Fort George Medical Centre
Quality report

Ardersier
Inverness
Scotland
IV2 7TE

Date of inspection visit: 1 & 5 November 2018
Date of publication: 28 January 2019

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, information given to us by the practice and patient feedback about the service.

### Ratings

<table>
<thead>
<tr>
<th>Overall rating for this service</th>
<th>Good  ☬</th>
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<tbody>
<tr>
<td>Are services safe?</td>
<td>Requires improvement ☬</td>
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<tr>
<td>Are services effective?</td>
<td>Good ☬</td>
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<tr>
<td>Are services caring?</td>
<td>Good ☬</td>
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<tr>
<td>Are services responsive to people’s needs?</td>
<td>Good ☬</td>
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<tr>
<td>Are services well-led?</td>
<td>Good ☬</td>
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Fort George Medical Centre Quality Report 5 November 2018
This practice is rated as Good overall

The key questions are rated as:

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

We carried out this announced follow up comprehensive inspection on 5 November 2018. For reasons of availability, medicines management was inspected on 1 November. This report covers our findings in relation to the recommendations made and any additional improvements made since our last inspection.

The previous inspection took place on 17 January 2018 and the practice was rated inadequate overall. A copy of the report from that comprehensive inspection can be found at:

http://www.cqc.org.uk/what-we-do/services-we-regulate/defence-medical-services#army

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.

At this inspection we found:

- The group practice model meant the practice had more structure, was supported and had access to a wider range of skills and resources.
- Staff felt engaged, supported and valued by management.
- There was an open and transparent approach to safety. An effective system was in place for managing significant events and staff knew how to report and record using this system.
- Safeguarding systems were effective in ensuring vulnerable patients, including young people were monitored.
- The assessment and management of risks was detailed 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 had significantly improved. There was scope for further improvement in some areas.
- 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 practice worked collaboratively and shared best practice to promote better health outcomes for patients.
• There was clear evidence to demonstrate quality improvement was happening and starting to embed in practice, including the development of annual programme of clinical audit used to drive improvements in patient outcomes.
• The practice proactively sought feedback from staff and patients which it acted on. Results from the Defence Medical Services patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
• Information about how to complain was available. Improvements were made to the quality of care as a result of complaints.
• The building was owned by Historic Scotland thus restricted in how it could be adapted. The premises needed attention and the practice was due to close the day after our inspection for a refurbishment.
• The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

The Chief Inspector recommends:
• Updating the current medicines management action plan (MAP) to ensure it incorporates the findings from this inspection.
• The staff training programme is reviewed to ensure it includes sepsis training, training in thermal injuries/conditions and any other training relevant to the needs of the patient population.
• A review of safety measures to ensure the health and safety of staff, patients and visitors to the building.
• A review of the capacity, structure and sustainability of the group practice model to ensure it can provide consistent and continued leadership support to Fort George Medical Centre.

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

Our inspection team

Our inspection team was led by a CQC lead inspector. The team on the second inspection day included a GP adviser, practice nurse adviser and a practice manager adviser. A pharmacy adviser looked at medicines management on the first inspection day.

Background to Fort George Medical Centre

Fort George Medical Centre is in a remote coastal area of Ardersier approximately 13 miles from Inverness. It provides a primary care and occupation health service to The Black Watch, 3rd Battalion, Royal Regiment of Scotland. At the time of inspection 491 patients were registered. There were no patients over 60 and one patient under 18.

The medical centre is in a building within the 18th century fort. Although it has been upgraded over time, it is still dated and presents all the daily challenges expected when working in a building which is protected by Historic Scotland.
In addition to the services provided, patients are referred to Lossiemouth Medical Centre, approximately 35 miles away, for minor surgical procedures, maternity and midwifery care. Patients are referred to Kinloss Medical Centre for family planning and some women’s health services 22 miles away. Physiotherapy services and travel advice are available at Fort George.

The medical centre is part of a group practice model that includes Kinloss Medical Centre and Lossiemouth Medical Centre. As Lossiemouth Medical Centre is the hub practice for the group then the Senior Medical Officer (SMO) for that practice is overall responsible for clinical governance of the group practice. The practice manager at Lossiemouth Medical Centre was identified as the Group Practice Manager. A Regional Clinical Director (RCD) assumed overall accountability for quality of care of the group practice.

