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 from the provider and patients.

### Ratings

<table>
<thead>
<tr>
<th>Overall rating for this service</th>
<th>Outstanding ⭐</th>
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<tr>
<td>Are services safe?</td>
<td>Good ⬤</td>
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<tr>
<td>Are services effective?</td>
<td>Outstanding ⭐</td>
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<tr>
<td>Are services caring?</td>
<td>Good ⬤</td>
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<tr>
<td>Are services responsive to people’s needs?</td>
<td>Outstanding ⭐</td>
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<tr>
<td>Are services well-led?</td>
<td>Outstanding ⭐</td>
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Letter from the Chief Inspector of General Practice

We carried out an announced inspection at RAF Lossiemouth on 29 November 2017. Overall, the practice is rated as outstanding. Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The assessment and management of risks was comprehensive, well embedded and recognised as the responsibility of all staff.
- There was substantial evidence to demonstrate quality improvement was embedded in practice, including a comprehensive programme of clinical audit and quality initiatives used to drive improvements in patient outcomes.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and 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.
- Results from the patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment. The practice also held a record of compliments which showed high levels of satisfaction by patients.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear strong leadership structure and staff felt engaged, supported and valued by management.
- The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.
- All staff we spoke with, from all disciplines, referred to the practice leadership as inclusive, caring and inspiring. We saw there was a strong commitment from all staff to their role and career path within the military. The time invested in staff by leadership, translated into positive engagement and interaction with patients. This was confirmed by the high number of compliments received from patients who visited the practice.
We identified the following notable practice, which had a positive impact on patient experience:

- A comprehensive framework of protocols had been developed that brought together the National Institute for Health and Care Excellence (NICE), the Scottish Intercollegiate Guidelines Network (SIGN) and the Quality Outcomes Framework (QOF) so that clinical staff could ensure long term conditions were managed effectively.

- A comprehensive and wide-reaching active programme of audit and quality improvement initiatives was in place. It was clear the outcome of audit and quality projects, including investigations into significant events and complaints led to measurable improvements in the service for patients.

- The practice had a policy and procedure in place to ensure all tasks and patients were handed over to permanent staff when locums departed, for example this included ensuring all test results had been actioned and their mailbox in the administration office was cleared with nothing left outstanding.

**The Chief Inspector recommends:**

- Any backlog in note archiving to be completed.

- Ensure that the system to safely manage patients who take high risk drugs that require monitoring is supported by failsafe checks.

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

The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

The practice is rated as good for providing safe services.

- We found there was an effective system for reporting and recording significant events. From documented examples we reviewed, we saw lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients were informed as soon as practicable, received reasonable support, information, and a written apology.
- The practice had clearly defined systems, processes and practices in place to minimise risks to patient safety.
- The arrangements for managing medicines, including emergency medicines and vaccines in the practice, minimised risks to patient safety. However, whilst some measures were in place when monitoring patients on high risk medicines there was no formal search undertaken to ensure all patients had received the required monitoring.
- Staff demonstrated that they understood their responsibilities in relation to safeguarding vulnerable adults.
- The practice had adequate arrangements to respond to emergencies and major incidents.

**Are services effective?**

The practice is rated as outstanding for providing effective services.

- Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE), the Scottish Intercollegiate Guidelines Network (SIGN) and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients.
- A high number of audits were carried out and had been repeated several times to maintain effective care and
treatment of patients.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were above average and patients with long term conditions were managed well.
- Practice staff assessed needs and delivered care in line with current evidence based guidance.
- The practice valued and encouraged education for all practice staff giving them the skills, knowledge, and experience to deliver effective care and treatment.
- Patients were actively supported to live healthier lifestyles through a targeted and proactive approach to health promotion and wellbeing.

### Are services caring?

The practice is rated as good for providing caring services.

- Comment cards, completed by patients before our inspection, indicated that they felt practice staff treated them with compassion, dignity and respect and they were involved in decisions about their care and treatment. Patients told us on the day that they felt the care was good and they were treated with kindness. The practice kept a record of compliments received, this showed high levels of satisfaction from patients.
- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

### Are services responsive?

The practice is rated as outstanding for providing responsive services.

