Defence Medical Services

Leuchars Station Medical Centre

Quality Report

Leuchars
St Andrews
Fife
KY16 OJX

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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

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

Summary of findings

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced inspection at Leuchars Station Medical Centre on 20 September 2017. Overall, the practice is rated as outstanding. Our key findings across all the areas we inspected were as follows:

- There was an open and transparent approach to safety. An effective system was in place for managing significant events and staff knew how to report and record using this system.
- The assessment and management of risks was comprehensive, well embedded and recognised as the responsibility of all staff. There was a robust and consistent approach to the monitoring of patients on high risk drugs.
- The arrangements for managing medicines, including obtaining, prescribing, recording, handling, storing, security and disposal in the practice minimised risks to patient safety.
- Staff were aware of current evidence based guidance. Staff had received training so they were skilled and knowledgeable to deliver effective care and treatment.
- The practice worked collaboratively and shared best practice to promote better health outcomes for patients.
- There was 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.
- Results from the Defence Medical Services patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- The patients had access to a variety of health leaflets and information.
- Patients we spoke with said they found it easy to make an appointment and urgent appointments were available the same day.
- Facilities and equipment at the practice were sufficient 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 practice had robust and comprehensive governance systems in place. Although these systems had been developed and introduced in the last two years, they were clearly embedded

in practice and all staff understood their role and responsibilities in the governance structure.

- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.
- The layout of the building was not ideal to meet privacy and confidentiality needs of patients. In addition, there was damp, mould and a malodourous smell in the audiology assessment area used by patients.

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

- Strong governance structures were in place and were well embedded in practice. The army took over the station from the RAF in March 2015. Because RAF primary health care systems differ to those of the army, there was almost a total change in infrastructure, including a significant loss of staff, support services and governance structures. We found that leadership was strong, visible and encouraged collaborative team working, which supported with developing governance structures to a high standard in such a short time frame.
- 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 and high risk drugs 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 Chief Inspector recommends:

- Review the premises to establish whether improvements can be made to support better patient confidentiality and privacy, and to ensure that care is always delivered in an environment that minimises risk for the patient.

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.

Good

Are services safe?

The practice is rated as good for providing safe services.

- The practice prioritised safety. An effective and robust system was embedded for reporting and recording significant events. Significant events were reviewed at team meetings so lessons were shared with the wider staff team.
- When things went wrong patients were engaged and received reasonable support, relevant information and a written apology. They were advised about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined systems, processes and practices in place to keep patients safe and safeguarded from abuse. All staff, including non-clinical, staff were trained to the appropriate level for their role.
- Risks to patients were assessed and well managed to minimise risks to patient safety.
- Comprehensive protocols and guidelines to cover the dispensing of medicines were in operation.
- Effective recruitment processes were in place and sufficient numbers of staff were employed to meet population need.
- The practice had adequate arrangements to respond to emergencies and major incidents.
- There was notable damp, mould and a malodourous smell in the area used to carry out audiology assessments. This had been reported to Regional Headquarters by the practice.

Outstanding

Are services effective?

The practice is rated as outstanding for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were above average.
- Practice staff assessed needs and delivered care in line with

current evidence based guidance.

- A comprehensive programme of clinical audit and other quality initiatives demonstrated that staff embraced quality improvement to improve patient outcomes.
- 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.
- All registered patient records had been summarised.
- There was evidence of appraisals and personal development plans and support for all staff.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Patients were treated with compassion, dignity and respect, and were involved in decisions about their care and treatment.
- The patient's experience survey demonstrated that patients were satisfied with the care and attitude of staff at the practice.
- Information for patients about the service available was accessible.
- Systems were in place to maintain patient and information confidentiality. However, the fabric and layout of the building was not ideal to support patient privacy at all times.
- We received 24 comment cards and interviewed six patients. All of the feedback was positive about the standard of care received.

Are services responsive?

Good

The practice is rated as good for providing responsive services.

- The patient's individual needs were central to the planning and delivery of their individual care.
- The service was flexible to ensure patients' needs were met in a timely way. For example, vaccination clinics were held in the evenings for service personnel who were due to deploy at short notice.
- Patients found it easy to make an appointment and urgent appointments were available the same day. Appointments for children were available outside of school hours.
- Telephone consultations were provided as an alternative to

visiting the practice.

- Patients could select the gender of clinician they wished to be seen by.
- Physiotherapists were employed within the practice. All referrals to this service were made by the doctors and the average waiting time for an appointment was less than one week.
- Eye care and spectacles vouchers were available to service personnel at the medical centre.
- Transport for patients to hospital appointments was available if needed.

Are services well-led?

Outstanding

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.
- Clinical and management led governance structures and systems were strong and took account of current models of best practice. They were well embedded especially as they had been developed within the last two years.
- There were highly effective systems and processes in place to identify and monitor risks to patients and staff, and to monitor the quality of services provided. Regular practice and multi-disciplinary team meetings took place, which supported effective communication and shared learning within the team.
- The practice was aware of and complied with the requirements of the duty of candour. A culture of openness and honesty was promoted at the practice.
- The practice proactively sought feedback from staff and patients, which it acted on. The practice was in the early stages of developing a patient participation group. A patient representative had recently been appointed.
- There was a strong focus on continuous learning and improvement at all levels.

