Defence Medical Services

Fort George Medical Centre

Quality Report

Ardersier
Inverness
Scotland
IV2 7TE

Date of inspection visit: 17/01/2018
Date of publication: 08/05/2018

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

Summary of findings

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced inspection at Fort George Medical Centre on 17 January 2018. Overall, the practice is rated as inadequate. Our key findings across all the areas we inspected were as follows:

- There was an organisation wide policy in place for reporting and recording significant events. Staff were aware of this and how to report and record significant events. However, our findings on the day suggested there needed to be greater awareness on what constituted a significant event. Incidents had occurred that had not been reported through the system.
- There was a lack of assessment and management of risks, particularly in the management of medicines and in some patients with long term conditions. There was no definite arrangement in place for collection of samples and transporting these to the laboratory; staff had to request a car and driver to perform this duty and availability was not guaranteed. There were no failsafe's in place for the tracking of samples and receipt of results. Staff did not have access to Legionella risk assessments and steps to take to reduce this risk.
- The system for managing pathology results was not sufficient and staff had not been trained to ensure safe management of results.
- There was no monitoring of cleaning in place, and a cleaning audit had not been undertaken.
- The practice had a newly appointed nurse, who had taken on a leadership role in the absence of the Regimental Medical Officer who was deployed with the regiment at the time of our inspection. We saw examples of recently introduced improvements and collaborative working with neighbouring practices, to promote better health outcomes for patients at the practice.
- There was limited evidence of audits and quality improvement at the practice. There was no evidence that the practice had used data to identify areas for improvement.
- There was evidence of some very recent practice meetings, but no evidence that practice meetings were consistently held and attended by all staff.
- The arrangements for managing emergency medicines minimised risks to patient safety. However, management of medicines within the dispensary at the practice (including obtaining, prescribing, recording, handling, storing, security and disposal) of medicines required improvement. We saw that out of date treatment materials and some out of date medicines were available for use in the dispensary.
- There were gaps in staff awareness around current evidence based guidance. When we spoke to some staff, it was apparent that they had not received training relevant to their role, to deliver effective care and treatment. Some staff had requested the training they needed but these requests had not been met.
- 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. We received 15 completed patient comment cards, all of which were positive about the staff and treatment provided at the practice.

- Information about services and how to complain was available. We saw that there was a common theme across some complaints, relating to the availability of exercise rehabilitation instructors (ERI) and physiotherapy staff and access to these.
- The practice was located in a building which dates back to the 18 century; this presented challenges for the practice and staff. Adaptations had been made to ensure it had facilities and equipment to treat patients and meet their needs. Further work was planned for upgrades to the building but it is unclear if these would be progressed. Although wheelchair access to the building was possible, the entry to toilet facilities would be obstructed by the layout of building.
- There was a leadership structure in place. However, the Regimental Medical Officer (RMO) was deployed with the regiment, leaving a gap in leadership for extended periods. We were told that of the 107 weeks that the RMO had been based at Fort George, they had been in the medical centre for 24 weeks.
- It was difficult to secure locum GP cover when the RMO was not at Fort George, due to the isolated location of the medical centre. This had an impact on patient access to GP care, if they could not be seen by GPs at Kinloss or Lossiemouth. RAF Lossiemouth is a one hour car journey away (approximately 35 miles) and Kinloss Barracks is a 40 minute drive away (approximately 22 miles).
- The nurse we spoke with on the day of inspection demonstrated their understanding of the requirements of the duty of candour.

The Chief Inspector recommends:

- Persons employed should receive appropriate support, training and development to enable them to carry out the duties they are employed to perform. For example, for all newly appointed staff and for those staff moving into new roles. This should also include refresher training for staff on significant events and application of learning in the operational environment.
- Review of the GP locum induction pack to ensure this remains current and fully accessible to all new locum staff at the practice.
- Introduction of staff and/or systems to safely and effectively manage equipment, medicines and their use, particularly in the dispensary, and in respect of ordering, storage and management of vaccines.
- Review of premises to ensure they are suitable for the purpose for which they are being used.
- A review of the establishment of GPs at the practice, to include deputising arrangements and cascade of GP responsibilities within the practice during any absence to assure safe and effective patient care.
- All governance systems be reviewed to ensure all necessary checks are in place, for example, in relation to the receipt, recording, sharing and discussing relevant safety alerts, in respect of Legionella management, building cleaning and cleanliness, medicines security checks and security of prescription pads.
- Responsibility for clinical audit to be reviewed to ensure there is ongoing activity to drive quality improvement.

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.

Inadequate

Are services safe?

The practice is rated as inadequate for providing safe services.

