Redford Medical Centre

Colinton Road, Edinburgh, EH13 0PP

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	**Requires improvement**	
Are service caring?	**Good**	
Are services responsive to people's needs?	**Good**	
Are services well-led?	**Good**	

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About this inspection

We carried out this announced comprehensive inspection on 30 September 2025.

As a result of this inspection the practice is rated as good overall.

Are services safe? – good

Are services effective? – requires improvement

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 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 observations and recommendations within this report.

This inspection is 1 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 the Chain of Command. Patients were involved in decisions about their treatment and care.
- Patient feedback about the service was positive. It demonstrated patients were treated with compassion, dignity and respect.
- Effective safeguarding arrangements were in place. Patients vulnerable due to their mental health and/or social circumstances were well managed and supported.
- The practice worked flexibly to accommodate the needs of units and individual patients.
- Staff spoke highly of the culture within the team and described an inclusive and supportive leadership style.
- The healthcare governance workbook was comprehensive and used to monitor a range of governance activities. We identified gaps with some clinical governance systems including the process to ensure the recall of patients for cervical screening, retinal screening, clinical coding/alerts, offer/use of a chaperone, physiotherapy referrals the management of sample results.

- Not all staff had completed training in learning disability and autism.
- ASER, the organisational-wide system for reporting significant events was effectively used and changes were made as a result of incidents.
- Evidence of appropriate recruitment and completion of mandated training was in place for all staff.
- Patients received their medicines in a safe way. However, some medicines management processes needed to be strengthened. Not all patients new to the practice had received a medication review.
- There was a culture of improving the service through quality improvement activity. A comprehensive audit programme was in place, including clinical audits based on population need.
- Appropriate measures were in place to minimise the risk of infection. Infection prevention and control audits were regularly undertaken.

We identified the following notable practice, which had a positive impact on the patient experience:

With a 39 week wait for Gold Standard Audiogram (GSA) in NHS Scotland, funding was obtained for an Institute of Naval Medicine audiologist to undertake peripatetic clinics in Edinburgh, Inverness and Glasgow. In 5 days, over 100 personnel in Scotland received a GSA. Analysis showed this initiative saved 1,580 weeks (or 30 years) of NHS waiting time collectively in Scotland. Importantly, service personnel were downgraded for a shorter time which meant the unit's deployability increased. The peripatetic clinic was low cost, high impact, and easily reproducible. The initiative was raised as a quality improvement project.

The Chief Inspector recommends to the practice:

- Ensure the use of a chaperone is recorded for all minor operations.
- Review the process for the management of sample results to ensure doctors confirm they have reviewed results by signing paperwork, and recording in the patient's record, that the result has been reviewed and whether follow-up action is required.
- Systems to support the safe management of medicines should be strengthened to include the management of prescriptions and destruction of controlled and accountable drugs.
- Ensure patients new to the practice receive a medication review.
- Review all patient with diabetes to ensure they have been recalled for retinal screening.
- The management of cervical screening should be reviewed along with an audit of all eligible women and people with a cervix to ensure those eligible have a diary date for recall, non-responders are managed correctly and recall letters sent monthly. The cervical screening register should be reviewed, updated and accurately maintained.
- Ensure relevant clinical coding and alerts are used to identify all patients with a caring responsibility, so that appropriate support can be provided.

- Ensure all staff complete training in learning disability and autism in accordance with the DSMR Healthcare Defence Code of Practice.
- To ensure formal monitoring of referrals made by the Primary Care Rehabilitation Facility, include these referrals in the practice-wide referral tracking process.

Professor Bola Owolabi

Chief Inspector of Primary and Community Services

Our inspection team

This inspection was undertaken by a CQC inspector supported by a team of specialist advisors including a primary care doctor, pharmacist, physiotherapist, nurse and practice manager. Two recently recruited specialist advisors shadowed the inspection as part of their induction.

Background to Redford Medical Centre

Located in Redford Barracks, the medical centre provides a primary care, rehabilitation and occupational health care service to a military population of 1,443. Many of the units supported by the practice are deployable, often at short notice. The majority of the patient population is aged between 18-40 with 21% of patients over the age of 40. In addition, the practice provides a service to a transient population, including reservists. This means the patient population can increase to 2,000. Families of service personnel are not registered at the practice and are signposted to local NHS primary care services. A Primary Care Rehabilitation Facility (PCRF) and dispensary are located in the building.

The practice is accessible to patients from 08:30 to 16:30 hours Monday to Thursday and from 08:30 to 13:00 hours each Friday. Total triage is open from 08:30 to 10:00 hours Monday to Friday. A duty doctor, nurse and medic are available each weekday until 18:00. Outside of these hours including weekends and public holidays, patients are advised to contact Lothian Unscheduled Care Service (NHS 24).

The staff team

Doctors	Senior Medical Officer MOD GP x 2 Unit Regimental Medical Officers x 2 - **1 post vacant** General Duties Medical Officer
Nurses	Senior Nursing Officer Military nurse x 2 Civilian nurse x 2 Health care assistant – 16 hours a week
Practice management and administration	Military practice manager (WO2) Business services manager Administrators x 4
Dispensary	Pharmacy technician x 2
PCRF	Band 7 physiotherapist – **post vacant** Band 6 physiotherapist x 2 Band 6 Physio - 0.4 whole time equivalent (WTE) Exercise rehabilitation instructor x 2 – 1 post 0.6 WTE
Unit medics	14 – **5 posts vacant**

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

The Senior Medical Officer (SMO) and one of the MOD GPs were the safeguarding leads for the practice. Reviewed in July 2025 and accessible to staff, the adult and children safeguarding policy referenced and included contact details for the local safeguarding teams. These details were also displayed in clinic rooms and communal areas. The majority of staff were in-date for safeguarding training at a level appropriate to their role. Those overdue were scheduled to attend Defence Primary Healthcare (DPHC) level 3 training on 9 October 2025.