Leuchars Station Medical Centre

Detailed findings

Our inspection team

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

Background to Leuchars Station Medical Centre

Leuchars Station Medical Centre is located in the military station located in the small town of Leuchars near the north east coast of Fife in Scotland. The station was under RAF control until March 2015 when the site was transferred to the army. The medical centre operates over two floors within the building and is co-located with the station dental centre.

The medical centre offers care to both service personnel and their dependants, including children. At the time of inspection the patient list was approximately 2,300, including 242 women and 282 children. Occupational health services are also provided to service personnel and reservists.

In addition to routine GP services, the medical centre offers physiotherapy services and travel advice. Other services provided include a Well Woman clinic, sexual health clinic, chronic disease management, smoking cessation, over 40's health screen and family planning advice. Maternity and midwifery services are provided by NHS practices and community teams who hold clinics at the practice. Childhood immunisations and vaccinations are also offered at the medical centre.

At the time of our inspection the medical centre staff team comprised a mix of military and civilian staff, including a Senior Medical Officer (SMO), Regimental Medical Officer (RMO), four civilian GPs, a locum GP and a General Duties Medical Officer (GDMO). Four practice nurses were in post and a pharmacy technician who was responsible for the practice dispensary. The medical centre was led by a practice manager supported by four administrative staff. Located in a nearby building and integral to the practice team, was the primary care rehabilitation team consisting of two physiotherapists and an exercise rehabilitation instructor (ERI). There was a good gender balance in the clinical team so patients had a choice of whether they were seen by a male or female clinician.

The medical centre was open from 08.00 to 18.00 Monday to Friday for routine and duty doctor appointments. Emergency access was available for service personnel from 08.00 to 08.30 each morning. Routine doctor and nurse appointments were available from 08.30 to 12.00 and from 14.30 to 16.30 Monday, Tuesday and Thursday. Clinics that could be accessed by appointment included sexual health, well woman, chronic disease, smoking cessation and over 40's health check. A duty doctor was available from 08.00 to 18.00 in accordance with the requirement of NHS Fife. The dispensary opening times were displayed at the practice and in the practice leaflet.

The arrangements for access to medical care outside of opening hours were clearly displayed and outlined in the practice leaflet and directed patients to contact NHS 111for non-emergency issues.

The nearest A&E department was identified on the leaflet.

Throughout this report the medical centre will be referred to as ‘the practice’.

Why we carried out this inspection

The Care Quality Commission (CQC) carried out this inspection as one of a programme of inspections at the invitation of the Surgeon General in his role as the Defence Authority for healthcare and medical operational capability. Defence Medical Services (DMS) are not required to register with CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. Consequently DMS services are not subject to inspection by CQC and CQC has no powers of enforcement. However, where CQC finds shortfalls in the quality of services during inspection, we will report them by making a recommendation for action to the Surgeon General’s office.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice.

We carried out can announced inspection on 20 September 2017. During the inspection we:

- Spoke with a range of staff including the SMO, three doctors, the practice manager, three practice nurses, the nursing officer, a physiotherapist, ERI, pharmacy technician and two administrative staff.
- Spoke with the patient representative and six patients who were attending the practice during the inspection.
- Reviewed 24 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, including anonymised patient records.
- Looked at information used to monitor the quality and safety of services.

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?

Good

Are services safe?

Our findings

Safe track record and learning

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

- The nursing 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 the practice used 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.
- Fifteen 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 in relation to a sample not being processed due to incorrect labelling led to the practice acquiring an NHS computer to print the labels. There had been no further labelling errors since.
- The practice carried out a thorough analysis of all significant events at the monthly health care governance (HCG) meetings attended by clinical staff. For example, the meeting minutes from August 2017 showed a significant event in relation to out-of-date childhood immunisations was discussed and a root cause analysis undertaken with the clinical team. Following this, the standard operating procedure for immunisation was revised, including the introduction of a more rigorous system for checking stock. There had been no further out-of-date immunisations identified since the changes had been made.
- 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 and this was confirmed in the August 2017 HCG meeting minutes. A register of alerts received at the practice was maintained. When the doctors provided confirmation that an alert had been actioned then the register was updated. For example, the practice carried out checks of its defibrillator in response to receiving an alert warning about faulty defibrillators.
- When unintended or unexpected safety incidents happened patients received reasonable support, truthful information, a verbal and written apology, and were advised about any action taken to improve processes in order to prevent the same thing happening again. For example, a patient was given a vaccine that was out-of-date. The practice took necessary action by informing and apologising to the patient, and advising them of the changes to prevent a similar incident happening again.