Two groups of staff work at the medical centre; Regimental Aid Post (RAP) staff are employed by the Field Army and can be deployed at any point. They include a full time Regimental Medical Officer (RMO), Medical Sergeant, Battalion Nurse and six Combat Medical Technicians (referred to as medics). A medic is trained to provide medical and trauma support on various operations and exercises. In a medical centre setting, their role is similar to that of a health care assistant in NHS GP practices but with a broader scope of practice.

The second group of staff are employed by the Department of Primary Health Care (DPHC) and include a full-time practice nurse, physiotherapist and two administrators who do not deploy away from the medical centre. A military practice manager who did not deploy was responsible for the day-to-day management of the practice.

When the RMO is deployed medical cover is provided by doctors at Lossiemouth Medical Centre. A pharmacy technician from Kinloss Medical Centre provides support to the practice.

The practice is open from Monday to Friday each week, between 08:00 hours and 17:00 hours. The practice closed on Wednesday afternoon from 14:00 hours for staff training. Arrangements are in place for medical cover when the practice is closed.

<table>
<thead>
<tr>
<th>Are services safe?</th>
<th>Requires improvement</th>
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<td><strong>We rated the practice as requires improvement for providing safe services.</strong></td>
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Following our previous inspection, we rated the practice as inadequate for providing safe services. We found gaps in processes to keep patients safe, including systems for managing significant events, safeguarding of vulnerable patients, infection prevention and control (IPC), staffing levels and medicines management.

At this inspection we found the recommendations we made had mostly been actioned. Some further action was required in relation to medicines management. The practice is now rated as requires improvement for providing safe services.

**Safety systems and processes**

Systems were in place to keep patients safe and safeguarded from abuse.

A framework of regularly reviewed safety policies was in place and accessible to staff, including locum staff. Staff received safety information for the practice as part of their induction and refresher training.
• Measures were in place to protect patients from abuse and neglect. Adult and child safeguarding policies were available to all staff. All staff had received up-to-date safeguarding training appropriate to their role and knew how to identify and report concerns. The SMO at Lossiemouth Medical Centre was the safeguarding lead and had completed level 3 training. The practice nurse was also trained to level 3 safeguarding and deputised if the SMO was not available.

• A register of vulnerable patients was maintained and their care was discussed at the end of each practice meeting. In addition, vulnerable patients were reviewed at the Unit Health Committee (UHC) which the practice nurse and/or RMO attended, along with the Army Welfare Officer and Chain of Command. Codes and alerts were used on the electronic patient record system to identify patients who were vulnerable. We were provided with an example of how a concern about a vulnerable patient was managed to ensure the patient’s safety. The practice learnt from this and made changes to its administration as a result.

• 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. Notices were displayed advising patients that a chaperone was available. A detailed chaperone checklist was displayed outside each clinical room for the clinician to refer to prior to using a chaperone.

• The full range of recruitment records for permanent staff was held centrally. However, the practice manager could demonstrate 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. Arrangements were in place to monitor the registration status of clinical staff with their regulatory body. All staff had professional indemnity cover. Information was in place to confirm staff had received all the relevant vaccinations required for their role at the practice.

• There was an effective system to manage infection prevention and control (IPC). The practice nurse was the lead for IPC and had completed a Royal College of Nursing accredited course relevant for the role. All staff currently working at the practice had received IPC training. A comprehensive IPC audit had been completed and the practice achieved a compliance score of 81%. Areas of low compliance were in relation to the building, including fixtures and fittings. The practice had no control over making environmental improvements and had appropriately reported all concerns. The day after our inspection the practice was due to close temporarily for a refurbishment, including replacement flooring. Arrangements were in place for environmental cleaning, including regular deep cleans.

• The lead for managing healthcare waste did not have terms of reference defined for the role. Clinical waste bins were not stored securely. The annual waste audit was due to be completed when the practice closed for refurbishment in November 2018.

• The practice ensured that facilities were safe. Electrical safety checks were completed as required and water safety checks were undertaken regularly by the medics. A legionella risk assessment had been carried out for the camp and the medical centre had access to the report.

• Fire safety management including regular checks were carried out with the last check taking place in October 2018. Firefighting equipment tests were all in-date. Staff were up-to-date with fire safety training and had practiced a full evacuation in August 2018. There were bars on the window of the PCRF which meant it could not be opened or used in the event of a fire or emergency. This issue had been appropriately escalated and added to the risk register.