Vulnerable patients, including care leavers, were identified through the patient registration process, summarisation of patient records and through identification from the welfare team. A clinical code and alert was applied to individual DMICP (electronic patient record system) records to ensure patients assessed as vulnerable were readily identified. Regular DMICP searches and a compliance check were undertaken to ensure all vulnerable patients were captured on the register.

Clearly defined escalation pathways and a range of forums were in place to monitor and review these patients including the daily team ‘huddle’, monthly safeguarding meeting and monthly healthcare governance (HCG) meeting. A Vulnerability Risk Management (VRM) process was in place to monitor the care of service personnel identified as vulnerable and to monitor trends for each unit. The SMO attended the VRM meetings and case conferences as requested. At the time of the inspection there was 1 patient under the age of 18 registered at the practice.

Commanders Monthly Case Review (CMCR) meetings were established for each of the 5 units. A clinician represented the practice at each CMCR at which downgraded and vulnerable personnel were discussed with the Chain of Command. Welfare also attended the CMCRs.

Externally, the practice had links with local safeguarding teams and the multi-agency safeguarding hubs. Staff outlined how vulnerable adults and service personnel were protected and supported through multi-agency collaboration. Direct referral pathways were established should staff have concerns about the vulnerability of a patient. Clinical staff attended local safeguarding forums and training updates to ensure practice policies aligned with national/local requirements. We were given an example of how an out-of-area safeguarding concern had been managed with the involvement of social services and the safeguarding team based in the area.

The practice followed the DPHC chaperone standard operating procedure (SOP). The availability of a chaperone was displayed in clinic rooms and patient waiting area. It was also outlined in the practice information leaflet. Chaperone training was facilitated in February and August 2025. Further training was planned for staff who still needed to complete it. Our review of patient records showed the offer/use of a chaperone was

assigned the appropriate clinical code and an entry made in the notes by both the clinician and chaperone. The exception was for minor operations as we noted a chaperone was not recorded for approximately half of the procedures undertaken. We were assured a nurse was always present. In accordance with the DMSR Healthcare Defence Code of Practice, the use of a chaperone and their identity should be recorded in the records.

Although the full range of recruitment records for permanent staff was held centrally, the practice manager demonstrated that relevant safety checks had taken place at the point of recruitment, including Disclosure and Barring Service (DBS/England) and 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 DPHC policy and staff were informed 6 months in advance when their DBS/PVG check was due for renewal. The professional registration for clinical staff was monitored and was up-to-date for all staff. The nursing team monitored the vaccination status of staff, and all were in-date.

One of the nurses was the lead for infection prevention and control (IPC) and the Senior Nursing Officer (SNO) deputised. The SNO had completed the required IPC training and the lead was awaiting a date to attend the training. The SNO attended link nurse meetings and provided feedback back to the nursing team. All staff were in-date for IPC training.

An IPC audit was completed in September 2025 for both the medical centre and Primary Care Rehabilitation Facility (PCRF). It showed compliance with high scores across all 14 standards. PCRF staff had undertaken an additional hand washing audit. Whilst the building was functional, the SNO identified some of the infrastructure was not IPC compliant. An action plan was in place and IPC infrastructure concerns added to the issues log. Statements of need had been submitted for improvements to the walls, flooring, sinks and worktops. The practice manager was liaising with the with area manager weekly to establish whether funding had been approved and updated the staff team at the practice meetings. A new build was planned for 2032.

The spread of infectious diseases was minimised by the practice adhering to the IPC compendium policy. Staff were trained in outbreak management. They had noticed an increase in PVL (contagious bacterial infection) but no trends had been identified and monitoring was ongoing. The units were informed if any trends in infectious diseases were identified.

All clinical areas were regularly cleaned and were equipped with hand hygiene facilities. IPC audits and HCG meetings were utilised to ensure ongoing awareness and monitoring in line with MOD, DPHC and public health protocols. Disposable privacy curtains in clinical rooms/areas were changed in July 2025.

A risk assessment was in place for the delivery of acupuncture, and an acupuncture audit was scheduled later in the year.

An environmental cleaning schedule was in place, which aligned with the British Institute of Cleaning Science (referred to as BICs) standards. A colour coding system was used to indicate the frequency of each area and cleaning product to use. It corresponded to matching coloured buckets and mops. A deep clean was carried out annually with the next due in December 2025. A cleaning schedule was in place for gym equipment.

The practice management team described how they had a good rapport with the cleaning team and cleaning supervisor. The contractor shared its assurance checks/audits with the practice manager. In addition, the practice manager and/or business services manager attended meetings with the cleaning contractor and a representative from the Defence Infrastructure Organisation (DIO) each month to address issues. The current cleaning contract was under review to ensure it was in line with NHS standards.

The practice manager was identified as the lead for managing clinical waste and attended a meeting with the DIO in August 2025 to discuss the contract. A clinical waste log and consignment notes were in place and up-to-date. Pre-acceptance audits were completed for 2023 and 2024 with the 2025 audit due in October. Sharps boxes were labelled, dated and disposed of appropriately. Clinical waste was securely stored outside the building.

Risks to patients

Staffing levels and suitably qualified/experienced personnel (SQEP) were the top risks identified on the risk register. In particular, SQEP impacted the nursing team and this was being monitored and addressed by the SNO. Staffing levels were monitored regularly against patient demand incorporating parades, such as the Edinburgh Military Tattoo and an increase in training based on external influences.

To address the transient nature of the military workforce, continuity measures were employed, including the use of locums, cross-cover arrangements, and prioritisation of clinical need through triage. These measures supported with maintaining patient access and safety, with the practice management team reviewing clinics regularly to monitor waiting times and trends.

Planned staff absences were managed in advance. Rotas were reviewed and adjusted to ensure safe cover for clinical and administrative staff. Unplanned absences were discussed and managed at the daily ‘huddle’ meeting. Risks with staffing capacity and capability were reviewed at the HCG meetings and the risk register updated. and unplanned absences were discussed and managed at the daily ‘huddle’ meeting.