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 SMO was the lead member of staff for safeguarding. Effective deputising arrangements were in place.
- The staff we spoke with demonstrated they understood their responsibilities regarding safeguarding and had received training in relation to safeguarding children and vulnerable adults. Doctors had received level three training in child safeguarding.
- 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. Staff described how concerns were logged on the risk register and discussed with other clinicians at the vulnerable patients meeting held every two weeks. From the examples provided, it was evident the practice 'went the extra mile' to minimise the risk to the patient by providing and/or sourcing relevant support from external stakeholders.
- 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. A vulnerable patient meeting was held every two weeks and any concerns were discussed at these meetings. The child safeguarding pathway protocol was located in all treatment rooms. Safeguarding was a standard agenda item at the HCG meetings. We noted the status of staff safeguarding training was reviewed at the HCG meeting in August 2017.
- 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.
- An infection prevention and control (IPC) policy was in place. The lead nurse for IPC had attended annual infection control training relevant to the role. IPC audits were carried out every six months and the last audit was completed in May 2017. With a score of 80%, the practice achieved partial compliance with the audit. The resulting improvement plan identified 23 actions; 11 of these were in relation to the building. In particular, the audit highlighted damp in a number of areas. IPC was a standard agenda item at the HCG meetings and we noted from the minutes that the status of the action plan from the last IPC audit was discussed at the HCG meeting held in August 2017.
- Appropriate standards of cleanliness and hygiene were in place. Throughout the inspection we noted the premises were clean and tidy. However, we observed extensive damp, mould and a malordourous smell in the audiology area that patients accessed for assessment. The SMO advised us that they had submitted relevant statements of need (requests for improvement) to Regional Headquarters (RHQ) in relation to the building, including the damp.
- 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. Although clinical waste was generally stored appropriately and securely, we found a small sealed sharps bin had been inappropriately disposed of in a clinical waste bin. When we highlighted this, staff raised it as a significant event on the system. The practice manager was

the lead for waste management. Waste was collected from the practice by an external contractor and appropriate documentation was in place to support effective waste collection.

- Effective arrangements for managing medicines, including emergency medicines and vaccinations, were established to keep patients safe. The SMO was the medicines management lead for the practice and the pharmacy technician had the delegated responsibility for ensuring effective medicines management in accordance policy and procedure. This included arrangements for obtaining, prescribing, recording, handling, storing and the security of medicines. Controlled drugs were subject to regular checks and we found no discrepancies or gaps in the checking system.
- The cold storage unit for medicines was monitored twice a day to ensure temperatures were within the correct parameters. A second fridge was available to provide back up in the event of a fridge failure.
- During a routine monthly check the pharmacy technician noted that six Diazepam tablets were missing. This had been raised as a significant event and the matter was subject to investigation at the time of our inspection. The practice carried out regular medicine audits with the regional pharmacist to ensure medicines were managed and prescribed was in line with best practice guidelines. These audits were not recorded and the pharmacy technician said they would record them in the future so evidence of assurance was available. Robust and effective measures were in place to monitor the use of high risk drugs.
- 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. An effective system was in place to monitor prescriptions/medicines that had not been collected. This involved contacting the patient and if the medicine was no longer required then a note was made on the patient's record.
- 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 regulatory body. The practice manager confirmed all staff had professional indemnity cover. Information was in place to confirm staff had received all the relevant vaccinations required for their role at the practice.
- A meeting was held each Monday to ensure adequate staff were available to manage the workload for the week, including an appropriate gender mix of staff.

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. A health and safety poster was displayed at the practice office which identified local health and safety representatives. The practice manager was the lead for health and safety and had completed relevant training for the role. Risk management meetings were held every two weeks 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 HCG meetings. The minutes of the HCG held in August 2017 informed us that staff were reminded to raise any issues for inclusion on the register with the management team. For example, the minutes showed temperature control in the nurse's treatment room had been raised as a risk so a statement of need was submitted for an air conditioning unit.
- We noted the room used by the cleaning team had an exceptionally low ceiling. It had not been assessed to determine the risk this presented to staff who used the room. During the inspection the nursing officer completed the assessment, which highlighted that staff should not spend longer than 20 minutes at a time in this area.
- We looked at the building inspection report completed by the Defence Infrastructure Organisation in May 2016. It was produced to explore options for an alternative location or a new build. The report highlighted that the configuration of the building did not meet the needs of the medical centre. A number of issues were indicated that impacted on hygiene requirements in relation to its use, including damp, inappropriate ventilation and asbestos tiled floors. At the time an alternative suitable location could not be identified and a new build would be dependent on the future size of the patient population.
- The leaders of the practice had done as much as they could to mitigate the risks associated with the building. They had plans to increase the population size but were unable to move forward with this in the current building. We were advised that a potential alternative location to Leuchars Station had been identified for the medical centre. Staff indicated that it could be years before they got a clear decision on this.
- Several of the issues identified in the report had been addressed over the last 18 months, including some of the damp. Rather than remove the asbestos, a decision was taken to encapsulate the asbestos and minimise the risk of it being disturbed. The asbestos was identified on the station asbestos risk register.
- The layout of the practice meant not all patients in the waiting area could not be observed by reception staff. This was particularly important in the event of a medical emergency. Within 24 hours of the inspection the nursing officer confirmed that a statement of need had been submitted for CCTV to be installed and the practice had accessed CQC's policy on the use of CCTV. Within nine working days the practice confirmed CCTV was in place and operational. They provided photographic evidence of this and a copy of the notice displayed informing patients of the CCTV. We inspected the dental practice located in the same building on 11 October 2017 and noted that the CCTV was operational.
- Staff mentioned that one of the fire escape routes may not be appropriate as it crossed the roof of the dental centre. We looked at the fire safety risk assessment undertaken by the station fire safety officer in October 2015. It was a comprehensive document in accordance with the Fire (Scotland) Act. No concerns regarding the fire escapes had been raised in the report. The next fire risk assessment was due in October 2017 and staff said they would discuss their concerns with the fire officer during this assessment. Records showed the fire alarm was checked weekly and the practice conducted regular fire drills. The fire equipment was checked by an external contractor on an annual basis.
- The station was responsible for the electrical safety of the building. Portable electrical equipment was checked on a regular basis to ensure the equipment was safe to use. The last portable electrical check was undertaken in March 2017.
- Clinical equipment was checked in line with DMS policy to ensure it was working properly. A process was in place to check equipment each day to ensure it was in working order and

appropriately calibrated. A checking sheet for the equipment located in each clinical room was in place and the checks were up-to-date.

