Kinloss Medical Centre

Kinloss Barracks, Forres, Scotland IV36 3UH

Defence Medical Services inspection report

This report describes our judgement of the quality of care at Kinloss Medical Centre. It is based on a combination of what we found from information provided about the service, patient feedback, our observations and interviews with staff and others connected with the service.

Overall rating for this service	**Requires improvement**	
Are services safe?	**Requires improvement**	
Are services effective	**Good**	
Are service caring?	**Good**	
Are services responsive to people's needs?	**Good**	
Are services well-led?	**Requires improvement**	

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About this inspection

We carried out this announced comprehensive inspection on 16 November 2021.

As a result of this inspection the practice is rated as requires improvement overall in accordance with CQC's inspection framework.

Are services safe? – requires improvement

Are services effective? – good

Are services caring? – good

Are services responsive to people's needs? – good

Are services well-led? - requires improvement

The CQC does not have the same statutory powers with regard to improvement action for the Defence Medical Services (DMS) under the Health and Social Care Act 2008, which also means that the DMS is not subject to CQC's enforcement powers. However, as the military healthcare regulator, the Defence Medical Services Regulator (DMSR) has regulatory and enforcement powers over the DMS. DMSR is committed to improving patient and staff safety and will ensure implementation of the CQC's observations and recommendations.

This inspection is one of a programme of inspections that the CQC will complete at the invitation of the DMSR in their role as the military healthcare regulator for the DMS.

At this inspection we found:

- Patient feedback about the service was positive. It showed patients were treated with compassion, dignity and respect and were involved decisions about their care and treatment. Information about services and how to complain was available to patients.
- Patients found it easy to make an appointment and urgent appointments were available the same day.
- An annual programme of quality improvement activity (QIA) was in place. Whilst there were some gaps, key clinical audits were taking place to drive improvements in patient outcomes.
- Unresolved relationship issues within the practice team had been recognised by recently appointed leaders. Measures were being taken and a plan was in place to improve cohesion and harmony within the team.
- The recently appointed practice manager had identified shortfalls in risk management, contractual arrangements and governance systems. They were pro-actively addressing these deficits and were realistic that it would take time to make all of the improvements required.

- The sustainability of leadership capacity was insecure given that leaders and staff in key positions had other commitments either within the 'group of practices' or because of attachment to the unit.
- Although the practice received effective support from regional Headquarters (RHQ), individual staff were inconsistent in their understanding of what the 'group of practices' structure meant for Kinloss Medical Centre.
- The practice had good lines of communication with the unit, welfare team and co-located Department of Community Mental Health (DCMH) to ensure the wellbeing of service personnel.
- Effective medical cover was in place on weekdays between the times when the practice closed and NHS 111 commenced providing a service.
- Arrangements were in place for managing medicines including high risk medicines. Some improvement was required in how medicines were managed, notably with the monitoring of fridge and ambient temperatures in accordance with Defence Primary Healthcare (DPHC) policy.
- The arrangements for infection prevention and control (IPC) were not effective, in particular environmental and equipment cleaning. Contract monitoring arrangements were not established and a deep clean of the practice had not taken place.

The Chief Inspector recommends that the medical centre:

- The review of governance monitoring systems should continue as a priority to ensure they are comprehensive and effective. They should include:
    - The identification of risks to ensure all are captured and managed in accordance with DPHC policy;
    - the development of the health governance workbook;
    - the development of a formal process for contract monitoring, including the cleaning contract;
    - a record of when duty of candour has been applied;
    - a review of the business continuity plan; and
    - a review of secondary role duties allocation to ensure proportionality.
- Ensure staff receive child and adult safeguarding training at a level appropriate to their role and in accordance with the Ministry of Defence (MOD) policy (JSP 950 Lft 4-6-6, v2.1 Oct 21).
- A review of how the medical emergency kit is monitored to ensure it is secure at all times and held in a safe area. Checks should be put in place for the first aid kit.
- The process of managing internal referrals should be considered with a view to a central monitoring process in line with how external referrals are managed.
- A risk assessment should be undertaken to establish the impact of not having a pharmacy technician regularly on the premises. Medicines management arrangements should be reviewed to ensure the fridge temperatures are consistently monitored in

accordance with DPHC policy. In addition, a process should be established for stock rotation of all medicines.

- A review of the lone working standard operating procedure (SOP) to ensure it takes into account recent staff relocation from the Primary Care Rehabilitation Facility (PCRF) which has meant the physiotherapist often works in isolation of the wider team.
- The practice should consider adopting a formal approach to peer review and clinical supervision by making a record of each session.

The Chief Inspector recommends to DPHC:

- A review of the capacity and sustainability of clinical leadership to ensure it is adequate to meet the needs of the practice.
- A review of clinical staffing levels to ensure the practice has sufficient clinical capacity to provide continuity of care for patients.
- Improvements should be made to the infrastructure, facilities, cleaning arrangements and clinical waste management in line with the Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'.
- The effectiveness of the WIFI should be reviewed to ensure all staff have access in their work area when treating patients.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

The inspection team was led by a CQC inspector and comprised specialist advisors including a primary care doctor, nurse, physiotherapist, pharmacist and practice manager. Three of the specialist advisors carried out the inspection virtually.

Background to Kinloss Medical Centre

Located in Kinloss Barracks, the medical centre provides a primary care, occupational health and rehabilitation service to a highly deployable engineering regiment. At the time of the inspection there were 734 registered patients within the age range of 17 to 56. In addition, occupational health services are provided for two reservist units. Families and dependents of military personnel are not registered at the practice so are signposted to local NHS practices.

Facilities within the building include a dispensary and a Primary Care Rehabilitation Facility (PCRF). The Department of Community Mental Health (DCMH) is based within the building but was not included in this inspection.

Kinloss Medical Centre is one of three practices in the region that work together to share resources. The other two practices are Fort George Medical Centre and Lossiemouth Medical Centre. Within the region this informal arrangement is termed a 'group of practices'. In this inspection report it is referred to as 'the group'.

The staff team

Medical team	Senior Medical Officer (SMO) Regimental Medical Officer (RMO) General Duties Medical Officer (GDMO)
Nursing team	Civilian Band 6 practice nurse Civilian Band 5 practice nurse Military reservist practice nurse (vacant)
Practice management	Military practice manager
PCRF	Locum physiotherapist Exercise rehabilitation instructor (ERI) – unit asset
Dispensary	Pharmacy technician
Administrators	Four
Military medic team*	One Medical Sergeant; three junior medics

* In the army, a Medical Sergeant and Medics are soldiers who have 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?