• Arrangements were in place for the monitoring and maintenance of equipment. Testing of portable electrical appliances and medical equipment was in-date.
Risks to patients

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

- Although the practice was adequately staffed at the time of our inspection, ensuring there was sufficient staff to provide continuity of care was an ongoing challenge. This was predominantly due to the regular deployment of military staff; the RMO and medics. A business case for the recruitment of a full-time civilian GP was approved shortly after our inspection. The physiotherapist hours recently increased which had improved access for patients. In line with Project Thor, an organisation initiative to reduce musculoskeletal injuries, recruitment was taking place for an Exercise Rehabilitation Instructor.

- At the time of inspection, the SMO was responsible for ensuring adequate clinical cover at the practice. This was provided by the doctors and a dedicated medic at Lossiemouth Medical Centre. We noted a significant event had been raised in July 2018 as clinics had to be cancelled due to a shortage of staff. This was not a regular occurrence and patients still had access to clinical care by travelling to one of the other medical centres.

- A staff induction pack had been developed and new staff received both generic and role-specific induction. In addition, there was an effective induction system for locum staff to ensure they were familiar with systems and ways of working in defence primary care. The induction of locum doctors was overseen by the group practice SMO or group practice manager.

- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. Emergency medicines and equipment were in place and records confirmed they were checked weekly. The treatment room lacked an appropriate warning notice to identify that oxygen was stored in the room.

- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Although staff had not received specific training in sepsis, an algorithm was available for staff to follow. Staff had not had specific training in managing thermal injuries. With incidents like these, staff said they would contact emergency services.

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 looked at on electronic patient record system (referred to as DMICP) showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way. Staff described very occasional loss of connectivity with DMICP but said this did not have a significant impact on patient care.

- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. There were no electronic links with the NHS. Information that arrived by post was scanned and added to the patient electronic record. A system was in place for the processing and monitoring of referrals.

- A process was in place for the management of specimens, including the transport of specimens to the laboratory. Specimens were recorded in a register which was updated as results were returned. Test results were forwarded to the doctor for action. If a doctor was not available then results outside of the normal range were scanned and sent to the Kinloss medical officer or the group practice SMO to review.
Safe and appropriate use of medicines

A management action plan (MAP) for medicines had been developed following the previous inspection and staff were working to this plan to make improvements in how medicines were managed. Improvements were evident but we found that further improvement was needed.

- The practice did not have a dispensary so a policy and process was in place for the storage and monitoring of stock medicines. A list of stock drugs was in place for the practice. We noted that stock items which expired in September 2018 still appeared on the list even though the stock had already been destroyed.

- The outsourcing paperwork used was a local version created by the pharmacy technician, rather than the DPHC paperwork for outsourced medical facilities. This posed a risk to continuity for medics who moved between medical facilities. There was no specimen prescribers signature list to share with the contracted outsourced pharmacy.

- Controlled drugs were not held at the practice. Private Prescription Controlled Drug (PPCD) forms were accounted for. However, the final digit of all the PPCD forms had been omitted which could lead to ambiguity.

- There was a process for managing the stock of vaccines. It relied on the pharmacy technician’s weekly visit to register the vaccines, which meant a wait of up to seven days before the vaccines were entered on the system. The process was protracted and could be effectively managed by the nursing team. All vaccines were date checked prior to entry into the system. Medication requiring refrigeration was monitored to ensure it was stored within the correct temperature range.

- Although held securely in a locked room, prescriptions were not fully accounted for. A complete box of 500 prescription forms had not been added to the receipts on the register. Prescription forms were loose leaf which is contrary to DPHC procedure that requires a bound book for recording prescription forms. Repeat prescriptions were accepted by telephone and verbally in person. This was contrary to DPHC procedure on repeat prescribing which requires all repeat prescriptions to be written.

- Patient Group Directions (PGD) had been adopted by the practice to allow nurses to administer medicines in line with legislation These were current and signed. There was no evidence that nurses working to PGDs were monitored by the SMO in accordance with the group practice model.

- Medics Issue Protocols (MIP) were in use. Following a competency test, medics had been signed off under the MIPs protocol by the SMO. A signed authorisation sheet from the SMO was available in the dispensary room. There was no evidence to ascertain if the issue of MIPs was subject to ongoing monitoring. We looked at one record on the system and it showed the appropriate medicine had been supplied in accordance with the MIP.

