Lossiemouth Medical Centre

RAF Lossiemouth, Moray, IV31 6SD

Defence Medical Services inspection report

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information given to us by the practice and patient feedback about the service.

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?	**Good**	

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Summary

About this inspection

We carried out this announced comprehensive inspection of Lossiemouth Medical Centre on 23 July 2024.

As a result of the inspection the practice is rated as good overall in accordance with the Care Quality Commission's (CQC) inspection framework.

Are services safe? – good

Are services effective? – good

Are services caring – good

Are services responsive to people's needs? – good

Are services well-led? – good

CQC does not have the same statutory powers with regard to improvement action for Defence delivered healthcare under the Health and Social Care Act 2008, which also means that Defence delivered healthcare 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 Defence delivered healthcare. DMSR is committed to improving patient and staff safety and will take appropriate action against CQC's observations and recommendations.

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

At this inspection we found:

- The practice demonstrated a person-centred approach to accommodate the needs of individuals and units. Patients were included in decisions about their individual treatment and care.
- The practice sought feedback from patients about the service and then acted on feedback to improve the patient experience. Feedback about the service was positive. It showed patients were treated with compassion, dignity and respect.
- Effective safeguarding arrangements were in place station-wide and the practice had good lines of communication with the units and welfare team.
- At the time of the inspection, staffing levels were adequate. The leadership considered succession planning to ensure sufficient capacity and capability.
- The practice was in the early stages of transitioning to a 'combined practice' with Kinloss Medical Centre.

- There were mixed views expressed by staff about the culture of the staff team.
- The electronic organisational-wide system (referred to as ASER) was used to record significant events, incidents and near misses.
- Whilst patients received their medicines in a safe way, some medicines management systems required strengthening, including controlling access to the dispensary.
- The practice had processes in place to mitigate the risks with sample management. Further measures could be put in place to monitor trends.
- Quality improvement was embedded in practice, including various approaches to monitor outputs and outcomes used to drive improvements in patient care. There was scope to develop clinical audit based on population need.

The Chief Inspector recommends to the practice:

- Ensure a risk assessment is completed for the emergency medicines and the controlled drugs cabinet.
- Consider entering sample results manually in patient records so that trends with results can be easily tracked for audit purposes.
- Review the throughput of staff within the dispensary with the aim to reduce staff access so risk associated with access to medicines is minimised, including the risk of dispensing errors from environmental distractions.
- Undertake a regular search to identify patients prescribed valproate (medicine to treat epilepsy and bipolar disorder) so that risks associated with this medicine can be monitored.
- Consider developing quality improvement activity further with an emphasis on clinical audit based on population need.
- Review the management arrangements for the nursing team to ensure they are in line with Defence Primary Healthcare policy.
- Seek the views of staff as part of a broader plan to improve the staff culture.
- Ensure training in learning disability and autism is provided in accordance with DSMR regulatory instruction issued in April 2024.

Dr Chris Dzikiti

Interim Chief Inspector of Healthcare

Our inspection team

The inspection team was led by a CQC inspector supported by a team of specialist advisors including a primary care doctor, nurse, pharmacist, physiotherapist and practice manager. As part of their induction, a new specialist advisor shadowed the inspection.

Background to Lossiemouth Medical Centre

Lossiemouth Medical Centre provides a primary care rehabilitation and occupational health service to a patient population of 2,200 comprising regular and reserve service personnel. This number will rise to approximately 3,000 by the end of 2024. The population is predominantly working age adults with the occasional patient under the age of 18. Families of service personnel registered at local NHS primary care services.

The practice has a dispensary and a Primary Care Rehabilitation Facility (PCRF). It facilitates 24-hour airfield crash cover, aviation medicine advice 24 hours 7 days a week and deployment preparation.

The practice is open 08:00 -18:00 hours Monday to Friday. Except for medical emergencies, the practice is closed Wednesday afternoon from 12:00 hours for staff training. Urgent medical advice or treatment out-of-hours (OOH) can be accessed via NHS 24 on 111. In addition, the duty medic provides airfield cover and urgent aviation support OOH.

The staff team

Doctors	Senior Medical Officer Deputy Senior Medical Officer Civilian medical practitioner x 2 - 5.5 full time equivalent (FTE) Unit Medical Officer x 2
Nurses	Practice Nursing Officer - **position vacant** Military nurse Civilian nurse Civilian Nurse x 2 (1 x Band 5, 1 x Band 6 FTE)
Practice management	Warrant Officer Practice manager Deputy practice manager
Administrators	3.5 FTE
Pharmacy technician	2
PCRF	OC (lead) physiotherapist

	Band 7 physiotherapist Band 6 physiotherapist – **position vacant** Band 6 Physio 0.4 Exercise rehabilitation instructor x 2 (1 position filled by a locum) Administrator
Medics	Junior Non-Commissioned Officer x 3 Air Specialist (class 1) x 9

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

A safeguarding lead and deputy were identified for the practice. All staff were in-date for safeguarding training at a level appropriate to their role. Reviewed in July 2024, a safeguarding policy for adults and children was in place along with contact details for the local safeguarding teams.

Patients identified as vulnerable and those under the age of 18 had a clinical code and alert applied to their record on DMICP (electronic patient record system). Equally, coding and alerts were applied to care leavers identified when registering with the practice and through clinical notes summarisation. DMICP searches were run each month to keep track of patients who were safeguarded and/or vulnerable. A clinical risk/vulnerable person register was maintained and reviewed at the monthly clinical meeting. Any vulnerable patients attending the Primary Care Rehabilitation Facility (PCRF) were seen by the OC or Band 7 physiotherapists, both of whom were trained in level 3 safeguarding.

The practice was represented at the station welfare meeting referred to as the Service Personnel Support Committee (SPSC) at which vulnerable patients were discussed including additional individuals known to the unit but not to the practice. Based on the station, SSAFA (the armed forces charity) informed the practice if the team became aware of any vulnerable additional patients outside of the SPSC meeting. The safeguarding lead facilitated regular training for new staff and 6 monthly training to capture policy changes.

