South (Scotland) Group Practice

Quality report

MRS Edinburgh
Redford Barracks
Edinburgh
EH13 0PP

Date of inspection visits:
7 June 2018 and 2 August 2018

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This report describes our judgement of the quality of care at this hub and spoke Group Practice. It is based on a combination of what we found when we inspected both locations and information given to us by the services, patients and other organisations.

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?	Good

Chief Inspector's Summary

South (Scotland) Group 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? - Good

We carried out an announced comprehensive inspection of South (Scotland) Group Practice with MOD Caledonia Medical Centre inspected on 21 June 2018 and MRS Edinburgh inspected on 2 August 2018.

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.

The overall findings from the inspection:

- There was an open and transparent approach to safety. A system was in place for managing significant events and staff knew how to report and record using this system. Staff acknowledged that the system was not up to date at the time of inspection and provided additional evidence to show that significant events were managed effectively.
- The assessment and management of risks was comprehensive, well embedded and recognised as the responsibility of all staff.
- The arrangements for managing medicines, including obtaining, prescribing, recording, handling, storing, security and disposal in the practice minimised risks to patient safety. There was an effective approach to the monitoring of patients on high risk medicines.
- Staff were aware of current evidence based guidance. They had received training so they were skilled and knowledgeable to deliver effective care and treatment.
- The Group Practice worked collaboratively and shared best practice to promote better health outcomes for patients.
- There was evidence to demonstrate quality improvement was embedded in practice, including the outcome of clinical audit used to drive improvements for patients.
- The Group Practice proactively sought feedback from staff and patients which it acted on. Results from the Defence Medical Services (DMS) patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.

- Patients we spoke with said they found it easy to make an appointment.
- Facilities and equipment were sufficient to treat patients and meet their needs.
- There was a clear strong leadership structure and staff felt engaged, supported and valued by management. The Group Practice proactively sought feedback from staff and patients, which it acted on.
- Staff were aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.
- The Group Practice had a comprehensive governance system in place and all staff understood their role and responsibilities in the structure. Some systems were not integrated as would be expected with a hub and spoke organisational model. For example, clinical audit was not integrated and there was a risk to the patient population of Caledonia Medical Centre being excluded from audit activity.

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

Induction for new staff was comprehensive. Induction packs included the specific requirements and culture for each location. For example, a pack was available at Caledonia Medical Centre for non-Naval staff, which included Navy specific policies, Navy terminology, local guidance and local referral pathways. Role specific inductions were in place to ensure clinical staff were competent in all aspects of military based primary care. For example, competency checks carried out for new doctors included undertaking boxing, diving and discharge medical reviews and interpreting the result of an abnormal audiogram. This approach was particularly important for civilian doctors joining the group practice who had to take account of the specific needs of a predominant Army patient population at MRS Edinburgh and Navy population at Caledonia Medical Centre.

The Chief Inspector recommends:

- Review the vision, strategy and objectives to ensure they reflect the organisational model for the South (Scotland) Group Practice.
- The Group Practice review its operational model and governance arrangements giving consideration to fully integrating all systems and processes.
- The Group Practice in collaboration with the regional team pursue full connectivity between Lab Links and DMICP. Ensure laboratory result values are always coded for patients with long term conditions.
- A review of the management of sharps to ensure it is in accordance with Health and Safety (Sharp Instruments in Healthcare) Regulation 2013.
- Ensure significant events are raised for connectivity issues in relation to DMICP.

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

Our inspection team

The team that inspected MOD Caledonia Medical Centre included a CQC lead inspector**,** a GP specialist adviser and a practice manager specialist adviser. For consistency the inspection of MRS Edinburgh was carried out by the same CQC lead inspector, GP specialist adviser and practice manager specialist adviser, with the addition of a specialist nurse advisor and a specialist physiotherapist advisor. A representative of CQC's scheduling team also participated in both inspections.

Background to South (Scotland) Group Practice

Formed in 2015, the South (Scotland) Group Practice is based on an organisational hub and spoke model. MRS Edinburgh is the hub practice and supports one spoke practice, MoD Caledonia Medical Centre, which is located 18 miles away. All clinical services are based in the hub practice and are provided to the smaller spoke practice on a sessional basis. The Group Practice is led by a Senior Medical Officer (SMO) who is responsible for the overarching governance structure. A Regional Clinical Director (RCD) is overall accountable for the quality of care at the Group Practice.

MRS Edinburgh

Located in Redford Barracks, MRS Edinburgh provides a primary care service to a predominantly deployable army population of 1850, including Scotland's Infantry Regiment and the Rifles Infantry Regiment. Most of the patient population is male between the ages of 18 and 40. At the time of inspection there were three registered patients under the age of 18 and 67 patients over the age of 50. Families and dependants are not registered at the practice and are signposted to local NHS primary care services.

The practice is open from 08:00 to 16:30 Monday to Thursday and 08:00 to 13:00 on Friday. A duty doctor is available all day, including from 16:30 to 18:00 and from 13:00 on Friday. From 18:00 weekdays, weekends and public holidays patients are advised to contact NHS 24.