- The practice had an effective system in place for handling complaints and concerns.
- The practice held unit health fairs at least annually, where patients could seek advice on healthier living.
- The practice did not provide services to families and dependants, but recognised that patients may have some caring responsibilities for their relatives. Alerts were set on the records of these vulnerable patients.
- The service was flexible to ensure patients’ needs were met in a timely way. For example, bespoke evening appointments could be made if a patient was unable to attend within daytime hours and home visits could be made if necessary. If families were due to move overseas with the patients the
practice ensured they received any vaccines required.

- There was good engagement with the community midwives who were located nearby. The deputy SMO was trained and able to provide care, advice and treatment in respect of family planning.

- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day. Patients were directed to the NHS24 service out of practice hours after 18:30.

- The practice had good facilities and was well equipped to treat patients and meet their needs.

Are services well-led?
The practice is rated as outstanding for providing well-led services.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.

- There was a very strong leadership structure and staff felt engaged, supported and valued by management. Staff spoke positively about leaders and the transformation they had brought about in the delivery of healthcare to patients.

- Clinical and management led governance structures and systems were strong and took account of current models of best practice.

- The practice had policies and procedures to govern activity and held regular governance meetings. We saw that following a period of staff changes, the practice had focussed on governance systems to promote safety of patients and improve working practices.

- Approximately 400 patient records had not been archived. These were not current patients but patients who had moved on but their paper notes remained. These notes were over 10 years old.

- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities. Staff had access to mentorship, to enable them to progress their career both within healthcare and the wider military field.

- Leaders encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.

- The provider was aware of the requirements of the duty of candour. We saw evidence the practice complied with these
requirements

- The practice proactively sought feedback from staff and patients, which it acted on.
Our inspection team

The inspection was led by a CQC Lead Inspector. The team included a GP specialist adviser, a practice nurse specialist adviser, a second CQC inspector and a practice manager specialist adviser.

Background to RAF Lossiemouth

RAF Lossiemouth is a fast jet base whose primary role is to provide Quick Reaction Alert (Interceptor) North, 365 days a year. At the time of inspection, the patient list was 1872, this includes 24 patients aged 60+, four under 18 years, 1691 are male patients and 181 female. Occupational health services are also provided to personnel and a number of reservists.

RAF Lossiemouth ‘parents’ the following units:
Armed Forces Careers Office (AFCO)
Remote Radar Head – 33 personnel based across all three remote radar head locations, in addition to a further four personnel at Tain Ranges
Force Development Training Centre – 16 personnel based at Grantown on Spey. They provide occupational health services to all. They also deliver primary health care to Grantown, both AFCO’s, Inverness and Aberdeen, and Tain ranges. The senior medical staff and the practice manager also have clinical and managerial oversight of two other sites, Kinloss barracks and Fort George, visiting these sites every two weeks.

The senior management team visit all of the above units on an annual basis, to ensure there are no issues with either accessing primary health care services locally (if not delivered by Lossiemouth), or with their occupational oversight (to ensure that all personnel remain fit to undertake the jobs that they are assigned to).

RAF Lossiemouth has recently been accredited as a GP training practice.

At the time of our inspection, the facility had four GPs, including one civilian GP. In addition there were four nurses, the practice manager, a deputy practice manager, 11 medics, an office manager, practice administrators, and a pharmacy technician.

No extended hours were routinely offered. However, appointments were made available if a patient, for example a shift worker, was unable to attend in core hours. A duty medic is on call 24 hours a day at 10 minutes notice for any aircraft incidents.

The facility was open from Monday to Friday between 08:00 and 17:00. Access to a GP by telephone was available between the hours of 17:00 and 18:30. After these hours, patients were diverted to out of hour’s services provided by NHS 24.
Why we carried out this inspection

The Defence Medical Services (DMS) are not registered with the CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014 and are not required to be. Consequently DMS services are not subject to inspection by the CQC and the CQC has no powers of enforcement. This inspection is one of a programme of inspections that the CQC will complete at the invitation of the Surgeon General in his role as the Defence Authority for healthcare and medical operational capability.

How we carried out this inspection

Before visiting, we reviewed a limited amount of information provided to us about the facility.

We carried out an announced visit on 29 November 2017. During our visit we:

- Spoke with a range of staff, including four GPs, the practice manager, office manager, pharmacy technician, three practice nurses, administrative staff and three medics.
- Reviewed 39 comment cards completed by patients who shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.
- Spoke with four patients who said they received good care and were treated with kindness.
- We looked at patients notes which were comprehensive and complete.