From our discussions with staff, we were advised that current staffing levels were adequate to meet the needs of the patient population. With peaks in busy periods, the team adapted and re-grouped. For example, unit medics supported with administrative gaps. From the feedback received from 40 patients as part of the inspection, just 5% indicated it had not been easy to secure an appointment in a timely way.

The seal on the medical emergency trolley was checked and recorded daily by the nursing team and a full check of the kit and emergency medicines was undertaken monthly or if the trolley had been opened/used. All the emergency equipment was in-date.

The SNO was the lead for resuscitation and a nurse deputised. The staff team was up-to-date with basic life support training, anaphylaxis and the use of an automated external defibrillator. Emergency response training and training regarding the layout of the emergency trolley was facilitated in April 2025. Staff had received training this year in recognising and managing the deteriorating of a patient, including sepsis, heat injuries and acute medical events. The PCRF team had also completed heat injury modules 1 and 2.

Both clinical and non-clinical staff were familiar with the signs and symptoms of sepsis. Sepsis information was in displayed in the practice. Scenario-based or moulage training was not routinely held and we were advised that the practice intended to introduce more of this type of training.

Information to deliver safe care and treatment

In the event of an extended or unforeseen outage of the DMICP system, the practice followed the business continuity plan. Routine clinics were cancelled and only patients with an emergency need were seen. Consultations were recorded on an FMed5 (medical summary forms) and handwritten prescriptions were used. When connectivity resumed, these records were scanned to DMICP. Routine appointments were triaged and rescheduled where possible. At the end of each working day the administrative team printed the clinics for the next day should a DMICP outage occurs.

A ‘battle box’ was held in a central area and contained the relevant clinical documentation to use in the event of an outage. The practice manager indicated that prescribing protocols ensured patients still received essential medication safely. Staff were informed and received training in these processes during induction.

Following an outage, an audit was completed to ensure all records were accurately entered in DMICP. Any Incidents reported during outages were reviewed as part of risk and governance processes.

Summarisation was nurse-led with doctors providing support if needed. All new patients completed the eRegistration which was reviewed by the administrative team and passed to the duty nurse. The duty nurse had dedicated time each day to summarise records, which this was carried out in accordance with DPHC and local summarisation policies. Monthly searches were undertaken to monitor for 5-yearly summarisation checks. At the time of the inspection, 99% of records had been summarised.

A schedule was established for the annual audit of record keeping for each clinician including physiotherapists, exercise rehabilitation instructors (ERI), doctors, nurses and medics. To ensure objectivity, the SMO’s record keeping was audited by another doctor at the practice. With reference to the audit of nurses’ record keeping, there was evidence that concerns with standards from previous years had been addressed and improvement noted. The SNO indicated that working alongside doctors during Total Triage had vastly improved nurses’ skills in consultations, record keeping and confidence with seeing patients.

The PCRF team audited record keeping annually, with ERIs auditing each other’s notes and the same for physiotherapists. For new staff joining the team, their record keeping was audited within the first 3 months. All audits were conducted using the audit template within the DPHC rehabilitation template SOP.

A comprehensive process was in place for managing external referrals to secondary health care services. The referrals lead had a log-in to access NHS Scotland SCI Store; an information repository providing clinicians with secure access to patient information,

including clinical reports and letters. There was a central hub for the majority of referrals with 3 local hospitals were mainly used.

Following a task from the doctor, the lead checked and processed the referral before sending it, ensuring the referral included the patient's CHI number; a unique identifier for each patient in Scotland to link their health records across the system. If an acknowledgement of receipt of the referral was not received then the lead followed this up.

The referral was added to DPHC centralised register/tracker for managing referrals, which was regularly reviewed to monitor the status of referrals. The hospital sent the appointment directly to the patient. As the practice was not informed, the referrals lead contacted the central hub each week to check if an appointment had been allocated and then updated the referral tracker. Consultation outcome letters were downloaded from the SCI Store. They were uploaded or scanned to DMICP and the relevant clinician was tasked to review and action. Urgent and 2-week-wait (2WW) referral reports were proactively monitored on a weekly basis to ensure urgent reports were not delayed. At the time of the inspection, there were 132 active referrals and no 2WW referrals.

The PCRF team had oversight of its own referrals made to internal departments and teams. As there was no formal process in place, we discussed the benefits of including these referrals within the wider practice referral tracker.

The practice recognised that poor interoperability between the DMS and NHS Scotland IT systems was a concern, and this was captured as a high risk on the risk register. The RHQ Information Systems Security Officer was liaising with NHS Scotland to determine whether additional staff could have access to SCI Store.

The risk was compounded by only the referrals lead having access to SCI Store. Not having sight of appointments and waiting lists coupled with the manual tracking of clinic letters was time consuming and potentially vulnerable to error. In the absence of the referrals lead, other staff could process referrals and check if appointments had been issued but could not check if outcome letters were available on SCI Store. Mitigations were in place, including the business services manager and other administrators processing referrals and monitoring the tracker. Although not as timely, routine correspondence could be received by post or email. If a doctor requested an outcome letter sooner, the hospital could be contacted directly for the report to be emailed.

The SNO was the lead for sample management and samples were managed in accordance with the local working policy. With no access to Pathlinks in Scotland, clinicians described the process for managing samples as 'work intensive'. The risk of a transcription error was recognised and had been added to the risk register.

DMICP tests requested by the doctor were transcribed by the nurse onto a 'Lothian labs' paper request form. These were then added to the sample register. The duty nurse reviewed the sample results daily. We noted the sample tracker was well maintained with any outstanding results highlighted and followed up. Bloods were transported by military transport to the laboratory each afternoon.

Results were emailed to the group mailbox and printed for the duty nurse to review and triage. They were then passed to the requesting clinician or, in their absence, the duty

doctor. All abnormal results were reviewed by the duty doctor. Once reviewed and signed, the paperwork was scanned by an administrator and uploaded to DMICP. The nurses transcribed the results to the patient's record and assigned a clinical code using DMICP templates. The SNO reported there had been no occasions when paper results went missing.