In addition to routine GP services, the practice provides a range of other services including occupational health, minor surgery, a new joiner's health screen, immunisations, sexual health, smoking cessation, cervical cytology, over 40's health screen and chronic disease management. A Primary Care Rehabilitation Facility (PCRF) and dispensary are located in the building. Maternity and midwifery services are provided by NHS practices and community teams.

The large practice team comprised a mix of military and civilian staff. The core team included four GPs (two Civilian Medical Practitioners and two Regimental Medical Officers), a Senior Nursing Officer (SNO); three practice nurses; a pharmacy technician; three physiotherapists and two exercise rehabilitation instructors. The practice was managed on a day-to-day basis by a full-time practice manager supported by five administrators.

Additional staff included a GP trainee and two General Duty Medical Officers (GDMO). A GDMO is a junior army doctor attached to a field unit before commencing higher specialist training. Patients of the practice were supported by a range of RAP (Regimental Aid Posts) staff, including nurses and medics. A RAP is a front-line military medical asset that is attached to a military unit. A medic is a unique role in the forces and has greater scope than that of a health care assistant found in

NHS GP practices. An additional six nurses were in post following the closure of the attached ward facility in April 2018.

MoD Caledonia Medical Centre

The medical centre is located in MoD Caledonia, a tri-service MoD site providing a primary care service to a non-deployable navy population of 336. The population is mostly male and all over the age of 18, with a third of the population over the age of 40. Families and dependants are not registered at the practice and are signposted to local NHS primary care services.

The staff team includes a full-time practice manager, a Department of Primary Health Care (DPHC) medic and an administrator. Clinical staff are provided on a sessional basis each week from MRS Edinburgh including three GP clinical sessions (full day Tuesday and Thursday morning), one practice nurse session (Wednesday morning) and three physiotherapy sessions. In addition, a unit asset medic provides clinical support at the practice. Patients also have the option to access all clinics and facilities at MRS Edinburgh. A Department of Community Mental health (DCMH) psychiatric nurse provides a session on Wednesday morning and the Regional Occupational Health Consultant holds a clinic one day every quarter.

The practice is open from 08:00 to 16:30 Monday to Thursday and 08:00 to 12:00 on Friday. Access to routine and urgent appointments is also available at MRS Edinburgh, including access to a duty doctor outside of the clinical sessions at the practice. A duty doctor at MRS Edinburgh is available each day from 16:30 to 18:00 and from 12:00 on Friday. From 18:00 weekdays, weekends and public holidays patients are advised to contact NHS 24.

Are services safe? | Good

We rated the Group Practice as good for providing safe services.

Safety systems and processes

The Group Practice had clear systems to keep patients safe and safeguarded from abuse.

- A framework of safety policies was in place, regularly reviewed and accessible to staff, including temporary staff. Staff received safety information about the practice they were working in and as part of their induction and during refresher training. They received safety information for both practices if their work meant they worked at both MRS Edinburgh and Caledonia Medical Centre.
- Measures were in place to protect patients from abuse and neglect. Adult and child safeguarding policies were available and took account of local arrangements. The SMO was the safeguarding lead and the SNO the deputy lead and both had received training to the appropriate level for the role. All other staff were up-to-date with safeguarding training appropriate to their role. They knew how to identify and report concerns.
- Measures were in place to highlight and monitor vulnerable patients, including the use of Read codes and application of alerts on electronic patient records. A central register of vulnerable patients was maintained. We looked at the registers for both practices and noted all patients had alerts on their records. The SMO attended welfare meetings at Caledonia Medical Centre and this forum was used to discuss and monitor the needs of vulnerable patients. MRS

Edinburgh was represented at both Unit Health Committee (UHC) meetings and army welfare meetings, and vulnerable patients were discussed at these forums.

- Staff who acted as chaperones were trained for the role and had been subject to safety checks to ensure they were suitable to work with young people and vulnerable adults. The chaperone policy and notices were displayed advising patients of the service. Non-clinical staff attended in-house chaperone training delivered by the SMO in June 2018.
- The full range of recruitment records for permanent staff was held centrally. However, the practice managers could demonstrate that relevant safety checks had taken place at the point of recruitment, including a Disclosure and Barring Service (DBS) check to ensure staff were suitable to work with vulnerable adults and young people. DBS checks were renewed every five years. They also monitored each clinical member of staff's registration status with their regulatory body. All staff had professional indemnity cover. Information was in place to confirm staff had received the relevant vaccinations required for their role at the practice.
- There was an established system to manage infection prevention and control (IPC). A practice nurse was IPC lead for the Group and was suitably experienced for the role, having completed an internal course in IPC and attended relevant study day. The IPC audits completed in the last 12 months showed an 85% compliance rate for Caledonia Medical Centre and a 92% compliance for MRS Edinburgh. Actions identified had been appropriately addressed. For example, handwashing training had taken place in June 2018.
- Acupuncture was provided at the Caledonia Medical Centre. We noted the room it took place in was not suitable from an IPC perspective. The physiotherapist said they would in future use the treatment room.
- During a walkaround in MRS Edinburgh we observed environmental cleaning was stored incorrectly. The day after the inspection the practice manager confirmed the building contractor and cleaning supervisor were due to visit that day to review the storage of the mops and to instigate a more thorough checking approach to take account of IPC standards.
- Arrangements were in place for the safe management of healthcare waste including consignment notes, a pre-waste acceptance audit and appropriate storage arrangements. At MRS Edinburgh we noted small sharps boxes used for disposal of acupuncture equipment had no date recorded for when they were first put into use. We highlighted this to the practice manager at the time of the inspection who removed them.
- Systems were in place to ensure facilities and equipment were safe. Water safety and electrical safety checks were undertaken in accordance with policy. Fire safety including a fire risk assessment, fire plan, firefighting equipment tests and fire drills were all in-date. Portable appliance and clinical equipment checks were up-to-date and records maintained.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