- Staff required further training in what constitutes a significant event; there had been five events reported in over 12 months. On the day of inspection, we were made aware of events that had not been reported.
- Management of medicines was inadequate. Security checks on some medicines did not reflect current guidance. We found medicines in use were out of date. The access to the practice dispensary was not controlled.
- Staff did not have access to key risk assessments which detailed actions they should take to minimise risks, for example, in relation to Legionella.
- The current practice in place for recording, sharing and discussing relevant MHRA alerts was inadequate.
- There was no audit of cleaning or checks made to ensure cleaning met the required standards.
- The absence of key staff, for example the Regimental Medical Officer (RMO), for extended periods, meant some patients requiring follow up treatment and on-going monitoring were overlooked.

Inadequate

Are services effective?

The practice is rated as inadequate for providing effective services.

- The effective follow-up and management of patients with long term conditions required review to ensure they were effective.
- There were no failsafes in place for the tracking of results from analysis of specimens sent to the local laboratory.
- Staff had not received the training they required to effectively deliver their duties.
- There was no effective, permanent arrangement in place that could be relied upon for the collection and transportation of

samples to the local laboratory. A military car could be requested for this but the availability of this was not guaranteed.

- Staffing was not effective within the practice. The pharmacy technician worked between half a day and one full day per week at the practice, which did not fully provide the expertise and knowledge required to effectively manage medicines stock, ordering and cold chain management. It was not always possible to secure a locum GP for the practice due to it's isolated location. Gaps in leadership had not been effectively covered over an extended period of time. The Exercise Rehabilitation Instructor was linked to another unit, but was giving two days of support to the practice, alongside a physiotherapist who worked part time. Feedback from staff was that this input was insufficient to meet needs of patients.
- Only GPs did note summarising. As a GP was not always at the practice the potential for backlog of note summarising had not been effectively addressed.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Feedback from patients in practice surveys and comment cards showed that patients felt they were treated with dignity and respect.
- We noted that all visitors to the medical centre on the day of our inspection were treated with respect and courtesy by all staff.
- Waiting areas for patients were welcoming and provided information displays on local support groups, and contact details for external organisations providing a range of social services.

Are services responsive?

Requires improvement

The practice is rated as requires improvement for providing responsive services.

- The practice staff confirmed that there were times when no locum GP was available to provide services. Where this happened there was a contingency for patients to be seen by GPs from Lossiemouth or Kinloss Barracks. However, travel to these practices involved a car journey of one hour or 40 minutes respectively.
- From the practice leaflet we could see that opening hours were given as being from 0800 hours to 1700 hours. There was no patient information on access arrangements outside these hours, other than for NHS 24 services or 999 emergencies. Also the practice was closed on Wednesday

afternoon for training. There was no information in the practice leaflet on GP access arrangements for Wednesday afternoon.

- Referals to secondary care were carried out in a timely manner. However, appointments for secondary care could be subject to a lengthy wait. There had been no work carried out to demonstrate the impact of this on patients of the practice, and therefore the operational capability of the regiment. Any two week wait referrals (for urgent cases) were met in a timely manner.
- The ability of the nurse to respond to patients needs was severely limited by the lack of training afforded in primary health triage and minor illness and ailments.
- We saw that there was a common theme across some complaints, relating to the availability of exercise rehabilitation instructors (ERI) and physiotherapy staff and access to these.

Are services well-led?

Inadequate

The practice is rated as inadequate for providing well-led services.

- The absence of the Regimental Medical Officer whilst deployed with the regiment, left a leadership gap that was not adequately addressed or filled.
- As a result, other leadership duties such as clinical audit, work on continuous improvement of practice, staff guidance and mentorship and adequate clinical management of patients was not carried out.
- All governance required improvement.
- Staff who had been appointed to roles in the practice had not received the training required to carry out these roles.
- Where staff had started to tackle areas of governance that required improvement, a lack of co-operation from contract staff had impeded progress. For example, in respect of access to risk assessments for Legionella control and management, and for assurance on electrical safety of the building. Staff had not been able to progress this further in the absence of a leader with ownership of these areas.
- There was some evidence of recent practice meetings but no evidence that meetings were consistently held and routinely attended by all staff.

Fort George Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by a CQC inspector. The team included a GP specialist advisor and a pharmacist specialist advisor.

Background to Fort George Medical Centre

Fort George Medical Centre is located in the remote area of Ardersier, which is approximately 13 miles from Inverness, Scotland. The treatment facility offers care to forces personnel and is home to the third Battalion The Black Watch, The Royal Regiment of Scotland. At the time of inspection, the patient list was approximately 550 patients. Occupational health services are also provided to personnel and a number of reservists. The medical treatment facility (referred to as the practice throughout this report) is a building within an 18th century fort. Although the building has been upgraded over time, it is still dated and presents all the daily challenges expected when working in a building which is protected by Historic Scotland.