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

Safety systems and processes

- The Regimental Medical Officer (RMO) was the lead for safeguarding and the Senior Medical Officer (SMO) was the deputy lead. Both had completed level 3 safeguarding. The General Duties Medical Officer (GDMO) was also trained in level 3 safeguarding. The RMO and SMO were absent from the service at the time of inspection, so the practice had access to the level 3 safeguarding lead at Lossiemouth Medical Centre. Other staff had completed the required level of training for their role except for nursing staff who had not completed level 3 safeguarding training in accordance with the Ministry of Defence safeguarding for healthcare staff policy (JSP 950).
- Displayed in clinical areas, the practice standard operating procedures (SOP) for both adult and child safeguarding had been reviewed in November 2021 and included contact details for local safeguarding teams. Staff interviewed during the inspection were aware of the policy, including how to report a safeguarding concern. We were given an example of the practice's involvement with a reported safeguarding concern, including liaison with the welfare team, police and social services.
- Monthly searches were undertaken to identify under 18s in the patient population. Our review of DMICP (electronic patient records) demonstrated that alerts were applied to patients under 18 and those with additional vulnerabilities. The practice had effective links with the unit Welfare Officer and monthly meetings were held to discuss vulnerable patients. In addition, vulnerable patients were discussed at the unit health committee meetings. Domestic violence information was displayed in the patient waiting area.
- Clinical staff had received chaperone training. The chaperone policy was displayed in the patient waiting area and the availability of a chaperone was detailed in the patient information leaflet.
- The full range of recruitment records for permanent staff was held centrally. The practice could demonstrate that relevant safety checks had taken place at the point of recruitment, including Protecting Vulnerable Groups (PVG/Disclosure Scotland) checks to ensure staff, including locum staff, were suitable to work with vulnerable adults and young people. Recent staff to join the team did not have a PVG check but had a current English Disclosure and Barring Service (DBS) check. This had been added to the risk register and applications had been submitted for a PVG check. A process was in place to monitor the professional registration of clinical staff. All relevant staff had indemnity insurance.
- The Band 6 nurse was the lead for infection prevention and control (IPC) and had completed link practitioner training. All other staff were up to date with IPC training. The last IPC audit was undertaken in December 2020 and the practice achieved a compliance score of 83% compliance; marginally below the 85% set by Defence Primary Healthcare (DPHC). Although the audit indicated a review would take place three months later, we received no evidence to demonstrate this had happened.

- Concerns we identified with the infrastructure had been recognised through the IPC audit. For example, there was damage to flooring, skirting boards, window blinds and paint work. The strip light cover in the treatment room was secured with tape. Many of the strip lights contained dead insects and some clinical areas were carpeted. With the changeover of practice manager and the absence of a fault register, we had no means to confirm how issues with the infrastructure were being addressed. After the inspection, the practice manager confirmed a paper copy and electronic version of the fault register were in place but had not been provided as evidence during the inspection.
- When looking around the building, including the Primary Rehabilitation Facility (PCRF), dust was evident on both low and high surfaces. The following day when we inspected the co-located dental centre, the dust was still evident on low surfaces in the patient waiting area despite the building being cleaned that morning. The practice had only been given access to the cleaning contract the week before the inspection. The cleaning contract also covered the PCRF and dental centre.
- There was insufficient equipment in place to maintain cleanliness of the practice. For example, there was no carpet cleaner available so the carpets had not been washed. We were told of an occasion when a patient was sick on the carpet and nursing staff had to clean the carpet. We were advised that cleaning equipment used in the building was possibly being used elsewhere on the camp. Cleaning was carried out by two cleaners. One session took place from 06:00 to 08:00 Monday to Friday so clinical areas could be cleaned without interruption. The second session was from 08:00 to 11:00 four days a week. PCRF staff were regularly cleaning their own clinical area due to the inadequate standard of cleaning. We noted that cleaning records were not consistently completed. The practice had not been deep cleaned and we were not provided with evidence to demonstrate monitoring of the cleaning contract.
- Shortly after the inspection both the medical and dental centre engaged with the general manager of the cleaning company and the facilities manager for the Defence Infrastructure Organisation (DIO). The concerns we raised at the feedback were discussed and a meeting was scheduled for the following week.
- Clinical privacy curtains were changed in September 2021. Sharps' bins were labelled and used correctly. Some of the waste bins were not pedal operated. We noted not all equipment was clean, such as the top surfaces of the audiology booths and the first aid kit. Notice boards in clinical and patient areas were washable. All posters were laminated, and washable magnets were holding these in place.
- The Band 6 nurse was the clinical waste lead. The waste contract was for both the medical centre and dental centre. This was due to change as the dental centre was to have a separate contract. Copies of consignment notes were held by the practice and the originals retained at the dental centre. A clinical waste log was maintained and the external clinical waste bin was locked and secured to the building. The practice did not have any purple lidded waste bins. These had been requested following the clinical waste audit in September 2021 and added to the risk register.

Risks to patients

- From a patient perspective, clinical staffing levels were sufficient as patients interviewed told us they had prompt access to a clinician. Waiting times for an appointment with a clinician confirmed this. However, there were potential risks with the capacity and consistency of clinical staffing levels. One of the Band 5 nursing posts had been vacant since August 2020. The recently recruited Band 5 nurse needed additional support as they had not previously worked in primary health care or a military setting. This meant the Band 6 nurse role was stretched. At the time of the inspection, the pharmacy technician (PT) was supporting the three practices within 'the group'. In addition to responsibility for medicines management at Fort George Medical Centre, the PT had been based at Lossiemouth Medical Centre for the last three months whilst the PT was absent from that practice. The rationale for this was because Lossiemouth was a larger and busier dispensing practice. The SMO worked four days a week; two days at the practice and two days as a GP trainer at Lossiemouth Medical Centre. Whilst there was doctor cover from Lossiemouth for these two days, the consistent doctor presence was the RMO, who could be deployed at any time, as could the medics. The exercise rehabilitation instructor (ERI) was a unit post attached to the regiment and it was unclear how protected this post was.
- The locum physiotherapist had not received a formal induction due to the lack of an appropriate mentor at the practice. The physiotherapist from Lossiemouth Medical Centre provided the locum with a clinical handover and walk around the facilities. Locum staff were required to complete mandated training and this was checked prior to their employment.
- The emergency trolley was located outside the treatment room and near the one-way system exit door for patients. Staff did not have regular oversight of this area. We found the trolley had not been secured meaning emergency medicines were accessible. This was rectified on the day of the inspection. The trolley needed to be easily accessible to the doctors and nurses who were based at the different sides of the building. The dental centre was a continuation of the corridor where the doctors held their clinics. We discussed with both the practice and dental centre the possibility of doctors having access to the dental centre emergency equipment meaning the emergency trolley could then be stored securely in the nurses' clinic room or treatment room.
- The emergency trolley seal was checked daily. The contents of the trolley were being checked monthly and this recently increased to daily. A form which listed all the equipment and stock was completed for each check. An electronic form was held on Sharepoint and completed when the seal was removed to replace stock or when the trolley was used for training purposes. A defibrillator was located in the main gym for the ERI to access. The first aid box located in the reception had an expiry date of August 2020, which meant items may not be have been effective. It was clear it was not regularly checked as it was covered in dust.
- All staff completed sepsis training in August 2021. Recently a patient with symptoms of sepsis was treated promptly at the practice. The patient was managed at the practice for a longer period of time due to delays with the ambulance service to transfer the patient to secondary care. Information about sepsis was displayed in various areas of the practice. The administrative team had access to a fact sheet about recognising the sick and deteriorating patient. We were advised that clinical staff had not received

training in climatic injury/illness and noted on the training timetable this training had been added to the 2021/22 training timetable.