- Staffing levels were monitored by the practice managers, including staff absence. Clinics were planned six to eight weeks in advance. If it was noted insufficient staff were available then the SMO was alerted. Emails were sent to the doctors requesting cover. We were advised that staff were accommodating with changing hours to support clinics. Caledonia Medical Centre was supported by MRS Edinburgh if short of staff and because of the Group Practice model staff could move between both services. There had been a shortage of doctors in May 2018 so clinics at Caledonia Medical Centre were reduced. Patients were made aware of this and

advised that the wait time for an appointment would likely increase or they could book an appointment at Edinburgh.

- There was an effective induction system for locum staff. It included a specific induction locum pack that was managed by the SMO, SNO and practice manager. This applied to MRS Edinburgh as locum staff would not be expected to work at Caledonia Medical Centre. The PCRF had a specific checklist for locums for their first day and this was managed by the lead physiotherapist.

- Both practices were equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. They had received medical emergency training in the last 12 months in asthma, myocardial infarction, seizure and thermal injuries.

- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Staff, including reception staff, had received awareness training in identifying and manage patients with severe infections, such as sepsis.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- Summarisation of records was completed on the patient electronic record system (DMICP) and were flagged for the nurse and/or doctor to review. Summarisation of records was up-to-date.
- The practice manager was a member of the DMICP working group and said it was effectively used to assign tasks and share information within the Group Practice. Staff at MRS Edinburgh told us that DMICP could be slow and that there were occasional losses with connectivity; the longest period being a full morning. Staff did not indicate that this had presented a risk to patient safety. This loss of connectivity was not being reported through ASER and/or the Single Point of Contact (SPOC) for DMICP which meant there was no opportunity to identify whether it was an actual fault or user error.
- The Group Practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. Because the practices were located in different NHS regions, each practice had different systems to monitor the progress of its referrals.
- A safe but labour-intensive system was established for the tracking and monitoring of test results. Lab Links was not connected to DMCIP and this meant the system relied on staff scanning and manually entering test results onto DMCIP. All test results were passed to the duty doctor to ensure no urgent results were missed and then scanned onto the clinical records. Whilst the practice was doing all it could reasonably do to mitigate the risks associated with this lack of system integration, risks remained due to potential human error and staff absence.
- Data codes were not to applied to scanned test results which meant test values could not be searched for through DMICP. Alerts were not used on DMICP to identify patients with long term conditions (LTC) to mitigate against this. Because the number of patients with LTCs was low, the lead nurse for LTCs was familiar with patients and could follow-up on concerns and non-responders. This would not be the case in the absence of the nurse and another member of staff relying on DMICP to identify patients requiring follow-up.

- The practice was actively involved with the Scottish Patient Safety Programme, a national quality improvement programme, and participated in events facilitated through the programme.

Safe and appropriate use of medicines

The SMO was the Group Practice lead for medicines management. Each practice had different arrangements for the supply and management of medicines.

- Both practices had safe systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment. Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. A policy and process was in place for the storage and monitoring of stock medicines with an appropriate risk assessment completed to identify medicines that the practice should stock. Medication requiring refrigeration was monitored to ensure it was stored within the correct temperature range. Prescription pads were securely stored and their use monitored.
- MRS Edinburgh had a dispensary that was managed by the pharmacy technician. Controlled drugs (CD) were safely managed, including their disposal. A CD register was in place and we noted the regional pharmacist carried out spot checks of stock against the register. Caledonia Medical Centre did not have a dispensary and the supply of medicines was outsourced to a local pharmacy. Prescribed CDs awaiting a patient's collection were stored in a locked cupboard.
- The Group Practice had recognised the risk associated with the absence of a second checker and addressed this by recording the batch number on the prescription and checking the patient's electronic record. We observed several out-of-date copies of the British National Formulary (BNF) in clinical areas and highlighted this to the pharmacy technician. We were advised that staff mainly used the on-line guide but also that current hardcopies had been ordered.
- Relevant guidance had been followed for the use of Patient Group Directions (PGD), a prescriber instruction for the administration of a medicine without the need to refer to the doctor for an individual prescription. Equally, we noted that medics had received training regarding the use of Patient Specific Directions (PSD) which had been signed off by the SMO. A PSD is a prescriber instruction for a medicine for a named patient.
- Records were in place to confirm the nurse prescriber had satisfied the criteria to practice as a non-medical prescriber. These included a signed competency check, terms of reference and areas of practice.
- Patients were routinely involved in reviews of their medicines. A process was in place to monitor changes made to patients' medicines by other services, such as secondary care. Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately, including patients on medication for long term conditions.
- There was an effective and consistent Group Practice approach to the management of patients taking high-risk medicines. Alerts were used on the electronic patient record system to identify the patient taking such a medicine. Shared care agreements were stored as an attachment. A monthly search was carried out to ensure records were up-to-date. A recall system was established to ensure patients were monitored as required.
- MRS Edinburgh was a yellow fever centre. A yellow fever lead was identified and they were up-to-date with the training for the role.