- 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, lone working and legionella. 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. A triage system was in place for patients who presented without an appointment and a duty doctor and nurse were available throughout the day for patients with urgent health care needs.
- A system was in place to manage high risk patients, such as patients with mental health needs. Providing an example, one of the doctors highlighted how the patient was identified on the high risk patient register and their needs and risks were discussed between staff at a meeting held every two weeks.

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 emergency button in all the consultation and treatment rooms which alerted staff to any emergency.
- An emergency kit, including a defibrillator, oxygen with adult and childrens' masks and emergency medicines were accessible to staff in a secure area of the practice; all staff knew of their location. A first aid kit and accident book was available. Routine checks were in place to ensure the required kit and medicines were available and in-date. Medicines we checked were in date.
- The staff training records provided assurance that all staff received basic life support training on an annual basis.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. A copy of this plan was available on the staff intranet and additional copies were kept off the premises.

Are services effective?
(for example, treatment is effective)

Outstanding 

Our findings

Effective needs assessment

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

- Clinical staff were aware of evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) and The Scottish Intercollegiate Guidelines Network (SIGN) best practice guidelines. Staff referred to this information to deliver care and treatment that met patients' needs. They described how updates on NICE and medicines management were outlined in a newsletter circulated to clinical staff by the Defence Primary Health Care (DPHC) Team each month.
- NICE and SIGN guidance were a standard agenda item at the HCG meetings. We looked at the minutes of the governance meeting held in August 2017 and they provided staff with a link to the DPHC newsletter. Gout and prophylaxis were examples given by doctors of guidance discussed and acted on. The DPHC newsletter was also discussed at the practice meetings.

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 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 processes to monitor high risk drugs (HRD) and long term conditions (LTC) were aligned so both were reviewed simultaneously. A comprehensive framework of protocols had been developed that brought together NICE, SIGN and QOF so that clinical staff could ensure LTCs and HRDs were managed effectively. Staff were trained so knew how to use the protocols. The data we looked at indicated that outcomes for patients with LTCs were above average. A coding system was used on patient records to identify patients prescribed HRDs by the doctor, and also HRDs prescribed by secondary care doctors. The nurses carried out a search every two months for patients on HRDs and any patients identified were registered in the 'diary recall system'.

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

- There were four 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 two of these diabetic patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. Both patients were receiving support to manage this. For all four patients the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.

- There were 34 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, 24 had a blood pressure reading of 150/90 or less. Patients were being supported to encourage them to make lifestyle changes in order to reduce risks associated with hypertension.
- The number of patients with long term physical or mental health 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 one which is 100% of the smoking patient population. The NHS target for this indicator is 90%.
- There were 39 patients with a diagnosis of asthma. We reviewed the treatment and care offered to these patients and found that current NICE/SIGN guidance had been followed. Of these, 27 had an asthma review in the preceding 12 months which included an assessment of asthma control using the 3 Royal College of Physicians questions.
- There were 15 patients with a new diagnosis of depression in last 12 months. All had been reviewed within 10-35 days of the date of diagnosis.

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 above 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 98.6% regionally and 99% for DPHC nationally.
- 96% of patients' audiometric assessments were in date (within the last two years) compared to 86% regionally and 86% for DPHC nationally.

There was substantial evidence to demonstrate that quality improvement was embedded in the practice culture.

- 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 identify actions leading to measurable improvements in health care delivery. A comprehensive and wide-reaching active 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 September 2016 the spreadsheet showed 35 completed audits (both clinical and administrative) and two audits in progress. 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 up to three cycles for some audits.
- Examples of completed clinical audits we looked at and discussed with staff included antibiotic prescribing, opiate prescribing, consent for cervical smear taking, diabetes, hypertension and sexual health. We also looked at specific quality improvement projects, the outcome of which

had been actioned by the practice. They included a results handling project, sepsis identification and a proteinuria identification project.

