Fort George Medical Centre

Quality report

Ardersier
Inverness
Scotland
IV2 7TE

Date of inspection visit:
28 January 2020

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16 March 2020

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

Overall rating for this service	Good
Are services safe?	Requires improvement
Are services well-led?	Good

Chief Inspector's Summary

This practice is rated as Good overall

The key questions are rated as:

Are services safe? – Requires improvement
Are services well-led? - Good

We carried out an announced comprehensive inspection of Fort George Medical Centre on 17 January 2018. The practice was rated as inadequate overall, with a rating of inadequate for the safe, effective and well-led domains. The caring domain was rated as good and responsive as requires improvement.

We then carried out an announced comprehensive follow up inspection on 1 and 5 November 2018. The practice was rated as good overall overall, with a rating of good for all domains except for safe, which was rated as requires improvement.

A copy of the previous inspection reports can be found at:

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

We carried out this announced follow up focussed inspection on 28 January 2020. The report covers our findings in relation to the recommendations made and any additional improvements made or concern identified since our last inspection.

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:

- An inclusive team approach was supported by all staff who valued the opportunities available to them to be part of a patient-centred service.
- Systems to keep patients safe including safeguarding from abuse were established. Improvements were needed to the system for managing and monitoring vulnerable adults.
- There was an open and transparent approach to safety. An effective system was in place for managing significant events and staff knew how to report and record using this system.
- The practice was clean, tidy and well maintained. Cleaning schedules and a process for monitoring cleaning standards were not in place. An annual clinical waste audit had not been undertaken.
- Summarisation of patient records was not up to date.
- The 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 minimised risks to patient safety.
- The building was owned by Historic Scotland thus restricted in how it could be adapted. Any concerns with the building had been included on the risk register.
- The group practice model had not been formalised.

The Chief Inspector recommends:

- Strengthening the approach to managing and monitoring vulnerable adults.
- Developing a process to monitor the professional registration status of staff
- Formalising the environmental cleaning schedules for the practice and set up a process of monitoring cleaning standards.
- Completing an annual waste audit.
- Developing a plan to manage the summarisation of patients' records in a timely way.
- Conducting a workload and skills analysis to determine the capacity and capability of staff to undertake practice management activities as part of the short and medium term practice management plan.
- Formalising the strategic and operational arrangements for the group practice model so roles, responsibilities, accountabilities and governance arrangements are clear.

Dr Rosie Benneyworth BM BS BMedSci MRCGP
Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team included a CQC lead inspector and a specialist advisor practice manager**.**

Background to Fort George Medical Centre

Fort George Medical Centre is located 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 470 patients were registered. There were no patients over 60 and eight patients under the age of 18. There were nine female patients registered with the practice.

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 main 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.

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.

The following table outlines the group practice staff team at the time of the inspection:

Position	Numbers
Group Senior Medical Officer (SMO)	One
Group practice manager	One
Civilian medical practitioner (CMP)	One
Regimental aid post[1] - Medical Officer (RMO)	One
Civilian practice nurse	One
Regimental aid post - nursing	One
Regimental aid post – medics[2]	Seven
Civilian physiotherapist	One
Civilian exercise rehabilitation instructor (ERI)	One (locum)
Administrators	Two
Pharmacy technician (based at Kinloss Medical Centre)	One

[1] Regimental Aid Posts (RAP) are front-line military medical staff posts attached to a military unit and are subject to deployment, often at short notice. When not deployed, RAP staff work in medical centres to update and maintain their clinical skills. They also have a focus on ensuring the occupational health requirements of unit personnel are up-to-date.

[2] In the army, a medic is a soldier who has received specialist training in field medicine. It is a unique role in the forces and their role is similar to that of a health care assistant in NHS GP practices but with a broader scope of practice.

Are services safe? | Requires improvement

We rated the practice as requires improvement for providing safe services.