Track record on safety

The Group Practice had a good safety record.

- The practice managers were the lead for health and safety at each of the locations and had completed training relevant for the role. Risk assessments pertinent to each practice were in place including patient handling, needle stick injury, lifting and handling and lone working. The PCRF had a specific risk assessment for the safe use of needle acupuncture.
- Each practice monitored and reviewed activity. This supported staff to understand risks and gave a clear, accurate and current picture that led to safety improvements.
- MRS Edinburgh had an alarm system in clinical areas and the PCRF for staff to summon assistance in the event of an emergency. An alarm button was also located at reception and the alarm system was linked to the guardroom. Reception staff carried mobile alarms. Caledonia Medical Centre had a panic alarm in the treatment room only. The absence of a panic alarm in the consultation room was on the risk register. A business request had been submitted but the practice had been advised there was no funding available.

Lessons learned and improvements made

The Group Practice learned and made improvements when things went wrong.

- There was an electronic organisational-wide system (referred to as ASER) for recording and acting on significant events, incidents and near misses. Staff working at each location had access to the system. The SMO had remote access to the Caledonia Medical Centre ASER system when working at Edinburgh. Staff provided numerous examples of significant events which demonstrated incidents were being reported and discussed with staff.
- Significant events and other incidents were reviewed and investigated to determine what went wrong. However, the ASER system at MRS Edinburgh was incomplete as it did not show, for example, action taken to prevent a reoccurrence or full detail of the investigation into a significant event. Staff acknowledged the system was not up-to-date and provided a comprehensive summary report of recent events, the action taken and changes made to improve safety of the service. Staff told us that all significant events were discussed at the Group Practice healthcare governance meetings. A quarterly analysis of significant events was undertaken and forwarded to the regional team. It was also discussed at the quarterly ASER meetings. In addition, the PCRF staff discussed any raised significant events for their team at the weekly PCRF meeting.
- There was a system for receiving and acting on medicine and safety alerts. Staff learned from external safety events as well as patient and medicine safety alerts.

Are services effective?	**Good**

We rated the Group Practice as good for providing effective services.

Effective needs assessment, care and treatment

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

- 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 in their delivery of care and treatment to patients.

- NICE, SIGN and other guidance was a standard agenda item at the healthcare governance meetings. The minutes of the meeting held in July 2018 highlighted the SIGN Stable Angina Guideline was discussed. We also noted the GINA Report; Global Strategy for Asthma Management and Prevention was a topic on the agenda. Guidance was a standing agenda item at practice meetings as confirmed by the minutes from the meeting in July 2018.
- The Scotland Rehabilitation Forum (SRF) had representation from each of the PCRFs and Regional Rehabilitation Units (RRU). The forum took account of current guidance. For example, the minutes from July 2018 provided an update from the ACL (Anterior Cruciate Ligament) working group as to the how the Melbourne ACL Rehabilitation Guidelines would translate to practice.
- The Group Practice participated in a regional sepsis working group had been set up to the implement the NICE guidance on identifying and assessing people with suspected sepsis. Staff had received training and clinical staff worked to a 'sepsis decision support tool' when assessing patients.

Monitoring care and treatment

A practice nurse was identified as the Group Practice lead for chronic disease management. A team of three nurses monitored the patients with long term conditions and carried out monthly chronic disease searches, recalling patients annually or more frequently if required.

The practice used data collected for the Quality and Outcomes Framework (QOF) 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 following QOF data took account of the total patient population for the Group Practice and was provided for us when we inspected MRS Edinburgh:

- There were nine patients on the diabetic register. DMICP records for these patients showed that cholesterol levels had been measured and were 5mmol/l or less. For six patients, their last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.
- There were 35 patients recorded as having high blood pressure. All patients had a record for their blood pressure taken in the past nine months. Twenty-six patients had a blood pressure reading of 150/90 or less.
- There were 29 patients with a diagnosis of asthma. Twenty-three patients had an asthma review in the preceding 12 months which included an assessment of asthma control using the three Royal College of Physicians questions.

Patients receiving treatment for depressive symptoms or a depressive disorder were not categorised specifically as having a chronic disease. The SMO advised us that repeat prescriptions of anti-depressant medication were not issued unless the patient was reviewed, which meant patients therefore received regular clinical reviews. We looked at the clinical

records for selection of the 40 patients identified on the system as being treated for depressive symptoms. We were assured their care was being effectively and safely managed, often in conjunction with other relevant stakeholders such as the welfare team and the Department of Community Mental Health (DCMH). The system showed that 34 patients had been referred to the DCMH in the last 12 months. Staff, including reception staff, had attended a mental health first aid course to recognise concerns of a mental health nature so they could escalate to the appropriate clinician.