To get to the heart of patients’ experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people’s needs?
- Is it well-led?
Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

The senior medical officer was the dedicated lead to oversee significant events and staff said they would approach the lead if they were unsure of any issues in relation to significant events. Staff were familiar with policy and with using the standardised Defence Medical Services (DMS) wide electronic system to report, investigate and learn from significant events, incidents and near misses. They said there was a strong culture of reporting and learning from incidents at the practice.

- 15 significant events had been identified and managed over the last 12 months. Staff provided a number of examples and described how the incidents were managed. They highlighted any changes made as a result of the investigation. For example, a significant event was raised when a medic in the practice dispensary checked the outsourced prescriptions on return from the local pharmacy and had spotted a number of errors. These were monitored and analysed and a trend was spotted over some months. This was raised to regional level and to the external pharmacy, who launched their own significant event process. Significant events were also a standing agenda item at the monthly practice meetings where they were discussed with the wider staff team.

- We reviewed safety records and national patient safety alerts, including the minutes of meetings where these were discussed. The senior medical officer (SMO) had an overview of the alerts and the pharmacy technician was the lead for circulating safety alerts to the wider staff team. A register of alerts received at the practice was maintained and any further action needed was clearly recorded.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient’s welfare. The civilian medical practitioner (CMP) was the lead member of staff for safeguarding, having worked at the practice for over 20 years. They attended a weekly meeting to discuss any patients of concern. Effective deputising arrangements were in place. The staff we spoke with demonstrated they understood their responsibilities regarding safeguarding and had received training relevant to their role in relation
to safeguarding children and vulnerable adults.

- The practice had effective and well managed systems in place to maintain an accurate and up to date register of patients subject to safeguarding arrangements, and patients assessed to be ‘at risk’. We were provided with a variety of examples of patients currently deemed vulnerable and at risk; these were discussed with all the GPs each week. Staff described how concerns were logged on the risk register and discussed at the vulnerable patients meeting, this included a list of any under 18 year old military personnel. An alert facility within the patient record system; Defence Medical Information Capability Programme (DMICP) ensured any risks showed clearly when the medical record was opened. Safeguarding was a standard agenda item at healthcare governance meetings held monthly.

- Notices in the waiting room and consultation rooms advised patients that chaperones were available if required. 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 practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice had an infection control policy and the senior nursing officer was the lead person who had attended annual infection control refresher training. We saw all staff had completed annual infection control training and all were up to date. Infection control audits were carried out every six months, the last being in July 2017 which showed compliance of 97%. This audit identified that single use aprons were to be provided as part of personal protective equipment (PPE). We saw that this was actioned and they were in use.

- All single use items were stored appropriately and were within their expiry date. Specific equipment was cleaned daily and daily logs were completed. Spillage kits were available and clinical waste was stored appropriately. Clinical waste removal was managed well and clearly audited.

- Effective arrangements for managing medicines, including emergency medicines and vaccinations, were established to keep patients safe. The CMP was the medicines management lead for the practice and the pharmacy technician had the delegated responsibility for ensuring effective medicines management in accordance with policy and procedure. This included arrangements for obtaining, prescribing, recording, handling, storing and the security of medicines. Controlled drugs were subject to robust and regular checks and we found no discrepancies or gaps in the checking system.

- We looked at the records for some patients taking high risk medicines that required monitoring and found the processes in place to be safe. The pharmacy technician checked if a blood test was necessary before the medicine was dispensed. New patients taking high risk medicines were placed on a list when they were identified, for example in a new patient questionnaire, or when they attended the dispensary for repeat medicines. However, no routine monthly search for those patients on high risk medicines was undertaken. We looked at patient records and saw all patients on the list for shared care / high risk medicines were being managed in accordance with best practice and all had the appropriate alerts, shared care agreements, bloods tests done at the correct intervals and results managed appropriately.

- Prescription pads were securely stored and there were systems in place to monitor their use. Patient Group Directions (PGD) had been adopted by the practice to allow nurses to administer medicines in line with legislation. The processes in place were comprehensive demonstrating that PGDs were well managed.