We were advised that the nurses could not be 100% certain that all results had been seen by a doctor. We reviewed a sample of patient records and identified gaps in record keeping with no evidence to confirm a doctor had reviewed the results. For example, we found scanned copies were unsigned, there was no record in DMICP consultations that the blood result has been reviewed and no comments as to whether follow-up action was required. As scanned copies can be difficult to find on DMICP, a record confirming a review and action by a doctor is important, so it is clear and visible to other clinicians.

Safe and appropriate use of medicines

The SMO was the lead for medicines management and the pharmacy technician was responsible for the day-to-day operation of the dispensary; both had up-to-date terms of reference for these key roles.

Standard military prescriptions (Fmed296) were recorded in a bound book without page numbers. The FMed296 register for blank forms did not reflect the quantities received (although they could be worked out from the serial numbers received). In addition, there was no running total that reflected the current holdings at time of receipt. Although the names of the clinicians supplied with prescriptions was recorded, signatures were not recorded for staff who supplied the prescriptions.

Controlled drugs (medicines with a potential for misuse) and accountable drugs (AD) were stored in a locked cabinet. However, the controlled drugs (CD) cabinet did not comply with the Misuse of Drugs Act 1973 (Safe Custody) as amended. The cabinet was sited in a safe and secure location so there was no requirement to change it. The CD/AD keys and dispensary keys were not managed in line with the organisational protocol (JSP 950 leaflet 9-2-1) as they were required to be sealed in a dispensary bag at the end of the day and returned to the safe. This was rectified during the inspection. The drawing out and return of the keys was correctly recorded in the key log.

Posters were displayed on the CD/AD cabinet indicating the CD/AD schedule of checks. These were removed during the inspection to ensure there was no indicator highlighting the presence of medicines with a potential for misuse.

CD/AD drugs were not always checked in accordance with DPHC CD SOP 3-7-1, which involves 2 registrants. We highlighted that it was not best practice for the pharmacy technician working at the practice to act as registrant. The practice assured us this would not happen in the future.

The delegated authority to hold CDs had been signed off in March 2025. It was not correct as the SMO had inappropriately authorised their own delegated authority. Promptly after the inspection, we received a revised Notice of Delegation signed by the Commanding Officer (CO) for the camp.

The destruction of CD/ADs was not in accordance with DPHC CD SOP 3-7-1. CD/AD drugs are required to be destroyed in the presence of the account holder (SMO) and an officer appointed by the Commanding Officer of the camp. The pharmacy technician can prepare the items for destruction with subsequent destruction carried out by the SMO and the CO or their representative.

The pharmacy technician was responsible for ordering vaccines. The nurses and medics could fulfil this role in the absence of the pharmacy technician. Vaccines were in-date and appropriately stored in the fridge away from the walls and with adequate airflow. Fridge temperatures were correctly monitored and were in range.

Emergency medicines were in-date and compliant with the DPHC standard operating procedure 4-07-01. The absence of ketone testing strips on the medical emergency trolley was rectified on the day. Medical gases were in-date and in sufficient supply. The treatment room where gases were stored required signage (Hazchem 5.1 and Hazchem 2.0) on the door and the pharmacy technician rectified this on the day of the inspection to highlight the presence of hazardous substances. This was addressed during the inspection.

High risk medicines (HRM) were pro-actively managed, taking into account the local SOP, DPHC policy and the local NHS Lothian policy. One of the doctors oversaw HRMs and carried out monthly practice searches and checks of the register. In addition, all doctors were asked to identify any patients prescribed a HRM as a secondary capture of patients. HRMs were tracked on the chronic disease register.

Patients prescribed amber and red drugs were tracked, including those requiring a shared care agreement (SCA). The process for SCA was followed and medicines were not issued until a SCA was in place. The pharmacy technician had been directed not to issue HRMs unless appropriate SCAs were in place. An example was discussed of a patient prescribed a HRM medicine privately. The practice declined to issue the medicine until the patient was reviewed and a SCA was in place.

Annual HRM audits were undertaken. The 2025 audit identified 8 patients prescribed an HRM. All had an alert on their medical record, were assigned the correct clinical code and had an in-date SCA on record.

We carried out a random review of patients prescribed repeat medicines. Of the 5 records reviewed, we identified 1 patient that needed a medicine review. Following a review of this patient’s record, we determined the patient’s medicine and care was regularly reviewed by a clinician in the Department of Community Mental Health, but the medicine review date had not been updated on DMICP. Some of the records were for patients new to the practice so their medicines had not yet been reviewed. We discussed with staff how the records of new patients should be checked for repeat medication and medication reviews. We highlighted that medicines can be reviewed in the absence of the patient, and it is recommended to use the ‘NO TEARS’ template from DMICP to record these.

Patient Group Directions (PGD) for nurses to administer medicines in line with legislation were used. PGD training was current and PGDs had been signed off by the SMO. We noted the HPV (to protect against the human papillomavirus) was out-of-date with no record of a revised authorisation. However, we confirmed no HPV vaccinations had been

administered since its expiry. Our review of patient records showed the appropriate PGD template was used and consultations for administration were correct. Annual practice and individual PGD audits were evident for the last 4 years. Patient Specific Directions (PSD) were appropriately completed by the prescriber, signed and authorised. Competency was assessed by the prescriber and administration of vaccinations was completed by nominated medics. The PSD records we reviewed had been accurately completed and clinically coded.

Authorisation from RHQ was in place for the non-medical prescriber (NMP) along with evidence of annotation on the Nursing and Midwifery Council register. The NMP was working within their sphere of competence and were in the process of completing advanced practitioner training. Our review of clinical records showed correct completion for the prescribing of antibiotics.

Requests for repeat prescriptions were handled via eConsult, the group mailbox or presentation of the repeat section of the prescription.