Information from the Force Protection Dashboard, which uses statistics and data collected from military primary health care facilities, was also used to gauge performance. 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 we were provided with for the Group Practice showed:

- 94.5 % of patients had an audiometric assessment within the last two years compared to 86.9 % regionally and 85.5 % for DPHC nationally.

There was evidence that clinical audit was taking place. Audit activity for each practice was recorded and monitored by the practice managers through the healthcare governance (HCG) workbook, a system that brings together a comprehensive range of governance activities, including the risk register, significant events, patient safety alerts, Caldicott log, building fault log, quality improvement and audit.

- Both practices carried out routine non-clinical audits, such as those in relation to health and safety, information governance and administrative systems. Each practice also routinely monitored vaccination uptake, screening eligibility, referrals, waiting times and audited record keeping.
- Clinical audit was undertaken by clinicians at MRS Edinburgh. The absence of an integrated approach to clinical audit for the Group Practice meant it was not always evident from the Edinburgh HGC workbook if each audit took account of the whole patient population or just those patients registered with MRS Edinburgh. In addition, it was not always identified what cycle each audit was at. The audit log on the HGC workbook was incomplete in that the section reporting on the impact of each audit had not been completed.
- Group Practice clinical audits undertaken for the whole population included: an antibiotic prescribing audit (August 2017); prescribing audit (October 2017; second cycle); minor surgery audit (April 2016 to October 2017) and asthma audit (June 2018). Diabetes audit (June 2016; second cycle); chronic disease management with shared care agreements audit (July 2017)
- A cervical smear audit (July 2018), PGD audit (November 2017), results handling bundle (October 2016) and smoking cessation audit (August 2017) had been undertaken for the patient population at MRS Edinburgh. The results handling audit had not been repeated despite a complete turnover of staff at MRS Edinburgh.
- Audits carried out by the PCRF took account of the whole population for the Group Practice and included an audit of the referral process of physiotherapists to ERI staff (second cycle 2018), an audit of patients receiving rehabilitation longer than nine months, acupuncture audit, Achilles tendinopathy audit (2015; second cycle) and audit of appointment cancellations/non-attendance (2015).

- An audit calendar was in place that identified the audits to take place going forward. Again, this did not clarify whether each audit was for the Group Practice population or just those patients registered at MRS Edinburgh.

A log of quality improvement initiatives was maintained for the Group Practice including an evaluation of the impact on practice. Examples relevant to monitoring care and treatment included:

- Although we did not see the minutes, staff advised us that a quarterly chronic disease working group meeting had started with the aim to check the chronic disease register was up-to-date and the Group Practice was working with best up to date guidelines.
- Introduction of a one page mental health resource leaflet for patients so that patients leave with a resource that they can later refer to.
- Although still in the early stages, a 'Diabetic Forum' had been developed as a support and educational setting for patients with type 1 diabetes. This was in response to patient feedback.
- Medicines management meetings were held quarterly to look at prescribing patterns within the Group Practice. We were provided with an example of how this forum had helped doctors understand when and in what circumstances to prescribe a particular SSRI (anti-depressant).

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The group practice demonstrated a positive training ethos. Staff told us they were supported to develop their skills and encouraged to participate in training. Records of skills, qualifications and training were maintained for all staff employed to work for the group practice. The training records for RAP staff linked to the units were not retained or monitored at practice level. These were held by the units. Shortly after the inspection the practice manager at MRS Edinburgh provided evidence supplied by the units to confirm RAP staff had received the required training to work at the practice and treat patients. They said they would liaise with unit commanders to ensure RAP staff training records were routinely provided to the group practice.
- A comprehensive generic induction pack was in place for newly appointed staff. The induction packs took account of the specific requirements and culture for each location. For example, a pack was available at Caledonia Medical Centre for non-naval staff. It included navy specific policies, navy terminology, local guidance and local referral specifications. An additional induction pack was in place for staff specifically appointed to work in the PCRF.
- Role specific induction packs were also in place. We particularly noted the induction for clinical staff was thorough and competency based to ensure clinical staff were fully skilled in all aspects of military based primary care. For example, competency checks carried out for new doctors included a boxing medical, diving medical, discharge medical and interpreting the result of an abnormal audiogram. This approach was particularly important for civilian doctors joining the group practice who had to take account of the specific needs of a predominant army patient population at MRS Edinburgh and navy population at Caledonia Medical Centre. Similarly, a competency based induction was in place for nurses that covered matters, such as ear irrigation, audiograms. spirometry, pathology and vaccination.

