at attend.
- There was a staffing structure in place and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. We queried the level of integration between the medical centre and PCRF as we noted the PCRF did not have the lead for many roles, despite having the expertise. The PCRF also had a separate system for reporting compliments and complaints.
- The practice was proactive in ensuring provision and delivery of care was monitored through an ongoing programme of QIA. Clinical audit was a routine method used to monitor and improve clinical safety and the effectiveness of outcomes for patients.
- A room was maintained within the PCRF for holding satellite MIAC clinics administered via Aldershot RRU. However, the equipment held was reliant on RRU Aldershot for servicing. There was no memorandum of understanding to highlight this relationship and mitigate liability.

## Managing risks, issues and performance

- A risk and retired risk register linked to the healthcare governance workbook was in place. An issues and retired issues log was also maintained. The portfolio of practice risk assessments were reviewed in December 2021. The risk register was reviewed and discussed at practice meetings. Although leaders were aware of the 'four T's' (transfer, tolerate, treat, terminate) DPHC Guidance Note on managing risk, the approach had not been introduced to clearly indicate where and how risks were being managed.
- The business continuity plan was reviewed in December 2021 and took account of the usual and expected risks such as a fire, flood and loss of power.
- Systems were in place to monitor national and local safety alerts, incidents, and complaints.
- Processes were in place to manage under performance of individual staff. Through examples provided, it was clear leaders understood the process and applied it appropriately.
- Supervision and appraisal was in place for all staff. Whilst there was an emphasis on the safety of staff, there was a risk that the health and wellbeing of staff could be impacted by reduced staffing levels. This reduction had meant some clinicians were working over their contracted hours and taking work home.

## Appropriate and accurate information

- The eCAF (Common Assurance Framework) commonly used in DPHC services to monitor performance is an internal quality assurance governance assurance tool to assure standards of health care delivery within defence healthcare. The practice manager referred to the eCAF to monitor the practice.
- National quality and operational information were used to ensure and improve performance.
- Systems were in place that took account of data security standards to ensure the integrity and confidentiality of patient identifiable data, records and data management.

## Engagement with patients, the public, staff and external partners

- There were various options in place to encourage patients to provide feedback on the service and contribute to the development of the service. Due to COVID-19, options for patients to provide feedback while visiting the practice were limited, including use of the suggestion box. Patients were directed to the online survey. The QR code to complete the survey was handed out in paper form to the patients. The patient participation

group (PPG) was led by a physiotherapist but the last two PPGs had not attracted any attendees.

- The practice has conducted two staff questionnaires (Safequest). The second questionnaire showed an improvement in staff morale from the first survey.

## Continuous improvement and innovation

- The staff team was committed to making improvements and took all opportunities to continually enhance the service for patients. Improvements were implemented based on patient population need, feedback about the service, complaints, the outcome of audits and significant events. The following are some of the service improvements we identified during the course of the inspection:
    - The practice led on a regional quality improvement project to introduce community pulse oximetry and training specific to the patient population;
    - The practice was subject to a GP Educational Committee (GPEC) inspection in 2021. The practice was deemed appropriate to accommodate GP trainees due to the varied skill mix of educators within the practice and a suitable mix of patients to cover a range of conditions and learning opportunities. There were two GP trainers and a GDMO supervisor at the practice. The PCRF supervised undergraduate physiotherapists;
    - Shortly after the inspection the staff team received the John Fry prize for 2021, an award for general medical practice which has demonstrated exceptional practice or has had the greatest improvement in standards and service development for the year;
    - PCRF participation in the WIRA project, a pilot in selected facilities which included an exercise prescription capability trial;
    - Emergency sanitary box;
    - The PCRF developed an injury prevention strategy to the support the farriers at Hyde Park to better manage occupational stresses and minimise MSK injury through postural education and workplace cues; and
    - The PCRF developed an injury prevention programme for Grenadier Guard musicians, which involved a series of leaflets and educational information to aid better postural control.