- The practice maintained a register of high risk medicines. A recent search confirmed no patients were prescribed any commonly prescribed high-risk medicines. The RMO had been monitoring two patients prescribed a strong painkiller that was classified as a controlled medicine. Although the RMO was aware that the 10 registered female patients of child bearing age were not prescribed Valproate (medicine used to treat bipolar disorder, migraine and other disorders), a formal search was not routinely undertaken.

- The practice adhered to the NHS Highlands guidance. The regional pharmacist last visited the service in February 2018. An audit to identify concurrent prescribing of SSRIs (medicine to treat
depression) and NSAIDS (anti-inflammatory medicine) was undertaken in August 2018. No formal monitoring of the RMO’s prescribing had been undertaken.

**Track record on safety**

The practice had a good safety record.

- The practice manager at Kinloss Medical was the lead for health and safety. Risk assessments pertinent to the practice were in place including risk assessments for acupuncture, needle stick injury and for products hazardous to health.

- Sufficient security measures were in place to ensure the safety of staff and visitors to the building. This was particularly important as the Fort George was open to the public.

- All staff had a personal alarm to summon assistance in an emergency. We tested the alarm in the PCRF and it did not activate on the first attempt. On the second attempt it worked and it took staff longer than would be expected to respond to the alarm. In addition, it was not easy to determine where the alarm had been activated in the building.

**Lessons learned and improvements made**

The practice learned and made improvements when things went wrong.

- All staff had electronic access to the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events, incidents and near misses. The second stage of each ASER was processed at Lossiemouth Medical Centre. Staff provided several examples of significant events demonstrating they were effectively reporting incidents. For example, a delay with receiving mail had led to a change in how it was managed.

- A log was maintained of reported events. It included the forum each event was discussed at, any changes made to practice and the outcome. Significant events were a standing agenda item at practice meetings. They were also discussed at the group practice clinical meeting if appropriate to that forum.

- The practice manager checked the Central Alerting System (CAS) website on a regular basis and disseminating alerts to the clinicians via email. However, two recent alerts; the supply disruption alert in relation to a medicine to treat epilepsy and the pregnancy prevention programme dear doctor letter were not recorded and thus not actioned. This had not impacted on patient care. Medical alerts issued by Regional Headquarters (RHQ) had not been received by the practice in a timely way. For example, information regarding a shortage of emergency medicine to treat an allergic reaction was only forwarded to the practice eight days after it was first released.

**Are services effective?**

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**We rated the practice as good for providing effective services.**

Following our previous inspection, we rated the practice as inadequate for providing effective services because processes for monitoring patient care and treatment were not consistently adhered to. There was minimal evidence of quality improvement activity, including clinical audit. In addition, not all staff had received training for their role.

At this inspection we found the recommendations we made had been actioned. The practice is now rated 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 guidance from the National Institute for Health and Care Excellence (NICE). Staff referred to this information to deliver care and treatment to meet patients’ needs. They described how updates on NICE and medicines management were outlined in a newsletter circulated to clinical staff by the DPHC each month.

- The practice was represented at the group practice clinical meetings. Representation was predominantly by the practice nurse. The physiotherapist only recently increased their hours to full time so intended to participate in these meetings now they had capacity.

- We looked at the meeting minutes from August and September 2018 and noted standing agenda items included NICE guidance updates, audit, chronic disease register, prescribing and health promotion. Clinical cases were presented and discussed at each meeting. NICE guidance was also discussed at the practice meetings. For example, guidance on the flu vaccination and hearing loss in adults was discussed at the meeting in September 2018.

- The physiotherapist referred to best practice guidelines in their treatment of patients, such as the Defence and Directory rehabilitation website.

Monitoring care and treatment

The RMO was the lead for chronic disease management. Both the RMO and practice nurse carried out regular system searches to ensure patients were recalled appropriately.

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.

We were provided with the following patient outcomes data during the inspection:

- There was one patient on the diabetic register and their last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.

- There were three patients recorded as having high blood pressure. One patient had a record for their blood pressure taken in the past nine months. We established the coding for one of the patients was incorrect as they no longer had high blood pressure. Another patient declined further clinical input and this was documented in their records. No patients had a blood pressure reading of 150/90 or more.

- There were two patients with a diagnosis of asthma and both had an asthma review in the preceding 12 months which included an assessment of asthma control using the three Royal College of Physicians questions.