- The policy for Wet Bulb Globe Temperature (WBGT), used to indicate the likelihood of heat stress, was displayed on the ERI notice board. The unit physical training instructors monitored and recorded temperature readings and the ERI had access to these as they used the same building. The ERI had completed training in heat injury and WGBT use. The gym was well ventilated and adequately heated.
- CCTV covered the reception, waiting room and the corridor adjacent to the nurses treatment rooms. The practice had obtained an additional camera for the area outside the medics treatment room and it was awaiting installation.

Information to deliver safe care and treatment

- We were advised that recent improvements with IT had led to better access to DMICP and less technical problems and outages. Remote access to DMICP was working well and was frequently used during COVID-19. Staff had been provided with laptops and WIFI was recently installed. However, the WIFI did not reach the PCRF which meant the physiotherapist had to walk through to the medical centre for access. Although the business continuity plan had been reviewed recently, it did not articulate the action to be taken in the event of a DMICP outage. It included details of the reporting process but did not make reference to how patient care would be managed in the interim. DMICP clinics were not routinely printed. Hard copies of some forms were held but they were out of date and not used.
- There were 116 sets of notes requiring summarising which represented 15.8% of the patient population. The SMO had summarised all patient records within the last 18 months. However, since then there had been a turnover of service personnel. We were advised that a plan was in place to address the gaps in summarisation. This plan would involve the nursing team identifying patients when they registered at the practice. Nursing staff had requested training in summarisation and this had been added to the training programme. The audit programme identified that a quality of note summarisation audit was due in December 2021.
- The SMO had carried out a formal audit of clinical records for doctors and nurses in both 2020 and 2021. We were also told that doctors and nurses regularly looked at each other's clinical records so were continually peer reviewing records on an informal basis.
- The clinical records completed by medics had been subject to a recent formal review. As a result, training was planned to take place at the end of November. The senior physiotherapist (OC PCRF) at Lossiemouth PCRF conducted a records audit of the locum physiotherapist within their first month in post confirming clinical competency and appropriate record keeping. The ERI's records were subject to an audit in June 2021, which identified 82% compliance for individual patients and 84% for class therapy. The recommendations made regarding use of goal setting and documented reference flags had been actioned and were evidenced through our review of clinical records. From our review of clinical records, clinical coding was used by the PCRF as set by the referring doctor and the template was appropriately used. However,

electronic ERI referrals or self-referral codes were not used. By not capturing accurate statistics of defence rehabilitation, the work of the PCRF may not reflect the actual caseload.

- An SOP was in place for the management of specimens and we found they were well managed. Specimens were held in the sluice room until collection. A specimen results audit was completed in June 2021
- A detailed process was in place for the management of external referrals with a dedicated administrator tracking referrals and monitoring their progression, including urgent referrals. The administrator audited referrals twice a year; the most recent in November 2021. It identified delays with securing secondary care appointments and the practice was working with NHS Grampian to hasten appointment times. Internal referrals such as those to the Department of Community Mental Health (DCMH), Regional Rehabilitation Unit (RRU) and Regional Occupational Health Team (ROHT) were monitored by the referring clinician. The physiotherapist managed the referrals they made but did not maintain a referrals log. However, the physiotherapist regularly monitored the list on DMICP and also the caseload spreadsheet. Although there was no evidence that internal referrals had been missed or lost in the system, the absence of a central monitoring systems for internal referrals presented a risk given the number of clinicians providing clinics at the practice.

Safe and appropriate use of medicines

- The SMO was the lead and the pharmacy technician (PT) the deputy lead for medicines management at the practice. As the PT was working from Lossiemouth Medical Centre, medicines for Kinloss registered patients were dispensed from Lossiemouth. Military transport collected the medicines from Lossiemouth for patients to collect from Kinloss Medical Centre. In the absence of the SMO and RMO, the PT said they would contact the medicines management lead at Lossiemouth Medical Centre or the regional pharmacist for advice.
- The PT did not know how long they would be supporting Lossiemouth. They were not aware of a long-term solution or plan to cover the PT absence at Lossiemouth. No risk assessment had been carried out to demonstrate that the risks associated with this arrangement had been considered and how they would be managed.
- A range of dispensary SOPs were in hard copy in the dispensary as well as on a shared drive. However, there was no formal monitoring process for compliance with the SOPs. At the time of the inspection, the PT ordered medicines for the three medical centres which were delivered to Lossiemouth. Once logged on DMICP they were delivered to each medical centre. When the PT was not at the practice, the doctors, medics or nurses accepted the delivery. The medics and nurses had received training in the cold chain policy for vaccine storage. Only clinicians handled controlled drugs (medicines with a potential for misuse) deliveries.
- Patient Group Directions (PGD), which allow practice nurses to administer medicines in line with legislation, were written by the regional pharmacy and had been signed off. At the time of the inspection just the Band 6 nurse had been authorised by the SMO to use PGDs for travel vaccinations and for minor ailments. Annual competency

assessments were carried out with nurse. PGD medicines were held in a locked cupboard in the corridor. We were advised that stock rotation and expiry checks of the PGD's were not undertaken in line with the medicines management policy.