- The full range of recruitment records for permanent staff was held centrally at RHQ. However,
the practice manager 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 were suitable to work with vulnerable adults and young people. DBS checks were renewed every five years. They also monitored each clinical member of staff's registration status with their professional body. The practice manager confirmed all staff had professional indemnity cover. Information was in place to confirm practice staff had received all the relevant vaccinations required for their role at the practice.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety, including a health and safety policy. The practice manager was the lead for health and safety and had completed relevant training for the role. Risk management meetings were held and any risks in relation to health and safety were discussed with the wider team at the practice meetings.

- Staff were aware of their role in the reporting and management of incidents, including when to report in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). Such incidents were reported through the DMS-wide electronic incident reporting system.

- A risk register was established for the practice and it was a standard agenda item at the monthly quality assurance meetings. We saw examples of forward planning on the risk register so that the practice was proactive in managing risk, for example ensuring adequate manning.

- The practice had up to date fire risk assessments and carried out regular fire drills.

- The practice manager monitored this to assure all checks were completed. Fire alarms were tested weekly and all electrical equipment was checked on a regular basis to ensure the equipment was safe to use. Clinical equipment was checked in line with policy to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella risk management. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients’ needs. There was a rota system in place for all staffing groups to ensure that enough staff were on duty. The practice had a record of the minimum number of GP sessions needed per week and used this to manage GP staffing levels. The practice would use the same locums if required and completed the necessary checks and monitored their training. Staff had a flexible approach towards managing the day to day running of the practice.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an alarm facility in place for use in emergencies.

- All staff received annual basic life support training and there were emergency medicines available in the treatment room.

- There was a defibrillator available on the premises and oxygen with adult masks. A first aid kit
and accident book were available.

• Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.

• The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage.

• The practice was integral to a major incident exercise. It included a whole station aircraft crash scenario at RAF Lossiemouth and Kinloss Barracks.
Are services effective?  
(for example, treatment is effective)

Our findings

Effective needs assessment

- Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) and the Scottish Intercollegiate Guidelines Network (SIGN).

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE/SIGN and used this information to deliver care and treatment that met patients’ needs.

- Regular clinical meetings were held and we viewed minutes from meetings which confirmed that guidance across several clinical domains had been discussed. Peer review between GPs further ensured that guidelines were followed.

Management, monitoring and improving outcomes for people

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 DMS 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 five patients on the diabetic register. We reviewed the treatment and care offered to these patients and found that current NICE guidance had been followed. For four out of five (80%) of these diabetic patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For 100% of the diabetic patients, the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.

- There were 26 patients recorded as having high blood pressure. We reviewed the treatment and care offered to these patients and found that current NICE guidance had been followed. All had a record for their blood pressure in the past nine months. Of these patients with hypertension, approximately 73% had a blood pressure reading of 150/90 or less.

- The number of patients with long term physical or mental conditions, who smoke and whose notes contained a record that smoking cessation advice, or referral to a specialist service had been offered within the previous 15 months was seven which is 100% of the smoking patient
population. The NHS target for this indicator is 90%.

- There were 19 patients with a diagnosis of asthma. We reviewed the treatment and care offered to these patients and found that current NICE guidance had been followed. Of these 15 (79%) had had an asthma review in the preceding 12 months which included an assessment of asthma control using the three RCP questions.

- Information from the Force Protection Dashboard, which uses statistics and data collected from military primary health care facilities, was also used to gauge performance. Data from the Force Protection Dashboard showed that instance of audiometric hearing assessment was average compared to DMS practices regionally and nationally. Service personnel may encounter damaging noise sources throughout their career. It is therefore important that service personnel undertake an audiometric hearing assessment on a regular basis (every two years). Data from July 2017 showed:
  - 100% of patients had a record of audiometric assessment, compared to 99% regionally and 99% for DPHC nationally.
  - 98% of patients’ audiometric assessments were in date (within the last two years) compared to 86% regionally and for DPHC nationally.

There was a member of staff responsible for every long term condition.

There was evidence of quality improvement including clinical audit:

- From discussions with staff, it was clear the practice was pro-active in using a quality improvement approach to review its underlying systems of care and to identify actions leading to measurable improvements in health care delivery. A comprehensive and wide-reaching programme of audit was in place that focussed on the needs of the population and demonstrated a commitment to improving outcomes for patients. The audit spreadsheet provided a link to the actual audit, date of completion and audit review date. From January 2016 the spreadsheet showed 58 completed audits (both clinical and administrative). Audits undertaken were relevant to the needs of the patient population, including a rolling programme of audit for long term conditions. There was evidence of two cycles for some audits.