- No patients had been diagnosed with depression in the last 12 months. Twelve existing patients were being effectively treated for depressive symptoms.
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 showed:

- Audiometric assessments were in date for 89% of patients. There was no comparable regional or national data. Audiometric assessments were appropriately recorded in accordance with the Hearing Conservation Programme.

An audit programme had been developed for 2018 with evidence of audit activity since the last inspection. All audits were on the first cycle. Audit examples included those in relation to obesity, asthma, smoking, backpain, acupuncture and hypertension. A mental health audit was carried out in August 2018 to identify patients current or with a history of severe mental health concerns. This was achieved used the QOF codes for mental illness (schizophrenia, bi-polar affective disorder, other psychoses). A further search was conducted to check for patients prescribed Lithium used in the treatment of bipolar disorder. No patients were identified through this audit. A re-audit was planned in six months.

Effective staffing

We found that staff had the skills, knowledge and experience to carry out their roles. For example, the practice nurse had completed several courses relevant to the role.

- The practice manager had a system in place and checked each month that staff were up-to-date with mandated training, competencies and appraisals.
- Records of skills, qualifications and training were maintained for all staff. Staff were encouraged and given opportunities to develop. Staff had access to one-to-one meetings, appraisal, mentoring and support for revalidation.
- Clinical staff were given protected time for professional development and evaluation of their clinical work. Peer review was achieved through case discussion and clinical supervision.
- 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 practice had their medical record details scrutinised checked and clinical notes summarised. The medics, nurse and doctor were involved in the process. Summarisation was at 98%. A summarising audit was undertaken in August 2018.
- We looked at a range of patients’ records, including those with a chronic condition. They showed patient care was person-centred care and well managed, including involvement of other teams, services and organisations. Processes were in place to monitor referrals to other services and ensure they did not get lost in the system. For example, a tracker was in place to monitor patients referred by the physiotherapist.
• The RMO, physiotherapist and nurse attended the Unit Health Committee (UHC) meetings held monthly. Along with commanders, the remit of these meetings was to review patients who were medically downgraded and those who were vulnerable.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives. Based on population characteristics and need, this involved a focus on injury prevention and healthy lifestyle.

• The lead physiotherapist made referrals to the Staff Sergeant who was trained to deliver the DoFit programme, which supports weight loss through exercise and education to address lifestyle issues. Health fairs were facilitated by the base and the medical centre participated with these. Staff advised us that the health fair for 2018 had been cancelled.

• The practice supported national priorities and initiatives to improve the population’s health including, stop smoking campaigns and tackling obesity. Health promotion displays were available for patients and were regularly refreshed. At the time of the inspection, there was a display promoting antibiotic awareness.

• No sexual health service was provided at the practice. However, condoms were available and patients were signposted to local sexual health clinics.

• Routine searches were undertaken for patients eligible for bowel and breast screening and appropriate action taken if patients met the criteria. None of the patient population were over 60 and there were no women over the age of 50.

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 patients using the practice:

• 94% of patients were recorded as being up to date with vaccination against diphtheria.
• 94% of patients were recorded as being up to date with vaccination against polio.
• 83% of patients were recorded as being up to date with vaccination against hepatitis B.
• 92% of patients were recorded as being up to date with vaccination against hepatitis A.
• 94% of patients were recorded as being up to date with vaccination against tetanus.
• 91% of patient were recorded as being up to date with vaccination against typhoid.

Searches of the system were undertaken each month and a list sent to unit commanders of personnel who were due to have vaccinations. Regular searches were also undertaken for patients eligible for screening.

Consent to care and treatment

The practice 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.

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<th>Good</th>
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**We rated the practice as good for caring.**

**Kindness, respect and compassion**

• Throughout the inspection staff were courteous and respectful to patients arriving for their appointments.

• Results from the October 2018 Patient Experience Survey (five respondents) indicated that patients were treated with dignity and respect. The 26 CQC comment cards completed prior to the inspection were very all complimentary about the caring attitude of staff.

• 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. In relation to physiotherapy and rehabilitation, expectations were discussed with each patient to ensure bespoke goals and a treatment plan was identified for the patient.

• Interpretation services were available for patients who did not have English as a first language. Information was available informing patients this service was available.

• The October 2018 Patient Experience Survey indicated respondents felt involved in decisions about their care. Feedback on the CQC patient feedback cards highlighted that patients received information about their treatment to support them with making informed decisions about their treatment and care.

• The practice proactively identified patients who had caring responsibilities, even if that was an indirect caring role. If necessary, the practice liaised with the welfare team. One patient was identified as having a caring role.

