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	**Good**	
Are services safe?	**Good**	
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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Summary

About this inspection

We inspected Kinloss Medical Centre in November 2021 and at that time we rated the service as requiring improvement due to shortfalls in safety measures and leadership.

We carried out a second announced comprehensive inspection on 21 February 2023 to see whether the improvements had been made.

As a result of this inspection the practice is now rated as good overall in accordance with CQC's inspection framework. Nevertheless there was scope to deliver additional improvement in the area of leadership and we have made some recommendations below.

Are services safe? – good

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.

- Staff confirmed that they felt valued and that they could impact service delivery as their voices were heard. However some staff reported some fractious relationships at work which hampered decision making and clear communication at times.
- Shortfalls in risk management had been addressed and risks had been appropriately escalated to Regional Headquarters (RHQ).
- There remained scope to ensure that healthcare governance information was comprehensive and easily accessible to all staff.
- Leadership capacity had improved following the merger of the Kinloss and Fort George Medical Centres. Additional resilience was delivered through cover arrangements with Lossiemouth.
- 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.
- Considerable progress had been made to address some contractual challenges with the cleaning contractor and additional cleaning hours had been forthcoming.

The Chief Inspector recommends:

- DPHC/DIO should ensure that Kinloss Medical Centre infrastructure is fit for its purpose
- The station must ensure that the hot water system is permanently fixed
- Deliver heat injury training to all relevant staff
- The policy and risk assessments for lone working ERIs should be reviewed to ensure their safety.
- Ensure that all patients prescribed a repeat medicine have been reviewed and that this has been Read coded correctly.
- Ensure that all medicines and consumable items are within their expiry date. Regularly check blood glucose machines with control solutions.
- Ensure that all patients prescribed a high risk medicine and who require a shared care agreement with secondary care, have one.
- Comply with policy (JSP 950 leaflet 9-2-1) with regard to safe storage of the controlled drugs key.
- Comply with ‘The misuse of Drugs Regulation 2001, point 20(c)’ which states that no cancellation, obliteration or alteration of entries in the CD register.
- Ensure warning signage is in place wherever flammable gases are stored, along with ‘no smoking’ signs. Ensure that people do not smoke near gas storage areas and

remove the wasps nest. Ensure that nursing staff have received medical gas cylinder training as per JSP 319.

- Extend quality improvement work to deliver improvements in patient outcomes. This should include monitoring and auditing outcomes for patients undergoing rehabilitation and extending the quality improvement work within the PCRF to cover all clinical areas including the referral pathway.
- Take proactive steps around team building in order to ensure that decision making and communication between staff members is optimal.
- Ensure that healthcare governance information is logically recorded and easily accessible to all team members.

Dr Sean O Kelly

Chief Inspector of Healthcare

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. One of the specialist advisors carried out the work virtually.

Background to Kinloss Medical Centre

Located in Kinloss Barracks, the medical centre provides a primary care, occupational health and rehabilitation service to a frequently deployed engineering regiment. At the time of the inspection there were approximately 1250 registered patients. In addition, occupational health services were 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 has recently transferred 500 patients from Fort George Medical Centre which no longer provides care. Kinloss works closely with Lossiemouth Medical Centre and shares some resources. 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) x 2 Medical Officer General Duties Medical Officer (GDMO) x 2
Nursing team	Band 6 practice nurse x 2 Band 5 practice nurse (vacant) Band 5 Military reservist practice nurse (vacant)
Practice management	Military practice manager
PCRF	Band 6 physiotherapist (x2) Exercise rehabilitation instructor (ERI) x2
Dispensary	Pharmacy technician
Administrators	Four (one vacant)
Military medic team*	Two Medical Sergeants (1x 39ENGR and 1 x 3 SCOTS) Ten junior medics (3 x 39 ENGR and 7 x 3 SCOTS)

* 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 good for providing safe services.