In addition to routine GP services, the practice can refer patients to its sister practice at RAF Lossiemouth for minor surgical procedures, and to Kinloss Barracks for family planning and some women's health services. RAF Lossiemouth is a one hour car journey away (approximately 35 miles) and Kinloss Barracks is a 40 minute drive away (approximately 22 miles).
RAF Lossiemouth provides referral to NHS community services for maternity and midwifery that hold clinics at RAF Lossiemouth on a weekly basis. Physiotherapy services and travel advice are available at Fort George practice.

At the time of our inspection, the practice had one full time Regimental Medical Officer (RMO). This GP was attached to the regiment and when the regiment deployed, the RMO deployed with the regiment. This was the case at the time of our inspection. A locum GP was covering for the RMO, providing GP services full time at the practice at the time of our inspection. This GP was supported by one full time practice nurse, one full time regimental nurse (who was not deployed with the regiment on this occasion), one medical sergeant (deployed), seven combat medical technicians (six of whom were deployed). There were also two civilian administrative staff. The combat medical technician who was not deployed was working as a newly appointed practice manager (the work of a military medic has greater scope than that of a health care assistant found in NHS GP practices). There was also a pharmacy technician who visited the practice one day each fortnight from Kinloss Barracks to provide support in the practice dispensary. Physiotherapy staff at the practice provided patient services for 25 hours each week.

The practice was open from Monday to Friday each week, between 0800 hours and 1700 hours. The practice closed on Wednesday afternoon from 1400 hours for staff training. There was no information on the patient leaflet outlining cover arrangements outside of these hours. When we asked we were told there was currently no GP cover between 1700 and 1830 hours, Monday to Friday. Patients were advised to contact NHS 24 or if an emergency to dial 999.

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 information provided to us about the facility. We carried out an announced visit on 17 January 2018. During our visit we:

- Spoke with a range of staff, including one locum GP, the supporting practice manager from a neighbouring practice, the newly appointed practice manager, the pharmacy technician, the practice nurse, the regimental nurse and two administrative staff. We were able to speak briefly with two patients who used the service.
- Reviewed 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.
- Conducted a visual inspection of the building, treatment rooms and patient waiting areas.

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?

Inadequate

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events. Our findings show that not all incidents or events were appropriately reported through this system.

- Staff told us there was a recording form available on the practice computer system. We reviewed significant events at the practice and saw that only five incidents had been recorded between December 2016 and January 2018. Three of these incidents were reported in the period from September 2017 to December 2017.
- We were aware of other incidents that had occurred but not been reported in this period.
- For the five incidents that were reported, we could see staff had completed a significant event record form. We were told that each event would be discussed at a practice meeting. However, from the three sets of meeting minutes available, it was not recorded that incidents that had occurred between September 2017 and November 2017 had been discussed with staff.
- Following review of minutes from the three meetings that had taken place, we could see that log in details for some staff, for the incident recording system (ASER) were discussed and only requested when the new practice nurse started work at the practice and raised the issue of under reporting of significant events within the practice.

We reviewed safety records, incident reports and national patient safety alerts. In the limited sets of minutes of practice meetings that we were provided with, there was no standard agenda item in relation to safety alerts, such as those from the Medicines and Health Care Products Regulatory Agency. There were no examples of patient safety incidents for us to review. When we made checks, we saw that there was an expectation that the pharmacy technician who visited the practice once every two weeks would check these. However, this was not working safely or effectively for the practice. There was no evidence of dissemination of these at practice level. The practice manager was aware of the existence of the alerts but this could not be verified through shared emails or discussion at practice meetings. When asked, the practice manager and visiting pharmacy technician could explain how they would handle a relevant alert. However, the arrangements in place for managing, recording and sharing of these across the practice required review.

We were told by staff that when there were unintended or unexpected safety incidents, patients received reasonable support, information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.

Overview of safety systems and processes

Not all systems were effectively developed or consistently used to keep patients safe and safeguarded from abuse.