- The PT carried out a PGD audit annually and the latest was undertaken in October 2021. The aim of the audit was to ensure that each PGD had been correctly authorised by the SMO, was within date and signed by the authorised nurses to use. The PT sampled 10 prescriptions to ensure the inclusion criteria of the PGD were met, including a review of consultation notes to determine if correct PGD templates and clinical codes were used. An overall compliance score of 66% was achieved. The PT shared the data collected with the SMO. We were not provided with evidence to confirm what action had been taken resulting from the outcome of the audit. Patient Specific Directions (PSD) were not being used at the practice at the time of the inspection.
- A process was in place for the management of information about changes to a patient's medicines received from other services. Incoming correspondence, such as from out-of-hours services, hospital discharge letters and out-patient clinics was actioned by the doctors.
- All blank prescriptions were stored in the dispensary in a locked cupboard. There was a logbook for receiving new blank prescriptions. When doctors took blank prescriptions from the dispensary they recorded the serial numbers. Prescriptions were removed from the printers overnight and placed in a locked cabinet in the consultation rooms.
- All repeat prescriptions were forwarded to the doctors for authorisation. The PT only dispensed prescriptions if they had been signed by the doctor. Doctors carried out medicine reviews for patients with long term conditions.
- Uncollected prescriptions were checked monthly by the PT. Any high risk medicines or medicines used in the management of long term conditions that were uncollected were brought to the attention of the doctors to follow up with patients. Where prescriptions were no longer needed by the patient, a note was made on the patient's record including the prescription serial number before the prescription was destroyed.
- Medicines held at the dispensary were stored securely including controlled drugs (CD). All CD prescriptions were stored in a locked CD cabinet in the dispensary. It was the doctor's responsibility to log in the CD register when a prescription was taken to use. Doctors took a photocopy of the prescriptions they wrote and left them in the dispensary for audit purposes.
- The keys to enter pharmacy were kept in a coded key press. This key press was only accessible by the PT, nurses, doctors and practice manager. CD keys were locked in a key lock box. The PT and doctors were aware of the code to access the key lock box. Another metal box in the CD cabinet was locked with a second key which held accountable drugs (drugs that don't require safe custody but has been deemed to be good practice). Two registers were maintained; one for CDs and one for accountable drugs.
- CDs were logged in on delivery and when handed out to the patients. Monthly CD stock checks were carried out by the PT. Each quarter an external stock check was undertaken by an officer from the unit. We carried out a random physical check of a CD and it matched the last stock check recorded.

- Destruction of CDs was completed in accordance with the local SOP and records maintained. Out of date CDs were held in the CD cabinet and labelled 'quarantined'. At the quarterly check these were destroyed using CD denaturing kits and recorded in the CD register.
- The temperature checks of the medicine fridges and the ambient temperature of the dispensary were held electronically. We checked the records from August 2021 to the day of the inspection. Although the temperatures recorded were within range, there were significant gaps in the records. Whilst the PT was based at Lossiemouth Medical Centre, the checking of fridge temperatures had been delegated to a non-clinical member of staff. Although an SOP was in place, the member of staff had not received sufficient awareness training about the temperature ranges or what to do if the temperature was out of range.
- The practice had backup arrangements in place in the event of a power failure impacting the medicine fridge. A power/battery packs had been installed two months ago to ensure safe storage of COVID-19 vaccines. A few days after the power installation, the practice had a power cut but it didn't affect the fridges as the fridge was connected to the batteries. The practice manager received prior notice of any planned power outages.
- The practice followed the DPHC protocol and local SOP for high risk medicines (HRM). The RMO carried out regular searches to identify patients on HRMs. There was just one patient prescribed HRMs and no patients were subject to a shared care agreement with secondary care. An HRM audit was undertaken in November 2021.
- Doctors used the NHS Grampian guidance for antibiotic prescribing. Antibiotic prescribing audits were scheduled bi-annually. The most recent audit was completed in November 2021 and showed a 90% compliance, which was an improvement on the previous audit.
- Searches for valproate (treatment for epilepsy and a mood stabilising medicine) were undertaken to check pregnancy prevention information for women of childbearing age. The most recent search took place in October 2021 and identified no patients were prescribed this medicine.

Track record on safety

- The recently appointed practice manager had undertaken a full review of the practice risks and had developed both current and retired risk registers, and current and retired issues logs. Although the registers were not yet fully compliant with DPHC policy, they covered the main risks identified by the leadership team. We did, however, identify additional risks, such as the lone working of the physiotherapist without an audible alarm. Some risks appeared to have been transferred to RHQ but there was no evidence available to the practice manager to confirm whether those risks had been accepted by RHQ. Risk was a standing agenda item on the monthly healthcare governance meeting.
- There were a wide range of risk assessments in place for both clinical and non-clinical risks. These included management of sharps, slips, trips and falls, pregnancy and lifting/handling. All risk assessments were overdue a review. The cleaning COSHH

(substances hazardous to health) risk assessments had expired in 2018 and the six clinical COSHH risk assessments were overdue an annual review.

- A range of risk assessments were in place for the PCRF including non-impact cardiovascular training, return to running, outdoor and indoor class therapy and rehabilitation hydrotherapy. These risk assessments were in date with appropriate control measures in place. However, they required sign off by the current members of staff and also by one of the leadership team.
- Due to age, the heating system did not meet minimum temperature requirements resulting in reduction of clinical outputs. This had been added to the risk register with the mitigation to monitor room temperatures daily and twice daily where medicines were stored. The latter was not consistently happening as we found gaps in the ambient temperature records.
- The practice was working to the COVID-19 risk assessment undertaken in July 2020. The number of people accessing the building had been reduced, social distancing measures were in place, face coverings were mandated and the number of chairs in the waiting room had been reduced. There was signs about COVID-19 displayed, a protective screen at reception and a one way entry and exit system had been introduced. Hand sanitiser and sufficient supplies of PPE were available. The practice had introduced a self-collection mail system in the foyer where all patient correspondence was available for collection; this was removed at our request due to the potential of a confidentiality breach.
- The practice manager was the lead for health, safety, fire and equipment. Fire, gas and electrical checks were up to date. Portable appliance testing was carried out in September 2021 and a legionella risk assessment in March 2021. The risk of legionella in infrequently used rooms due to the old heating and water system was identified on the risk register and mitigation was in place. The equipment audit (referred to as LEA) was scheduled for the end of November 2021. The gym equipment was in date for servicing. The practice manager in the dental practice was the building custodian and checked the fire alarm weekly. A fire safety plan for evacuation of the building was displayed. An evacuation practice took place in June 2021. Staff were up-to-date with fire safety training undertaken as part of the DPHC mandated training policy.
- There was a fixed alarm system in the doctors and nurses rooms. We were advised the alarm system was checked but the checks were not recorded. PCRF staff used handheld personal alarms. The physiotherapist's alarm was set off for approximately three minutes during the inspection but no one in the building responded to the alarm as it was not audible. Since the PCRF administrator had relocated, the physiotherapist often worked alone so this was a risk. The dispensary door was secured with a dead lock but no emergency call system was available in the dispensary. The SMO and regional pharmacist had recently been made aware of this and the PT had been informed the lock to the dispensary would be changed. There was no time scale for this and it was not on the risk register.