We were given an example of a recent safeguarding concern. The practice supported the patient to engage with the social work team and also signposted them to other supportive services.

A chaperone policy was in place and was reviewed in June 2024. The availability of a chaperone was outlined in the practice information leaflet and displayed in the patient waiting area along with a list of staff who were trained chaperones. Annual training was provided for staff acting as chaperones.

Although the full range of recruitment records for permanent and locum staff was held centrally, the practice manager demonstrated that relevant safety checks had taken place at the point of recruitment, including Protecting Vulnerable Groups (PVG/Disclosure Scotland) certificates to ensure staff were suitable to work with vulnerable adults and young people. PVG checks were renewed in accordance with Defence Primary Healthcare (DPHC) policy. The vaccination status for staff members was checked by one of the nurses as part of the induction process.

One of the nurses was the lead for infection prevention and control (IPC) and had completed the IPC link practitioner training. The IPC deputy lead post was unfilled at the time of the inspection. All staff were in date for IPC training. Measures were taken to minimise the spread of infectious diseases, including regular hand washing, assessed as part of IPC audit. If a patient telephoning for an appointment was suspected to have an infectious disease, then they were triaged by telephone. Patients requiring a face-to-face

appointment were chaperoned through a different entrance and be given a face mask to wear. Masks were available staff when seeing patients with an upper respiratory illness.

The IPC lead had good links with Public Health Scotland. Tracking of FMED 85s (notifications for infectious diseases in Defence settings) was undertaken by the nursing department. The practice also regularly communicated with the environmental health practitioner who worked within the practice. Although the station was the risk holder, its outbreak plan was out-of-date so the practice developed its own plan. An annual IPC audit was undertaken with the latest completed in June 2024. The findings and action plan were discussed in the healthcare governance (HCG) meeting. Sinks were identified as non-compliant and the risk was tolerated locally.

The Warrant Officer oversaw the environmental cleaning contract. A change in cleaning staff had led to a decline in cleaning standards, which the practice manager had since addressed. A cleaning issues log was also maintained, and the cleaning manager reviewed the standard of cleaning quarterly. The cleaning manager reviewed the quality of cleaning each month and regularly engaged with the practice to ensure satisfaction with service provision was satisfactory. The last deep clean took place in December 2023.

Acupuncture was provided at the PCRF. A risk assessment and standard operating procedure (SOP) was in place to support this procedure.

Clinical waste was safely managed. The medical and dental centres shared the clinical waste storage with the dental centre providing transfer notes. Consignment notes were in place and up-to-date. Secure storage for clinical waste was located outside of the building. The last annual clinical waste audit was undertaken in June 2024. Sharps boxes were labelled, dated and used appropriately.

Risks to patients

The practice was established for 37 posts and 33 staff were in post; 19 uniformed, 14 civilian including 3 locums. Despite the staffing gaps, staff advised there was sufficient clinical cover at the time of the inspection. Gaps were managed by the use of locums, although locum staff were sometimes difficult to secure due to remote location. The practice working collaboratively with Kinloss Medical Centre and often shared resources. For example, the unit exercise rehabilitation instructor (ERI) from Fort George had been providing support. In addition, the 2 physiotherapists at Kinloss Medical Centre were also available to support. Feedback from patients indicated there was access to timely and flexible appointments suggested staffing levels were sufficient to ensure provision of person-centred clinical care.

The emergency trolley was secured with a serialised tag. We checked all the emergency medicines held on the trolley and they were in-date. Equally, the oxygen cylinder was full and in-date. Appropriate hazard warning signage (referred to as Hazchem) was displayed in the rooms were gases where stored. Expiry date checks were completed each month for emergency medicines. Time expiry reports were run for all medicines held on the emergency trolley DMICP list. Evidence was seen that ambient temperature monitoring was being completed in accordance with the DPHC SOP regarding temperature monitoring. There was no evidence that the emergency medicines risk assessment had been completed in line with DPHC policy.

The Senior Medical Officer (SMO) and deputy SMO were the resuscitation leads for the practice. The staff team was up-to-date with Basic Life Support training, anaphylaxis and the use of an automated external defibrillator (AED). An AED was also located in the squash court area of the PCRF gym. The paramedic for the RAF regiment and the mountain rescue service facilitated trauma training for staff. Scenario-based training or moulages were held on a regular basis. For example, a scenario had recently been held at the station to test crash response. Staff had received training in managing spinal injuries. Both clinical and non-clinical staff we spoke with were aware of the signs and symptoms of the deteriorating patient/sepsis.

Information to deliver safe care and treatment

The practice was notified of any planned network outages via the group mailbox from Regional Headquarters (RHQ). Most planned outages occurred out-of-hours (OOH) so did not impact clinics. Few unplanned outages happened, but when they did, the practice referred to the business continuity plan. This included reducing services to urgent care only in accordance with DPHC direction. Clinic lists were printed at the end of each day for the next day, which allowed for appointments to be cancelled/re-prioritised if required. The practice could also lean on Kinloss Medical Centre for support if needed.

Effective processes were in place for the summarisation of patients' records, including regular DMICP searches. At the time of the inspection, 98% of records had been summarised.

An internal process was in place for the auditing of clinical records for all staff with a clinical role, including PCRF staff. One of the nurses reviewed the record keeping of the duty medic following the morning triage clinic.

The nursing team oversaw the process for the management of samples. A specimen register was maintained. With no access to Pathlinks in Scotland, the practice used ICE (standalone system for requesting and receiving laboratory results) to print results each day. Unlike Pathlinks, ICE was not connected to DMICP. This presented a potential risk of delays with results and inaccuracies with requesting bloods. Results were scanned to DMICP and, where required, recorded on a template which had different parameters to the local laboratories. This could give the impression results were abnormal/normal when it was the opposite. Following an initial review by the duty doctor, results were scanned to DMICP and tasked to requesting doctor. Previously, staff manually entered results into DMICP but said they stopped doing so because of a couple of transcription errors. By not entering results in DMICP tracking trends in results presented a challenge. Patients received results via email, text, telephone call or through a face-to-face.