Local working practice protocols were in place to manage correspondence related to the prescribing of medicines from other healthcare services and secondary care. All correspondence was scanned to DMICP and the doctor tasked to take the appropriate action. The administrative team carried out checks to ensure all action had been taken. Documents from external sources were scanned to the patient's records and the doctor tasked to review the information.

Although a valproate (medicine to treat epilepsy and bipolar disorder) and topiramate (medicine to treat migraine) search had been completed for September 2025, evidence was not available to demonstrate if searches had been conducted in the previous months. At the time of the inspection, no patients were prescribed these medicines. The prescribing of antibiotics was regularly audited with evidence in place to show this took place every 6 months over the last 3 years.

Track record on safety

The practice manager and the business services manager were the building custodians and the leads for safety, health, the environment and fire (SHEF). Two staff were identified as the fire leads. The practice manager carried out SHEF spot checks both daily and weekly. These recorded checks included inspection of the fire exit, fire extinguishers, first aid kits, panic alarms and clinical waste storage. In addition, a SHEF audit was completed in September 2025.

The 5-yearly fire risk assessment for the premises was completed in February 2023. Weekly fire alarm testing took place and also other weekly and monthly checks of the fire alarm system and firefighting equipment. Staff we spoke with confirmed a fire evacuation drill was held annually with the most recent taking place in August 2025. Fire action information cards were available at each fire exit.

Processes were in place for the regular monitoring of utilities. The electrical installation safety report was issued in March 2024 and the emergency lighting was checked in July 2025. Records showed electrical equipment testing was undertaken in August 2025. There

was no piped gas in the building. A legionella management and control risk assessment was carried out in November 2024. The weekly water checks carried out by the practice were recorded and the contractor undertook annual water checks.

The SMO and SNO were the leads for clinical risk. The practice manager and business services manager oversaw non-clinical risk. The practice manager maintained the risk register with oversight from the SMO and governance team. Risks are reviewed monthly and updated in the HCG workbook and discussed at HCG meetings. The risk register was updated during the inspection to reflect the DPHC '4 T's process' (transfer, tolerate, treat, terminate) to illustrate at what level each risk was being managed. Two risks were transferred to RHQ. Ownership and mitigation actions for each risk were recorded with appropriate review dates in place.

Risk assessments for substances hazardous to health (COSHH) were reviewed annually or if there was a change to the products used. The 11 risk assessments were reviewed in September 2025. Cleaning staff were responsible for managing the COSHH products they used. We noted they held data sheets and risk assessments for each product in the cleaning store cupboard. All COSHH products in the building were stored securely.

The practice manager and an ERI were the leads for equipment care. The annual equipment inspection (referred to as a LEA) was completed in November 2024. The 1 area of non-conformance identified was outside the control of the practice but the responsibility of the medical and dental servicing section (a military capability referred to as MDSS). Equipment was in-date for servicing.

The ERI maintained a logbook of the rehabilitation equipment checks. Unsafe equipment was quarantined or if the piece of equipment was too large to move then tape and a notice was placed on the item. A physical training instructor oversaw the non-DPHC equipment used by PCRF staff in the gyms.

The PCRF gym was well ventilated and a thermometer was available to guide exercise intensity. No end stage rehabilitation was undertaken within the gym. This took place in the garrison gyms where there was a wet globe bulb test to indicate the potential for heat stress.

The PCRF team used the Edinburgh Garrison swimming pool for rehabilitation swim sessions. The PCRF risk assessment for the pool was reviewed in September 2025. In addition, a garrison pool emergency plan and normal operating procedure were in place. Garrison technicians with Pool and Spa Operators Qualifications maintained the pool plantroom and checked chlorine levels 3 times a day. The recordings were stored in the plantroom and are accessible for auditing of the pool when requested. Staffing levels for swim session were correct with 1 ERI for a group of 15 patients. If 2 lifeguards were not available then the swimming session was cancelled.

Staff carried handheld personal alarms to summon assistance in the event of an emergency. We noted from the risk register that personal alarms were not audible throughout the medical centre, so we tested the alarm in the administrators' office behind reception. Only the receptionist heard it and promptly responded. Following the inspection, the SNO confirmed the practice had re-activated and tested the old wall mounted alarm system that sets off a loud alarm in reception with a room number. A laminated card in

reception with room numbers was put in place to direct the response. Due to the age of the system, it was not available in all rooms, so the plan was to order louder high decibel alarms for the areas not covered.

The lone working risk assessment for the practice was reviewed in November 2024. Although rare, if lone working took place in the gym, duty staff and the guard room were informed in line with the lone working SOP.

Lessons learned and improvements made

The practice worked to the DPHC policy for reporting and managing significant events, incidents and near-misses, which were recorded on the ASER system; organisational-wide process for reporting significant events. The SNO was the lead for ASER and a range of other staff deputised. The staff database showed all staff had completed ASER training to access the system.

A comprehensive ASER register was established and any new incidents/events were discussed at HCG meetings. Minutes showed action was taken and changes made if appropriate. Staff provided examples of ASERs that were discussed at the meeting, including the action taken, changes made and lessons learnt. The practice identified an ASER theme of scanning errors. The process was reviewed and individual training delivered. In addition, a time analysis was undertaken for the administrative team. As a result, multi-tasking was reduced and protected time for scanning introduced.

The pharmacy technician was the lead for managing medical alerts received via the Central Alerting System (CAS). All CAS alerts were correctly recorded and actioned. Meeting minutes showed they were discussed at the HCG meetings. We noted there was no evidence that National Patient Safety Alerts received from the regional team were recorded or discussed. Evidence was provided promptly after the inspection to confirm the matter had been rectified.

Are services effective?