- The consent audit completed in November 2016 was on its second cycle and used an appropriate DMCIP template for cervical cytology. Of the 20 patient notes selected, 19 showed compliance with policy.
- A hypertension audit was undertaken in February 2017. The practice managed a small number of patients with hypertension and the audit showed they were all being actively managed, including the provision of advice on lifestyle choices. Vital sign checks showed that the blood pressure for these patients was within the target range.
- The antibiotic prescribing audit completed in March 2017 exceeded the DPHC target of 90%. Despite the high score, action points were identified for doctors in relation to the use of FeverPAIN Score and the use of an antibiotic (Nitrofurantoin) as first line treatment for urinary infections.
- Acknowledging sexual health as a public health priority for the Government, the sexual health audit considered current provision and staff training. It also took into account the rates of sexually transmitted infections (STIs) for the population over a three year period. Results showed a marked decline in the prevalence of two common STIs in the patient population between 2016 and 2017.
- The diabetes audit and subsequent detailed report outlined the provision of diabetes care at the practice, including a review of staff training and expertise. The report provided four case examples of patients with diabetes and included an overview of each patient's diabetes treatment and management plan. The plans for all these patients were individual to their needs and in line with best practice.
- The results handling project outlined the care bundle measures and the associated problems with each measure. A baseline audit in both April and May 2015 showed overall compliance with care bundle measures at 25% and 40% respectively. Systems were revised for recording and monitoring of samples sent and returned, including whether action was taken in response to a review of sample results. A re-audit in June 2015 showed compliance had increased to 80% and a further re-audit in July 2015 placed compliance at 90%. This clearly demonstrated continuous improvement to the way samples were managed at the practice.
- The proteinuria identification project involved an audit and re-audit to determine the scope of the issue. A comparison was made for four months pre-project and for four months after action was put in place to improve the system. Results showed the number of cases of proteinuria had decreased following changes made in response to the findings. It was also evident that repeat urinalysis had increased as a result of the findings.
- We spoke with the physiotherapist who identified that a trend of knee injuries had been identified amongst young fit service personnel when they were exercising on a particular outdoor surface. In collaboration with the SMO and unit commanders, including a root cause analysis, it was identified that the footwear was possibly causing the injuries. As a result of the findings the footwear was changed and the trend for this type of knee injuries had ceased. The outcome of the investigation was shared at the regional rehabilitation meetings.
- Monitoring exercises were in place to check that standard operating procedures continued to meet the needs of the practice and its patients.
- An internal quality assurance tool, the 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. The CAF we were

provided with pre-inspection had been undertaken by regional headquarters in May 2016. When a CAF assessment is undertaken by RHQ it is referred to as a Health Governance Assurance Visit (HGAV). It showed that seven of the eight domains were partially complaint, with the remaining domain (premises and amenities) rated as non-compliant. When we reviewed the CAF we saw that significant improvements had been made and the majority of deficient areas had been actioned effectively. We also noted that the practice had used this self-assessment tool to aid with 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.

- 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. Records confirmed all staff had received mandatory training in subjects such as fire, basic life support and infection control and this training was refreshed in accordance with organisational policy.
- Staff told us there was a strong culture of continuous learning promoted and said leaders were supportive with releasing them for courses and/or updates. They also received role-specific training where appropriate. For example, one of the nurses specialised in the management of asthma and had been supported to gain a diploma in asthma. The nurse who had the lead for sexual health was highly qualified and experienced in the subject area. Furthermore, the infection prevention and control lead had attended a relevant course.
- All clinical staff had been trained around the application of Gillick competence. Gillick is a term used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment without the need for parental permission or knowledge. Staff who acted as chaperones had received training.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training including an assessment of competence. They could demonstrate how they stayed up to date with changes to the immunisation programmes. The medical centre was Yellow Fever registered and the practice nurse was up to date with training for this.
- Nurses and doctors told us they maintained their own continual professional development (CPD). They said they attended external forums, conferences, peer review and both internal and external training events. This was confirmed by one CPD file we looked at. Nurses meetings were held each month. From our discussions with nurses and doctors, we determined they had a detailed knowledge relevant to their specialist roles and shared their knowledge when relevant with the wider staff team.
- In particular, we saw a strong programme of support in place for the General Duties Medical Officer (GDMO) at the practice. A GDMO is a junior army doctor attached to a field unit before commencing higher specialist training. We noted that the SMO set aside four hour sessions per week to support and advise the GDMO's clinical decision making and with maintaining high quality patient records. The GDMO had good access to all mandatory and additional training. The GDMO described how their learning through improvement projects at the practice had supported with developed skills and knowledge. They demonstrated a good understanding of

the Mental Capacity Act (2005) and the principals behind Caldicott. Their experience at Leuchars Station Medical Centre had been instrumental in their decision to pursue a career in military primary care.

- The learning and support 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.

Coordinating patient care and information sharing

There were well managed systems in place to ensure effective coordination of patient care.

- 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. The DMICP system was used for managing patient records. Read coding, a system used to support clinical encoding of patient details, including diagnosis was used by all clinical staff with access to patient records. The sample of anonymised patient notes we looked at was of a very high standard. Notes included risk assessments, care plans, consultation records and investigation/test results. There was an appropriate summary screen of patients' health needs on DMICP. At the time of inspection there was no backlog in summarising notes.
- We found the practice shared relevant information with other services in a timely way. For example, one of the administrators was the dedicated lead for managing and monitoring the progress of referrals to secondary care services. The spreadsheet they maintained and monitored for referrals was used to indicate urgent and non-urgent referrals, and to highlight when the patient had received an appointment. The administrator showed us how the system worked by logging an actual appointment. In addition, doctors said they maintained their own record of the patients they referred.
- Reports were usually received from the out-of-hours service (OOH) service within 48 hours of a patient having accessed treatment. These reports were scanned on to DMCIP and alerts sent to a doctor to ensure they were reviewed and appropriate follow up instigated if necessary. The reviewing doctor coded problems/conditions as necessary on DMCIP. If practical, patients seen by the OOH service were required to present to the practice the next day for review.
- A register was in place for samples sent to the laboratory. It was checked weekly and any outstanding results were followed up. Results received at the practice were logged, dated, stamped and scanned onto the patient's record by the administration team. They were then passed to the doctor to review. There had been connectivity issues with the NHS IT system and this was reported as a significant event. Changes had been made as a result and there had been no further issues with connectivity raised.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- Where a patient's mental capacity to consent to care or treatment was unclear, the doctor or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment. Although they had no specific examples, staff highlighted that alcohol, drugs and mental health issues could impact a patient's mental capacity when making decisions about their treatment

and care.

