

RM Condor

Quality report

Arbroath
Angus
DD11 3SP

Date of inspection visit:
5 June 2018

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25 July 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 by the practice and patients.

Ratings

Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Outstanding 

Chief Inspector's Summary

This practice is rated as good overall.

The key questions are rated as:

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

Letter from the Chief Inspector of General Practice

We carried out an announced inspection at Royal Marines Condor on 5th June 2018. Overall, the practice is rated as good. Our key findings across all the areas we inspected were as follows:

- There was an open and transparent approach to safety. All staff knew how to raise and report an incident and were fully supported to do so. We saw the management of significant events included clear indication that a root cause analysis had been completed and actions were identified to address what had occurred and actions put in place to reduce the likelihood of re-occurrence.
- The assessment and management of risks was comprehensive, well embedded and recognised as the responsibility of all staff.
- There was good evidence to show collaborative working and sharing of 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.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Feedback from CQC comment cards and patient surveys showed patients were treated with compassion, dignity and respect. We saw that the practice was highly responsive to patient's needs. Patients we spoke with said they found it easy to make an appointment with urgent appointments available the same day.
- Information about services and how to complain was available.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.
- There was a clear strong leadership structure and staff felt engaged, supported and valued by management.

We saw an area of notable practice:

From discussions with staff, it was clear the practice was pro-active in using a quality improvement approach to review its systems of care and identifying actions leading to measurable improvements in health care delivery. A comprehensive and wide-reaching active programme of audit, both clinical and non-clinical, was in place that focussed on the needs of the population and demonstrated a commitment to improving outcomes for patients.

The practice used every opportunity to learn from internal and external incidents, to support improvement. Learning was based on a thorough analysis and investigation.

The Chief Inspector recommends:

Ensure adequate arrangements are in place to respond to emergencies by the introduction of alarms in clinical areas for staff.

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

Our inspection team

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

Background to RM Condor

Royal Marines (RM) Condor provides primary care and occupational health primarily to Royal Marines, a small number of army personnel and The Military Provost Guard Service (MPGS). There is a high turnover of the patient population, which on the day of the inspection was approximately 652.

The medical centre has one full time civilian GP and one General Duties Medical Officer (GDMO), the GDMO is away on deployment. There is one civilian nurse, one medical assistant, two administrative staff, and one physiotherapist. There were also two Exercise Rehabilitation Instructors (ERI). Seven medics who were not Defence Primary Healthcare Staff but were part of the regiment also worked out of the medical centre when not deployed.

In addition to routine GP services, the treatment facility offers physiotherapy and rehabilitation services. Family planning advice is available within the practice and maternity and midwifery services are provided by NHS practices and community teams. Mental Health referrals are made to HMS Neptune located approximately 115 miles away.

The practice is open on Monday 1300 to 1700 hours, Tuesday, Wednesday and Thursday between 0800 and 1700 hours and Friday 0800 to 1230 hours. On a Monday morning and a Friday afternoon duty cover is provided by Leuchars Medical Centre which is 23 miles away. Outside of these times, patients were referred to NHS 24 or local out of hours' services. The nearest minor injuries unit is located in Arbroath which was approximately 2 miles away from the base.

Are services safe?**Good**

We rated the practice as good for providing safe services.

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, which included:

- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role.
- 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. There was a lead member of staff for safeguarding and this was the GP. Effective deputising arrangements were in place.
- Notices in the waiting room and consultation rooms advised patients that chaperones were available if required. All 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).
- All clinical notes were complete and had been summarised.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The nurse undertook weekly inspections of the practice to check that good standards of cleanliness were upheld. The practice had an infection control policy and the lead staff member had attended annual infection control refresher training. The last infection control audit was undertaken in October 2017 and it showed some areas requiring improvement including, wall mounting of a paper towel dispenser and management of sharps bins. We saw actions had been taken on all issues that were within the practices ability. Other issues such as the installation of a fixed sink in the nurse's room (instead of a temporary one) and wipe clean chairs were still awaiting action from the region. The building itself was old and in need of improvement with recurrent problems frequently causing problems. For example, ants in and around the building and issues with emergency power supplies. The practice worked hard to keep on top of these issues keeping patient safety as a priority.
- All single use items were stored appropriately and were within their expiry date. Specific equipment was cleaned daily and daily logs were completed. Spillage kits were available and clinical waste was stored appropriately and securely and was collected from the practice by an external contractor.
- The full range of recruitment records for permanent staff was held centrally at Regional Headquarters (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.
- The practice manager confirmed all staff had professional indemnity cover. Information was in place to confirm practice staff had received all the relevant vaccinations required for their role at the practice

Risks to patients

Risks to patients were assessed and well managed.