Safety systems and processes

- There was a named lead and deputy lead for safeguarding. Both had completed level 3 safeguarding. However some staff were unsure about who the safeguard lead was, but they knew how to find out if required. All Doctors and Nurses were trained to level 3 for Safeguarding both children and vulnerable adults.
- There were safeguarding signs displayed in clinical rooms and these included links to the local safeguarding teams. The practice also has an SOP (Standard Operating Procedure) (SN 047) which was accessible to all staff. 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.
- The practice actively searched for <18yr old service personnel and the units were reported to track these soldiers too. On arrival at Kinloss these patients are generally about to turn 18yrs within a few weeks and generally the practice has 0-5 patients <18yrs at any one time.
- Management of patients with vulnerabilities centred around engagement with the Units, including Vulnerability Risk Management and Unit Health committees. Patients subject to a Care Action Plan were Read coded and Alerts placed on their DMICP records. The medical centre team actively managed a caseload of around 100 vulnerable patients.
- As part of our inspection we spoke with a unit welfare officer who worked with the medical centre team. They confirmed that the medical centre worked effectively with other key stakeholders and that monthly meetings were held to discuss vulnerable patients. In addition, vulnerable patients were discussed at the unit health committee meetings. Domestic violence information and how to access support was displayed in the patient waiting area.
- Chaperone training was provided to staff who take on this role. Only healthcare professionals perform the chaperone duty. The Practice SOP was comprehensive and detailed the role of a chaperone and how to Read code to record whether a chaperone was offered, accepted or declined. There were posters advertising the availability of Chaperones for patients in clinical rooms and information was included in the practice leaflet.
- All staff held appropriate PVG (Protecting Vulnerable Groups) and DBS (Disclosure Barring Service) certificates which were recorded on the staff database. All required professional registrations were in place and also documented on the staff database. The practice nurse held a staff vaccination register. Hepatitis B status was reviewed as part of the recruitment process for all civilian staff and on induction of military staff. All staff had indemnity insurance. Both the SMO and RMO had undertaken clinical notes audits in 2022 and they had reviewed chaperone recording as part of their work.

- A 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 2022 with 94% overall compliance. Since then actions had been completed with the exception of some infrastructure issues that could not be remedied by the medical centre team. IPC audits were scheduled to take place every quarter.
- At our previous inspection we raised some concerns with the infrastructure which the medical centre team had also recognised through their own IPC audit. For example, there was damage to flooring, skirting boards, window blinds and paint work. Strip lights contained dead insects and some clinical areas were carpeted. At this inspection we noted that whilst the infrastructure was still not designed as a bespoke medical facility, staff were doing the best with what they had. Issues had been added to the risk register and escalated appropriately. Medical centre teams are unable to make improvements to the buildings they work in: they rely on the station and DIO to (Defence Infrastructure Organisation) to mitigate risks.
- Cleaning was provided on a contractual basis by Aramark and the medical centre team had only recently been able to view the contract. We noted that the practice manager and IPC Lead had made considerable progress to address some contractual challenges with the cleaning contractor and that additional cleaning hours had been forthcoming. A deep clean was undertaken in August 2022. On the day of our inspection the facility was visibly clean.
- Clinical privacy curtains were changed in line with guidance. Sharps' bins were labelled and used correctly. Clinical waste was stored in lockable bins at the rear of the medical centre which are padlocked to a secure post to prevent the bins being removed. Waste consignment notes were held and referenced to the clinical waste log. The most recent waste audit had been undertaken in January 2023. Purple lidded bins were available for the safe disposal of cytotoxic waste.
- The PCRF team followed a current and comprehensive acupuncture policy which included an information sheet and a written consent form which was scanned onto DMICP. A sharps box was in place and in date. A log was maintained of all patients who had acupuncture.
- PCRF equipment was managed by the ERI. At the time of this inspection equipment within the PCRF was out of date for servicing due to delays in approval at HQ level and then an issue with Leidos. The equipment was therefore not currently being used, although staff confirmed that most exercise therapy was completed in the gym. The equipment in the gym was shared with the physical training instructors (PTIs) who were responsible for servicing. It was all in date and evidence was held within the ERI's room.