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

Effective needs assessment, care and treatment

‘Policy, guidance and standard operating procedures’ was a standing agenda item at the healthcare governance (HCG) meetings held each month. It included updates for staff on developments in clinical care including National Institute for Health and Care Excellence (NICE) guidance, the Scottish Intercollegiate Guidelines Network clinical pathways, standards and other best practice guidance (BPG). The August 2025 HCG meeting minutes demonstrated that guidance was discussed in detail and included a link to access the relevant guideline. For example, the NICE quality standards related to overweight/obesity management and cardiovascular risk assessment were discussed. Updates to JSP 950 (Defence medical standards) were also considered, including malaria prevention in UK Armed Forces personnel.

It was evident that clinicians worked collaboratively with a focus on shared learning. Informal clinical discussions were held each morning during the coffee break. Staff described these discussions as valuable as they were patient-based and a form of problem-based learning. For example, a recent journal article regarding the management of high blood pressure through the titration (gradually adjusting the dose) of ACE inhibitors (medicine to lower blood pressure) was discussed by the team and led to changes in individual practice.

The Senior Nursing Officer (SNO) attended the doctor’s clinical meetings and provided feedback to the nurses. The nurses also held team meetings at which patients with complex needs were discussed.

Furthermore, staff were kept informed of clinical and medicines updates through the Defence Primary Healthcare (DPHC) newsletter circulated each month. Updates were also discussed at the weekly doctor’s meetings. Topics included patients of interest, cancer management and patients with mental health needs. The doctors expressed that they found these discussions very useful.

The Primary Care Rehabilitation Facility (PCRF) team were aware of the rehabilitation BPG guidance on the Defence Learning Environment. They used objective markers to gain direct feedback from patients about their symptoms and to assess functional ability. These included the hop test, 1-repetition maximum (referred to as 1RM), the Solider Conditioning Assessment (army fitness test) and completion of tabbing build up prior to referral to level 2 physical training.

Our review of PCRF patient records confirmed the Rehabilitation Master Template was used for each DMICP entry. The Musculoskeletal Health Questionnaire (MSK-HQ) and Functional Activity Assessment (FAA) were routinely used. Both the MSK-HQ and FAA are standardised outcome measure for patients to report their symptoms and quality of life. The MSK-HQ was completed within the time frames indicated by Defence Rehabilitation

and exercise rehabilitation instructors (ERI) completed it more regularly than the 6-weekly recommendation. The use of the MSK-HQ was clinically coded via the DMICP template.

Patients accessed rehabilitation exercise programmes through Rehab Guru (software for rehabilitation exercise therapy). The rehab guru prescription was copied and pasted to the patient's clinical record along with the prescription code.

The PCRF was well equipped with sufficient space and equipment to meet the needs of patients. There were 6 staff members and only 4 plinths, which could be a challenge at times when clinics were full. Group rehabilitation-based therapy sessions were planned and run by the ERIs. Swimming sessions were also offered for cardiovascular and aqua therapy.

Practice staff had effective relationships with the Chain of Command for each unit, which meant concerns about the mental health of service personnel was identified early. The practice managed low level mental health concerns locally and referred to 'SilverCloud', a recently introduced digital psychological wellness resource to support with issues like stress, anxiety and depression. Clinicians described effective links with local community psychiatric nurses who provided informal advice. The Department of Community Mental Health (DCMH) engaged with multi-disciplinary team meetings as requested. The doctors had a good awareness of the indications for urgent and direct referral to the DCMH. Our review of clinical records showed patients with a mental health need were well managed and appropriate clinical coding was used.

In addition, clinicians could refer patients to the unit welfare services. They also had access to organisations in the community, particularly useful for those transitioning out of the service or those wishing to use an alternative to options available in the Army. Posters with a quick response/QR code were displayed for patients to access information about services.

Monitoring care and treatment

The SNO and one of the doctors were the leads for long-term conditions (LTC). Responsibility for the management of LTCs was shared amongst the nurses. A register capturing patients with an LTC was in place and was updated following a monthly search. Patients were added to the 'due list' log and contacted to make an appointment. Nurses completed the initial consultation and follow-up using the DMICP SOP LTC Management Tool. Non-responders were recorded on DMICP. We discussed with the nurses the benefit of introducing a process to discuss non-responders with the doctor to determine any further follow-up.

Twenty-four patients were registered as having a diagnosis of asthma and all had an asthma review in the last 12 months. The asthma template and grading template were used to complete the reviews in line with the DPHC LTC best practice protocol.

Our review of patient records showed 6 patients were prescribed a short-acting beta-2 agonist (SABA) as a repeat medication. The lead doctor for LTCs undertook an asthma audit in March 2025. In line with updated NICE guidelines, the aim was to reduce reliance on short-acting beta agonists (SABA) inhalers by promoting maintenance/reliever therapy

(AIR/MART) and sustainable dry powder inhalers (DPI). All asthmatic patients were recalled for review of their current inhaler regimens and assess opportunities for treatment optimisation. Where clinically appropriate, patients were moved to AIR/MART and DPI treatments. Several patients remained on separate inhaled corticosteroid inhalers and SABA inhalers. This work was raised as a quality improvement project.

Of the 49 patients identified as having high blood pressure, 48 had a record of their blood pressure taken in the past 12 months. Thirty-three patients had a blood pressure reading of 150/90 or less. The records we reviewed showed patients with high blood pressure were well managed.

There were 11 patients on the diabetic register. For 10 patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. Ten patients had a blood pressure reading of 150/90 or less which is an indicator of positive blood pressure control. Patients at risk of developing diabetes were identified through new patient screening, through consultations and routine over 40 health checks.

From the small sample of records reviewed, we identified inconsistencies with the recording of retinal screening (test to detect the eye condition diabetic retinopathy). For example, recall dates in the diabetic register did not correlate with those on DMICP. The outcome of screening was not always clear on DMICP and a small number of patients appeared to be overdue for screening. Although a diabetes audit was undertaken in the last 12 months, retinal screening was not an audit criterion.

Hearing Conservation Programme searches were undertaken each month and audiometry assessments were in-date for 71% of the patient population. Our review of patient records demonstrated Joint Medical Employment Standards (referred to as JMES) were appropriately managed.