- Staff had access to one-to-one meetings, appraisal, coaching and mentoring, clinical supervision and support for revalidation. Clinical staff were given protected time for professional development and evaluation of their clinical work.
- Peer review was evident. For example, the consultation records of medics were audited and medics had access to specific training days with peers. The doctors had a lunchtime meeting each Thursday. They also reviewed each other's consultations. Nurses had an informal approach to peer review in the form of a 'weekly huddle'. Notes of these meetings were recorded on the health governance workbook. Doctors, nurses, PCRF staff and practice managers attended regional forums specific to their discipline.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- New patients to the group practice completed a 'new joiners form', had their medical record details checked and were referred to the appropriate nurse.
- Records showed that all appropriate staff, including those in different teams, services and organisations were involved in assessing, planning and delivering care and treatment appropriate to the needs of each individual patient.
- Referrals to the PCRF were managed through the task system on DMICP. Clinical meetings to discuss patients were held each month between the physiotherapists and doctors. Patients referred to the PCRF were reviewed every two to four weeks. PCRF staff referred patients to other clinics if it was deemed appropriate to their rehabilitation, such as weight management and smoking cessation.
- A register was in place for referrals at each practice by dedicated administrators. Each practice was in a different NHS region with different systems. Outcome referral letters received were scanned and tasked to the appropriate clinician. Processes were in place to monitor the status of referrals.
- The SMO and a representative from the PCRF attended UHC meetings to update unit commanders on medically downgraded patients. In addition to UHC meetings, the SMO attended welfare meetings where the needs of vulnerable patients, including patients with mental health needs were discussed.
- The SMO told us about how interagency meetings had been established for MRS Edinburgh so the practice could develop relationships with health and social care agencies affiliated with the medical centre. Local GP practices were invited to attend as they provided primary care to the families and dependants of service personnel.
- Shared care agreements were in place for patients where both the hospital and the GP were providing care to a patient.

Supporting patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may need extra support and directed them to relevant services. This included patients at risk of developing a long-term condition and carers. The new patient joiners form included a question about whether a patient was a care giver.

- Records showed, and patient feedback confirmed, that staff encouraged and supported patients to be involved in monitoring and managing their health. Staff also discussed changes to care or treatment with patients as necessary.
- The practice supported national priorities and initiatives to improve the population's health including, stop smoking campaigns and tackling obesity. A health promotion display board was available to patients and was refreshed on a regular basis.
- The number of eligible women whose notes recorded that a cervical smear had been performed in the last three to five years was 69, which represented an achievement of 95%. The NHS target was 80%.
- Patients had access to appropriate health assessments and checks. Routine searches were undertaken to identify for patients eligible for bowel and breast screening.
- A sexual health clinic had recently been set up in response to population need. Information was available in the waiting area and patients could attend without referral.

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 following illustrates the current 2018 vaccination data for the Group Practice patient population.

- 94% of patients were recorded as being up to date with vaccination against diphtheria compared to 95% regionally and 94% for DPHC nationally.
- 94% of patients were recorded as being up to date with vaccination against polio compared to 95% regionally and 94% for DPHC nationally.
- 91% of patients were recorded as being up to date with vaccination against hepatitis B compared to 80% regionally and 77% for DPHC nationally.
- 90% of patients were recorded as being up to date with vaccination against hepatitis A, compared to 90% regionally and 90% nationally.
- 94% of patients were recorded as being up to date with vaccination against tetanus, compared to 95% regionally and 94% for DPHC nationally.
- 88% of patients were recorded as being up to date with vaccination against typhoid, compared to 68% regionally and 52% for DPHC nationally.

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

There was a three-stage process for screening recall including a record on DMICP, a phone call to the patient and the final stage was to inform the unit commander. A process in place for patients who did not attend for screening which continued until the patient responded. The units were responsible for monitoring vaccination recalls and the RAP nurses and medics were responsible for this activity.

Consent to care and treatment

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

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.

- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Are services caring?	Good

We rated the practice as good for caring.

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.
- MRS Edinburgh and Caledonia Medical Centre carried out a separate Patient Experience Survey in 2018. The methodology for each was different, including the time frame of the survey, so it was not possible to aggregate the results for the Group Practice. For MRS Edinburgh, 90% of patients (115 responses) either agreed or maybe agreed that their comments and complaints were listened to. For Caledonia Medical Centre, 84% of patients (50 responses) felt their comments and complaints were listened to.
- We received 49 CQC comment cards completed prior to the inspection for MRS Edinburgh and 38 for Caledonia Medical Centre. All feedback in relation to how patients were treated by staff was positive, including feedback about the service provided at the PCRF. A theme identified for the Group Practice overall was that patients felt respected, listened to and well cared for. The four patients we spoke with echoed this view.
- 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.

Involvement in decisions about care and treatment

Staff supported patients to be involved in decisions about their care.

- An interpretation service was available for patients who did not have English as a first language and all staff we spoke with were aware of how to access it.
- The Patient Experience Survey showed 88% of patients at Caledonia Medical Centre felt involved in decisions about their care. For MRS Edinburgh, 95% of patients either agreed or maybe agreed that they were involved in decisions about their care. Feedback from the CQC patient feedback cards supported this positive outcome. Themes from the feedback indicated patients felt listened to and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- Processes were in place to identify patients who were also had a caring responsibility so that additional support or healthcare could be offered if needed. The new joiner's registration form included a question about caring responsibilities. Alerts could be used on DMICP to identify carers. The needs of carers were discussed at unit welfare meetings. There were seven carers identified for the group practice.