Following our previous inspection, we rated the practice as requires improvement for providing safe services. We found gaps in processes to keep patients safe, including medicines management, staff training and safety of the building and facilities.

At this inspection we found the recommendations we made had been actioned. We identified other processes that needed to be strengthened. The practice continues to be rated as requires improvement for providing safe services.

Safety systems and processes

Systems to keep patients safe including safeguarding from abuse were established. These systems needed improving.

- Measures were in place to protect patients from abuse and neglect. A combined adult and child safeguarding policy, and flowchart was in place. All staff had received up-to-date safeguarding

training appropriate to their role and knew how to identify and report concerns. The practice nurse was the safeguarding lead and had completed level 3 training for the role. The RMO was undertaking online safeguarding training and the CMP, who was new to post, was booked to attend level 3 training on 11 March 2020.

- The practice maintained a vulnerable patient register, which was held on Sharepoint, the electronic document management system that all staff could access. Alerts were used on DMICP (electronic patient record system) to identify patients as vulnerable adults. We noted that not all alerts where in place when we checked a selection of patient records. Vulnerable patients were discussed at the quarterly clinical meetings. In accordance with DMS policy, these meetings should be held monthly. It was not clear from the register what outcomes were discussed in the meetings as there did not appear to be corresponding DMICP entries on the patient record from the dates the meetings had taken place. In addition, vulnerable patients were reviewed at the Unit Health Committee (UHC) which a representative of the practice attended, along with the Army Welfare Officer and Chain of Command.
- Staff who acted as chaperones were trained for the role in 2018 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. The practice 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. The database showed some medics had no recorded DBS. The DBS checks had been applied for and the practice nurse clarified that risk assessments had been carried out to confirm the medics could continue working with patients. The issue had also been added to the risk register. There were no recorded monitoring of the professional registration status of clinical staff as the practice manager was unaware they were required to do so.
- The practice nurse was the lead for infection prevention and control (IPC) and had completed the IPC link practitioner course with NHS Highlands for the role. All staff currently working at the practice had received IPC training. The IPC lead completed an annual IPC audit. Environmental cleaning was carried out by a contractor. A schedule of cleaning was not in place and there was no process established for monitoring the effectiveness of cleaning standards. Although staff were aware to conduct management checks of cleaning standards, they were unable to produce evidence to support these checks had taken place. The practice nurse was certain a deep clean had taken place in the previous 12 months but could find no evidence to support this.
- A planned refurbishment had taken place after the last inspection. We noted there was still one sink in the doctor's room that needs replacing to meet IPC standards. This had been captured on the practice risk register and minutes showed that the matter was discussed at a practice meeting in January 2020 with an action for a statement of need to be re-submitted for replacement taps.
- The practice nurse was responsible for managing healthcare waste. Clinical waste bins were now stored securely and consignment notes were retained. The annual waste audit had not been completed.
- The practice ensured that facilities were safe. Electrical safety checks were completed as required and water safety checks were undertaken regularly and recorded. A legionella risk

assessment had been carried out for the camp and the medical centre had access to the report.

- A building fire risk assessment was conducted by the Defence Fire and Rescue Service with no concerns were identified. Regular fire safety checks were carried out, including tests of the firefighting equipment. Staff were up-to-date with fire safety training.

Risks to patients

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

- Improvements to the consistency of clinical staff had been made since the last inspection. A civilian SMO had been appointed in October 2019 on a three-day week contract and were going through a process of induction. A locum ERI had been appointed to support the physiotherapist. A battalion nurse had also started working at the practice since the last inspection.
- The acting practice manager had recently moved to Kinloss Medical Centre and we were advised funding for a practice manager role was not available. In the short term, practice staff were taking on elements of the practice management role. They highlighted this as risk due to increased workload and not having a key person with oversight of the practice governance. There was a medium and long term plan to fund a practice manager position but these arrangements were not confirmed at the time of the inspection.
- Locum staff had completed the same induction as permanent staff and had undertaken mandated training relevant to their role.
- 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. At the last inspection the treatment room lacked an appropriate warning notice to identify that oxygen was stored in the room. Signage was now displayed on the door.
- Since the last inspection, the staff team had attended group practice training on the identification and management of sepsis in August 2019 and January 2020 and this was recorded on practice training database.