With significant changes detected through audiology, clinicians are obligated to downgrade service personnel and refer them for a Gold Standard Audiogram (GSA). There was a 39 week wait for a GSA in NHS Scotland, which meant a decrease in unit deployability. The Defence Audiology Service (DAS) employed 2 audiologists at the Institute of Naval Medicine (INM). Funding was obtained for an INM audiologist to undertake peripatetic clinics in Edinburgh, Inverness and Glasgow. In 5 days, over 100 personnel in Scotland had a GSA. Analysis showed this initiative saved 1,580 weeks (or 30 years) of NHS waiting time collectively in Scotland. Importantly, patients were downgraded for a shorter time which meant the unit's deployability increased. The peripatetic DAS clinic was low cost, high impact, and easily reproducible. The initiative was raised as a quality improvement project. It has been presented to Commander DPHC to promote the INM DAS team replicating peripatetic clinics at other military hubs across the UK.

The SNO was the lead for quality improvement activity, including clinical audit, and 1 of the nurses deputised. An integrated, comprehensive and well evidenced rolling audit cycle was established, which was used to evaluate the quality of care and improve patient outcomes. It consisted of the mandatory DPHC audits (must) along with good practice audits (should) and clinical audits relevant to the needs of the patient population. 'Audit and quality improvement projects' was a standing agenda item at the HCG meetings. The meeting minutes from August 2025 showed gout and high risk medicine audits were discussed and a link provided to access each audit.

We reviewed a selection of recent clinical audits including an asthma audit and hypothyroidism (low levels of thyroid hormones) audit. Asthma had audit cycles dating back to 2018. The cycles evidenced progress with auditing new asthma management guidance instead of simply re-running/repeating the same audit over and over. The hypothyroidism had been completed since 2019. Good practice has been identified for hypothyroidism LTC monitoring using the criteria of a disease register, annual reviews and blood tests achieved.

Audits undertaken by the PCRF team confirmed compliance with the Defence Rehabilitation BPGs and included patella (kneecap) tendonitis and ankle injury. If appropriate, the results of audits were shared at the Commanders Monthly Case Review meeting, including injury causation, to enable modification of physical training sessions.

Effective staffing

Staff new to the practice completed a structured generic induction covering general policies, such as governance, health and safety, equality and diversity and IT systems. In addition, they completed a role specific induction to ensure they had the skills and information in duties relevant to their position. New staff had an assigned mentor and supervision. The Senior Medical Officer covered the occupational health elements of the job with new doctors. Locum staff received a role specific induction and the practice management team conducted additional checks to ensure they were safe to practice.

Mandatory training was monitored by the practice manager and business services manager. Training updates were discussed at the practice meetings. At the time of the inspection, compliance with mandatory training was 98%.

The in-service training (IST) register confirmed that a comprehensive schedule of training had taken place. IST was facilitated each week and included a wide range of topics relevant to the patient population and operation of the practice. IST supported staff with continuing professional development (CPD) and each of the staff had an individual staff training plan aligned with their role requirements. All staff were encouraged and supported to undertake CPD relevant to their role.

Clinical staff had completed training relevant to their role, such as smoking cessation, minor surgery and women's health. Aviation medicals were undertaken at Leuchars Medical Centre and diving medicals at Neptune Medical Centre. The majority of staff undertaking secondary roles had completed the relevant training and this was reflected in their terms of reference. The infection prevention and control (IPC) lead was awaiting a date to complete the IPC training. In the interim, they were supported by the SNO who had completed the required training.

Cervical screening and spirometry were outsourced as none of the nurses were trained in these procedures. Although the nurses provided vaccinations under Patient Group Directions (PGD), simple treatments were not issued under PGD as a prescription was raised by the doctor. The SNO had plan to upskill the nurses. This involved a skills needs analysis, refresher PGD training in November 2025 and training regarding simple treatments in December 2025.

Doctors and nurses participated in peer review sessions and these were recorded in the HCG workbook. Support was in place for the General Duties Medical Officer. This included an assigned mentor, one-to-one sessions, joint clinics and tutorials. Informal clinical supervision took place at the regularly held nurses meetings and the SNO clinical planned to formalise clinical supervision. A quarterly forum for practice nurses was facilitated by the Regional Nurse Advisor.

The physiotherapists and ERIs conducted peer review between themselves. The process included observed assessments along with case discussions. In addition, a unit-based military ERI supported the DPHC ERIs by providing training, peer reviews and an audit of their record keeping.

Coordinating care and treatment

The practice, including the PCRF, had effective relationships with the units and were represented at the various unit-led Commander Monthly Case Review meetings. At these meetings vulnerable patients, downgraded patients and occupational health statistics were discussed. The practice also had good links with internal defence services including the DCMH, Regional Occupational Health Team and Regional Rehabilitation Unit.

Informal links were established with hospital specialties, mainly driven by staff members who had been in post for many years, such as the lead for referrals. These relationships were key for the practice given the connectivity issues, particularly for referrals and sample management. Midwifery and health visitor services were accessed via a local NHS practice.

The practice adhered closely to organisational policy for release medicals including 3 copies of the FMed133 (paperwork generated for the NHS GP) signed by the patient. The patient and practice retained a copy and the third copy was sent to Primary Care Support England. The practice encouraged those being discharged on medical grounds to register with an NHS GP before formally exiting the service so that a discussion between both doctors could be facilitated if needed. Patients were also provided with information about additional services, such as Op COURAGE, a free NHS service in England that provided mental health support for veterans and their families. In addition, patients were advised about the Armed Forces Covenant, which is a guarantee that those who have served in the armed forces are treated with fairness and respect.

Helping patients to live healthier lives

The health care assistant was the lead for health promotion. The practice followed both the NHS and DPHC health promotion calendars so health topics were refreshed regularly on a rolling programme. The waiting area monitor screen system provided a range of educational information and videos for patients to watch while they were waiting.