- Examples of completed clinical audits we looked at included antibiotic prescribing, cervical cytology, results handling, scanning, non-medical prescribing audit, diabetes, hypertension and depression. We also looked at a pathology results audit which had ensured that test results were handled safely;

- An audit was undertaken in another practice showing a high risk area of practice due to the lack of electronic lab links available in Scotland. The original audit data in 2015 showed poor results in the safe handling of test results. The audit was adopted by RAF Lossiemouth and also identified concerns with respect to performance in results handling, and so this was implemented as a monthly audit. Following this the SMO agreed to take on the role of the Short Life Working Group Chair for Scotland and Northern Ireland (SNI) Region. A review was undertaken of data from all SNI practices resulting in the recommendation and implementation of a single protocol for the management of patient results (and hospital letters). This was introduced in April 2017 and has now been adopted DPHC wide; therefore enabling RAF Lossiemouth and other SNI practices to share this area of good practice/improved patient care with their colleagues.

- A depression audit was undertaken in September 2017. The practice managed a small number of patients with depression and the audit showed they were all being actively managed, with timely referral to the Defence Community Mental Health Team (DPMH).

- The non-medical prescribing audit completed in January 2017 showed the non-medical prescriber had met all the standards as required by the Nursing and Midwifery Council scoring
100% in all standards set.

- An internal quality assurance tool, the Defence Medical Services (DMS) Common Assurance Framework (CAF) was used to monitor safety and performance. The DMS CAF was formally introduced in September 2009 and since that time has been the standard healthcare governance assurance tool utilised by DMS practices to assure the standards of health care delivery within DMS. When we reviewed the CAF we saw that any areas requiring further action or updating were being managed effectively. We also noted that the practice had used this self-assessment tool effectively, which aided the effective management of areas that needed attention.

**Effective staffing**

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

We evidenced a very good training and staff development ethos within the medical centre driven by the SMO and practice manager. Wednesday afternoons were set aside for training and development for all staff but the practice remained open for emergency appointments.

The practice had a generic induction programme for all newly appointed staff. This included topics such as safeguarding, infection prevention and control, fire safety, health and safety, information governance and Caldicott accountability. There was also a specific programme and training for new staff depending on their role, and a separate induction for locum staff. Staff had access to e-learning training modules and in-house training. Relevant competency checks were undertaken before staff engaged in practice or a procedure that was new to them. The practice manager organised mandatory training and used a traffic light system to be able to plan for training instead of waiting until training had become overdue. As a result, all staff training was in date.

The practice had recently introduced a policy and procedure to ensure all tasks and patients were handed over to permanent staff when locums departed. For example, this included ensuring all test results had been actioned and the departing GPs mailbox in the administration office was cleared with nothing left outstanding.

Staff administering vaccines and taking samples for the cervical screening programme had received specific training including an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes.

The nurses maintained their own continual professional development. The practice manager organised mandatory training and the practice nurses managed their own nursing update training. We were told there was no issue with being released for courses and/or updates.

The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. All staff had received an appraisal within the last 12 months. Staff on a specific career pathway had access to a mentor.

**Coordinating patient care and information sharing**

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice’s patient record system and their intranet system.
- This included care and risk assessments, care plans, medical records and investigation and test results.

- The practice shared relevant information with other services in a timely way, for example when referring patients to other services. We spoke with the administrator who undertook booking of follow on appointments for patients including those who were required to have appointments made within two weeks of seeing their GP. There was a good system in place which ensured appointments were made in a timely way. There were also failsafe checks by the administrator to ensure the patient had attended their appointment and a follow up letter had been received.

- Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients’ needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital.

- The practice had a good knowledge of shared care agreements (a shared care agreement outlines suggested ways in which the responsibilities for managing the prescribing of a medicine can be shared between the specialist and general practitioner.)

- From the sample of anonymised patient notes we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.

- Reports were usually received from the OOH service within 48 hours of a patient having accessed treatment. These reports were scanned on to DMICP and alerts sent to a doctor to ensure they were read and appropriate follow up instigated if necessary. All clinicians used the tasking system within the electronic patient record effectively. When we made checks we saw that all tasks assigned to clinicians had been actioned without delay.