**Privacy and dignity**

The practice respected patients’ privacy and dignity.

• Privacy was provided in consulting rooms to maintain patients’ dignity during examinations, investigations and treatments. Clinic room doors were closed during consultations.

• The layout of the reception area and the seats in the waiting area meant that conversations between patients and reception could not be easily overheard. If patients wished to discuss sensitive issues or appeared distressed at reception they could be offered a private room to discuss their needs.

• If patients wished to see a female GP then could have an appointment at one of the other practices in the group. The PCRF only had male staff so all female patients were offered the option of a chaperone.

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Following our previous inspection, we rated the practice as requires improvement for providing responsive services. This was because there was no medical cover when the practice was closed for training on a Wednesday afternoon and between 17:00 and 18:30 on the remaining weekdays.

At this inspection we found the recommendation we made had been actioned. The practice is now rated as good for providing responsive services.

**Responding to and meeting people’s needs**

The practice organised and delivered services to meet patient needs and preferences.

- Staff understood the needs of its population and tailored services in response to those needs. For example, clinics were organised around the occupational health needs of service personnel due to deploy.
- The CQC feedback comment cards completed prior to the inspection highlighted that it was easy to secure an appointment, in particular a short notice appointment.
- Although an access audit as defined in the Equality Act 2010 had not been completed for the premises, reasonable adjustments had been made to accommodate patients. As the building belongs to Historic Scotland there are constraints on how it can be modified. All services were on the ground floor and were accessible for patients who were wheelchair users or who had limited mobility.

**Timely access to care and treatment**

Patients’ needs were met in a timely way.

- Patients with an emergency need were seen on the same day by a doctor and/or the nurse. The waiting time for a routine appointment was one to two days. The Patient Experience Survey showed that all relevant respondents had received their appointment at a time that suited them. The nurse advised us that failure to attend rates averaged at six to seven appointments per month.
- Telephone consultations and home visits were available. A home visit policy was in place and staff provided an example of a patient who received home visits as they were unable to attend the practice. Arrangements were in place for patients to access primary care when the practice was closed, including emergency care. Shoulder cover when the practice closed was provided from Lossiemouth Medical Centre.
- Specialist medicals were undertaken at Kinloss Medical Centre and waiting times for these were approximately four weeks. The waiting time for grading medicals was also approximately four weeks.
- The Direct Access to the Physiotherapy Service (DAPS) directive was introduced in February 2018. Due to limited PCRF resources, DAPS was not yet available at the practice.
- At the time of the inspection the next available routine physiotherapy appointment was within two to three working days. Appointments slots were available at the PCRF for patients with an urgent need. The physiotherapist advised us that failure to attend rates were below average when compared to other PCRFs.

**Listening and learning from concerns and complaints**

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.
• Information was available to help patients understand the complaints process. The practice managed complaints in accordance with the DPHC complaints policy and procedure.
• The RMO was the lead for complaints and the practice manager was the designated responsible person who managed the complaints. A record of complaints was maintained, including verbal complaints. The RMO provided an example of how a complaint in relation to delayed access to an x-ray was effectively managed. Three complaints regarding the lack of an ice machine to treat injuries lead to the practice being funded for an ice machine. A complaints audit was undertaken in September 2018.

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<td>Following our previous inspection, we rated the practice as inadequate for providing well-led services. This was because governance arrangements were not strong, including processes to monitor clinical performance and support from the regional management team. At this inspection we found action had been taken to address the concerns identified. The practice is now rated as good for providing well-led services.</td>
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**Leadership capacity and capability**

• The management capacity of the practice had increased through the strengthening of the group practice model. This model identified Lossiemouth Medical Centre as the hub practice with Kinloss and Fort George medical centres the spoke practices. The SMO for Lossiemouth was responsible for the clinical governance of the group. The practice manager at Lossiemouth was identified as the practice manager for the group. There was clear evidence that being part of the group practice model had been key to the improvements made to service provision at Fort George Medical Centre following the last inspection.
• However, this arrangement had not been formalised as there was no business plan outlining the vision, goals, objectives, governance arrangements and sustainability of this new model. In addition, it was unclear how the new model would work given the distance between all practices. Although we did not see the terms of reference, the SMO advised us that the role had been formalised on April 2018. Without access to the terms of reference, including those for the group practice manager, we were unable to fully confirm the scope of roles and responsibilities.
• Staff said that being part of the group practice model had provided structure, support and guidance to the practice.