Lessons learned and improvements made

- Significant events and incidents were reported through the electronic organisational-wide system (referred to as ASER). A local ASER SOP was in place and was due for review. All staff had an ASER login and this was discussed and confirmed in practice meeting minutes.
- Part 2A ASER access was held by the SMO, RMO, practice manager and Band 6 nurse. Root cause analysis for each significant event was undertaken by the member of staff who was the subject matter expert for the incident reported. An ASER log was maintained which included details of outcomes and the date the ASER was discussed at the practice, management and governance meetings. ASERs were a standing agenda item on the practice meeting and were identified in the minutes by ASER number. Although details on the log and in the minutes were brief, it was clear from our discussions with staff that lessons learned were shared with the team.
- Both clinical and non-clinical staff provided examples of incidents reported through the ASER system, including improvements made as a result of the outcome of investigations. As an example, a patient was prescribed the incorrect formulation of a medicine. This was identified by a member of staff and the prescription corrected. The event was reviewed and it was identified the error occurred due to the clinician being interrupted during a consultation. Measures were put in place to minimise interruptions during clinics and there had been no further prescription errors. We noted that ASER trends were discussed at the healthcare governance meeting in May 2021.
- The PT was responsible managing patient safety alerts. Since the PT transferred to Lossiemouth Medical Centre this task had been delegated to the practice manager. The PT had registered the practice's group mailbox with the Medicines and Healthcare products Regulatory Agency so the administrative team received the alerts and forwarded them to the practice manager. The PT was contacted by the practice manager on receipt of an alert and a check was made to determine if the medicine was stocked in dispensary and a check to see if the medicine has been dispensed. If appropriate, the patient was contacted. The PT also emailed a link to the alert to the prescribers for their own information when prescribing.
- A spreadsheet was held with all alerts recorded and the action that had been taken. Most alerts stated no action needed as the dispensary stocked very few medicines and patients had not been prescribed these medicines.

Are services effective?

We rated the practice as good for providing effective services.

Effective needs assessment, care and treatment

- Processes were in place to support clinical staff to keep up to date with developments in clinical care including NICE (National Institute for Health and Care Excellence) guidance, the Scottish Intercollegiate Guidelines Network (SIGN), clinical pathways, current legislation, standards and other practice guidance. Staff were kept informed of clinical and medicines updates through the DPHC newsletter circulated to staff each month.
- Updates were discussed at regional clinical meetings. Attended by clinical staff, the quarterly optimal care meetings for patients with complex needs was recently established and facilitated case reviews and discussions about evidence-based care.
- PCRF staff were familiar with Department of Defence Rehabilitation Guidance and provided examples of treatment provided based on evidence-based guidelines and care pathways. For example, the physiotherapist referred to best practice protocols for back pain. The PCRF used Rehab Guru (software for rehabilitation exercise therapy) and, if appropriate, this was documented in the clinical records we looked at.
- The PCRF had a treatment room and gym. New equipment acquired two years ago was sufficient to meet patients' needs. Additional space and a larger gym would have meant the physiotherapist and ERI could work from the same building rather than the ERI using the unit gym.

Monitoring care and treatment

- The Band 6 nurse was the lead for long term conditions (LTC) and the SMO the deputy lead. LTCs were well managed and a spreadsheet used to monitor them. DMICP searches were run monthly and patients were contacted when their review was due, initially by telephone and, if no response, contact was made by letter.
- There were nine patients recorded as having high blood pressure. All had a record for their blood pressure taken in the past 12 months. Six patients had a blood pressure reading of 150/90 or less.
- There were very few patients on the diabetic register and all had a last measured total cholesterol of 5mmol/l or less which is an indicator of positive cholesterol control. A process was in place to identify and monitor patients at risk of developing diabetes. A QRISK 3 (calculation the determine risk of developing a heart attack or stroke) search was undertaken each month which identified patients over 40 who required screening and who were not captured through LTC monitoring. As part of the QRISK 3 assessment, HbA1C (blood glucose levels) were tested every three years for patients over 40 and annually for those with an existing LTC. Urine was also checked for

glucose when patients attended the practice for a medical. Annual glucose and HbA1C testing were carried out for patients identified as having pre-diabetes.

- There were 20 patients with a diagnosis of asthma. All but three patients had an asthma review in the preceding 12 months. The remaining three patients were awaiting a definitive diagnosis or were deployed. The asthma DMICP template was used which included asthma control test results. An asthma UK action plan was issued to each patient.
- Sixty five percent of patients' audiometric assessments were in date (within the last two years). During COVID-19 routine audiometry had ceased in line the April 2020 DPHC directive. The practice had resumed audiometry as restrictions relaxed. We were advised the unit managed audiology recalls and prioritised those with a high readiness for deployment and those most at risk. The medics held audiology clinics each week but were restricted to using just one of the two booths in the audiology room due to social distancing measures.
- Step 1 of the DPHC mental health pathway was delivered by the doctors at the practice. The DCMH was based in the building so doctors had prompt access to mental health practitioners for advice. Effective support systems were in place for patients vulnerable due to their mental health, including a pro-active culture of checking up on patients with the unit welfare team and DCMH.
- The selection of patient records we looked at demonstrated that patients received timely and effective care. We identified a small number of records where incorrect clinical coding had been applied. Equally, PCRF clinical records showed patients received appropriate treatment and care in line with their clinical need. Patient Reported Outcome Measures (PROMs) and the musculoskeletal Health Questionnaire (MSK-HQ) were not always captured on admission or at six weekly intervals as mandated by Rehabilitation Headquarters or advised by rehabilitation best practice guidance. There could be an acceptable reason for this but it was not evident in the records.
- The RMO was identified as the lead for quality improvement activity (QIA) and audit. A QIA programme comprising clinical audits, mandated audits and data searches was established for 2021/22, including the frequency and lead for each audit. A QIA tracker was used to monitor the status of activity. The tracker showed some of the audits planned for quarter one (April to June 2021) had not been completed. It was unclear why but likely related to staff vacancies. Activity increased in quarter 2. We discussed with one of the doctors the DCMH referral audit; a good quality audit with an outcome to review clinical coding for mental health There was evidence of repeat audits, such as for minor surgery consent and cervical cytology.
- The outgoing physiotherapist had completed two audits this year. The PCRF administrator recorded discharge outcomes for all patients each month. The available statistics demonstrated that most patients seen at the PCRF were discharged fully fit. For example, the October 2021 data showed 42% patients were discharged fully fit, 14% were back to reconditioning physical therapy (injury resolved but needing fitness build up), 27% were downgraded to maintenance physical therapy (permanently downgraded; rehabilitation complete) and 14% were posted or transferred. This information was not being regularly used to monitor for trends and could be a valuable means to inform a change in outcomes and evidence the effectiveness of the PCRF.