Risks to patients

- Clinical capacity allowed patient needs (including urgent) to be met. Clinicians felt their work load was quite heavy at times and the key element to this variability was doctor

availability and nursing staff gaps. Cross cover with and support from DPHC Lossiemouth was part of routine business. Whilst the clinical team at Kinloss featured 2 RMOs and currently 2 GDMOs, only one or two of these MOs may be routinely expected to be delivering at any given time. A comprehensive review of how clinician capacity was used, and how this was best supported by the Units, was conducted by a cross practice team, resulting in a 'clinical optimisation directive' which was reported to have delivered a reduction in inefficient use of clinical time, and pushed the units away from ill-timed surges in requests for pre-deployment medical activity. With the two Band 5 posts vacant, a Band 6 nurse due to leave and the other Band 6 nurse having accrued 6 weeks leave, nursing capacity was presenting some concerns for the team, particularly given the challenges around recruitment locally.

- Physiotherapy staffing levels were sufficient to meet patient need. The transfer of the physiotherapist from Fort George to Kinloss had facilitated more resilience during times of annual leave or sickness. There was one military ERI working from Kinloss. He confirmed that his caseload was busy and when accompanied by all the governance activities, he did indicate that there had been times when he had been required to work long hours. At the time of this inspection there was no cover for ERI patients during his leave periods, but he provided ongoing programmes for patients to complete and tried to take his leave when the unit were on block leave where possible. There was also an ERI working 4 days at Fort George. Given the recent merger with Fort George, staff felt that the ERIs within the group practice would be able to work more closely and provide more resilience for each other in the future.

- An induction programme for all new staff (including locums) was available on SharePoint. Locum staff were required to complete mandated training and this was checked prior to their employment.
- The emergency trolley was both accessible to clinicians and secure. The emergency trolley seal was checked daily. The contents of the trolley were checked monthly. A list of emergency medicines was held in DMICP and included expiry dates. A defibrillator was located in the main gym for the ERI to access. A first aid kit was available and was in date.
- Sepsis training was last conducted on 25 January 2023 and there were sepsis red flag posters displayed within the practice. A non freezing cold injury simulation session was also held on 25 January 2023. The administrative team had access to a fact sheet about recognising the sick and deteriorating patient. Heat injury training had been deferred until March 2023.
- The policy for Wet Bulb Globe Temperature (WBGT), used to indicate the likelihood of heat stress, was displayed on 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.
- Waiting patients (including those who had received vaccinations) could be observed by staff. CCTV covered the reception, waiting room and the corridors adjacent to the nurses and medics treatment rooms.

Information to deliver safe care and treatment

- Issues with DMICP connectivity and reliability were both highlighted, but the medical centre team were well aware and had reviewed what activities they could safely conduct with short term loss of access to eHCR. This had been articulated in the business continuity plan which had been recently reviewed, Hard copies were also held at reception and the guard room.
- Recently 473 patients moved from Fort George and were registered at Kinloss Medical Centre. The SMO had personally summarised all 473 of these new records. A review of DMICP showed that 100% of patient notes had been summarised. The SMO conducted patient records audit at least annually for all doctors and delegated the review of her own clinical records to the RMO. The band 7 physiotherapist at Lossiemouth undertook annual notes audits.

- An SOP was in place for the management of specimens and we found they were well managed. Results were printed from SCI Store (NHS computer system) and then scanned on to DMICP by the office manager and tasked to the referring doctor (or the duty doctor) during protected time daily. The nursing team actively tracked the results coming in to make the system failsafe. The practice had a dedicated results line with limited hours of operation for patients to call up for results if they did not require a follow-up appointment. Doctors felt this was a useful feature and reduced time spent on appointments and calls.
- 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 practice worked across two different NHS Boards and the e-RS (electronic referrals system) was known to be ineffective. To mitigate this risk, the office manager engaged in extensive diligent management of a referrals tracker, with access and oversight shared with SMO/RMOs as resilience. We discussed a number of patients currently waiting for appointments including some who were not being correctly recognised by the NHS as being resident in their postcode (since Fort George patients had registered with Kinloss). Every effort was being made to engage with NHS stakeholders to ensure that patients were seen promptly and in the area that was most appropriate for the patient.