- Arrangements for safeguarding reflected relevant legislation. Policies were accessible to all staff. The policies outlined who to contact for further guidance if staff had concerns about a patient's welfare. We noted that other than in the GPs consulting room, these contact details were not displayed in other areas of the practice, for example other treatment rooms. There was a lead member of staff for safeguarding and this was the newly appointed practice nurse. However, there was no designated deputy safeguarding lead in place.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs and the practice nurse were trained to child protection or child safeguarding level three. The practice did not maintain an accurate and up to date register of patients subject to safeguarding arrangements and patients deemed to be 'at risk'. Staff were not using the alert facility within DMICP (Defence Medical Information Capability Programme) to ensure that risks showed clearly when the medical record was opened. We reviewed an example of one patient deemed to be vulnerable. This was not supported by the appropriate alerts on the patient records or by the name of the patient being recorded on a vulnerable patient register at the practice.
- Notices in the waiting room and consultation rooms advised patients that chaperones were available if required. Staff designated to act as chaperones had not been trained for the role. When we checked the staff register we saw there were several gaps for staff confirmed as having an up to date Disclosure and Barring Service (DBS) check or the Scottish equivalent, the Protecting Vulnerable Groups (PVG) membership (DBS checks and the PVG membership scheme 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). Checks of the register on the day showed five staff with either out of date checks on no confirmation that a check was in place.
- The practice did not maintain appropriate standards of cleanliness and hygiene. We observed the premises to be dirty in places, particularly in the dispensary area. We noted that curtains around examination couches had not been replaced every six months as is expected. The date of the last change of curtains around one bed was May 2017. The curtains around the treatment couch in the physiotherapy room were not date-labelled and were visually dirty.
- The practice had an infection control policy and the infection control lead was the newly appointed practice nurse, who had attended infection control refresher training. An infection control audit had recently been conducted by the practice nurse. This highlighted areas that required improvement. In addition, we noted that there was no audit of cleaning carried out at the practice. There were no cleaning schedules which showed how frequently areas should be cleaned. When we asked staff about the times the cleaner visited the practice to clean, staff couldn't say what time the cleaner started in the morning, but that the cleaner left as staff arrived between 0730 hours and 0800 hours. The dispensary was visibly dirty; the floor had not been swept in some time. We found sharps bins that were more than two thirds full.
- All single use items were stored appropriately. We found two sets of sterile forceps in the nurse's treatment room that were out of date. We saw a number of items in the physiotherapy room that were out of date, for example, acupuncture needles and gloves, which went out of date in 2015 and 2014 respectively. There was massage oil in use with an expiry date of 2011.

- Spillage kits were available and clinical waste was stored appropriately and securely and was collected from the practice by an external contractor on a fortnightly basis.
- The arrangements for managing medicines, including emergency medicines and vaccinations, in the practice required improvement. This included arrangements for obtaining, prescribing, recording, handling, storing and the security of medicines.
- When medicines arrived they were stored in the locked dispensary or transferred to a fridge if required. The paperwork was kept at the practice until the visiting pharmacy technician came to the practice on one day each fortnight. This arrangement is contrary to recognised Department for Health guidance. Vaccines should be checked against the order before signing for the delivery by a person trained in this duty.
- We were told that when the pharmacy technician arrived at the practice to add these items to the stock recording system, some may have been used, which required backtracking to record batch numbers and expiry dates against the applicable patient record.
- We found prescriptions for antibiotics that had not been collected. There was no evidence that attempts had been made to contact these patients. These prescriptions medicines had been dispensed over a month ago.
- Patient group directions were signed by the nurse and the Regimental Medical Officer (RMO); however, as the RMO was deployed, these should be signed by either the long term locum GP or by the lead group practice Senior Medical Officer (SMO).
- The practice had a system for production of Patient Specific Directions for use when appropriate.
- Although prescription forms were held securely, accountability for these was not monitored and managed. GPs and medics took batches of prescription forms when required, without recording the serial ‘from and to’ numbers in a log, used to manage the use of prescription pads. This is contrary to DPHC policy and procedures.
- When we reviewed controlled and accountable medicines we saw that all drugs listed as being stocked were present and correct. We did note that the required specimen signatures on paperwork to support the safe storage, dispensing and disposal of these medicines were incomplete and did not have specimen signatures of staff that had performed checks. The specimen signature for the pharmacy technician was also missing.
- We found an ammunition tin within the controlled drugs cabinet that belonged to the battalion. The medicines in this box do not belong to the practice but were being stored in the dispensary. These medicines should be held by the Quarter Master.
- All staff had access to the controlled medicines cabinet key. Access to this should be limited. We also saw that all staff could access the key to the dispensary on request and did not uniformly sign this key in and out. Again, the access to the dispensary should be limited for security purposes.
- The practice had not conducted any medicines audits, to ensure prescribing was in line with best practice guidelines for safe prescribing. The newly appointed practice nurse was working on a calendar of audits that would be introduced shortly.
- We reviewed three personnel files and found some recruitment checks were incomplete. For example, the appropriate checks through the Disclosure and Barring Service. All checks in respect of the locum GP who had recently started with the practice where in place.

Monitoring risks to patients

Some risk management processes needed to be developed and/or reviewed to minimise the risks to patients and others.

- A health and safety policy was available which identified local health and safety representatives. The practice had fire risk assessments and carried out fire drills.
- The fire equipment was checked by an external contractor on a six monthly basis. Fire alarms were tested weekly. Equipment we looked at carried a testing sticker, confirming it had been tested in the last 12 months. However, the practice did not have a copy of an electrical safety certificate for the building. Clinical equipment was checked in line with Defence Medical Services policy to ensure it was working properly. The practice had other risk assessments in place to monitor safety such as control of substances hazardous to health and infection control. The practice did not have access to a legionella risk assessment and management plan (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). When staff had asked for a copy of this, the contractor had failed to supply it. Without this, staff had not been aware of any requirements to flush pipes or take water temperature checks. These safety measures are likely to have been required but had not been implemented.
- We saw evidence to confirm the practice was taking the necessary action to manage the maintenance of the practice. However further maintenance work required and due to be undertaken this year, may be delayed due to the current maintenance contracting arrangements.