- There was a failsafe system in place for the monitoring of laboratory results.
- There were procedures in place for monitoring and managing risks to patient and staff safety. The practice had up to date fire risk assessments and carried out regular fire drills. The fire equipment was checked by an external contractor on a monthly basis. Fire alarms were tested weekly and all electrical equipment was checked on a regular basis to ensure the equipment was safe to use. Clinical equipment was checked in line with Defence Medical Services policy to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- The lead ERI was the designated lead for Primary Care Rehabilitation Facilities (PCRF) equipment. All the medical equipment had an annual inspection and this was up to date. Some gym items were old or visibly worn, which made effective cleaning difficult.
- The current staffing establishment was adequate and provided a good mix of staffing skills and experience. The practice did not use locum staff so that patients had continuity of care. A GP and nurse from Leuchars Medical Centre supported RM Condor regularly. Staff had a flexible approach towards managing the day to day running of the practice.
- The building was old and there were no alarm system in any of the consultation and treatment rooms which alerted staff to any emergency.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. A table top exercise of emergency facilities in the practice had also been undertaken to check the appropriateness of medicines and equipment needed in emergency care.

Safe and appropriate use of medicines

- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe. This included arrangements for obtaining, prescribing, recording, handling, storing and the security of medicines. 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 defibrillator available on the premises and oxygen with adult masks. A first aid kit and accident book were available.
- The practice carried out regular medicines audits for example an antibiotics audit, to ensure prescribing was in line with best practice guidelines for safe prescribing. We saw evidence to show the regional pharmacist had undertaken regular reviews measuring prescribing against DPHC and Tayside's formulary, and highlighting areas for discussion.
- Prescription pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.

Track record on safety

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

- The GP 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. All staff were familiar and confident 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. There was a strong culture of reporting and learning from incidents at the practice.
- Ten significant events had been identified and managed since April 2017. 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, we saw that on one occasion specimens due to go for laboratory testing were inadvertently left in the specimen box for an extended period of time. This led to patients being recalled for new specimens to be taken and an explanation and an apology given to them. Following this the process of specimen handling was immediately amended and improved upon. The practice was clear that 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.
- Significant events (SE) were a standing agenda item at the monthly practice meetings where they were discussed with the wider staff team. We saw that root cause analysis was conducted and that actions to address what had occurred, or to reduce the likelihood of re-occurrence were applied.
- We reviewed safety records and national patient safety alerts, including the minutes of meetings where these were discussed. The Medicines and Healthcare products Regulatory Agency (MHRA) alerts were received via the automated system from DPHC HQ. All alerts were checked against equipment registers and DMICP (Defence Medical Information Capability Programme) patient records/stock reports. Alerts were shared with practice staff as appropriate, they signed to confirm they had read them and they were documented in meeting minutes.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system and policy for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were good systems in place for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice.

Are services effective?	Good
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We rated the practice as good for providing effective services.

Effective needs assessment, care and treatment

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

- 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 and was a standard agenda item at the monthly practice meeting.

- Clinical staff met weekly to discuss NICE and SIGN guidance and also to discuss any topics that were current in the British Medical Journal and the British Journal of General Practice. We saw an example where information gained regarding the need for a vitamin D supplement was used in some health promotion work demonstrated by the practice nurse.

Monitoring care and treatment

The practice used information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. QOF is a system intended to improve the quality of general practice and reward good practice. It is used across many NHS practices. The 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 those prescribed by secondary care doctors. The nurse carried out a search every two months for patients on HRDs and every three months for patients identified as needing regular reviews for long term conditions. They were identified and a diary entry made on the computer system, this was shared with the nurse from Leuchars so that these reviews were never missed. The practice provided the following examples of patient outcomes data to us from their computer system on the day of the inspection.

- There were 10 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, seven (70%) had a blood pressure reading of 150/90 or less.
- There were four patients with a diagnosis of asthma. We reviewed the treatment and care offered to these patients and found that current NICE guidance had been followed. Of these four, all (100%) had received 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 two patients with a new diagnosis of depression in last 12 months. Both 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 instance of audiometric hearing assessment was higher 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. Data from January 2018 showed:

- 100% of patients had a record of audiometric assessment, compared to 97% regionally and

99% for DPHC nationally.

- 89.5% of patients' audiometric assessments were in date (within the last two years) compared to 75% regionally and 86% for DPHC nationally.