- When providing care and treatment for young people, some of whom may be aged between 16-18 years, staff carried out assessments of capacity to consent in line with relevant guidance. We saw that any parental or guardian involvement in patients' care or treatment was with the consent of the patient.
- The process for seeking consent was monitored through audit.

Supporting patients to live healthier lives

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

- All new patients to the practice were asked to complete an assessment form 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. A sexual health lead was also in post and the practice provided sexual health advice, free condoms and, if appropriate, referral to local community clinics for more comprehensive services including family planning.
- The practice had a health promotion calendar to promote specific issues relevant to the service population and its requirements. Heath 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 had carried out audits to see if they were working effectively in accordance with the QOF targets. QOF related audits undertaken in 2016 included atrial fibrillation, asthma and heart failure. At the time of inspection smoking and gout audits were in progress.
- 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 50-64 years who were entitled to breast screening. The practice also engaged with all national screening programmes and had a mechanism to ensure that eligible patients were referred into the bowel cancer or abdominal aortic aneurysm (AAA) screening programs. For example, the practice had 32 patients registered patients over the age of 50 and all had received an offer to participate in the Scottish Bowel Screening Programme. Patients over the age of 50 who had not had a cholesterol check in the past five years were called in to be tested. Flu vaccinations had been offered to all patients over 65.
- The number of women aged 25-49 and 50-64 whose notes recorded that a cervical smear had been performed in the last 3-5 years was 164 out of 181 eligible women. This represented an achievement of 90% 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 ensuring a female sample taker was always available. The practice had been successful with its promotion of cervical screening and could demonstrate that there had been an increased uptake of screening since 2015. Data showed that in November 2015 the uptake was 54%, it was 71% in August 2016 and 86.5% in December 2016.

- A monthly search was undertaken to monitor the status of childhood immunisations. Childhood immunisation rates were above the DMS average. The population of children under the age of two was 34 and 63 for children aged two to five years. Staff advised us that the practice bench marks itself against the European Region of the World Health Organisation Target of 95% that is used across Scotland. Data we looked at showed immunisation rates for the vaccinations given to under two year olds was 97% and ranged between 95% and 97% for two to five year olds.

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:

- 96% of patients were recorded as being up to date with vaccination against diphtheria compared to 95.5% regionally and 95% for DPHC nationally.
- 95.7% of patients were recorded as being up to date with vaccination against polio compared to 95% regionally and 95% for DPHC nationally.
- 87.5% of patients were recorded as being up to date with vaccination against Hepatitis B compared to 84% regionally and 83% for DPHC nationally.
- 94.8% of patients were recorded as being up to date with vaccination against Hepatitis A, compared to 94% regionally and 94.5% for DPHC nationally.
- 96% of patients were recorded as being up to date with vaccination against Tetanus, compared to 95.5% regionally within DMS and 93% for DPHC nationally.
- 64.7% of patients were recorded as being up to date with vaccination against Typhoid, compared to 69% regionally and 53% for DPHC nationally.

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

Good

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; although we noted that conversations taking place in some rooms could be overheard. We observed that the waiting area was very loud and noisy at times and the sound carried through to consulting rooms.
- The layout of the reception area and the seats in the waiting area meant that conversations between patients and reception could be overheard. Staff minimised this by using a television in the waiting area. Reception staff said that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. There was a notice to this effect in the waiting area.
- The practice offered patients the services of either a female or a male doctor. A chaperone was available for any intimate examinations that were performed by a clinician at the practice.
- There was an accessible toilet in the building. A room was available for baby changing and/ or breastfeeding.
- A suggestion box for patients to leave feedback was located in the waiting area. A 'You said We did' was displayed for patients and it detailed what the practice had done in response to feedback.
- We had the opportunity to speak with six patients during the inspection. They told us they were satisfied with the care provided by the practice and said they were able to get an appointment when needed.
- Results from the June 2017 DMS Patient Experience Survey showed patients felt they were treated with compassion, dignity and respect. For example:
    - 100% of patients said their privacy and dignity was respected and maintained throughout their visit to the practice.
    - 98% of patients said they were seen by the most suitable practitioner to meet their need.
    - 94% of patients said that the medical centre would keep information about them confidential.