A process was in place for managing both internal and external referrals including urgent 2-week-wait referrals. The doctor tasked the administrator who managed referrals who processed the referral and added it to the referrals spreadsheet. The referral register was regularly reviewed and updated. The practice was in the process of moving to a new DPHC centralised process for managing referrals. Hospital referrals were discussed at the practice meetings including the nature of the referral and NHS waiting times for each speciality.

Safe and appropriate use of medicines

The SMO was the lead for medicines management and the pharmacy technician (PT) was the deputy lead and also responsible for the day-to-day management of the dispensary. The terms of reference for the leads held on the health governance workbook were not the same as the printed copy held in the dispensary. We highlighted this during the inspection.

A bound book held in the dispensary was used to record the receipt and supply of the FMed296 prescription forms. Forms received were stored in the dispensary and the serial numbers of the first and last FMed296 were documented in the book. We observed that FMed296 prescriptions were issued by serial number and clinicians had signed and dated the receipt of prescriptions in batches of 100.

Copies of Patient Group Directions (PGD), which authorise nurses to administer medicines, were signed by the SMO and kept in the dispensary along with staff training certificates. The last PGD audit was undertaken in February 2024. Patient Specific Directions were not used in the practice.

Clear processes were in place for the requesting and issuing of repeat medication. On discussion with the PT and review of DMICP records, it was evident that there was a clear audit trail for the request of repeat medication. Patients could access requests via email and repeats slips. There were also printed copies of repeat slips for patients to complete and place in a secured post box outside of hours; all which was clearly communicated to patients via signage at the front of the dispensary.

The PTs were aware of their responsibilities and knew when requests should be tasked to a senior clinician. Repeat prescriptions were only re-issued if the patient's review date was in-date and there were available repeat counts on the patients prescribing record.

Prescriptions were signed before they were dispensed. The process for handing out prescriptions to patients was discussed and witnessed and was in-line with DPHC policy. Appropriate side-effect warning cards were held in the dispensary. We observed patients being given comprehensive counselling regarding their medicines, including a reminder to read the patient information leaflet in the medicine's container.

Dispensed medications awaiting collection were checked every 4 to 6 weeks and removed from the shelf. Some medicines were placed in quarantine for another 2 weeks giving patients a chance to collect and reduce waste. Uncollected medicines were appropriately recorded on DMICP and clinicians informed. Expired medications were destroyed using the appropriate pharmaceutical waste bins and latest destruction certificate was witnessed.

From discussion with clinicians and a review of patient records, we were assured that patients' medicines were appropriately reviewed, including treatment and clinical medicine reviews. All entries had been clinically coded.

Although the PTs were unable to locate the local working policy (LWP) for managing changes to a patient's medication OOH or by secondary care, they described a clear process for the management of secondary care prescription requests. Our review of 2 patient records evidenced that the process was followed.

There were well defined processes in place for the ordering and receiving of vaccines, including OOH or when the PTs were not present. All vaccines were in-date and the vaccines were being correctly rotated in the pharmaceutical fridges. There was sufficient

space around the vaccine packages for air to circulate. No food or specimens were held in the pharmacy fridges. The temperature of the fridges was monitored twice a day when the practice was open. The external thermometers were in-date. We checked 5 different vaccines and noted stock levels were correct in accordance with DMICP.

We carried out a spot check of prescription only medicines and vaccines and all items were in-date. Containers for temperature sensitive medicines were available in the event of a fridge failure or outage. A detailed process was in place for the action to take on discovery of a failure. External thermometers were in-date and records confirmed the temperature of the pharmaceutical fridges was monitored twice a day. We checked 5 different vaccines and stock levels were correct on DMICP.

Stock was effectively managed and medicines with the shortest time expiry were placed at the front of the shelf. Time expiry reports were being run one month in advance and stock due to expire within the month was separated from the main stock to minimise the risk errors. Evidence was seen of a rolling stock check taking place.

There was a nominated high risk medication (HRM) lead. A collaborative approach was taken between the prescribing clinicians and the PTs regarding the managing of patients prescribed an HRM. The HRM register supported the safe and comprehensive management of patients. HRM prescribing was discussed at the practice clinical meetings at which the PT participated. A HRM audit was completed in June 2024. Our review of 3 patients confirmed appropriate HRM and shared care alerts were identified on the patients' DMICP records. A HRM audit was undertaken in July 2024, which confirmed monitoring of HRMs was correct. A small number of patients did not have an alert on their records but the recall was in place with blood tests in-date and the monitoring process shown to be safe.

Controlled and accountable drugs (CD/AD) were kept in the dispensary in a controlled drugs (CD) cabinet, with a separate CD cabinet for the storage of CD/ADs that form part of the response modules. Schedule 2 and 3 medicines were kept within the inner compartment of the CD cabinet. The CD cabinets were not compliant with the Misuse of Drugs (Safe Custody) 1973 Regulations as hinges were externally positioned; there was no evidence of this being risk assessed internally or by unit security.

A spot check of physical stock, DMICP and documentation in the BMed 12 found no errors in the accounting of the controlled and accountable medicines. All FP10CDs were also correctly accounted for in a bound book. Documentation in the BMed 12 was legible and in accordance with DPHC policy. The specimen signature log in the BMed 12 had been completed accurately by all those involved in the accounting of CD/AD medicines. Internal monthly and external quarterly checks had been completed in line policy for all CD/Ads held as dispensary stock. The self-declaration had been completed and the annual CD audit undertaken in April 2024.

A review of the most recent destruction certificate confirmed that accountable and controlled drugs were appropriately destroyed. The dispensary procured Fentanyl (strong painkiller) for the Mountain Rescue Service and the management of this medicine was in accordance with DPHC's SOP for the supply of medicines to the mountain rescue service.

An LWP was in place to advise on accessing the dispensary and CD cupboard if required OOH. The practice had a key press that held the CD/AD keys. A safe log controlled access to the dispensary and CD keys, which were kept separate from the dispensary keys.