Following a significant event and subsequent complaint in 2014 where a patient's suboptimal lower audiometry test result was not actioned, the practice audited and introduced quality improvement changes. This included yearly recall for RM Condor personnel, repeat testing only to be carried out by the practice nurse and if the patient failed they were referred for a clinical (not screening) audio at ENT/audiology. Medics could only undertake testing if they had completed training and were deemed competent, medics were also supported and encouraged to undertake a two day gold standard audiometric course. This protocol was shared and disseminated to other practices within the Region and was also submitted to the Scotland NHS safety project. Since this was implemented referrals for staff to undertake the audiometry study event has increased showing others being proactive in providing safe and effective audiometric care.

Management, monitoring and improving outcomes for people

There was evidence of quality improvement work including clinical audit, this led to improved outcomes for patients.

From discussions with staff, it was clear the practice was pro-active in using a quality improvement approach to review its systems of care and identifying actions leading to measurable improvements in health care delivery. A comprehensive and wide-reaching active programme of audit, both clinical and non-clinical, was in place that focussed on the needs of the population and demonstrated a commitment to improving outcomes for patients. An audit spreadsheet showed 19 completed audits (both clinical and administrative) completed in the past six months. 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, diabetes, hypertension and clinical notes. We also looked at specific quality improvement projects, the outcome of which had been actioned by the practice. They included a results handling project and the hearing conservation project.

The whole practice was encouraged and were proactive to participate in their own audits. Some examples of this were, the practice nurse undertook a yearly audit in smoking cessation, and the receptionist audited prescription collections.

We looked at audits undertaken by the PCRf;

An audit of patient care pathways that checked patients had a review with a clinician at least every six weeks and an audit of subjective assessment of lower back pain patients against NICE guidelines. All showed positive outcomes for patients.

Effective staffing

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

- The practice had an induction programme for all newly appointed staff including locum staff. This included topics such as safeguarding, infection prevention and control, fire safety, health and safety, information governance and Caldicott accountability. Staff had access to and made use of e-learning training modules and in-house training. Staff had all received mandatory

training in subjects such as fire, basic life support and infection control. In addition, staff had received role-specific training. Staff who acted as chaperones had received training which had been devised and delivered by the practice themselves.

- Staff administering vaccines and taking samples for the cervical screening programme had received specific training including an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes. The medical assistants (MA) and nursing team triaged and ran fresh case clinics once a day for patients. This was overseen by the GP daily, who screened the MA's consultations and any concerns with standards were addressed with further training given.
- The nurse maintained their own continual professional development and managed their own nursing update training.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. All staff had received an appraisal within the last 12 months.

Coordinating care and treatment

- The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and investigation and test results.
- There was a weekly meeting with Harden troop (dedicated rehabilitation), fortnightly meetings with the Welfare committee (included the Padre, and Unit welfare officer) and quarterly meetings with the wider station personnel.
- 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.
- Discharge and hospital letters were received by the medical centre and there was a good system to ensure in place that a clinician reviewed and actioned these, this included an audit trail to record what had been done.
- A register was in place for samples sent to the laboratory. It was checked daily 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.

Helping patients to live healthier lives

The practice did not have any dependants or children registered with the practice.

- 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 identified patients who may be in need of extra support and signposted them to relevant services. For example, those requiring advice on their diet and alcohol consumption. The practice nurse had received specialist training in sexual health and gave sexual health advice, offered free condoms and referred to secondary services when required. They also communicated with the whole camp on a frequent basis to offer advice and to ask if there were

any specific issues regarding health promotion the practice could support them with.

- Advice on prevention of musculoskeletal injury was also available from physiotherapy staff at the practice, as well as the GPs providing services. Smoking cessation was promoted and the practice nurse was proactive in providing comprehensive support and care for those patients who required it. The latest audit from data collected between January 2017 and January 2018 showed the practice four week quit data was 85% compared to NHS England data of 49%. After 12 weeks data showed 64% continued to have stopped smoking compared to the NHS data of 23%.
- The PCRf staff engaging with wider aspects of patient care by the implementation of a well-being program led by the ERI (following attendance at a MoD training program). This was aimed at managing associated diet and weight issues in patients with musculoskeletal injuries.
- 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 had a mechanism to ensure that eligible patients were referred into the bowel cancer or abdominal aortic aneurysm (AAA) screening programs. All patients over 50 who had not had cholesterol check in the past five years were called in to be tested. Flu vaccinations had been offered to all patients who were eligible.

There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using public health information posters and they ensured a female sample taker was always available. 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 100%. The NHS target was 80%.