Information to deliver safe care and treatment

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

- Staff stated that DMICP outages are very infrequent but when required they actively manage them via the single point of contact (SPOC) or the regional information support officer.
- 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 so information that arrived by post was scanned and added to the patient electronic record.
- The practice was using the new patient registration form. Registration forms for new patients were summarised by the practice nurse and scanned by administration staff onto DMICP. Although patients notes had been summarised when they registered with the practice, only 25% of notes had been subject to a three yearly summarisation in accordance with the DPHC guidance note. The practice nurse was managing summarisation and due to their additional duties (elements of the practice management role) did not have capacity to address this backlog in a timely way.
- There was a dedicated administrator to manage external referrals. A clear system was in place for the processing and monitoring of these referrals. The administrator received a paper copy

referral from the doctor, which was emailed to the hospital and then scanned onto DMICP. A referral log was maintained and stored on Sharepoint and the administrator checked it weekly. Although the practice had never had a two-week urgent referral, the administrator said these would be managed through the current referral process. Arrangements were in place for the continued monitoring of referrals in the absence of the administrator.

- Internal referrals, such as those to the Regional Rehabilitation Unit (RRU) and the Department of Community Mental Health (DCMH) were managed by the referring clinician. There was a risk that internal referrals may not be monitored if the referrer was absent from the service. The administrator said there were plans to include internal referrals in the current monitoring system.

Safe and appropriate use of medicines

The practice had addressed the concerns we found with medicines at the last inspection.

- The pharmacy technician completed a monthly and quarterly stock adjustment report and completed DMICP stock control checks. This was confirmed in the regional pharmacist annual audit.
- Since the last inspection, the practice was using DPHC standardised paperwork and working to the dispensary SoPs. A specimen prescribers signature list had been developed and updated to include the new CMP. It had been shared with the contracted outsourced pharmacy. We checked prescriptions and confirmed they were fully accounted for, including the use of a bound book for recording prescriptions issued. In addition, the management of Private Prescription Controlled Drugs (PPCD) forms had been reviewed and were being completed in full to minimise any ambiguity. Repeat prescription request were now only accepted in writing.
- The pharmacy technician reviewed Patient Group Directions (PGD) every Thursday and all staff using PGDs were subject to mandated six monthly audits that were scrutinised by the DPHC pharmacist.
- The pharmacy technician confirmed high risk medicine searches were now being conducted monthly, including Sodium Valproate. A high risk medicines register was in place. At the time of the inspection no patients were identified on the search.
- An audit had been completed by the pharmacy technician of doctors' prescribing with a plan to undertake this audit annually.

Track record on safety

The practice had a good safety record.

- At the last inspection, we were concerned about the bars on the window of the Primary Care Rehabilitation Facility (PCRF) because the window could not be opened or used in the event of a fire or emergency. The practice had raised this issue after the inspection and were advised change could not be made because the building is protected by Historic Scotland. The concern with the bars had been added to the risk register. PCRF staff held personal alarms to summon assistance. We tested the alarm during the inspection and staff responded promptly. The practice maintained a record of alarm tests.
- The risk assessments for COSHH (products hazardous to health) and data sheets had recently been reviewed and were awaiting the RMO sign off.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- The practice nurse confirmed that all staff could access the system (referred to as ASER) in order to report a significant event, incident or near miss. There were no outstanding significant events on the ASER system. Significant events were investigated as a team and the ASER tracker showed documented root cause analysis had taken place. Significant events were discussed at practice meetings and this was confirmed from the January practice meeting minutes.
- The pharmacy technician forwarded alerts from the Medicines and Healthcare products Regulatory Agency to the practice for action. The practice nurse emailed these to individual staff and also maintained a local spreadsheet of the alerts. Relevant alerts were discussed at the practice meetings.