Concerns were raised about the appropriateness and safety of non-dispensary staff accessing the dispensary to give patients their dispensed medicines OOH. This should only be an exception in accordance with DPHC guidance. More broadly, many staff had access to the dispensary. All duty staff knew the combination to the dispensary for OOH access. The dispensary was used as a thorough-fare to the store area and during the inspection several non-dispensary staff were witnessed using the access code to enter the dispensary causing unnecessary disruption to the PT. Furthermore, there was a potential that the access code could be seen by people visiting the practice. Email evidence demonstrated that this concern had been raised to the chain of command and to RHQ. Promptly after the inspection, the practice manager provided us with a list of the staff authorised to enter the pharmacy.

There was no evidence that regular DMICP searches were undertaken to identify patients prescribed valproate. The PTs were unable to locate the patient information leaflets used as part of the pregnancy prevention programme. We confirmed there were no patients prescribed valproate at the time of the inspection.

Prescribing habits, such as for opiates (strong painkillers), were discussed at the clinical meetings. An antibiotic prescribing audit was undertaken in June 2024. It considered all antimicrobial prescriptions over a month period. A clinical record review was undertaken to assess against standards. This audit has had several full 6 monthly cycles and showed clinicians adhered to prescribing standards. The audit cycle had been appropriately changed to annual.

Track record on safety

The SMO was the risk owner and the Warrant Officer was the risk manager. Taking account of the ‘4 T’s process’ (transfer, tolerate, treat, terminate), the risk register was detailed and was reviewed each month at the healthcare governance meetings. Meeting minutes confirmed this.

A range of regularly reviewed clinical and non-clinical risk assessments were in place, including for the Control of Substances Hazardous to Health (COSHH). Data sheets and annually reviewed risk assessments were in place for COSHH products. The OC physiotherapist oversaw the risk assessments for the PCRF and any updates were highlighted to staff at the PCRF team meetings.

The legionella risk assessment for the building was reviewed in March 2024. Legionella was found in the water 12 months ago so the flushing of water outlets was carried out twice a week. Specialist filters had been fitted to all taps to reduce the risk of legionella in the water system.

The monitoring of environmental risk was delegated to the environmental health practitioner employed by the station. Checks related to lighting, pest control and hearing and sound surveys. Health and safety was considered within the staff induction process, including fire, first aid and flight safety.

An equipment lead and deputy were identified for the practice. Evidence was provided to demonstrate electrical, gas and portable electrical appliances checks were up-to-date. An equipment inspection (referred to as a LEA) was undertaken in October 2023. The 2 non-

conformances identified had since been addressed. An equipment servicing contract was in place for the PCRF, which the ERI oversaw.

Station gym staff carried out wet globe bulb testing (WGBT) to indicate the potential for heat stress and informed the PCRF staff of the temperatures.

A fire representative and deputy were identified for the practice. The station fire department carried out a fire risk assessment of the premises in September 2023. The fire department carried out regular checks of the fire system and firefighting equipment, including weekly fire alarm checks. Fire evacuation drills were held 6 monthly with the most recent undertaken in March 2024.

A risk assessment had been completed for the duty medic who worked in the building on their own OOH. An integrated emergency alarm system was installed in clinical areas including the dispensary. The alarm was checked on a regular basis and a record maintained. There was not an integrated alarm system in the PCRF portacabin or gym squash court. Alternative measures included the use of personal alarms, availability of a static phone and personal mobile phones.

Lessons learned and improvements made

A lead and deputy were identified for the management of significant events, incidents and near misses reported through the organisational-wide ASER system. The staff database showed all staff had completed ASER training and had access the system.

An ASER tracker was maintained, which included a description of the event/incident, classification and lessons learned. All staff we spoke with knew how to report an event/incident. Once an ASER was raised then a team was allocated to undertake a root cause analysis. Minutes confirmed events/incidents were routinely discussed the HCG meetings, including lessons learned. The full staff team attended these meetings. An ASER analysis was completed for June 2024 and discussed on the HCG meeting on July 2024.

From June 2023 to June 2024 a review of significant events was undertaken to identify trends. They included temperature outages on pharmaceutical fridges, waiting times for colposcopy (procedure to test for cancer or potential cancer cells) and eConsults received from patients not registered at the practice.

Staff provided numerous examples of improvements made following a review of a significant event. For example, a significant event was created when the incorrect usage of a container for temperature sensitive materials resulted in loss of stock. As result an LWP was created and dispensary staff were now training duty medics in the correct use of these containers

Effective processes were in place for the management and action of Medicines and Healthcare products Regulatory Agency (MHRA) and National Patient Safety Alerts. Evidence was seen of an in-date electronic MHRA alert register and that the practice had a system in place to ensure that they were receiving, disseminating and actioning all alerts and information relevant to the practice. Alerts were discussed at the clinical meeting.

Are services effective?

We rated the practice as good for providing effective services.

Effective needs assessment, care and treatment

Processes were in place for clinical staff to keep up-to-date with developments in clinical care including National Institute for Health and Care Excellence (NICE) guidance, the Scottish Intercollegiate Guidelines Network, clinical pathways, current legislation, standards and other practice guidance. Staff were kept informed of clinical and medicines updates through the Defence Primary Healthcare (DPHC) newsletter circulated to staff each month. A link to NICE guidance was available on front page of team SharePoint site. New or updated guidance was discussed at the weekly clinical meeting.

Patients with complex or concerning needs were discussed at the clinical meetings. Staff explained that a record was made of the meetings to protect identifying the patient. We discussed how it would be useful to keep a record of this meeting to allow staff unable to attend to keep abreast of clinical issues. Alternatively, a list of patients discussed could be held on the DMICP system.

The Primary Care Rehabilitation Facility (PCRF) team took a holistic approach when assessing patients and considered lifestyle factors, such as mood, sleep and diet; evident in clinical records we reviewed. Obesity and other lifestyle behaviours were a concern for the patient population. All PCRF staff were trained Defence Health and Wellbeing Advisors, which provided a base knowledge and skills for supporting patients with improving health. Now that the Department of Defence Rehabilitation website was no longer active, the PCRF team had access to best practice guidelines held on SharePoint.