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 January 2018 provides vaccination data for patients using this practice:

- 96% of patients were recorded as being up to date with vaccination against diphtheria compared to 96% regionally and 95% for DPHC nationally.
- 96% of patients were recorded as being up to date with vaccination against polio compared to 95.5% regionally and 95% for DPHC nationally.
- 88% of patients were recorded as being up to date with vaccination against Hepatitis B compared to 80% regionally and 77% for DPHC nationally.
- 85% of patients were recorded as being up to date with vaccination against Hepatitis A, compared to 89.5% regionally and 91% nationally.
- 96% of patients were recorded as being up to date with vaccination against Tetanus, compared to 96% regionally and 95% for DPHC nationally.
- 85% of patients were recorded as being up to date with vaccination against Typhoid, compared to 68% regionally and 53.5% for DPHC nationally.

Consent to care and treatment

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

Staff understood the relevant consent and decision-making requirements of legislation and

guidance, including the Mental Capacity Act 2005.

Are services caring?

Good

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, 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.
- We received 48 CQC comment cards from patients at the practice that described their care and treatment in a highly positive way. 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. They said staff were kind and respectful. We also saw 10 completed patient satisfaction questionnaires from Harden troop they were all equally positive about the care they received from the rehabilitation team.

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.

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. We spoke with three patients who were attending for injury rehabilitation and they told us that they were well supported to understand their injury, to set realistic personal goals and to commit to their care plan in order to achieve best results in terms of their recovery. Patients in the dedicated rehab troop (Harden troop) said they felt involved in the decision making about their care pathway and happy with their treatment to date. They were content with the availability of staff, both physiotherapist and ERI. They felt their treatment programme was individualised.
- Staff were observed to be supportive and responsive to patients demonstrating caring and compassion in their interactions.
- Interpretation services were available for patients who did not have English as a first language and staff knew how to access them. Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of organisations.
- The practice proactively identified patients who were also carers, there were three registered at the time of the inspection. There were systems in place which when patients identified themselves as carers, a code was added to their records in order to make them identifiable and so that extra support or healthcare could be offered as required. The GP attended welfare meetings every two weeks with other health professionals to discuss where extra support and care were needed.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. 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 only one male GP employed at the practice meaning if a female patient requested to see a female GP they were able to go to the nearby Leuchars base in an emergency or could see a female GP who visited their own base every two to three weeks. The practice had recognised that this may be difficult so ensured for any intimate examinations that were to be performed by a male GP at the practice, a chaperone was always available and all staff were trained to do so.

Are services responsive to people's needs?

Good

We rated the practice as good for providing responsive services

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. For example, minor operations, physiotherapy and travel advice.
- Patients could have 15 minute appointments with the GP and up to 30 minute appointments with the practice nurse or longer if needed.
- Patients were able to self-refer themselves to physiotherapy and were typically seen within five days.
- Patients were able to receive travel vaccines when required.
- Same day appointments were available for those patients who needed to be seen quickly.
- There were accessible facilities which included interpretation services 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.
- Weekend clinics were held when demand required them.

Timely access to care and treatment

The practice was open on Monday 1300 to 1700 hours, Tuesday, Wednesday and Thursday between 0800 and 1700 hours and Friday 0800 to 1230 hours. On a Monday morning and a Friday afternoon duty cover was provided by Leuchars Medical Centre which is 23 miles away. Outside of these times, patients were referred to NHS 24 or local out of hours' services. The nearest minor injuries unit was located in Arbroath which was approximately 2 miles away from the base. Results from the patient experience survey showed that overall patient satisfaction levels with access to care and treatment were high. For example 92% of patients said the opening times were convenient to them.

Clinicians referred patients recovering from injury to physiotherapy teams when appropriate. These were based at the medical centre and we saw good working relationships in place that supported patients back to full physical health.

The Defence Rehabilitation Headquarters collated a dashboard of information in relation to waiting times and patients who do not attend for their appointment. These are key performance indicators as timely access to physiotherapy and rehabilitation were important for effective patient recovery. Condor PCRf was performing ahead of regional and defence-wide peers:

For January to March 2018, 86% of new patients referred to see a physiotherapist were seen within 5 working days. This compares to a regional average of 54% and an overall PCRf average of 55%. Similarly 100% of new patients referred to see an ERI at Condor PCRf were seen within KPI target of 5 working days, compared to a regional average of 32% and an overall PCRf average of 49%. The PCRf proactively managed DNA (patients who did not attend) rates for their clinics and had achieved above average results with 1% of patient appointments lost to DNAs in January to March 2018, compared with a PCRf average of 7%.