**Vision and strategy**

• The practice worked to the DPHC mission statement of:
  “Delivering a unified, safe, efficient and accountable primary health care for entitled personnel to maximise their health and to deliver personnel medically fit for operations.”
• Specific to the practice the mission statement was:
  “To provide our patients with high quality accessible care in a safe, responsive and courteous manner.”
• The strategy was in line with health priorities across the region and the service was organised to meet the needs of the patient population.

**Culture**

The culture at the practice was inclusive and all staff were treated equally.
• Staff we spoke with said the group practice model was inclusive of all staff. They felt respected, supported and valued and described a leadership style that encouraged and valued everyone’s contribution to developing the service within the group model. Both formal and informal opportunities were in place so staff could contribute their views and ideas about how to develop the practice. They said the wider team worked well together and supported each other.

• Staff described an open and transparent leadership style and said they would feel comfortable raising issues. They said the SMO had an open-door policy to staff at Fort George. Openness, honesty and transparency were demonstrated when responding to incidents and complaints.

• The practice clearly demonstrated a patient-centred focus. Staff understood the specific occupational needs of patients and tailored the service to meet those needs. For example, facilitating additional clinics to meet the deployment needs of the regiment. In addition, the practice had planned the refurbishment to take place at a time that caused the least disruption for the regiment.

• 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.

• Staff were encouraged and supported to be the best they could be through training and developing their skills and expertise. A sharing of skills and pooling of resources was promoted through the group practice model.

• The practice actively promoted equality and diversity. Staff had received equality and diversity training.

**Governance arrangements**

An effective overarching governance framework had been developed which supported the delivery of good quality care at the practice.

• The RMO was the governance lead for the practice and the practice manager was responsible for the day to day running of the practice. The practice nurse had played an instrumental role in supporting the RMO and practice manager with strengthening the governance structure. The staffing structure was clear and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas.

• Staff said they were well supported by the SMO, group practice manager and regional management team. For example, the practice had worked closely with the management team at Lossiemouth to develop better working practices and update procedures.

• The practice was working to the management action plan (MAP) developed following the last inspection. Regular telephone conferences between the group practice, DPHC and regional management team were held to discuss progress against the MAP. In addition, the practice had regular advisory visits and support from Lossiemouth Medical Centre.

• The DPHC health governance workbook was used to monitor performance, 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.

• Practice meetings and healthcare governance meetings were integrated. We looked at the meeting minutes for September and October 2018. There was a clear structure to the meetings with standing agenda items.
• An annual audit programme was put in place after the last inspection for both clinical and non-clinical audit activity. The programme identifying an audit to be undertaken each month and showed that all staff were engaged with audit. Audit was discussed in detail at the health governance meetings and was having a positive impact on quality of care and outcomes for patients. There was clear evidence of action taken to change practice and improve quality of care provision.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

• The practice manager, practice nurse and RMO understood the risks to the service and kept them under scrutiny through the risk register. They had oversight of national and local safety alerts, incidents, and complaints.

• There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety.

• Processes were in place to manage current and future performance. Performance of clinical staff was demonstrated through peer review, including review of clinical records. The lead physiotherapist undertook supportive visits to the PCRF.

• A business continuity plan was in place for the practice.

Appropriate and accurate information

The 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 practice had recently started to use the newly introduced eCAF and staff confirmed they could all input to the system.

Engagement with patients, the public, staff and external partners

The 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 room.

• The practice had good working relationships with the regiment commander and attended regular Unit Health Committee meetings for the regiment to provide updates on the occupational health and welfare of personnel.

• The Staff Sergeant had good working relationships the physical training instructors (PTI) for the regiment and was the line of communication between the PTIs and the PCRF.

Continuous improvement and innovation

Examples of some of the quality initiatives introduced to the practice in 2018 include:

• A transport protocol had been developed and formal arrangement with military transport agreed to provide transport for transferring samples and collecting medication.

• Introduction of the Fever Pain Tool for medics to use when patients present with a sore throat.
• Introduction of a ‘casualty location board’ to monitor admissions to hospital and medical repatriation/evacuation

It was evident the staff had worked hard with the support of the group practice management team and regional management to meet the recommendations following the last inspection. The newly revised and implemented governance systems will need time to embed to ensure the improvements are sustainable and continue to be delivered across the practice.