Our review of patient records showed that the Musculoskeletal Health Questionnaire (MSK-HQ), the standardised outcome measure for patients to report their symptoms and quality of life, was routinely used by PCRF staff. It supported with monitoring and auditing patient progress, and also informed the patient pathway. Patients accessed rehabilitation exercise programmes through Rehab Guru (software for rehabilitation exercise therapy).

The PCRF was sited across 4 areas; the medical centre, portacabin and main gym (main gym had both an office/treatment room and a separate rehabilitation gym on a converted squash court). The OC physiotherapist mitigated the risks associated with a multi-site service by regularly visiting the 3 sites. There had been plans for a rehabilitation specific space funded by the unit but this plan had been withdrawn.

Doctors delivered step 1 of the DPHC mental health pathway. Patients who needed intervention beyond step 1 were referred for a Department of Community Mental Health (DCMH) in accordance with the unified care policy. We were advised that waiting times for DCMH psychology therapy were lengthy. Patients could access the RAF Benevolent Fund who provided easy access to talking/support therapies. Patients with complex/concerning mental health needs were discussed at the weekly clinical meeting. Our review of clinical records showed patients with a mental health need were well managed and appropriate clinical coding was used.

Monitoring care and treatment

A nurse and doctor were identified as the leads for long term conditions (LTC). Although the nurse maintained the LTC spreadsheet, all clinicians could update it. Monthly DMICP searches were undertaken and patients due a review were contacted. The nursing team conducted preliminary health checks prior to the patient being reviewed by the doctor. The lead nurse was in the process of transferring data and adjusting the recall process in line with the new centralised DPHC process, which will support a standardised recall process across the organisation, including the use of clinical coding.

The practice confirmed that the 9 patients identified as having diabetes had been followed up. Patients with gestational diabetes had an annual blood test to check for type 2 diabetes (referred to as HbA1C). A test for diabetes was offered at periodic medical examinations when the patient was 40 and aircrew were automatic recalled and tested from the age of 40.

Fifty nine patients were identified as having hypertension (high blood pressure) and 56 had a record confirming their blood pressure was checked in the past 12 months.

Twenty seven patients had a diagnosis of asthma and 24 had an asthma review in the preceding 12 months. The asthma template within the chronic disease DMICP menu was consistently used by clinicians.

We reviewed a random sample of clinical records for patients with an LTC. Overall, they showed appropriate recalls, monitoring and follow up was in place. The records indicated the management of a small number of patients with a LTC fell short of the expected standard. We provided the deputy Senior Medical Officer (DSMO) with the details so the care (and quality of record keeping) of these patients could be promptly reviewed. Following a review of the records, the DSMO responded with the action plan for each patient. Actions included recalling some patients for a review and discussion at the clinical meeting to remind doctors to use templates and adjust recall dates so follow ups are not missed.

Audiometry assessments were in date for 84% of the patient population. A review of patient records indicated appropriate Hearing Conservation Programme recalls were in place and patients were being managed in line with DPHC policy.

A lead and deputy were identified as the leads for quality improvement activity (QIA)/audit. QIA predominantly comprised organisational mandated audits, data searches and routine checks. An audit calendar was in place dating back to January 2023 and included the frequency of a repeat audit, when each audit had taken place and a link to the audit report. All DPHC mandated audits had been completed. Clinical audit based on the needs of the patient population was limited, particularly over the last 12 months. We looked at a clinical audit completed in April 2024. It considered endometrial protection and hormone replacement therapy following the licence change for a particular coil use. This assured us that the practice was fully adherent to current guidance in this area of practice.

Effective staffing

All new staff and locum staff had completed the generic DPHC induction programme. Role specific induction packs were also used. Staff new to the practice described the induction as comprehensive and said the practice team was supportive.

The training manager monitored the mandated training and followed up with individuals whose training was due to expire. Staff were given protected time to complete this required training. There was good compliance with mandated training with mitigating circumstances for staff who were out-of-date. A register of in-service training (referred to as trade training) was maintained, including a programme of planned training for 2024.

The staff database was regularly reviewed by the training lead and was overseen by deputy practice manager. Staff who were due to undertake or refresh training were reminded by email. Training updates was a standing agenda item at the practice meeting. Staff had protected time each Wednesday afternoon to complete training. Our review of the database indicated compliance levels for training were high across the team. A calendar was maintained of upcoming trade training/in-service training (IST). IST supported staff with their continuing professional development (CPD) and staff told us they were supported with taking time for revalidation.

Collectively, clinicians had a wide-range of skills and experience to meet the needs of the patient population. Aviation and diving medicals were provided. One of the doctors specialised in women's health. Along with the doctor, 3 of the nurses were trained to provide cytology and the doctor provided contraceptive implants. Two clinicians had completed sexual health training (referred to as STIF). Three nurses were trained in yellow fever.

Clinicians were supported to stay current with specialist roles. For example, all the doctors participated in the aviation dial-in update held each month. Staff administering vaccines had received specific training which included an assessment of competence. The medics were signed up to complete the Defence Medical Services apprenticeship scheme. The Senior Medical Officer checked that the doctors were fit to practice in their specialist role.

Clinical supervision/peer review arrangements were in place for clinical staff, both in-service and within the region. For example, clinical supervision was undertaken as part of nurses' team meeting. The regional nurse advisor also provided support to the team. PCRF staff attended the monthly regional rehabilitation meeting that incorporated in-service training and supervision. A network meeting was held between Lossiemouth and Kinloss medical centres and the sharing of updates supported clinicians with their CPD. Nurses participated in the Scotland nurse Facebook group for Defence to share information and develop clinical practice.

Coordinating care and treatment

The practice had effective relationships with the station, including SSAFA and the welfare team. The practice was represented at the station personnel support committee meetings, which provided the opportunity to discuss patients at risk and patients who were downgraded.