The practice held 'fresh case' clinics once a day. All patients were triaged by medics who referred on to a nurse or GP as required (a military medic delivers healthcare similar to a healthcare assistant in the NHS but has a greater scope of duties).

Any medicines could be collected on prescription from the pharmacy; this was located in nearby Arbroath. Alternatively any prescriptions sent to the pharmacy before 12 midday were delivered back to the practice by 1500 hours the same day. Patients commented that it was a really quick and efficient service.

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. There had been no complaints raised in the past year. We saw that there were processes in place to share learning from complaints.

Are services well-led?	Outstanding
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We rated the practice as outstanding for providing a well-led service.

Leadership capacity and capability

- On the day of inspection the leaders in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Everything we saw on the inspection day, and communications with the practice following the inspection, supported this.
- There was a clear leadership structure and staff felt supported by management. Staff told us the practice leaders were approachable and always took the time to listen to all members of staff.
- There were clearly allocated responsibilities in the practice with named deputies for cross coverage and resilience in the event of absence from the practice.

Vision and strategy

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

- Consistent, safe and effective care was clearly at the forefront of the strategy and vision for the practice and this was clearly projected to and adopted by the staff team. All staff we spoke with were content with their current working environment. 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.

Culture

All staff 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 team meetings and felt confident and supported in doing so. Staff indicated they felt well-supported by the management team and that they were approachable.

Staff told us that they enjoyed coming to work, and felt a sense of pride in their involvement in the delivery of high quality, safe and responsive care for patients. All staff we spoke with, from all disciplines, referred to the practice leadership as inclusive, caring and inspiring. We saw there was a strong commitment from all staff to their role showing their ability to work independently and strive for continual improvement and as a practice team to provide the best care for their patients'. Time invested in staff by leadership, translated into positive engagement and interaction with patients. This was confirmed by the high number of compliments received from patients who visited the practice.

The practice was aware of the dangers of being a small, single handed, geographically separated practice and had proactively taken steps to reduce its isolation and share experience, learning and processes with Leuchars to the benefit of its clinicians and patients. A practice development plan which was a 'roadmap' for short term, intermediate and longer term goals for the practice was in place and an example of insightful forward planning. Some examples were the implementation of improved audiometry, employing a dedicated receptionist and the GP working towards re-accreditation as a trainer.

Governance arrangements

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Policies from the national framework were implemented and were available to all staff. These were updated and reviewed regularly.
- An understanding of the performance of the practice was maintained. The practice manager used the Common Assessment Framework (CAF) as an effective governance tool. Practice meetings were held regularly and were used as an additional governance communication tool, for example to remind staff to complete all paperwork in respect of significant events. 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,

to ensure that 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. Fortnightly 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, issues and implementing mitigating actions. This included plans developed each year that took account of manning levels at the practice due to deployment of some staff.

Managing risks, issues and performance

There were clear and effective processes for managing many risks, issues and performance. However we identified some areas where improvement was required.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had some processes to manage current and future performance.
- Practice leaders had oversight of national and local safety alerts, incidents, and complaints.
- Clinical audit had clear impact on quality of care and outcomes for patients.
- The practice had a business continuity plan in place but had not fully trained staff in its use.
- There were no emergencies alarms available in the clinical rooms.

Appropriate and accurate information

The practice had appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- 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, for example, to discuss and share significant events. The meetings were also used for forward planning, for example, to ensure that patient needs were met during busy clinic times and periods of staff sickness. This provided an opportunity for staff to learn about how the performance of the practice could be improved and how each staff member could contribute to those improvements.
- There were robust arrangements at the medical centre in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

- Patients through the surveys and from any individual patient feedback received.
- 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. In May 2018 the practice participated in an online questionnaire, the Safety Climate Tool which explored employees' attitudes and perceptions in key areas of their work whilst guaranteeing anonymity. RM Condor scored highly showing staff satisfaction in all areas.
- 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 and innovation

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking. From minutes of meetings we reviewed, we noted that the leadership of the practice focussed on improving the speed and quality of delivery of care for all patients. Improvements implemented were evident from the quality improvement projects, outcome of audits and investigation into significant events. It was clear to us that the practice used its audit work to identify learning and make change. For example the work around health promotion and screening.

An example of good quality improvement was seen; the PCRf team led by the physiotherapist were starting a research project looking at the effect of load on biomechanics, and the potential influence on injury. The aim was to identify potentially modifiable risk factors for musculoskeletal injury. This physiotherapist had gained support from universities including the Institute of Naval Medicine and was currently obtaining ethics approval.