    - 93% of patients said if family, friends and colleagues could use the practice, they would recommend it to them.
    - 98% of patients said the practice always tried to improve services for patients.
- We did not receive any comparator data from Defence Medical Services to set out alongside the above data. However, the views of patients expressed on CQC comment cards and those from patients we spoke with aligned with the views above. We received 24 completed comment cards prior to the inspection and feedback was very complimentary about the practice. Patients said that they felt involved in decision making about the care and treatment they received. Comments indicated that patients felt listened to and supported by staff, and they had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- We spoke with a newly appointed patient representative. They were in the earlier stages of exploring approaches to promote patient engagement. As a starting point they were considering revising the patient feedback questionnaire and holding a focus group to determine what patients wanted from the role.
- 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

- The feedback provided by patients indicated that clinical staff took the time to explain their condition or injury and treatment plan.
- Young patients at the practice were treated in an age-appropriate way and recognised as individuals.
- Data received form the latest DMS patient experience survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. The practice received a green rating (score of 75% or above) in relation to receiving relevant information about their treatment, including involvement with making decisions about care options. The practice received a green rating for providing patients with full information about medicines they were prescribed, including side effects. The data presented by the practice was not benchmarked against regional and national averages for the DMS or against the previous year's performance.
- The practice provided a service to a small community of Nepalese personnel and we were advised that they spoke good English. However, an interpreter service was available for patients should the need arise.
- Comprehensive health promotion information leaflets were available for patients on notice boards throughout the medical centre.

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 that was age appropriate and relevant to the patient demographic was prominently displayed and accessible.
- The practice proactively identified patients who had caring responsibilities for a dependant. At the time of our inspection there were no carers identified on the system and the nursing officer confirmed this was accurate. The practice also registered and monitored vulnerable patients. A code was added to their records in order to make them identifiable so that extra support or healthcare could be offered as required. Clinical staff attended a vulnerable patient meeting held every two weeks. The wider staff team was made aware of any vulnerable patients at the practice meetings.

Are services responsive to people's needs?
(for example, to feedback)

Good

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 services and clinics were available to service personnel and their dependants. For example, a smoking cessation clinic, over 40's health screening, sexual health, Well Woman, physiotherapy and travel advice. Pre and post-natal clinics were held at the practice every week. The practice provided patients with access to midwives and health visitors.
- Access to a doctor was good for patients; most patients were seen within 48 hours of requesting an appointment. Patients could have 15 minute appointments with the doctor and up to 30 minute appointments with the nurse. If needed, patients could book a double appointment of 30 minutes with the doctor. Appointments were available after school hours. Late evening and weekend appointments were made available to accommodate deploying units and reservists. Telephone consultations were available with a doctor if a patient requested that option.
- There was a good mix of gender amongst clinicians so patients could reasonably select the gender of clinician they wished to seen by.
- Same day appointments were available for those patients who needed to be seen quickly. Children were seen at the practice on the day an appointment was requested.
- Physiotherapists were employed within the practice. All referrals to this service were made by the doctors and the average waiting time for an appointment was less than one week.
- Eye care and spectacles vouchers were available to service personnel at the medical centre. Transport for patients to hospital appointments was available if needed.

Access to the service

- The medical centre provided a service from 08.00 to 18.00 Monday to Friday for routine and duty doctor appointments. Emergency access was available for service personnel from 08.00 to 08.30 hours. Routine doctor and nurse appointments were available from 08.30 to 12.00 and from 14.30 to 16.30 Monday, Tuesday and Thursday. Clinics that could be accessed by appointment included sexual health, well woman, chronic disease, smoking cessation and over 40's health check. A duty doctor was available from 08.00 to 18.00 each day in accordance with the requirement of NHS Fife. From 18.00 to 08.00 hours, and including public holiday's, patients were diverted to the NHS 111 service. The practice leaflet gave clear directions on local accident and emergency unit access.

- Results from the Defence Medical Services Patient Experience Survey showed that overall patient satisfaction levels with access to care and treatment were high (score of 75% or more). For example:
    - 100% of patients said the opening hours were convenient for them and their family.
    - 91% of patients said they could normally get an appointment to see a doctor for non-urgent problems within two days.
    - 98% of patients said they could usually see the doctor of their choice within a week.
- Patients told us on the day of the inspection that they were able to get appointments when they needed them.
- The practice provided at short notice additional vaccination clinics to ensure all personnel due to be deployed were effectively immunised. For example, staff advised us that the practice provided a late night clinic to meet the needs of personnel being deployed at extremely short notice.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- The practice manager was the designated responsible person who handled all complaints in the practice. They and the staff team adhered to the Defence Primary Health Care's established policy on the management of complaints.
- We noted that information was available in the waiting area to support patients to understand the complaints system. How to make a complaint was summarised in the practice leaflet.
- We spoke with six patients who told us that they would feel comfortable with making a complaint and knew how to complain if the need arose. They confirmed that military rank would not be a barrier to them raising issues with the practice.
- There had been three complaints raised since January 2017. They were not clinical in nature and no theme or trend had been identified.
- Clinical complaints were forwarded to the SMO or, in their absence, one of the other doctors. We discussed a complaint with the SMO in relation to an alleged breach of confidentiality. The investigation into this complaint was thorough and involved a detailed analysis of the patient's care records and an audit of who had accessed them, which reassured the patient that their confidentiality had not been breached.
- We saw that there were processes in place to share learning from complaints. This was through the health care governance and practice meetings. Compliments and complaints was a standing agenda item at the practice meetings. We noted from the minutes of the meeting held in August 2017 that a compliment received about a member of staff was acknowledged at the meeting.
- 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)

Outstanding 

Our findings

Vision and strategy

The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients.