If the patient was referred to an exercise rehabilitation instructor (ERI) then the physiotherapist and ERI carried out a joint review every 6 weeks. There was evidence of this joint work in the patient records that we looked at. Multi-disciplinary team meetings were held 2 weekly every for the doctors and PCRF team to discuss the progress of patients with a musculoskeletal injury (MSK). A joint MSK clinic was held on Wednesday afternoon.

Staff had good links with the NHS primary care practice that shared the building, although completely separated. This was beneficial for the practice as many of the families of service personnel had registered at this practice. The relationship was developed via shared GP training for military doctors and women's health training. The nurses said they had a good link with the local midwife who visited the practice every 2 weeks. The practice had effective relationships with internal services including the DCMH, Regional Occupational Health Team and Regional Rehabilitation Unit. Clinicians described communication with NHS secondary care providers about the lengthy wait times for referrals as challenging.

For patients leaving the military, pre-release and final medicals were offered.

Helping patients to live healthier lives

One of the nurses was the lead for health promotion and a medic was the deputy lead. A health promotion calendar was established with a specific topic identified each month. July was 'Men's' health' and a 'MAN MOT' was displayed. Other displays included physical activity after pregnancy and suicide prevention. A wide range of health promotion/lifestyle information leaflets was available in the waiting area for patients. A station-led health fair was in the process of being planned. A nurse represented the practice at the station-wide women's health group.

The PCRF had developed a conditioning programme for aircrew, delivered by the physical training instructors. Patients had provided positive feedback and reported that neck pain was reduced when flying. The availability of peripatetic or mobile clinics improved access to this programme.

One of the nurses was the lead for sexual health. Sexual health advice, contraception and testing/screening were provided. One of the doctors had re-introduced the fitting of coils after identifying a population need. Patients were also sign posted to the local sexual health clinic, the details of which were displayed in the patient toilets.

Processes were in place to ensure patients eligible for national screening were recalled. DMICP searches were undertaken each month. Recalls for breast and bowel screening were received from the NHS for patients aged 50 and over and the practice then informed the patient. Cervical screening was managed by the nurses. A list sent to practice was confirmed against practice held records (both NHS and DMICP aligned). Recall letters were sent to the practice by the NHS and then forwarded to patient.

The number of women that had a cervical smear in the last 3-5 years was 155, which represented 95% of the eligible female population. The NHS target was 80%.

Regular DMICP searches were carried out for service personnel due a vaccination. The vaccination statistics were identified as follows:

- 96% of patients were in-date for vaccination against diphtheria
- 96% of patients were in-date for vaccination against polio
- 96% of patients were in-date for vaccination against tetanus
- 96% of patients were in-date for vaccination against hepatitis B
- 97% of patients were in-date for vaccination against hepatitis A
- 98% of patients were in-date for vaccination against measles, mumps and rubella
- 98% of patients were in-date for vaccination against meningitis

Consent to care and treatment

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. Clinicians understood the Mental Capacity Act (2005) and how it would apply to the patient population group. Mental capacity training had been delivered to all staff in July 2024.

Our review of patient records showed that implied and formal consent was sought depending on the procedure, including for cervical screening, coil fitting and acupuncture. The taking of consent was monitored as part of the clinical records audit.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

As part of the inspection, we received feedback about the service from 35 patients. Collectively, feedback highlighted that staff were caring and respectful. Patients said they were listened to and were treated with kindness and consideration.

The practice endeavoured to accommodate patients who wished to see the same clinician. In particular, the Primary Care Rehabilitation Facility (PCRF) aimed to maintain the same clinician throughout the patient's journey.

Managed by the station, an informative website provided the details of support services available, including emergency support. A support network (known as HIVE) was based on the station and provided a range of information to patients who had relocated to the base and surrounding area. SSAFA and welfare services were also available.

Staff provided various of examples of when the practice had 'gone the extra mile' to ensure timely and appropriate care, including delivering a patient's medicine to their home as they had been unable to collect it. Prior to delivery, the pharmacy technician telephoned the patient to provide advice about the medicine. Staff often accommodated patient appointments during their tea/lunch breaks, particularly for service personnel deploying.

Involvement in decisions about care and treatment

Feedback indicated patients were involved with planning their care, confirmed by our review of patient records. Support by a standard operating procedure, a translation service was available. It had previously been used to translate hospital letters.

One of the nurses was the lead for patients with a caring responsibility. Carers were identified through the patient registration process, through the welfare team or opportunistically. All carers had a care plan and were offered a health pack on arrival, an annual flu vaccine and longer appointments if needed. Information was displayed describing what constitutes a carer and additional services available for carers. Although the practice's search identified 17 carers, our search indicated 21 carers were registered.

Privacy and dignity

The reception area was well laid out with the waiting area set back from the desk, which meant conversations between patients and reception staff were unlikely to be overheard. If patients wished to discuss a sensitive issue or appeared distressed at reception, they were offered a private room to discuss their needs. This was supported by clear signage on the reception desk.

Patient consultations took place in clinic rooms with the door closed. Privacy curtains were available in all clinical rooms for intimate examinations. Private rooms were available in the PCRF and a radio was used in communal treatment areas to minimise conversations being overheard.

The staff team had completed Defence Information Management Passport training which incorporated the Caldicott principles. These principles were displayed at the practice.

At the time of the inspection, there was a good mix of male and female clinicians so patients had the option to see a doctor of a specific gender.

Are services responsive to people's needs?

We rated the practice as good for providing responsive services.

Responding to and meeting people's needs

A theme emerging from patient feedback was the responsiveness and flexibility of practice staff to accommodate their needs. Specific clinics were offered for aircrew medicals and there were a sufficient number of staff trained to provide these medicals in a timely manner. Patients under the age of 18 and those deemed to be vulnerable were offered longer appointments. The nursing team could accommodate all patients, including service personnel visiting the station who were not registered at the practice. A further example of responsiveness was the pharmacy technicians moving their breaks to enable more flexible access to the dispensary.

A specific women's health service has recently been set up to provide coils and implants. As this was a new service, there were plans to audit the service as it developed. Furthermore, there were intentions to expand this service to Kinloss Medical Centre as part of the planned 'Network' development.