Privacy and dignity

The Group Practice respected respect the privacy and dignity of patients.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. Clinic room doors were closed during consultations.
- The layout of the reception areas meant that conversations between patients and reception could not be easily overheard. A radio or television was playing to minimise conversations being overheard. Reception staff said that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- If patients wished to see a GP of a specific gender then this could be accommodated. We heard from staff that often young male patients expressed a preference for a male doctor. Patients who usually used Caledonia Medical Centre were required to travel to MRS Edinburgh if they wished to see a female doctor or female medic. We also were told staff accommodated patients who requested not to see certain clinical staff if they knew them through their work.

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 Group Practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- Staff understood the needs of its population and tailored services in response to those needs. For example, MRS Edinburgh due to a high failed attendance rate introduced a text message service to remind patients of their appointments. In addition, the safety of the location for the pharmacy used in Edinburgh was highlighted by a patient and as a result the practice had plans to transfer to a pharmacy in a safer location.
- The facilities and premises were appropriate for the services delivered and to meet patient need. Although an access audit as defined in the Equality Act 2010 had not been completed for the premises, reasonable adjustments had been made based on the patient population need. Both practices could support patients who were wheelchair users or who had limited mobility. The practice had designated parking spaces for these patients.

Timely access to care and treatment

- Patients at MRS Edinburgh usually received an appointment on the same day with a doctor or nurse. Patients at Caledonia Medical Centre could get an appointment within a week or alternatively could be seen earlier if they wished to travel to Edinburgh. Patients with an urgent need were seen on the same day and this included patients needing to see a physiotherapist.
- The PCRF collated a dashboard of information in relation to key performance indicators (KPI) for waiting times and patients who do not attend for their appointment. The PCRF was performing well in accordance with the KPIs. Between January and March 2018:
  - The PCRF met the target of <8% for DNA (patients who did not attend appointments) rates.
  - Fifty two percent of patients were seen by a physiotherapist within the target of five working days. This compared to 54% for all PCRFs in the region and 55% for PCRFs nationally.
  - Eighty two percent of patients were seen by an exercise rehabilitation instructor (ERI) within 10 working compared to 60% for the region and 78% nationally.

- The patient experience survey showed that 90% of patients at MRS Edinburgh were satisfied with the location of their appointment and 84% were satisfied with the time of their appointment. This level of satisfaction reflected the feedback submitted on the CQC comment cards.
- For Caledonia the survey showed a 96% satisfaction with the appointment location and an 90% satisfaction with the time of their appointment. However, 19 of the 38 CQC comment cards were negative. The negative themes included no doctor available, lack of doctor continuity, difficulty securing an appointment and travel to MRS Edinburgh. Because this feedback contrasted with the outcome of the patient survey carried in February 2018 we discussed it with the SMO. The CQC feedback was submitted in May 2018 and this coincided with a four-week period when both doctors who routinely facilitated clinics at Caledonia, one being the SMO, were not available. Clinics were reduced and facilitated by one of the other doctors from MRS Edinburgh. We discussed this with the receptionist and checked appointment records. There was no indication that waiting times for non-urgent appointments had significantly increased in May.
- Home visits were available but this service was little used. Telephone consultations could be booked and these were recorded in the patients notes. Out of hours arrangements were established with a duty doctor being available until NHS 24 was available at 18:00 hours. The timing of emergency access (referred to as sick parade) was coordinated around the needs of the units. Evening clinics were held for reservists to accommodate their working hours. Specific clinics were set up in September and January to undertake medicals for the University Officer Trainees. Patients could self-refer to physiotherapy which meant they could book an appointment that best suited them.
- A dedicated physiotherapist provided three sessions a week at Caledonia Medical Centre to carry out new assessments or undertake reviews carried out initial assessments. The introduction of this service had seen a decrease in the non-attendance rate of Caledonia patients attending MRS Edinburgh.

Listening and learning from concerns and complaints

The Group Practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information was available and displayed to help patients understand the complaints process.
- The practice worked with the DPHC complaints policy and procedure. The practice managers were the designated responsible persons for handling all complaints and they, along with the SMO, had attended complaints training in February 2018.
- A log of both written and verbal complaints was maintained. MRS Edinburgh had received no complaints in the last 12 months and Caledonia has received three complaints since November 2016; all of which had been effectively managed with no emerging theme. A system was in place to review complaints, including an annual complaints audit.

Are services well-led?	Good

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

The management team for the Group Practice demonstrated they had the capacity, experience and skills to deliver high-quality sustainable care.

- Based on a hub and spoke model, South (Scotland) Group Practice was formed in 2015 combining MRS Edinburgh (hub) and MOD Caledonia (spoke). A practice manager oversaw the day-to-day running of each of the practices with the SMO responsible for the overall leadership of the Group Practice, including the governance structure. The regional management team worked closely with the SMO. Staff we spoke with were extremely positive and spoke highly of the inclusive Group Practice model, management structure and leadership.
- The management team understood the risks to the service and kept them under scrutiny through the risk register for each practice that the SMO had oversight of.
- Staff told us everyone worked well together and there was an inclusive culture. This was particularly important to the staff at Caledonia Medical Centre who were the smaller team and reliant on MRS Edinburgh for all clinical input. Staff said the management team, including the regional team were approachable and supportive. They said an open culture was promoted within the Group Practice with the opportunity and support to raise any issues at team meetings.