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 instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff had personal alarms. The installation of alarms in treatment rooms was included in the proposed maintenance upgrade for 2018.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had 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 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 to staff in the practice and additional copies were kept off the premises.

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

Inadequate 

Our findings

Effective needs assessment

- Clinicians we spoke with 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) best practice guidelines.
- Staff had access to guidelines from NICE/SIGN and used this information to deliver care and treatment that met patients' needs.
- There was evidence available of clinical meetings held at the neighbouring practice of RAF Lossiemouth to which clinical staff from Kinloss Barracks and Fort George Medical Centre were invited. We could see that there had been no attendees from Fort George at any of these meetings in the previous four months.
- The Defence Primary Health Care (DPHC) Team produced a newsletter that was circulated to clinicians providing further information and a summary of relevant safety updates. The GP we spoke with could refer to this and gave examples of updates they had acted on. The locum GP at the time of our inspection also worked in general practice in the community and had access to all alerts and updates.

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 DPHC practices, we are not using NHS data as a comparator.

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

- There was one patient on the diabetic register. We reviewed the treatment and care offered to this patient and found that current NICE/SIGN guidance had been followed, but appropriate follow-up of the progress of treatment had not been delivered. This appeared to be due to poorly managed call and recall systems. The last measured total cholesterol of this patient fell into the target range which is an indicator of positive cholesterol control. The last blood pressure reading for this patient also fell within target range.
- There were five patients recorded as having high blood pressure. We reviewed the treatment

and care offered to these patients and found that current NICE/SIGN guidance had been followed. All had a record for their blood pressure in the past nine months. Of these patients with hypertension, three had a blood pressure reading of 150/90 or less.

- The number of patients 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 109 out of 215 patients, which is 51% of the smoking patient population. The NHS target for this indicator is 90%.
- There were four 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 two patients had had an asthma review in the preceding 12 months which included an assessment of asthma control using the three Royal College of Physicians questions.
- There were seven patients with a new diagnosis of depression in last 12 months. Only one patient had been reviewed within 10 to 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 the instance of audiometric hearing assessment was above the force average when compared to DPHC 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 September 2017 showed :

- 100% of patients had a record of audiometric assessment, compared to 99% 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 very limited evidence of quality improvement including clinical audit:

- There was no ongoing programme of clinical audit in place at the practice. The newly appointed practice nurse had highlighted this as one of the priorities for the practice and had drawn up an audit calendar to be followed. This took account of clinical and practice audits. The practice were able to show a baseline infection control audit and an audit on security of patient records. At the time of inspection these were at first stage cycle only, so any progress made since this initial cycle could not be gauged.
- An internal quality assurance tool, the Defence Medical Services (DMS) Common Assurance Framework (CAF) is used to monitor safety and performance within DMS. 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. There was no CAF information sent to us by the practice ahead of the inspection. When asked on inspection the practice were unable to locate any CAF data.

Effective staffing

Evidence reviewed showed that not all staff had the skills and knowledge to deliver effective care and treatment or to carry out the duties required of them in their current role.

- The practice had an induction programme for all newly appointed staff. This had recently been updated and included topics such as safeguarding, infection prevention and control, fire safety, health and safety, information governance and Caldicott accountability. We saw that there had been a recent focus on recommended training for staff. Staff had access to and made use of e-

learning training modules and in-house training packages.

- Staff had received mandatory training in subjects such as fire, basic life support and infection control. In addition staff had received some role-specific training. For example, the infection control lead had attended a relevant course. There was insufficient evidence to confirm that all staff, including medics, 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 not received training on how to deliver these duties.
- Some medics had been trained to administer vaccines. They told us their competency was monitored. Staff who administered vaccines, for example the practice nurse, could demonstrate how they stayed up to date with changes to the immunisation programmes.
- A recently appointed staff member was highly experienced and knowledgeable, but did not come from a primary care background. This meant they needed role specific training. At the time of inspection some of this training had been delivered. Other training had been delivered via e-learning, such as in infection control. However, there was some frustration at the time it was taking to organise other key training required.
- Although arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs, these did not always work effectively. For example, support from a pharmacy technician was only available for one afternoon each fortnight. Effective management of medicines alerts, intake of medicines stock and security checks for the dispensary had not been carried out.
- The GP based at the practice was the Regimental Medical Officer who deployed with the regiment. In their absence, it was not always easy to secure a locum to deliver GP services at the practice due to its remote location. In such cases, the practice was supported by GPs from neighbouring practices, even though they were approximately a 40 minute drive away. GP appointments provided in these cases were limited by the commitments of those GPs at their own practice. Wherever possible, the practice would use the same locums, if these could be sourced. We asked staff how frequently the RMO was absent due to deployment. From documents supplied to us on the day of inspection, we could see that the RMO had been at the practice for 24 weeks out of 107. This had a direct impact on patient services.
- A member of staff who had taken on a new administrative role within the practice, had not received training on key areas of work. Although this staff member was experienced in the work of a medical centre, they had not been given sufficient insight or time to understand the breadth and scope of work they were expected to undertake.
- There was no effective, permanent arrangement in place for the collection and transportation of samples to the local laboratory. A military car and driver was requested when samples needed taking away, but the availability of a driver was not guaranteed. There were no fail safes in place for the tracking of results from analysis of specimens sent to the local laboratory.
- The medic assessed "fresh cases" (patients being seen for the first time for a certain issue). In the absence of the RMO and a locum GP daily clinical oversight could only be provided by a doctor visiting from one of the neighbouring practices.
- Although staff had received an appraisal within the last 12 months, evidence from inspection showed that learning needs were not effectively identified.