In line with the Equality Act 2010, an access audit for the medical centre was completed in June 2024 and in February 2024 for the Primary Care Rehabilitation Facility (PCRF). An accessible parking space, automatic opening front door and accessible toilet was available. A wheelchair was available at the entrance and crutches were stored in the dispensary. The PCRF was based on the first floor and a lift was available for access. A hearing loop was not needed based on the access audit.

Issued by the Defence Medical Services Regulator in April 2024, we asked about the Regulatory Instruction, 'Training for staff in learning disability and autism' and how it was being implemented. Staff were unaware of this instruction at the time of the inspection and said they would ensure the instruction was reviewed and the training provided.

Staff were familiar with the new Defence Primary Healthcare (DPHC) transgender standard operating procedure. One of the nurses was the lead for LGBTQ+ and provided guidance for the team. A small number of patients were being supported with gender reassignment and their doctor regularly liaised with the secondary care services involved.

There was evidence that the practice responded to feedback from patients. For example, patients highlighted via a PCRF survey that some of the signage to the different clinical areas in the building was confusing so signage was altered as a result. Patients also indicated that outside of PCRF hours there was no rehabilitation equipment available. The PCRF have since provided a selection of rehabilitation equipment in the main gym for use out-of-hours. An audit regarding exercise prescribing suggested patients would prefer Rehab Guru so training was provided to improve delivery via this platform.

Timely access to care and treatment

Feedback indicated patients were satisfied with access to an appointment.

An urgent appointment with a doctor, nurse or medic could be accommodated on the same day. A routine appointment could be facilitated within 72 hours for a doctor, within 48 hours for a nurse and within 24 hours for a medic. There was a wait of a week for a medical. Home visits were available but it was very rare they were needed.

A patient could have an urgent appointment with a physiotherapist or exercise rehabilitation instructor (ERI) within 5 days. There was a wait of 8 days for a routine physiotherapy and 1 day for a follow-up appointment. There was a 1 day wait for an appointment with an ERI. Due to workforce vacancies, the Direct Access to Physiotherapy referral pathway (referred to as DAP) had ceased (except for aircrew) since October 2023. There was a plan in place for DAP to restart soon. Patients referred to the Regional Rehabilitation Unit were seen within 20 working days.

The patient information leaflet, and patient information board provided details about opening times and access to medical care out-of-hours (OOH). A duty medic was on call and based in the building 24 hours a day 7 days a week. Similarly, a duty doctor was on call OOH and available by telephone or they could come into the practice to see the patient.

Listening and learning from concerns and complaints

The Warrant Officer was the lead for complaints and the Senior Medical Officer oversaw any complaints related to clinical care. Complaints were managed in accordance with the DPHC complaints policy. Both verbal and written complaints were recorded on the complaints log.

Complaints were a standard agenda item at the healthcare governance meetings. An audit of complaints was completed on in November 2023. Relevant complaints were also discussed at the PCRF team meeting.

Patients were made aware of the complaints process through the practice information leaflet and information displayed in the area.

Are services well-led?

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

Vision and strategy

The practice worked to the Defence Primary Healthcare (DPHC) mission statement outlined as:

> "…. to provide safe, effective healthcare to meet the needs of our patients and the chain of command in order to support force generation and sustain the physical and moral components of fighting power."

The mission statement was defined as:

> "Quick Reaction Alert (Interceptor) North, Maritime Patrol, Airborne Early Warning & Control, Global Operations."

The purpose statement for Lossiemouth Medical Centre was to:

> "Protect our nation – in the air, over the sea and on land – at home and abroad."

It was evident the practice was meeting its mission as we found the service was highly responsive to the needs of individual patients and the occupational needs of units. Integration was promoted, evident through the close working relationship between medical centre staff and the Primary Care Rehabilitation Facility (PCRF) team. Previously, the governance of the PCRF was separate from the medical centre but staff said this had progressed to fully integrated systems.

To ensure the needs of the patient population was taken into account with service development, practice leaders regularly communicated with key station personnel. A Lossiemouth 'Lowdown' meeting happened every Monday to discuss any upcoming issues.

The practice worked closely with Kinloss Medical Centre. To maximise efficiencies in clinical care, a strategic plan was in place to create a 'combined north of Scotland practice' between the 2 practices. Alongside this and to strengthen the patient experience, triage in accordance with the January 2024 DPHC 'Total Triage' standard operating procedure (SOP) was being introduced. The aim of 'Total Triage' was to improve access, particularly at Kinloss Medical Centre. At the time of the inspection, both practices were working as a 'network' and looking at developing integration. For example, one of the doctors ran the 'Lossiemouth - Kinloss Network' meeting with the aim to improve collaborative working between the two services.

To address environmental sustainability, the practice aimed to reduce the use of paper by communicating via email and the use of links rather than producing paper booklets. Staff were vigilant with switching off lights, closing windows and the use of heating. A board was displayed illustrating the approach to 'energy conservation and climate change in the MOD'.

Leadership, capacity and capability

The Senior Medical Officer (SMO) was an experienced clinician and the deputy SMO had joined the practice 4 weeks prior to the inspection. They had previously worked at the practice so were familiar with the patient population's clinical and operational needs, and also governance processes. The Practice Nursing Officer's (PNO) post was vacant. The Warrant Officer, OC physiotherapist and practice manager were all experienced.

The majority of staff we spoke with advised that there was sufficient leadership capacity to meet the needs of the practice and patient population. The absence of a PNO was absorbed within the nursing team. However, it was a concern for the nursing team due to the Warrant Officer (non-registered clinician) taking on this managerial role as it meant there was no clear formal clinical lead, clinical understanding or awareness of Station Force Generation preparation. This line management arrangement was not in accordance with the organisational SOP, 'Functional Line Management Structures within DPHC'. Managerial arrangements were revised in April 2024 with the military nurse becoming the nurse manager/team lead. Although not directly in line with the DPHC SOP, the nursing team was in agreement with this change due to the military nurse's clinical expertise and knowledge. The Regional Nurse Advisor (RNA) was consulted for managerial and training issues and any clinical issues were raised in the multi-disciplinary team meeting.