Vision and strategy

- Unusual for a hub and spoke organisational model, there was not an overarching vison and strategy for the Group Practice. Each practice worked to a separate mission statement and separate service objectives; perhaps because of the differing cultures and demographics. Caledonia Medical Centre provided a service to mainly a non-deployable navy population, a third of whom were over the age of 40 whereas the patient population at MRS Edinburgh was mainly an army population of young males under the age of 40 and subject to deployment.
- We noted that Edinburgh's service aims and objectives were patient focussed whereas Caledonia's were more organisational focused. However, both strategies were in line with health priorities for the region and considered the needs of the units and patient populations.

Culture

Although the Group Practice model had only been adopted in 2015, it demonstrated that such an approach could support a culture that lent itself to high-quality sustainable care.

- Staff told us they felt respected, supported and valued. Staff at both practices described a healthy integrative approach involving all staff supporting each other. Opportunities were in place so staff could contribute to discussions about how to run and develop the Group Practice.
- Staff we spoke with clearly demonstrated a patient-centred focus and they said this ethos was promoted by leaders and embedded in practice.
- The practice had systems to ensure compliance with the requirements of the duty of candour, including giving those affected reasonable support, information and a verbal and written apology. 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.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- Staff were encouraged and supported to be the best they could be through training and developing their skills and expertise. There was also a strong emphasis on the safety and well-being of all staff.

- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally. Each practice worked to the HCG workbook.
- A process was in place for staff (MRS Edinburgh only) to provide feedback on the service. This was a simple process whereby staff provided a set number of keywords to describe the service. The results were then visually represented in a 'word cloud'.

Governance arrangements

The governance framework in place supported the delivery of good quality care even though it was not fully integrated for both practices.

- The SMO was the governance lead for the practice. The staffing structure was clear and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. Terms of reference were in place to support job roles.
- Policies from the national framework were implemented and were available to all staff. These were updated and reviewed regularly.
- The practice managers maintained a spread sheet of audit activity for their respective practices. Clinical audit was initiated from MRS Edinburgh and the HCG workbook did not always illustrate clearly if individual clinical audits were based on the Group Practice patient population or just the patient population for Edinburgh. The absence of an integrated approach to clinical audit could present a risk to the patient population for Caledonia Medical Centre being excluded from relevant audits.
- In addition, the methodology for seeking patient feedback for both practices differed which meant aggregation of the results was difficult. Furthermore, QOF data was collated, reported on and monitored separately for each practice. However, for the purposes of this inspection report we asked that the practice managers assimilate the QOF results.
- Effective internal communication systems were established. An integrated Group Practice approach to meetings, including clinical, management and practice meetings, meant that staff from both practices attended these meetings. In addition, Caledonia held its own practice meetings as did the PCRF. Minutes of meetings demonstrated that lessons learned from significant events, complaints and other investigations led to change and improvement across the Group Practice. Meeting minutes were comprehensive and were available for all staff to view. Nurses, PCRF staff and doctors attended either locality or regional meetings.

Managing risks, issues and performance

There were processes established for managing risks, issues and performance.

- There was a process to identify, understand, monitor and address current and future risks including risks to patient safety. A risk register was in place for the practice. It included relevant risks, such as those associated with the management of laboratory results. We noted it did not include DMICP connectivity or the non-coding of scanned test results.
- Processes were in place to manage current and future performance. Performance of clinical staff was demonstrated through peer review, including review of clinical records for medics.
- The practice managers and SMO had oversight of national and local safety alerts, incidents, and complaints.
- Plans were in place for major incidents and staff were familiar with how to respond to a major and/or security incident.

Appropriate and accurate information

The Group Practice acted on appropriate and accurate information.

- An internal quality assurance tool, the DMS Common Assurance Framework (CAF) was used to monitor safety and performance. The DMS CAF was formally introduced in September 2009 and since that time has been the standard healthcare governance assurance tool utilised by DMS practices to assure the standards of health care delivery within DMS.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.

Engagement with patients, the public, staff and external partners

The Group Practice involved patients, staff and external partners to support high-quality sustainable services.

- A patient experience survey was undertaken throughout the year and a suggestion box was in the patient waiting rooms.
- The Group Practice engaged with external partners in the development of policies and procedures. It had put in place measures to engage and develop relationships with local health and social care providers.
- The Group Practice, including a representative from the PCRF, attended unit welfare meetings each month.

Continuous improvement and innovation

A culture of continuous improvement and innovation was evident and all staff were involved in exploring ways to improve the practice. A register of quality improvement activity was in place. It was clear the outcome of audit, quality projects, investigations into significant events and complaints led to improvements in the service for patients.

Some examples included:

- The introduction of weekly nurse ‘huddle’ which staff said had supported with improving communication, teamwork and delegation of duties.
- Practice team ‘safety huddle’ each week; a brief five-minute meeting held on a Monday to pass on any safety issues that might impact patient safety during that week.
- A failure to attend appointment quality improvement project, the outcome of which led to the trial of text messages to remind patients of their appointment. The introduction of texting patients showed a marked reduction in failed attendance at appointments.
- Development of a desktop guide; a single document with relevant links to support staff to quickly locate information and assist if covering other staff positions.