Are services well-led?	**Good**

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

Following our previous inspection, we rated the practice as good for providing well-led services. However, we made a recommendation that a review of the capacity, structure and sustainability of the group practice model be undertaken to ensure consistent and continued leadership support for Fort George Medical Centre. We did so because there was no formal documentation in place outlining the vision, objectives, governance arrangements and sustainability of the model

At this inspection the group practice model was still in place. We found the recommendation had not been met as the group practice model had not been formalised.

Vision and strategy

- Fort George Medical Centre worked to the DPHC mission statement and also had its own mission statement identified as:

  "To provide our patients with high quality accessible care in a safe, responsive and courteous manner."

- A formalised vision and mission statement for the group practice model was not in place.
- The group practice structure had not changed since the last inspection with the SMO and practice manager for Lossiemouth Medical Centre continuing in the roles of group SMO and group practice manager respectively. As we found at the last inspection, this structure had not been formalised so there was not a documented formal agreement, such as a memorandum of understanding (MoU) outlining the strategic and operational arrangements for group practice model. Furthermore, roles, responsibilities, accountabilities and governance arrangements had not been formalised.

Leadership capacity and capability

- At operational level there had been changes to the leadership at Fort George Medical Centre. A civilian SMO had been appointed shortly before the inspection and this role would provide consistency both for clinical leadership and delivery of care. The acting practice manager had moved to Kinloss Medical Centre and funding to appoint a practice manager for Fort George Medical Centre was not available.
- Although the regional manager described a short, medium and long term plan for the management of the practice, we were not provided with documented evidence to support the proposals.

- As a short term arrangement, practice management tasks had been allocated amongst the staff team. We were not provided with evidence to confirm that a staffing workload and skills analysis had been undertaken to determine if there was sufficient capacity and capability to support with implementing the short term plan. Staff we spoke with were concerned taking on practice management roles could compromise clinical time. The backlog in summarisation supported this view as the practice nurse had limited capacity for that activity, and that was before the uptake of additional non-clinical duties.
- The medium term plan was for the newly appointed practice manager at Kinloss Medical Centre to jointly manage Fort George Medical Centre. Kinloss Medical Centre had been without a practice manager for a considerable amount of time so the new practice manager was busy establishing systems and processes. The Kinloss practice manager was informed of this additional role the week prior to our inspection and Fort George Medical Centre staff were informed the day prior to the inspection. We were concerned about whether the Kinloss practice manager would have capacity to support Fort George. Securing funding through staff movement for a practice manager post was the long term plan.
- We asked staff how integrated and well supported they were through the group practice model. Staff told us they valued the group clinical meetings. Meeting minutes confirmed that attendees from all three practices were active participants, including a rotation of the meeting chair and presentation of clinical audits. Clinical staff reported that their induction involved spending time at Lossiemouth Medical Centre shadowing other doctors. This was particularly beneficial to the CMP who had not previously worked in defence primary care. The group practice manager confirmed that staff from Fort George were invited to training at Lossiemouth, highlighting safeguarding training as an example.
- Since 2018, clinicians across the group practice were engaged with the Practice Based Small Group Learning (PBSGL); an innovative approach to continuing professional development that originated in Canada and is popular in Scotland for pharmacists and primary care clinicians in Scotland.
- Although staff said they were well supported clinically, they reported that more support with day-to-day governance activities through the group practice would be of benefit. The group practice manager undertook some governance work, including oversight of the doctor's rotas and producing the weekly group practice report for region. Although group practice leaders were available and responsive electronically, they infrequently visited the practice. Practice meetings for the whole group were not established and group practice standard operating procedures were not in place.