- The PCRF at Lossiemouth Medical Centre had the capacity and capability to support with audits for 'the group' The OC PCRF had a plan in place to set up searches for various audits including analysis and a report for the three PCRFs in 'the group'.

Effective staffing

- At the time of the inspection, the practice manager was unaware of the location of the in-service induction programme. After the inspection they confirmed it was in place and clarified that the formal DPHC induction was run twice a year for permanent staff. The practice manager also confirmed the Band 5 nurse appointed in October 2021 had completed the DPHC induction but it had not been recorded on any training register.
- The practice manager monitored the mandatory training database. Staff had dedicated time once a month to complete training and to keep up-to-date with their continual professional development (CPD). Compliance with mandated training was good.
- A log was maintained of in-service training and attendance. Various team members delivered the training topics. The practice manager was in the process of developing a training timetable for the remainder of 2021/22 based on practice and staff need. Locum staff were invited to join these training sessions.
- Staff had completed specific training specific to their primary or secondary role. For example, the Band 6 nurse had completed the IPC Link Practitioner training and had received training in how to use a spirometer. They had also received support from RHQ to undertake the advanced nurse practitioner course, which would be an asset to the practice as a doctor was not always in the building. The DPHC practice manager course had been cancelled due to Covid-19 so the practice manager had applied to attend the next course in January 2022. Both the SMO and RMO were trained in aircrew and diving medicals. The ERI was in the process of completing the post graduate mentoring programme.
- Before restrictions associated with COVID-19, clinicians within 'the group' met each month for clinical updates. For the second part of the meeting, clinicians split into their professional groups for clinical supervision. Although the meetings had continued virtually, the split into professional groups could not be facilitated virtually. From the doctors' perspective, COVID-19 had improved the levels of, and access to, remote CPD activity.
- Peer review and CPD was based more on individual links, such as trainers' groups or DPHC-wide rather than within the practice's internal processes. For the nursing team, clinical supervision was facilitated remotely via Lossiemouth Medical Centre. The RMO and GDMO were pro-active with supervision and training to develop and support the medics. Staff highlighted that the optimal care meetings for patients with complex needs/clinical meetings were a valuable forum for reflective practice.
- Although not documented, the Lossiemouth PCRF Band 7 physiotherapist provided informal clinical supervision for the locum physiotherapist including the opportunity to discuss patient care. The physiotherapist was providing informal peer review for the ERI. Formally documenting supervision and peer reviews would provide assurance of clinical competence. The Lossiemouth PCRF Band 7 physiotherapist had a formal plan to provide a twice yearly formal peer review for all physiotherapists within 'the group'.

Coordinating care and treatment

- The RMO, GDMO, physiotherapist and ERI attended the unit health committee meetings at which the health and care of vulnerable and downgraded patients was reviewed. The practice had effective communication links with internal services, such as the welfare team, DCMH, ROHT and RRU. Fortnightly injury management clinics were held involving the physiotherapist, ERI and doctors, and the RRU were invited to every alternate meeting.
- Clinicians had links with the wider health care environment. The SMO was a BASICS (British Association for Immediate Care) doctor. BASICS doctors assist ambulance services and provide medical services at social events such as concerts. The RMO was pursuing an honorary contract with the local emergency department to maintain their urgent care skills.
- For patients leaving the military, pre-release and final medicals were offered. During the pre-release phase, the patient received an examination and a medication review. A summary print-out of the patient's health needs was provided. For patients with complex needs moving to another medical centre, a summary letter was given to the receiving doctor. Patients were also made aware of the Veterans Health Service and, if appropriate, the Veterans Mental Health Transition, Intervention and Liaison Service (TILS).

Helping patients to live healthier lives

- A lead and deputy for health promotion were identified on the practice roles and responsibilities spreadsheet. It was clear from the patient records we looked at that promoting optimal health was routine, particularly in relation to smoking cessation. The nurses in 'the group' had recently discussed how they would address smoking cessation when the policy prohibiting smoking in the barracks and station came into force. The PCRF team was proactive with health promotion and asked lifestyle questions regarding smoking, lifestyle, sleep and mood. Where appropriate patients were referred to one of the clinicians or were sign posted to other services. The Medical Sergeant represented the practice at a recent unit-led health and wellbeing day.
- The health promotion board was based on the national public health promotion programme and refreshed each month. At the time of the inspection the display provided information about prostate cancer. There was also a detailed display about COVID-19.
- The Band 6 nurse was the lead for sexual health. They had completed the required training (referred to as STIF). The nurse completed update training in June 2021.The nurse referred patients with positive symptoms to the doctor. Patients could be referred to both internal and external specialist sexual health services. Free condoms and chlamydia kits were available at the practice. Information about sexual health, contraception and pregnancy was displayed in the patient waiting area.
- The Band 6 nurse was the lead for health screening. Regular searches were undertaken for bowel (10 patients identified), breast (no patients identified) and

abdominal aortic aneurysm screening (no patients identified) in line with national programmes. The number of eligible women whose records confirmed a cervical smear had been performed in the last five years (timeframe for Scotland) was 30 which represented an achievement of 93.7% which exceeded the NHS target of 80%. Valid reasons were given for the patients who had not yet received a smear.

- During COVID-19 routine vaccinations ceased in line the April 2020 DPHC directive. The practice had resumed the vaccination programme as restrictions relaxed. The vaccination statistics were identified as follows:
    - 91% of patients were in-date for vaccination against diphtheria.
    - 91% of patients were in-date for vaccination against polio.
    - 83% of patients were in-date for vaccination against hepatitis B.
    - 75% of patients were in-date for vaccination against hepatitis A.
    - 91% of patients were in-date for vaccination against tetanus.
    - 97% of patients were in-date for vaccination against MMR (measles, mumps and rubella).
    - 98% of patients were in-date for vaccination against meningitis.
- The practice recognised the percentage of patients vaccinated was not as high as it should be. Limited nursing hours during the summer coupled with a two month period when there was no nurse at the practice contributed to this shortfall. During this time the medics issued PSD vaccinations and nurses from Lossiemouth Medical Centre held a clinic at the practice. At the time of the inspection two vaccination clinics were being held each week to address the backlog with priority given to personnel at high readiness for deployment.

Consent to care and treatment

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making. They had a good understanding of the Mental Capacity Act (2005) and how it would apply to the patient population. Mental capacity training was incorporated in the safeguarding training.
- Consent was appropriately recorded in the clinical records we looked at for physiotherapists and nurses but not for doctors. A consent audit had not been completed. Although patients told us they were offered a chaperone, this was not always recorded in patient records. A records audit for all clinical staff was due to take place in December 2021. Consent and offer of a chaperone was to be included in the audit.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

- No patients responded to the DMSR patient satisfaction survey which complemented this inspection. We interviewed 12 patients as part of the inspection and feedback indicated staff treated patients with kindness, respect and compassion.
- An information network (known as HIVE) based at RAF Lossiemouth was available to members of the service community and provided a range of information to patients who had relocated to the base and surrounding area. Contact details for the Army Welfare service was available in the waiting room.