Safe and appropriate use of medicines

- The SMO was the lead (although this was not explicit in their terms of reference) and the pharmacy technician (PT) was the deputy lead for medicines management at the practice.
- Patient Group Directions (PGD), which allow practice nurses to administer medicines in line with legislation, were provided by Defence Medical Services. At the time of the inspection both Band 6 nurses had been authorised by the SMO to use PGDs for travel vaccinations and for pain relief. Annual competency assessments were carried out with the nurses. PGD medicines were held in a locked cupboard in the corridor. We were advised that since our previous inspection, stock rotation and time expiry checks of the PGD's were undertaken in line with the medicines management policy. The SMO

conducted an annual PGD audit and aimed to ensure that each PGD had been correctly authorised by the SMO, was within date and signed by the authorised nurses to use, including a review of consultation notes to determine if correct PGD templates and clinical codes were used. 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. The remaining prescriptions stayed in the printers over night as the doors to the consultation rooms were locked.
- All repeat prescriptions were forwarded to the doctors for authorisation. The PT only dispensed prescriptions if they had been signed by the doctor. We ran a clinical search in DMICP to include all patients prescribed a repeat medicine. The search results implied that 81% of these patients had not received a medication review. This was the case for some patients, but the main issue was a failure to Read code correctly.
- Uncollected prescriptions were checked monthly by the PT. A note was made on the patients record and the medicine destroyed including the prescription serial number. The PT alerted the prescriber if the medicine was a high risk medicine.
- Medicines held at the dispensary were stored securely including controlled drugs (CD). All CD prescriptions were stored in the 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. There was scope to ensure that CD and dispensing keys were held in a tamper proof sealed bag and an access log maintained.
- We noted that a number of items stored in medical surgery 2 and the medics treatment room had expired. Furthermore blood glucose had not been adequately checked.
- Medical gases were stored inside the nurse treatment rooms. There was no signage (HAZCHEM warning) on the doors to highlight that medical gases were stored. Nurses had not undergone medical gas cylinder training as per policy (JSP 319). The gas store outside the building did not have appropriate HAZCHEM warnings and there was no 'no smoking sign'. This could present a risk to fire crews attending a fire. We noted evidence that people had been smoking outside the gas store which constituted a significant risk to life. There was also a wasps nest which presented a hazard to staff using the gas store.
- 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, although the most recent had been missed. We carried out a check of a CD and it matched the last stock check carried out.
- 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 denaturing CD 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 for the past 12 months and saw that records were complete.
- The practice followed the DPHC protocol and local SOP for high risk medicines (HRMs). The Band 6 nurse carried out regular searches to identify patients on HRMs. There were two patients prescribed an HRM and one was subject to a shared care agreement with secondary care. The second patient did not have a shared care agreement in place and the medical centre confirmed that this would be actioned straight away.
- Doctors used the NHS Grampian guidance for antibiotic prescribing. Antibiotic prescribing audits were scheduled bi-annually. The most recent audit was completed in December 2022.
- We searched for patients prescribed valproate (treatment for epilepsy and a mood stabilising medicine) to ensure that pregnancy prevention information for women of childbearing age had been given. The search indicated that no patients were prescribed this medicine.