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. However, systems in place to ensure that those patients due for recall for review of treatment were not operating effectively. For example in the case of a patient on a high risk medicine had not been actioned, even though the patient had presented with illness that could be related to their treatment. We saw that for one patient prescribed medicines off licence there was no shared care agreement held on the system. We also found no record of why the patient had been started on this medicine (2014), and there was no evidence of review of this.
- 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. We noted that some patients experienced long delays waiting for secondary care appointments. There was no work in place to measure the effects of this, to present to senior officers within Defence Primary Health Care (DPHC), who may have been able to assist or provide alternative treatment pathways for patients.
- Patient records were current. When we reviewed notes that required summarising, we saw that 73% of patients' notes were summarised (406 sets of notes out of 548). However, the locum GP at the practice only provided patient consultations, and the practice nurse did not summarise notes. Therefore there was the potential for a backlog to develop. There was no contingency plan in place to address this.
- Reports were usually received from the out of hours service (OOH) 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. The reviewing doctor coded problems/conditions as necessary on DMICP. Patients seen by the OOH were required to present to the practice, if practicable, the next day for review.

Consent to care and treatment

We were told staff sought patients' consent to care and treatment in line with legislation and guidance. However, the practice was unable to demonstrate that formal written consent was obtained before any staff performed acupuncture.

- The GP and nurses we spoke with 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:

- Patients at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. An obesity register was in place and there were 30 patients on this register.
- 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 offered basic sexual health advice including the issue of free condoms and referral to local clinics in the community for more comprehensive services. Family planning and

women's health, for example, cytology screening could be delivered by Kinloss medical facility.

- 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. The practice also engaged with all national screening programmes and referred eligible patients (three) into the bowel cancer or abdominal aortic aneurysm (AAA) screening programs. All patients over 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 deemed as being at risk.
- The number of women aged 25 to 49 and 50 to 64 whose notes recorded that a cervical smear had been performed in the last three to five years was 11 out of 11 eligible women. This represented an achievement of 100% 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. Screening was delivered by female GPs and nurses at Kinloss Barracks 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 September 2017 provides vaccination data for patients using this practice:

- 97% of patients were recorded as being up to date with vaccination against diphtheria compared to 95.5% regionally and 95% for DPHC nationally.
- 97% of patients were recorded as being up to date with vaccination against polio compared to 95% regionally and 95% for DPHC nationally.
- 83% of patients were recorded as being up to date with vaccination against Hepatitis B compared to 84% regionally and 83% for DPHC nationally.
- 91% of patients were recorded as being up to date with vaccination against Hepatitis A, compared to 94% regionally and 94% nationally.
- 97% of patients were recorded as being up to date with vaccination against Tetanus, compared to 95.5% regionally and 95% for DPHC nationally.
- 91% 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 DMS practices should offer the Typhoid vaccination to personnel before deployment and not to routinely vaccinate the whole population. There has also been a typhoid vaccine shortage throughout the UK and stocks have been limited.

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; conversations taking place in these rooms could not be overheard, either on corridors or adjacent rooms.
- Reception staff knew 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 patient toilet available near the waiting area but this was not fully accessible due to a step on route to the toilet. Baby changing and/ or breastfeeding facilities were available if required.
- We were able to speak with two patients who told us they were satisfied with the care provided by the practice and said they were able to get an appointment when needed.
- Patients commented in feedback provided on CQC comment cards that they felt involved in decision making about the care and treatment they received. They commented that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- Results from the practice's Patient Experience Survey showed patients felt they were treated with compassion, dignity and respect. For example:
    - 100% of patients said the practice was good at listening to any compliments, comments or complaints.
    - 90% of patients said they had confidence that their medical treatment and records would be treated confidentially.
    - 100% of patients said their privacy and dignity was respected throughout their visit to the practice.
    - 80% of patients said the health professional they saw offered them advice and information about the treatment they received.
    - 100% of patients said if family, friends and colleagues could use the practice, they would recommend it to them.
- We did not receive any comparator data to help interpret the above patient survey results. However the views of patients expressed on CQC comment cards and those from patients we

spoke with, aligned with the views above.