Involvement in decisions about care and treatment

- All patients we spoke with said they were involved with decision making and planning their care.
- The PCRF appropriately used light duties prescriptions and occasionally used downgrade maintenance physical therapy and reconditioning physical therapy prescriptions.
- Patients with a caring responsibility were identified through the new patient registration process and a clinical code assigned to their records. There was a reminder for carers in the practice information leaflet and information about the Carer's Trust in the waiting area. DMICP searches were undertaken to monitor carers.
- An interpretation service was available for patients who did not have English as a first language.

Privacy and dignity

- All patients we spoke with said their privacy and dignity was respected. Consultations took place in clinic rooms with the door closed. Headphone sets were used for telephone consultations. Patient ID checks were completed prior to any information being disclosed. There were privacy curtains in all clinical rooms. Due to limitations with the reception infrastructure, the practice had identified a potential confidentiality risk for patients at the reception as the dispensary was in close proximity. However, access was limited as the front door was locked. There was a notice on reception advising patients they could speak with a member of staff in private if required. All staff had completed the Defence Information Management Passport training which incorporated the Caldicott principles.
- The practice referred patients to another practice if they wished to see a clinician of a specific gender that could not be accommodated.

Are services responsive to people's needs?

We rated the practice as good for providing responsive services.

Responding to and meeting people's needs

- The practice was responsive to the occupational needs of patients who needed to deploy. Staff sought support from the other practices within 'the group' if there was an increase in demand that they could not meet. Clinics were organised to take account of the unit taking long weekends. Clinics were generic in nature rather than specific, such as smoking cessation, to ensure that patients did not miss out on a specific clinic they wished to access.
- An equality access audit for the medical centre and PCRF was completed in October 2021. Most of the building was accessible for people with mobility needs including an accessible toilet. The PCRF corridor and door was not fully accessible. This had been added to the risk register and Statement of Need (SON) submitted for improvements to be made. A hearing loop was not required based on a review of the needs of people who used the building.
- Training regarding the rights of transgender people had been provided in 2020.

Timely access to care and treatment

- In response to restrictions associated with COVID-19, a remote triage model including, the use of eConsult and telephone consultation had been implemented by the practice. Staff advised us that patients were not keen on eConsult and patients we interviewed confirmed this. Face-to-face appointments were frequently needed as the patient population required pre-deployment checks and vaccinations.
- Urgent and routine appointments with a doctor could be accommodated within one day, including virtual and face-to-face appointments. Medics could see patients on the same day. The nurses provided patients who had an urgent need with a same day appointment and a routine appointment could be accommodated within three days. The patients we spoke with during the inspection confirmed they received an appointment promptly and at their preferred time.
- A self-referral SOP was in place for patients to directly access the PCRF. We were advised this SOP was due for review. Self-referral forms were triaged by the physiotherapist within 24 hours and the PCRF administrator telephoned the patient to book an appointment. The form was scanned onto DMICP. Self-referral forms were retained for a year. A routine physiotherapy appointment was available within five working days, a follow-up appointment within two working days and an urgent appointment facilitated within one working day. For the ERI, a new patient appointment and follow up appointment could all be accommodated within four working days. Patient access to a rehabilitation class could be facilitated within one working day.

- Locum staff were used if there were PCRF staffing gaps and the Lossiemouth PCRF covered clinics in the absence of a physiotherapist during August 2021. The PCRF group structure provided an effective level of support within 'the group' to ensure appropriate clinical cover for all three PCRFs.
- For quarter one (April to June 2021) 100% of urgent referrals were seen within the key performance indictor (KPI) but only 88% of routine referrals were seen within the KPI. Although the routine referral percentage was below the organisational PCRF average of 93%, it was an improvement on 80% for quarter 4 (January to March 2021).
- Quarter one had a 5% DNA (non-attendance) rate for physiotherapy and a 6% for the ERI. This was above the average of 3% for physiotherapy and 2% for ERI. The PCRF did not have a DNA policy. Previously a search for DNAs was undertaken and the unit was informed but this was no longer happening in line with DPHC guidance.
- There was a two to three week wait for access to the multi-disciplinary injury assessment clinic (MIAC). The RRU advisory visit from February 2021 identified that patients did not have timely access to orthopaedics due to delays in access for NHS Scotland. The risk of negative impact on the health and career of service personnel posted to Scotland had been added to the risk register and the risk transferred to RHQ.
- Access to emergency medical cover was provided by the duty medic by telephone until 18:00. The medic had access to the duty doctor at Lossiemouth until 18:00 when NHS 111 commenced.

Listening and learning from concerns and complaints

- The practice manager was the lead for complaints and the SMO the deputy manager. The practice complaints SOP referred to the organisational complaints policy (JSP 950) and was last reviewed in December 2020. A complaints log was maintained and there were two complaints recorded since September 2020. Although we were advised both written and verbal complaints were recorded, we were not assured that low level complaints were recorded. For example, we were advised that a patient raised a concern about the practice being closed at lunchtime. Whilst this was addressed by providing access to the practice at lunchtime, there was no record on the complaint log. It may be that this concern was raised through patient feedback.

- Patients were made aware of the complaints process through the practice information leaflet and a poster in the waiting room. Patients we interviewed were aware of how to complain but said they had no reason to make a complaint about the service.

Are services well-led?

We rated the practice as requires improvement for providing well-led services.

Leadership, capacity and capability

- The SMO worked at the practice two days a week and spent the other two days at Lossiemouth Medical Centre as a GP trainer. Leadership capacity had increased in recent months with the RMO and practice manager taking up post in August and October respectively. In addition, one of the two vacant nursing posts had been filled with the recent recruitment of a Band 5 nurse. This meant the Band 6 nurse now had capacity to fulfil their numerous secondary roles and engage with governance and quality assurance activity. The practice management meeting in August 2021 recorded that management meetings had not been taking place due to the absence of key personnel.

- However, we identified potential risks in terms of sustainability of leadership capacity notably due to the SMO's commitments at another practice. Although the RMO deputised for the SMO, they were a unit asset so had commitments to the unit and were subject to deployment. The practice manager took up post four weeks before the inspection and was also the practice manager for Fort George Medical Centre approximately 20 miles away. During the first month in post, the practice manager had not had the capacity to visit the Fort George practice. We were not assured that the practice manager had sufficient capacity to manage another medical centre given the issues that needed improving at Kinloss Medical Centre.