**Consent to care and treatment**

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

- Where a patient’s mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient’s capacity and recorded the outcome of the assessment.

**Supporting 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:

- All new patients were asked to complete a proforma on arrival. The practice nurse followed up any areas of concern, such as raised blood pressure.

- The practice took a pro-active approach to health promotion particularly in relation to patients at risk of developing a long term condition and those requiring advice on their diet, smoking habits and alcohol cessation. Dedicated staff leads for conditions such as diabetes and asthma were identified. The practice provided sexual health advice, free condoms and family planning.

- The practice had a health promotion calendar to promote specific issues relevant to the service population and its requirements. Health promotion sessions were held for military personnel, where appropriate patients were encouraged to attend smoking cessation clinics and other
health promotion initiatives within the local community.

- The practice participated in the station health fairs, which were held periodically to promote good health and lifestyle amongst the population and local community.

- Patients had access to appropriate health assessments and checks. A monthly search was undertaken for all patients aged 50 to 64 years who were entitled to breast screening. All patients over 50 who had not had cholesterol check in the past five years were called in to be tested.

- 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 128 out of 131 eligible women. This represented an achievement of 98%. The NHS target was 80%.

- There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using public health information posters and they ensured a female sample taker was always available.

It is important that military personnel have sufficient immunity against the risk of contracting certain diseases. The World Health Organisation sets a target of 95% for vaccination against diphtheria, tetanus, pertussis and polio and measles, mumps and rubella. The data below from July 2017 provides vaccination data for patients using this practice:

- 99% of patients were recorded as being up to date with vaccination against diphtheria compared to 95.5% regionally and 95% for DPHC nationally.

- 99% of patients were recorded as being up to date with vaccination against polio compared to 95% regionally and 95% for DPHC nationally.

- 94.5% of patients were recorded as being up to date with vaccination against Hepatitis B compared to 84% regionally and 83% for DPHC nationally.

- 97% of patients were recorded as being up to date with vaccination against Hepatitis A, compared to 94% regionally and 94% for DPHC nationally.

- 99% of patients were recorded as being up to date with vaccination against Tetanus, compared to 95.5% regionally and 95% for DPHC nationally.

- 45% of patients were recorded as being up to date with vaccination against Typhoid, compared to 70% regionally and 53% for DPHC nationally.

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

Our findings

Kindness, dignity, respect and compassion

- During our inspection we observed that members of staff were courteous and helpful to patients and treated them with dignity and respect.
- Curtains were provided in consulting rooms to maintain patients’ privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard. There was a simple but effective demarcation line in front of the reception desk which encouraged patients to step back when there was another patient at the desk.
- The practice offered patients the services of either a female or a male GP. For any intimate examinations that were to be performed, a chaperone was always available.
- There was an accessible toilet in the waiting area. A room was available for baby changing and/or breastfeeding.
- In the patient waiting area there was a “you said we did” board which showed what patients had requested via comments and surveys and any changes made. We saw a request for a water cooler machine to be provided, this request had been made to the region for consideration.
- Patients provided feedback to us on 39 CQC comment cards. Comments made indicated that they felt involved in decision making about the care and treatment they received. They commented that staff were kind and helpful, they felt listened to and supported and never felt rushed. We saw the practice compliments register which showed that 48 compliments had been received either verbally or in writing to the practice in the past twelve months. We saw that after each compliment was received praise was directly given to the member of staff involved and this was also celebrated at team meetings.
- Results from the latest patient experience survey (October 2017) showed patients felt they were treated with compassion, dignity and respect. For example:
  - 96% of patients said if family, friends and colleagues could use the practice, they would recommend it to them.
- The practice had an information network available to all members of the service community, known as HIVE. This provided a range of information to patients who had relocated to the base and surrounding area. Information included what was available from the local unit and from civilian facilities, including healthcare facilities. The information also signposted learning centres, for patients who may want to increase their fluency in English.
Care planning and involvement in decisions about care and treatment

- Data received from the patient experience survey in October 2017 showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example:
  - 100% of patients to whom it was applicable said they felt involved in decisions about their care.
- The practice provided a service to patients from different countries and some of these patients did not have English as a first language. Staff told us that interpreter services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