Track record on safety

- A risk assessments log was included in the healthcare governance workbook (HGW) with links to all practice risk assessments. There was a risk register, retired risk register, issues log and retired issues log on the HGW. All risks included detail of 4T's, Treat, tolerate, transfer or terminate and had a review date. There were a range of both clinical and non-clinical risks including lone working; management of sharps; COSHH risk assessment; slips trips and falls. Risk was a standing agenda item at the monthly healthcare governance meeting. 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.
- On the day of inspection, there was no hot water in the medical centre. The contractor had attended earlier in the week to provide a temporary fix and they attended once again whilst we were on site as the temporary fix had not prevailed. At the time of our previous inspection the hot water system had also failed raising the concern that this had become a long term issue that required a permanent solution. We noted that the cleaning staff were filling mop buckets from the wall mounted water boiler (used for hot drinks) in the staff kitchen. They had to lift the buckets up at waist level to do this. This constituted a health and safety risk to the cleaning staff who were lifting inappropriately and could be scalded by the boiling water.
- 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 August 2022 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 2022. The practice manager in the co-located dental practice was the building custodian and checked the fire alarm weekly. A fire safety plan for evacuation was of the building was displayed. An evacuation practice

took place in June 2022. 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. The ERIs at both Kinloss and Fort George worked alone at times. There was no alarm system within the gym at Kinloss, but the ERI did have a handheld panic alarm. This could be heard outside the room but would only be effective if there were other people around. The ERI in Fort George worked out of a room within the gym which was some distance from the PTI office. He did not have a panic alarm. There was an arrangement that military transport staff should check the building between 17.30 and 1800 but this did not always happen. The policy and risk assessments for lone working ERIs should be reviewed to ensure their safety.

Lessons learned and improvements made

- Significant events and incidents were reported through the electronic organisational-wide system (referred to as ASER) but worked to the DPHC ASER policy. A local ASER SOP was in place and was due for review in May 2023. All staff had an ASER login. 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 meeting. ASERs were a standing agenda item on the practice meeting and were identified in the minutes by ASER number. 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 had been referred for radiology investigation but a wrong email address had been used, delaying the patient's access to an appointment. The system had been improved to ensure that this could not happen again. We noted that ASER trends were discussed at the most recent healthcare governance meeting.
- Whilst the PT was responsible for managing patient safety alerts, they did not have access to the SharePoint area which would allow them to easily disseminate MHRA and CAS alert information. Nevertheless relevant alerts had been shared and recorded including if action was needed and when the action was completed. All relevant MHRA and CAS alerts had been discussed at management meetings.

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. A combination of monthly optimal care meetings, Unit Healthcare meetings and vulnerable register meetings and bespoke multidisciplinary team meetings were used to discuss patients with complex needs.
- 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, was documented in the clinical records we looked at.

Monitoring care and treatment

- The Band 6 nurse was the lead for long term conditions (LTC) and the SMO the deputy lead. Monitoring and recall was managed by the nurse using a system of monthly searches, supported by new patient registration reviews. Prerequisite assessments (blood testing, urinalysis) were ordered prior to periodic review by doctors. Management decisions sat with the GPs with regards changes in medication regimes. 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.
- We looked at the clinical records for 3 patients recorded as having high blood pressure. Appropriate Read codes were in place. We noted evidence of the team actively chasing patients with borderline readings to prompt engagement with reviews including blood tests. Management plans were in line with accepted practice and guidance.
- There were 5 patients with a diagnosis of diabetes. Appropriate management plans were in place and were reviewed regularly and routine screening assessments had been conducted. JMES (occupational health) gradings were appropriate and in date.
- There were 7 patients with a diagnosis of asthma. Where an established diagnosis had been given, regular reviews were evidenced with appropriate screening for asthma control. There was limited evidence of review of inhaler technique, but we noted

evidence of the use of asthma control plans, ACT (asthma control test) scoring, and consideration of use of salbutamol.