- From our discussions with staff, we identified some historical relationship issues within the team which had had not been resolved through active management. The newly formed leadership team were aware of the issues and the practice manager was pro-actively addressing the concerns.

- The leadership team described good support from Regional Headquarters (RHQ). Despite taking up post recently, the practice manager had received numerous support visits from key staff within RHQ. In addition, increased IT support had led to IT improvements. Despite this regional support, staff advised us that access to locum staffing was a challenge.

Vision and strategy

- The practice worked to the DPHC mission statement, identified as:

  > "DPHC will deliver a unified, safe, efficient and accountable primary healthcare and dental care services for entitled personnel to maximise their health and to deliver personnel medically fit for operations"

  The practice had its own mission statement, stated as:

"Treating with dignity and care, in compassion we share"

The PCRF had a separate PCRF mission statement:

"The aim of medical rehabilitation is to bring about the accelerated return of injured military personnel to their fullest physical and psychological fitness and back to duty in the shortest possible time"

- From our review of clinical care, including access to patient records and interviews with both patients and staff, we found practice staff were committed to delivering effective patient care. This focus showed patients were at the centre of practice delivery.
- With the exception of the PCRF which was effectively integrated across 'the group', our interviews with staff highlighted an inconsistent understanding of the 'group of practices' structure. Staff understood the structure involved permanent staff from Lossiemouth Medical Centre backfilling clinical staffing gaps at Kinloss Medical Centre with locums providing cover at the larger Lossiemouth Practice. Staff said this did not always happen and practice gaps were often covered by locums which impacted continuity of clinical leadership.

Culture

- Staff were positive about the leadership of the practice now that leadership capacity had increased. The practice manager had developed an open door policy with the team. Staff told us they valued the one-to-one interviews the practice manager was facilitating as it provided a safe space to share their perceptions and concerns about the service. This approach coupled with the practice manager's impartiality was effective as staff had shared their views, which provided a rounded view of the cultural issues and leadership approaches that needed improving. Staff were positive the refreshed leadership approach would lead to improved structure and a better working environment. Equally, they were confident disharmony and relationship issue's would improve, including feeling valued and listened to. Staff had started to see improvements in communication as meetings were more structured, transparent and inclusive. Staff anticipated these new arrangements would ensure they were consulted about and involved in decision making.
- Some staff had found returning to the workplace after COVID-19 a challenge, which had been exacerbated by the recent absence of both the SMO and RMO. The practice manager was providing effective leadership and direction to the team despite having had no handover and uncertainty of the role.
- Within the PCRF there was a good team dynamic and staff were well supported by the OC PCRF at Lossiemouth. The outgoing OC RRU nominated all PCRF teams in the region for a team award for keeping things going though COVID-19 and for the teamwork and support between individuals and practices to maintain clinical services throughout this challenging time. PCRF staff reported feeling valued within the rehabilitation chain as a result. The OC PCRF Lossiemouth had provided leadership support including attending practice management meetings at Kinloss Medical Centre.
- Staff were aware of the whistleblowing policy and were also aware of the Freedom to Speak Up (FTSU) process within the region. The whistleblowing SOP was due for review in November 2021.

- Processes were established 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. We were given an example of when duty of candour had been appropriately applied. However, this was not recorded in the duty of candour log.

Governance arrangements

- The healthcare governance workbook (HGW) was the overarching system used to bring together a range of governance activities, including the risk register, ASER tracker, training register, SOPs, QIA and complaints. The practice manager had identified improvements were needed with the flow of information and governance structures. These issues were being addressed as a priority. Work had started on the HGW to ensure it was developed and structured in line with DPHC expectations.
- There was a staffing structure in place and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. Due to staff vacancies some staff, notably the Band 6 nurse, had been allocated numerous secondary duties, which they had limited time to fulfil. The line management of the administrative team was fragmented as individuals in the team had various line managers. Staff advised us this arrangement had an impact on consistent communication and decision making.
- The practice manager had implemented a new meeting structure and agenda for the practice and healthcare governance meetings to ensure all key areas were covered. They planned to hold more regular meetings due to the number of changes needed and the need to strengthen the governance structure. The initial focus had been to identify and mitigate the known risks and develop the HGW to ensure it supported key functions.
- A QIA programme had been established for 2021/22. Although there were gaps in the annual programme of quality improvement activity (QIA), clinical audit in key areas had been maintained including antibiotic prescribing and cervical cytology.

Managing risks, issues and performance

- The practice manager had conducted a full review of the practice risks and had developed both current and retired risk registers and, similarly, current and retired issues logs. Although the registers were not yet fully compliant with DPHC policy, they did cover the main risks identified by the leadership team. We identified risks that were not included on the risk register and have highlighted them in this report. Risk had been added as a standing agenda item to the monthly healthcare governance meetings. The wide range of risk assessments were overdue for review.
- Processes were in place to monitor national and local safety alerts, incidents, and complaints.

- The business continuity plan was underdeveloped as it did not articulate the process to take when there was a DMICP outage. In addition, it was unclear if the practice had a role in the major incident plan for the barracks and whether the practice had the resources to deliver against it.
- From historical examples given to us by staff, staff performance may have not been managed proportionally or appropriately. The practice manager had a clear plan in relation to future performance management. This included ensuring underlying issues were identified, induction and training were appropriate and the offer of a mentor to ensure issues did not escalate. If this process did not effect change then formal performance management processes would be instigated.
- A formal approach was not in place for the management of the cleaning contract.

Appropriate and accurate information

- The eCAF (Common Assurance Framework) commonly used in DPHC services to monitor performance is an internal quality assurance governance assurance tool to assure standards of health care delivery within defence healthcare. The practice manager referred to the eCAF to monitor the practice.
- National quality and operational information were used to ensure and improve performance.
- Systems were in place that took account of data security standards to ensure the integrity and confidentiality of patient identifiable data, records and data management.

Engagement with patients, the public, staff and external partners

- There were various options in place to encourage patients to provide feedback on the service and contribute to the development of the service. Due to COVID-19, options for patients to provide feedback while visiting the practice were limited, including use of the suggestion box. We spoke with the member of staff identified as the lead for the patient experience survey. They were no longer involved in this work since the paper forms had not been used during COVID-19. The practice manager was focussed on encouraging patient feedback online via ‘My Healthcare Hub’ and aimed to set up a patient focus group once they were established in post.
- Staff were encouraged to complete the Ministry of Defence staff survey and also through the one-to-one staff interviews the practice manager was conducting with staff.

Continuous improvement and innovation

- Leaders who recently joined the team had identified deficits in governance arrangements and team dynamics and were working on making improvements. Although this work was in the very early stages, we could see improvements had

started to happen. For example, the risk register had been revised and staff had been given the opportunity to share their views. However, there was a way to go to ensure all improvements were actioned.