- The army took over the station from the RAF in March 2015. Because RAF primary health care systems differ to those of the army, there were significant changes in infrastructure, including a significant loss of staff, support services and governance structures. For example, RAF led medical centres include medics in their staffing establishment. However, in the army medics work for the units and to the instruction of unit commanders. They also deploy with units. The only remaining staff included a civilian doctor and four administrative staff. A medic or combat medical technician is a unique role in the forces and has greater scope than that of a health care assistant found in NHS GP practices.
- With the army takeover there was a 90% change in population with a large intake of service personnel and dependants who moved over from Germany. Staff described how 2016 was a period of rebuilding organisational infrastructure, including staff recruitment, implementing new systems and governance structures, understanding the new population and team building. Staff said 2017 had been about stabilisation and integration of services. The practice also achieved GPEC (General Practice Education Committee) accreditation in 2017.
- Consistent, safe and effective care was clearly at the forefront of the strategy and vision for the practice and this was clearly projected to and adopted by the staff team. All staff we spoke with were content with their current working environment. Administrative staff told us they found the transition from an RAF to an army led service unsettling and stressful, mainly due to staff shortages, changing systems and new learning. They highlighted that they now feel the benefit of a more structured service, which they have been part of developing. All staff described inclusive and supportive leadership, which acknowledged their opinions, observations and views.

The practice worked to the DPHC mission statement:

- “Safe Practice by Design” - The aim of the service was to provide the highest quality of care to all patients regardless of their background; to treat every patient holistically, looking at social, psychological and physical reasons when dealing with their problems; to continuously strive to improve the quality of care provided as a team by being a 'learning organisation' and to be involved in the teaching and training of other health professionals.
- Throughout the inspection, including interviews with staff and review of governance systems, it was clear the way the practice operated remained true to its mission statement. Staff could identify with this mission statement and understood the values and behaviours required to support it. It was evident the staff team worked hard and in cooperation with each other to develop the service to such a high standard in a short time frame. Staff were proud of what they

had achieved and were looking to develop the service further. For example, plans were in place to undertake more quality improvement projects and to extend the practice.

- 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 a well embedded 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. Doctors and nurses had defined lead roles in key areas. For example, there was a lead established for audit, occupational medicine and clinic organisation.
- Policies from the national framework were implemented and were available to all staff. These were updated and reviewed regularly. Staff we spoke with confirmed they were familiar with policies and other protocols, and used them in the delivery of high quality care.
- An understanding of the performance of the practice was maintained. The practice manager used the Common Assessment Framework (CAF) as an effective governance tool.
- 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. Two weekly meetings were held to discuss vulnerable and at risk patients.
- 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.
- A comprehensive programme of quality improvement, including clinical and administrative audit, was used to monitor quality and to drive improvements.
- There were appropriate arrangements for identifying, recording and managing risks, and implementing mitigating actions. This included plans developed each year that took account of staffing levels at the practice due to the potential deployment of some staff.
- Effective measures were in place to manage under performance by staff. We were provided with an example that clearly showed the member of staff was supported in a positive way to improve their practice. This included re-training in a specific area.

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,

including communications with the practice following the inspection supported this. Staff welcomed feedback on the service and how to improve it. For example, we highlighted that patients could not be observed in the waiting area by reception staff. Within nine days of the inspection the practice contacted us to say CCTV had been installed and was operational in accordance with CQC's CCTV policy.

- There was a clear leadership structure and staff told us they felt supported by management. They said practice leaders were approachable and took the time to listen to all members of staff. All staff were involved in discussions about how to run and develop the practice. We particularly noted the 'learning atmosphere' in the practice, which was promoted by leaders. Staff told us there was an open culture and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Systems were in place to ensure compliance with the requirements of the duty of candour and all staff had a good understanding of the matter. Duty of candour is a set of specific legal requirements that leaders of services must follow when things go wrong with care and treatment. This included ensuring all staff understood to communicate with patients about notifiable safety incidents. The doctors 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 DMS surveys and from any individual patient feedback received.
- The practice were looking at the possibility of forming a Patient Participation Group (PPG) and had identified a patient representative shortly before our inspection
- Completed CQC comment cards from patients supported our findings that there was an open door policy when it came to patient input and feedback.
- 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.
- Staff participated with the 'Safety Climate Survey' developed by NHS Education for Scotland. This staff feedback system covered areas such as communication, workload, leadership, teamwork, safety systems and learning. Results were positive and comparable with other medical practices in Scotland. From our discussions with leaders, it was evident staff feedback had been analysed as leaders were considering what more they could do to improve the working environment for staff.

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 changes. For example, the proteinuria identification project led to an increase in repeat urinalysis. Furthermore, the results of the root cause analysis into a trend of knee injuries led to unit commanders supporting a change of footwear for service personnel. With this change the trend in these injuries ceased. In addition, the baseline audit for the quality improvement project regarding the handing of samples showed 25% compliance. Compliance had increased to 90% following changes made as a result of the project.
- The results handling project outlined the care bundle measures and the associated problems with each measure. A baseline audit in both April and May 2015 showed overall compliance with care bundle measures at 25% and 40% respectively. Systems were revised for recording, monitoring samples sent and returned, including whether action was taken in response to a review of sample results. A re-audit in June 2015 showed compliance had increased to 80% and a further re-audit in July 2015 placed compliance at 90%. This clearly demonstrated continuous improvement to the way samples were managed at the practice.