- We reviewed clinical records for three patients with mental health needs. We saw evidence of engagement with chain of command, regular reviews and engagement with the Department of Community Mental Health (DCMH) where appropriate. Clear consideration had been given to risk and safety. Coding and alerts for vulnerable patients were widely evident.
- Step 1 of the DPHC mental health pathway was delivered by the doctors at the practice. Patients were able to speak with the wider team including welfare and the padre. The DCMH was based in the building so doctors had prompt access to mental health practitioners for advice, although there was an extensive wait for specialist input. Effective support systems were in place for patients vulnerable due to their mental health, including a proactive culture of checking up on patients with the unit welfare team and DCMH. Read coding for patients with mental health concerns is a DPHC-wide challenge and as at most facilities there was scope to improve the application of mental health titles at this practice too.
- Seventy-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. Both audiology booths were now back in use and efforts were being made to ensure that those who were out of date received a test. Patients were tracked on DMICP via population searches and managed on a practice spreadsheet. Priority recalls were given to those on deployments and high readiness. The practice restructured its clinics last year following a clinic optimisation project.
- Not all staff we spoke with were aware that the medical centre had a quality improvement activity (QIA) programme comprising clinical audits, mandated audits and data searches. A QIA tracker was used to monitor the status of activity. The tracker showed some of the planned audits had not taken place in 2022 due to staff vacancies. There had been no cytology audit in 2022. Audits around depression, referrals, consent for minor surgery and use of antibiotics had been undertaken.
- The PCRF team were using two outcome measures for patients undergoing rehabilitation:
    1. the MSK-HQ measure which is a generic, single musculoskeletal outcome measure that can be used throughout the healthcare pathway and covers patients with different musculoskeletal conditions. Outcomes had not been audited recently.
    2. the FAA (Functional Activities Assessment) which is used to assess which work tasks patients are able to safely undertake at different points in their recovery journey. At the time of this inspection the average total number of days that patients were undergoing rehabilitation was 62 working days.
- The PCRF had undertaken audit work around process markers such as patients who did not attend their appointment and referrals to an ERI but there had been no clinical audits in the last 12 months. All physiotherapy and ERI staff had completed their Defence Healthcare Advisory and Wellbeing course and discussed these aspects one-to-one within consultations. Sleep and mood were both headings within the physiotherapy synonym for new patients. The ERI based at Fort George ran 'healthy habits' classes for patients struggling with weight and injury.

Effective staffing

- Since our previous inspection the practice had implemented the DPHC induction process which included role specific domains. All staff had completed a workplace induction and this had been recorded on the staff training log. The Practice Manager retained copies of completed induction checklists and records within the practice database. 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 in most areas.
- Monthly meetings contained peer support CPD and there was ready access to online resources. We noted cross site peer review and support in partnership with SMOs of both Kinloss and Leuchars. One of the RMOs was accessing regular professional development as part of the GP trainer course.
- Staff had completed specific training specific to their primary or secondary role. For example, the Band 6 nurse had completed the infection prevention and control (IPC) Link Practitioner training. The SMO was trained in aircrew and diving medicals. The practice manager course was on hold and so the individual in post had not received any formal training around practice management during their time in the role.
- Staff competencies were managed per professional group; SMO reviewed doctors, Band 6 nurse managed the nurses, RMOs/SMO reviewed medics' work books and competency logs and the administrative team were line managed by the office manager. 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 staff reflective practice.
- In the PCRF, weekly multi-disciplinary team (MDT) meetings took place and were attended by medical officers, physiotherapists and ERIs. Usually a discussion took place around 5 or 6 patients a week identified either by the physiotherapist or an MO.

Coordinating care and treatment

- The two RMO's took the lead on participation with unit health committee meetings (UHCs). However the other GPs became involved in VRM/CAP meetings for those with acute, crisis or mental health issues. The practice had effective communication links with internal services, such as the welfare team, DCMH, Regional Occupational Health Team (ROHT) and Regional Rehabilitation Unit (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.
- 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 medical officer. 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

- It was clear from the patient records we looked at that promoting optimal health was routine, particularly in relation to smoking cessation. 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 39Engr Medical Sergeant represented the practice at unit-led health and wellbeing days. The PCRF team ran an injury prevention stall at the unit health fair. The Fort George ERI ran a 'healthy habits' course for patients.
- The Band 6 nurse was the lead for sexual health and they had completed Level one training (referred to as STIF). Patients could be referred to both internal and external specialist sexual health service. Free condoms and chlamydia kits were available at the practice. Information about sexual health, contraception and pregnancy was displayed in the patient waiting area. Where required referrals could be made to specialist sexual health services at Dr Greys Hospital and Raigmore Hospital. The military sexual health consultant was available for advice around long term prescribing and monitoring patient needs.
- The Band 6 nurse was the lead for health screening. Regular searches were undertaken for:

  1. Bowel cancer: 18 patients were identified and 12 were not responsive to an invitation for screening. The nurse confirmed that all 12 had been followed up and encouraged to attend
  2. Breast (no patients identified)
  3. Abdominal aortic aneurysm screening (no patients identified)

  The number of eligible women whose records confirmed a cervical smear had been performed in the last five years (timeframe for Scotland) was 31 which represented an achievement of 84% which exceeded the NHS target of 80%.

  The vaccination statistics were identified as follows:

  - 94% of patients were in-date for vaccination against hepatitis B.
  - 94% of patients were in-date for vaccination against hepatitis A.
  - 95% of patients were in-date for vaccination against Yellow Fever.
  - 99% of patients were in-date for vaccination against MMR (measles, mumps and rubella).
  - 100% of patients were in-date for vaccination against Revaxis.

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, nurses and doctors, although we did note some disparity in Read coding. The offer and use of a chaperone was recorded in patient records. A consent audit had been completed. A notes audit for clinical staff, including consent and offer of a chaperone had been undertaken by the SMO.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

- Sixteen patients responded to the Defence Medical Services Regulator (DMSR) patient satisfaction survey which complemented this inspection. Eleven patients responded to a question around whether staff treated them with care and concern and nine said that this was either good or very good. Two respondents stated that this was neither good nor poor.
- We interviewed 8 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

- Sixteen patients responded to a question around whether staff gave them enough time to understand information during their appointment and thirteen said that this was either good or very good. Three respondents stated that this was neither good nor poor.
- 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.
- An equality access audit for the medical centre and PCRF had been completed. 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 a statement of need (SON) submitted in 2021 for improvements to be made, but funding had not been forthcoming.
- We discussed patients with protected characteristics under the Equality Act 2010 and found that doctors were well appraised around meeting the needs of patients who were undergoing gender reassignment.

Timely access to care and treatment

- Sixteen patients responded to a question around whether their experience of making an appointment had been good. Twelve confirmed that their experience was good or very good. Two said it was neither good nor poor and two stated that it was fairly poor.
- Urgent and routine appointments with a doctor could be accommodated within one day. 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 two or three days. Diving and aviation medicals could be accessed in under two weeks according to operational requirement. The patients we spoke with during the inspection confirmed they received an appointment promptly and at their preferred time.
- Although there was no self-referral standard operating procedure (SOP) in place, patients could self-refer to the PCRF. 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 one working day, a follow-up appointment within two working days and an urgent appointment facilitated the same day. For the ERI, a new patient appointment and follow up appointment could all be accommodated within one working day. Patient access to a rehabilitation class could be facilitated within one working day. All PCRF key performance indicators were being met.

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). A complaints log was maintained and there were four complaints recorded in the last 12 months. We saw that improvements had been made as a result of complaints being investigated. Once complaint had prompted the moving of the audiology booth to a quieter area. Another had led to improved management of patients who are temporarily posted away from their home unit and may require referral.

- 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 four days a week. Leadership capacity had increased in recent months following the merger with Fort George and the transfer of staff to Kinloss. Cross cover with and support from DPHC Lossiemouth was part of routine business. Whilst the clinical team at Kinloss featured 2 RMOs and currently 2 GDMOs, only one or two of these MOs may be routinely expected to be delivering at any given time. A comprehensive review of how clinician capacity was used, and how this was best supported by the Units, was conducted by a cross practice team, resulting in a 'clinical optimisation directive' which was reported to have delivered a reduction in inefficient use of clinical time, and pushed the units away from ill-timed surges in requests for pre-deployment medical activity.
- With the two Band 5 posts vacant, a Band 6 nurse due to leave and the other Band 6 nurse having accrued 6 weeks leave, nursing capacity was presenting some concerns for the team, particularly given the challenges around recruitment locally.
- We noted that a listing of staff lead roles was in place but we were unable to open or view the terms of reference (ToRs) for these roles. We were told that there was an aspiration to separate the ToRs for sub roles to allow transfer between post holders depending on staffing churn and structures.
- The leadership team described good support from Regional Headquarters (RHQ) which included monthly visits and regular contact by email and skype. Staff advised us that access to locum staffing was a challenge.
- In general we noted a diversity in the practice clinician cohort that was broadly complimentary, some clinicians very much focussing on diligent clinical records management and outputs, some on innovative practice, but all with a view to good patient care and without apparent fratricide.