Patient and carer support to cope emotionally with treatment

- Patient information leaflets and notices were available in the patient waiting area, which advised patients about how to access a number of organisations. We saw that information was relevant to the patient demographic was prominently displayed and accessible.
- The practice proactively identified patients who had caring responsibilities for a dependant. There were 10 on the register. A code was added to their records in order to make them identifiable so that extra support or healthcare could be offered as required.
Are services responsive to people’s needs? (for example, to feedback)

Our findings

Responding to and meeting people’s needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- A wide range of clinics were available to service personnel for example, physiotherapy, health checks, travel advice, well woman clinics and family planning advice. Patients were able to receive travel vaccines when required.
- Patients could have 15 minute appointments with the GP and up to 30 minute appointments with the practice nurse. Patients requiring them could book a double GP appointment of 30 minutes.
- Same day appointments were available for those patients who needed to be seen quickly.
- There were accessible facilities which included interpretation services when required.
- Eye care and spectacles vouchers were available to service personnel from the medical centre.
- Eight clinics per year were put on at weekends for the reserve element that were parented by RAF Lossiemouth.

Access to the service

- The practice was open from Monday to Friday from 08:00 to 17:00 for routine appointments and emergency care. Patients had access to a GP by telephone until 18:30. Outside of the practice opening hours, patients were diverted to the NHS 24 out of hour’s service. The practice provided airfield cover 24 hours a day seven days a week and for 365 days a year. This was provided by a duty medic who was accommodated within the medical practice.
- Results from the Patient Experience Survey showed that overall patient satisfaction levels with access to care and treatment were good. For example:
  - 100% of patients for whom it was applicable said that their appointment was at a convenient location.
  - 100% of patients for whom it was applicable said their appointment was at a convenient time.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Defence Primary Health Care had an established complaints policy and the practice adhered to
The practice manager was the designated responsible person who handled all complaints in the practice. We saw that information was available to help patients understand the complaints system and was available in different languages. There had been six complaints raised since November 2016. Not all were directly involving the practice but regarding physiotherapy and previous medical centres. Nevertheless each complaint was dealt with thoroughly and in a timely way. We saw that there were processes in place to share learning from complaints. We looked at the complaints handling process for two complaints that had been received in the past two months and the method, attention to detail and analysis of the investigation of the complaint was extremely thorough. Every clinician involved had been afforded the opportunity to respond to the complaint and give their understanding and explanation of the circumstances around the complaint.

Complaints were audited through the Common Assessment Framework (CAF). This was used to focus on improvements to the service and to ensure that designated standards were being met on the handling of complaints.
Are services well-led?  
(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

Vision and strategy

- The practice had a clear vision to deliver high quality care and promote good outcomes for patients. Consistent, safe and effective care was clearly at the forefront of the strategy and vision for the practice and this was clearly projected and adopted by all members of staff. All staff we spoke with were content with their working environment. Staff also acknowledged that their opinions, observations and views were valued.

- DPHC had a mission statement: “DPHC will deliver a unified, safe, efficient and accountable primary healthcare and dental care service for entitled personnel to maximise their health and to deliver personnel medically fit for operations.”

- The practice mission statement was “The practice strives to provide exemplary primary health care services to all patients registered with us. We are committed to giving the best possible service, which we feel can only be achieved by you and us working together”.

- Staff we spoke with throughout the day could identify this mission statement, which was displayed in the waiting areas and staff knew and understood the values and behaviours required to support this. The practice had a clear strategy and supporting business plan which reflected the vision and values and these were regularly monitored.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas.

- Policies from the national framework were implemented and were available to all staff. These were updated and reviewed regularly.

- An understanding of the performance of the practice was maintained. The practice manager used the Common Assessment Framework (CAF) as an effective governance tool. This was managed by the Warrant Officer who allocated areas to specific individuals and/or departments. Staff, where appropriate, were rotated on average every six months to ensure a wide and varied skill set thus enabling cross department cover where and when required. All staff had individual job descriptions (JDs) or Terms of Reference (TOR) which were signed and retained.

- A comprehensive programme of quality improvement, including clinical and administrative audit, was used to monitor quality and to drive improvements.

- We saw that approximately 400 patient records had not been archived. These were not current patients but patients who had moved on but their paper notes remained. These notes were over
10 years old and a process was in place to complete this task in a timely way.