The civilian doctors and other civilian staff at the practice provided continuity for the service; some had worked at the practice for many years. Others were ex-military so had a good awareness of Defence processes. Deputy positions were established for all the leadership positions to ensure consistency of governance systems.

The leadership team described effective support from Regional Headquarters (RHQ), including support with policy and human resource queries. We were told the regional pharmacist visited regularly, the area manager visited at least once a month and the Regional Clinical Director (RCD) visited twice a year.

Culture

From patient feedback, interviews with staff, a review of patient records and outcomes/outputs for patients, we were assured patients were central to the ethos of the practice. Staff understood the specific needs of the patient population and tailored the service to meet those needs.

We received mixed views about the culture within the staff team. The majority of staff told us they were supported, respected and valued by leaders and would feel comfortable sharing their views. They also highlighted that both formal and informal opportunities were in place so they could contribute their views and ideas about how to develop the practice. On the other hand, we heard that there was disharmony within the team. Some staff said they did not feel always valued or supported, which was impacting their wellbeing. Views of staff differed regarding access to 'white space' activities with some staff confirming regular activities and other staff indicating their request for 'white space' was denied. We were advised that social events were held most months to encourage team cohesion.

Each staff group said they worked well together within their sub-team. The majority of staff indicated there was a positive culture of multi-disciplinary teamwork (MDT) to ensure the

delivery of effective clinical care. However, some staff highlighted that MDT working was not effective as there was limited interaction across the wider team.

Key leaders with knowledge of the issue were not available at the time of the inspection for further discussion or to confirm the measures being taken to address the matter. After the inspection, we received information from the SMO clarifying the steps taken to date and it was clear actions had been taken to try to resolve the matter. The issue was ongoing and we were advised the RCD was aware. Given the move towards a 'combined north of Scotland practice', it would be advantageous if staff disharmony was resolved prior to this significant change.

Staff said they would feel comfortable raising any concerns and were familiar with the whistleblowing policy. We were given an example of when concerns had been raised to the leadership team and/or the regional team. In addition, staff were familiar with the Freedom to Speak Up (FTSU) policy and were aware of how to access FTSU representatives.

Processes were established to ensure compliance with the 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 2 examples which highlighted that duty of candour requirements had been adhered to.

Governance arrangements

There was a clear staffing structure in place and staff are aware of their roles and responsibilities, including delegated lead roles in specific topic areas. Terms of reference (ToR) were mostly in place to support job roles, including staff who had lead roles for specific areas. Resilience was provided by appointed leads having named deputies. Some staff said their ToRs had recently been finalised before they had seen them.

A 5-week rotation of a range of meetings was in place to ensure effective communication and information sharing across the staff team. Each cohort of staff also held meetings. The Warrant Officer managed the healthcare governance (HCG) workbook. All staff had access to the workbook that included various registers and links to practice governance activity.

The last internal assurance review took place in March 2023 and the practice received a rating of substantial assurance.

Managing risks, issues and performance

An effective process to identify, understand, monitor and address current and future risks including risks to patient safety was in place. Risks identified for the service were logged on the risk register and kept under scrutiny through review at meetings. The Warrant Officer reviewed the risk register each month and it was an agenda item at the monthly meetings. We identified that a risk assessment for the emergency medicines and controlled drugs cabinet was needed, along with a review of access to the dispensary.

A business continuity plan (BCP) was in place for the practice and was last been reviewed in November 2023. The BCP was held on the practice SharePoint so could be accessed remotely if required. The plan was comprehensive covering the most likely causes of a major incident, including the key contacts. A station-wide major incident plan was also in place. A station crash exercise involving the medics had taken place in May 2024.

Processes were in place to monitor national and local safety alerts, incidents, and complaints. This information was used to improve performance.

The leadership team was familiar with the policy and processes for managing staff performance, including underperformance and the options to support the process in a positive way.

Appropriate and accurate information

The DPHC electronic health assurance framework (referred to as HAF) was used to monitor performance. The HAF is an internal quality assurance governance tool to assure standards of health care delivery within defence healthcare. All staff were involved with updating the HAF, which was a standing agenda item at HCG meetings. The management action plan (MAP) within the HAF was used to delegate information requests. The MAP was discussed during each HCG meeting to ensure requests were met in a timely manner.

There were arrangements at the practice in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. For example, safeguarding and vulnerable patients' information was kept in a limited folder within SharePoint and only DMICP numbers were used to identify patients.

Engagement with patients, the public, staff and external partners

Options were available to prompt patients to provide feedback on the service and the practice acted on feedback received. The patients' survey link was emailed every day to all patients who attended that day. In addition, a suggestion box with forms was available in the waiting area for patients to submit feedback. Feedback returns were analysed every 6 months with the most recent analysis taking place in May 2024. There was a good response to the survey. Overall, patients were satisfied with the service. A notice board in the patient waiting room provided patients with a response to their feedback.

Adaptions had been made as a result of feedback. For example, the dispensary opening times were changed to align with the last appointment of the day ensuring patients had access to prescriptions before the practice closed.

There were limited options for staff to provide leaders with feedback about the service. Although encouraged to share their views at meetings, no formal process was in place for staff to provide feedback about the service. Given the mixed views regarding the culture, undertaking a staff culture survey (with the option of anonymity) would support the leadership team with understanding the matter and thus developing a plan to address it.

The practice worked closely with the Chain of Command, welfare support services and SSAFA to ensure a collective approach to supporting vulnerable patients. The monthly MDT meetings included the PCRF team, welfare and sometimes a representative from the Department of Community Mental Health.

Continuous improvement and innovation

A quality improvement programme was in place. The audit register demonstrated that the practice had completed the DPHC mandated audit and had undertaken additional searches and. Quality improvement activity, including individual audits, were discussed at the clinical and/or practice meetings, confirmed by a review of meeting minutes. Good practice was showcased through the ASER system (purple ASER) or raised as a quality improvement project on the DPHC Healthcare Governance webpage. There was scope for the practice to broaden the approach to quality improvement by undertaking clinical auditing based on population need.