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"

- The management of the merger of Fort George and Kinloss medical centres had presented a wide range of challenges for the team and the patients they serve. The team articulated some of the logistical issues, such as additional travel time and the barriers posed by new NHS Board referrals. Nevertheless the team were making headway in tackling these challenges and forging new ways of working.
- From our review of clinical care, including access to patient records and interviews with both patients and staff, we found the practice was committed to delivering effective patient care.

Culture

- Our interviews with staff demonstrated some cohesive behaviours within the practice, including the involvement of a range of staff in the review of clinical service delivery. The staff training day on urgent care was cited as great for team building as it brought the non clinical and clinical staff together in considering the management of patients.
- Nevertheless some staff described an element of friction between staff members. They said that this caused additional tension in the workplace and sometimes slowed decision making.
- All staff confirmed that there was an open door policy in place and that they could approach departmental leads if they needed to report concerns. 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 a patient being given the wrong vaccination and how duty of candour was correctly applied.

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. Use of the HGW appeared limited with much of the functionality extracted into other spreadsheets and files with extensive use of filters. We found it difficult to access some key information during this inspection.
- A monthly meeting plan was in place and included management, practice and group clinical meetings. Monday morning huddles also took place. Staff confirmed their voices were heard in these meetings and that their contributions delivered improvements.

- Not all staff we spoke with were aware that the medical centre had a quality improvement activity (QIA) programme comprising clinical audits, mandated audits and data searches. A QIA tracker was used to monitor the status of activity. The tracker showed some of the planned audits had not taken place in 2022 due to staff vacancies. There had been no cytology audit in 2022. Audits around depression, referrals, consent for minor surgery and use of antibiotics had been undertaken.
- The PCRF had undertaken audit work around process markers such as patients who did not attend their appointment and referrals to an ERI but there had been no clinical audits in the last 12 months.

Managing risks, issues and performance

- The DPHC risk matrix was in place and included an option to escalate risks up to RHQ Scotland. Building related risks had been accepted by RHQ. Staff confirmed that the top three risks were regularly reviewed. The medical centre team engaged with RHQ risk meetings.
- Processes were in place to monitor national and local safety alerts, incidents, and complaints.
- The business continuity plan had been developed to articulate the process to follow in the event of DMICP outage. The role of the medical centre had been clarified in the event of activation of the major incident plan for the barracks. The RMO was the point of contact for this activity and a table top exercise took place in January 2023.
- Staff did not confirm any instances where formal staff performance management had been required. They stated that if issues were identified, induction, training and mentors would be offered in advance of the application of formal performance management processes.

Continuous improvement and innovation

- The introduction of nurse triage had led to better utilisation of appointments available, notes summarising and Read coding.
- Following the merger with Fort George, clinics had been optimised to better provide for all units (taking into account travel time for FG patients)
- A comprehensive new SOP had been implemented for e-registration of patients as of February 2023. This involved patients accessing a QR code during the joining procedure requiring the patient to complete a form. This new approach facilitated updates to referrals, blood results, immunisations and audiology.
- A clear flow chart and SOP for specimens was introduced in January 2023. Samples were requested on DMICP, the sample recorded through the template and then requested electronically through the NHS system and labels printed (duplicated). Each morning results were printed off the NHS computer and reviewed by the nurse. All results are scanned and any abnormal results were tasked to Duty Doctor.

- A ‘healthy habits’ class had been introduced in Fort George with the aim of improving wellbeing of patients.