- 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 younger patients at the practice were treated in an age-appropriate way and recognised as individuals.
- We were made aware that referral to secondary care could present long delays for patients. This was something beyond the control of the practice. However, staff ensured that patients were aware of any delays and provided advice to them on any possible alternative treatment routes.
- Data received form the patient experience survey (November 2017) showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. The data presented by the practice was not benchmarked against regional and national averages for DMS, or against previous performance.
- The practice sometimes 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.
- Information leaflets were available in reception.

Patient and carer support to cope emotionally with treatment

- Patient information leaflets and notices were available in the patient waiting area which informed patients how to access a number of organisations. We saw that information that was age appropriate and relevant to the patient demographic was prominently displayed and accessible. For example, we saw posters which explained how to use a condom safely, on symptoms that may suggest a sexual health screening appointment would be useful, on access to contraception and on the importance of completing any prescribed course of treatment.
- The practice had not established a register of patients who also acted as a carer.
- Patient information leaflets and notices were available in the patient waiting area which informed patients how to access a number of support groups and organisations.

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

Requires improvement 

Our findings

Responding to and meeting people's needs

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

- A wide range of clinics were available to service personnel, for example, minor surgery services could be accessed at RAF Lossiemouth. Physiotherapy and health checks were available at the practice.
- Travel advice was available, and patients could receive Yellow Fever vaccinations at RAF Lossiemouth. Any female patients could be referred to well woman clinics and for family planning advice to RAF Lossiemouth. All maternity services could be accessed at RAF Lossiemouth, where the midwives visited weekly.
- 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.
- Physiotherapists were employed within the practice and at the time of our inspection, the practice provided 25 hours of physiotherapy services each week. All referrals to this service were made by the GPs and the average waiting time for an appointment varied on the numbers of personnel based at Fort George. At the time of inspection numbers of personnel based at Fort George were low, so appointments could be accessed within one week.
- Interpreter services were available when required. Transport for patients to hospital appointments was available if needed.
- Eye care and spectacles vouchers were available to service personnel from the medical centre.

Access to the service

- The practice was open from 0800 hours to 1700 hours, Monday to Friday. There was no patient information on access arrangements outside these hours, other than for NHS 24 services or 999 emergencies. Also the practice was closed on Wednesday afternoon for training. There was no information on GP access arrangements for Wednesday afternoon.
- 'Sick parade' (an opportunity for patients to attend the practice for advice in person) took place from 1000 hours on Monday and from 0800 hours Tuesday to Friday each week.
- The practice provided GP clinics each day, 0830 hours to 1000 hours, 1030 hours to 1230 hours, and 1400 hours to 1600 hours except for Wednesday afternoon. Nurse clinics were available each morning and afternoon and offered 15 minute appointments or 30 minute

appointments if required.

- According to a policy document we were shown, telephone cover was provided by one of the medics between 1700 and 1830 hours each day. The document said that if the medic required further advice, they would contact the duty medic at RAF Lossiemouth, who would refer on to a GP if required. There was no description of cover available on Wednesday afternoon when the practice closed for training. When we asked the practice nurse about GP cover on Wednesday afternoon and between 1700 and 1830 hours, we were told there was no cover.
- The practice leaflet gave clear directions on local accident and emergency unit access. The nearest accident and emergency department was located at Raigmore Hospital.
- Results from the practice's patient experience survey showed that overall patient satisfaction levels with access to care and treatment were high. For example:
    - 80% of patients said they were able to obtain a suitable appointment when they needed one.
    - 100% of patients said staff listened to them and that they were given full information about the medicines given to them.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Defence Primary Health Care had an established policy and the practice adhered to this.
- 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.
- We spoke with two patients who told us that they felt comfortable and knew how to complain if they needed to. They confirmed that military rank would not be a barrier to them raising issues with the practice. This was reflected in the complaints we reviewed.
- There had been four complaints raised in the last 12 months. We saw that there were processes in place to share learning from complaints. Complaints are audited through the Common Assessment Framework (CAF) within DMS. However, no CAF data was submitted to us in respect of this inspection.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Inadequate 

Our findings

Vision and strategy

- Whilst practice staff wanted to deliver high quality care and promote good outcomes for patients, staffing issues had impacted on the ability of the practice to deliver this.
- The practice 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.”
- Staff we spoke with throughout the day could identify with this mission statement. Staff knew and understood the values and behaviours required to support this. The practice could not show us a detailed strategy and supporting business plan which reflected the vision and values, but in their presentation, demonstrated that they understood what was needed to take the practice forward and how they were gathering evidence to support their requests for additional resource. We did not see evidence that staff concerns about resource were supported by Regional Management.