- Practice meetings were held regularly and were used as an additional governance communication tool. Learning needs were discussed at practice meetings and appropriate training was requested and delivered through this forum. The meetings were also used for forward planning. For example, they provided the opportunity to ensure patient needs were met during busy clinic times and periods of staff sickness. This approach supported staff with learning about how the performance of the practice could be improved and how each staff member could contribute to those improvements. Minutes were comprehensive and were available for practice staff to view. In addition, regular health care governance meetings were held and minutes were produced of all matters discussed.

- There was clear evidence from minutes of meetings that lessons learned from significant events, complaints and other investigations led to change and improvement in practice.

- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. This included plans developed each year that took account of manning levels at the practice due to deployment of some staff.

- We saw evidence from minutes of meetings, a structure that allowed for lessons to be learned and shared following significant events and complaints.

Leadership and culture

- On the day of inspection the leaders in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Everything we saw on the inspection day, and communications with the practice following the inspection, supported this.

- There was a clear leadership structure and staff felt supported by management. Staff told us the practice leaders were approachable and always took the time to listen to all members of staff.

- The SMO had worked exceptionally hard to reinvigorate the practice team and had completely reviewed/revised all policies and procedures within the practice, implementing new procedures where required. For example, the Common Assurance Framework was completely re-written from scratch. They had also invested in the staff team in terms of their personal and professional development.

- There was a clear strategy to drive forward and progress high standards within the practice. The work that had been done and was planned aligned closely with wider service improvement plans such as the Region Group construct and the Scottish Patient Safety Programme.

- The practice has clinical oversight of North of Scotland Group practices and parented units such as the RRH's Benbecula, Buchan, Tain and Saxa Vord. Previously they were not visited on a regular basis. The practice visited group practices twice monthly as a minimum. All parented units (excluding AFCO’s as they continue to receive primary health care at Lossiemouth) have also been visited within the past 12 months. Personnel at these remote locations now have a point of contact within the medical centre to liaise with/highlight any concerns/issues.

- The practice had just been accredited as a training practice for GPs and was expecting their first GP trainee in the near future. This process had been undertaken with good links and co-working with the NHS practice co-located within the building who would also be sharing the training plan, enabling the trainee to experience all aspects of primary care and not just that of the military.

- All staff were involved in discussions about how to run and develop the practice. Staff told us the practice held regular meetings. Staff told us there was an open culture within the practice
and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. Minutes were comprehensive and were available for practice staff to view. All junior staff had a regular meeting to discuss concerns and ideas, and these are fed back through the Chain of Command (CoC) and actioned/implemented as appropriate. It was very evident that the staff felt listened to and cared for and that they were comfortable in expressing their views and ideas in an open manner.

- Staff told us that they enjoyed coming to work, and felt a sense of pride in their involvement in the delivery of high quality, safe and responsive care for patients. All staff we spoke with, from all disciplines, referred to the practice leadership as inclusive, caring and inspiring. We saw there was a strong commitment from all staff to their role and career path within the military. The time invested in staff by leadership, translated into positive engagement and interaction with patients. This was confirmed by the high number of compliments received from patients who visited the practice.

- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour (the duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included training for all staff on communicating with patients about notifiable safety incidents. The GPs and practice manager encouraged a culture of openness and honesty. We found that the practice had systems to ensure that when things went wrong with care and treatment, the practice gave affected people reasonable support, information and a verbal and written apology.

### Seeking and acting on feedback from patients, and staff

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

- Patients through the surveys and from any individual patient feedback received. The practice has trialled innovative ways of gaining patient feedback which were very well received by the patients. For example five jam jars were arranged and labelled with scores from one to five. Each patient that arrived that day was given a token to place in a jar to answer a specific feedback question. This resulted in a higher feedback rate than previously achieved.

- Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

- Completed CQC comment cards and the practice compliments record from patients supported our findings, that there was an open door policy when it came to patient input and feedback.

### Continuous improvement

- There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking. From minutes of meetings we reviewed, we noted that the leadership of the practice focussed on improving the speed and quality of delivery of care for all patients. Improvements implemented were evident from the quality improvement projects, outcome of audits and investigation into significant events. It was clear to us that the practice used its audit work to identify learning and make change. For example the SMOs work in the development and progress of the pathology results audit had not only improved standards for the practice, but had the possibility of improving standards in this area for the whole of DPHC.