Governance arrangements

- The practice manager was able to show us copies of DPHC overarching governance framework documents. Some of these had been adapted recently for use at Fort George. This work was on-going and the newly appointed practice nurse had identified governance as the key area for focus in the coming months. The new practice nurse was being supported by an experienced practice manager from a neighbouring practice, in trying to deliver some of this work.
- There was a staffing structure and staff were aware of their own roles and responsibilities. When we reviewed lead roles in key areas, we could see responsibilities that sat with the RMO, were not covered in his absence by the locum GP. The newly appointed nurse had significant lead responsibilities but at the time of our visit had not received training required to deliver these. Other staff had lead responsibilities which had not been acted on, for example, addressing issues with poor standards of cleaning. The absence of the RMO meant line management responsibility was not effective in addressing this. The newly appointed practice manager, although experienced in working in a medical centre, had a number of significant lead responsibilities but had not had any training in practice management.
- Policies from the national framework were not fully implemented or embedded.
- We were told by staff that data had never been used or referred to in practice meetings, as a tool for improving performance. There was no current CAF data available and the last Healthcare Governance Assurance visit (HGAV) was in excess of 12 months ago. Therefore, there was no understanding of the performance of the practice.
- We saw evidence that practice meetings had been held once a month for a three month period

covering September, October and November 2017. There were no minutes of meetings available prior to this. Clinical meetings were held at RAF Lossiemouth which staff were invited to. We found one clinical meeting had been attended by the newly recruited practice nurse, in November 2017. There was no evidence that clinical meetings prior to this had been attended by staff from Fort George. There was limited and inconsistent opportunities for the full practice team to come together to identify priority actions. As an example, staff told us they had to 'beg and borrow consumables'. Requests for things such as printers took an inordinate amount of time to process. Also the immediate training needs of staff were not being effectively brought to the attention of leaders at DMS HQ, leaving staff feeling they were being too demanding.

- There was no programme of clinical and internal audit used to monitor quality and to make improvements. Two audits had been done in November 2017, which were a patient notes audit and a baseline infection control audit.
- There was a lack of systems for identifying, recording and managing risks, issues and implementing mitigating actions. For example, staff had no access to the audit on Legionella management and control, so no flushing of water pipes or temperature checks were in place.
- The recording, reporting and learning from significant events was limited due to lack of reporting by staff and a lack of awareness of what could constitute a significant event.

Leadership and culture

- On the day of inspection the practice nurse presented themselves as a lead for the practice. This staff member, supported by the medical centre staff demonstrated they had the capacity and capability to run the practice and ensure high quality care. However, they also recognised they required additional training in primary care, a full complement of staff to 'share the load' and the services of a GP or GPs, consistently at the practice. One key thing recognised was that when locum GPs were posted to the practice to provide cover, they were tasked with seeing patients; no additional leadership or governance duties were allocated to locum GPs, or identified through contractual arrangements. This meant that many of these duties were overlooked, or delegated to staff who could not fully deliver due to lack of knowledge, training or experience.
- Everything we saw on the inspection day told us staff were willing, committed and passionate about delivering high quality care, but that factors beyond their control impacted their ability to deliver this.
- Staff did not feel supported by Regional Managers. Staff told us the practice leaders were approachable and took the time to listen to all members of staff, but that management beyond the practice did not seem to hear their requests for support. Staff said when asked they were involved in discussions about how to run and develop the practice. Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at practice meetings. However, they were not always confident that issues raised would be addressed. Staff were aware of and had systems in place 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 locum GP, practice nurse 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 feedback from patients and staff. It proactively sought feedback from:

- Patients through the Defence Medical Services surveys and from any individual patient feedback received.
- The practice had not formed a Patient Participation Group (PPG) and at the time of our inspection, this was lower down on the list of their priorities. Staff were aware that limitations were inevitable due to the transient nature of the patient population and deployable status of operational staff at the practice.
- Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management when the opportunity presented itself, for example, when the RMO was at the practice.
- Completed CQC comment cards from patients supported our findings, that there was an open door policy when it came to patient input and feedback.

Continuous improvement

- There was limited evidence of learning and improvement at all levels within the practice. The practice team had recently completed an audit on the security of patient records. This showed no patient information or records were left unattended and where locked away safely at the end of each working day. There had been a baseline IPC audit by the practice nurse, which identified areas for improvement. However, there were pressing issues that needed to be tackled and could have been addressed quickly. For example, the standard of cleaning at the practice had not been audited, and fell below standards required. This had not been addressed. Staff access to the dispensary was not controlled. Checks on medicines should have been audited but this had been overlooked; medicines management was found to be an area of concern during out inspection.