The main health promotion topic displayed at the time of the inspection was in relation to women’s health, notably the promotion of cervical screening. There was also a display about understanding blood pressure. A range of patient-orientated resources were

available regarding mental health wellbeing including QR codes and booklets for issues, such as suicide, stress, bereavement, post-traumatic stress disorder, managing depression and coping with suicidal feelings.

Primary health prevention interventions provided at the practice included over-40 health checks, health education and risk-factor reduction, such as a smoking cessation clinic held each week. Weight management was facilitated by the nurses. Clinicians were aware of the specific needs of women in combat roles and provided additional support in accordance with the standard operating procedure. During one-to-one sessions with patients, ERIs took the opportunity to discuss lifestyle issues with patients including checking their weight; necessary when determining relative strength.

The SNO was the lead for sexual health and had completed the required training (referred to as STIF). One of the doctors was also STIF trained. Asymptomatic screening carried out at the practice and patients with symptoms of a sexually transmitted infections were referred to the local NHS sexual health clinic. The SNO had provided training for the nurses on asymptomatic screening and provided supervision. We discussed with the SNO undertaking an audit to determine compliance with asymptomatic sexual health screening standards. Condoms were available in patient toilets.

The nursing team led on the national screening programme. DMICP searches for abdominal aortic aneurysm (referred to as AAA) were regularly carried out to identify patients meeting the criteria. Bowel screening was managed by the NHS who supplied the practice with bowel cancer test kits (referred to as FIT) which were issued to eligible patients. The recall for breast screening was managed by the NHS screening programme.

Once a patient was on the ‘Prior Notification List’, the practice received a prior notification letter from the Scottish Cervical Call Recall System (SCCRS). As there were no cervical screening trained nurses at the practice, patients accessed screening via NHS East Lothian. We were advised the nurse contacted the patient via text or email and a letter was also sent. Patients were provided with details of the clinic and opening times. Only 1 nurse had access to SCRRS, which meant there was no resilience if they were not in work.

Prior to the inspection, the statistics submitted by the practice indicated the number of eligible women whose records indicated that a cervical smear had been performed in the last 3-5 years was 25, which represented an achievement of 75%. This was below the NHS target of 80%.

A cervical screening register was maintained, and it identified 100 eligible patients at the time of the inspection. However, our DMICP search identified 104 eligible patients. The register indicated 25 patients had not been screened at the appropriate age. Recall and the follow-up of non-responders was not in accordance with the DPHC SOP, confirmed by our review of a selection of patient records. Records showed not all patients had been recalled within an appropriate timeframe, nor had the correct action been taken for patients who defaulted or did not respond. For example, records had no diary date for recall and/or recall dates had not been amended and monthly recall letters had not been sent to the patient. Furthermore, clinical coding was inaccurate on the records we looked at.

Unit staff were responsible for the monitoring and recall of service personnel occupational vaccinations. The SNO maintained a spreadsheet for oversight. At the time of the inspection, the status of vaccinations was:

- 93% of patients were in-date for vaccination against diphtheria.
- 92% of patients were in-date for vaccination against polio.
- 94% of patients were in-date for vaccination against hepatitis B.
- 95% of patients were in-date for vaccination against hepatitis A.
- 92% of patients were in-date for vaccination against tetanus.
- 99% of patients were in-date for vaccination against measles, mumps and rubella.
- 48% of patients were in-date for vaccination against meningitis.

Consent to care and treatment

Implied, verbal and written consent was taken depending on the intervention. Verbal consent was obtained from the patient for examinations requiring undressing, intimate examinations, blood samples and vaccinations. Written consent was secured for minor operations and occupational medical gradings.

All the PCRF patient records we looked at indicated consent had been appropriately taken. Acupuncture patient information leaflets were available to ensure patients were fully informed prior to verbally consenting to the treatment.

Consent was considered as part of the consultation audits and a separate consent audit was undertaken in October 2025. A clinical records review in February 2025 identified consent was recorded 89% of the time.

Clinicians understood the Mental Capacity Act (2005) and how it would apply to the patient population. The 5 statutory principles of The Act were displayed. Update training was facilitated in August 2025.

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 40 patients. In addition, we considered the results of the Defence Primary Healthcare (DPHC) patient feedback survey (January – July 2025) which generated 103 patient responses. All feedback reviewed suggested staff were friendly, understanding and caring. The survey showed that 96% of patients said the staff treated them with kindness and compassion. A patient provided the following comment, “I feel like a person, not a statistic”.

Staff supported vulnerable patients by providing longer appointments and ensuring continuity with same clinician. We were given various of examples of when the practice had shown compassion to patients. For example, a patient’s privacy and dignity was comprised in the waiting area due to a health issue. The patient was managed with compassion and their privacy maintained. The practice liaised with the patient’s line manager to ensure the work environment was suitability to support the patient with consideration given as to whether the patient could work from home.

An atrium waiting room adjacent to the main waiting area had been developed for patients. It had a relaxed non-clinical feel as it included a large range of plants. Through the CQC inspection feedback cards, patients commented about how they liked this room.

A wide range of support networks were available on the camp, including the Army Welfare Service, Chaplaincy, Padres and unit welfare teams. Family support included SSAFA (Armed Forces charity), a family welfare officer and HIVE (garrison support network).

Involvement in decisions about care and treatment

Feedback indicated patients were involved with planning their care with 96% of those who responded to the DPHC indicating they were given clear information about their treatment and care. Our review of patient records confirmed the involvement of patients in decision making about care. Some patients commented that they were listened to and provided with the information they needed.

A translation service was available for patients who did not have English as a first language and information was displayed for patients about how to access the service. A register was maintained of when it was used.

Patients with a caring responsibility were identified when they registered at the practice and through the summarisation process. Once identified, carers were added to the carers list on the long term conditions register. The list was checked each month by the Senior Nursing Officer (SNO). Our review of carers’ clinical records showed clinical coding/alerts were not consistently applied. Although carers were included in the flu vaccination programme, they had not been offered an annual health check. The SNO confirmed after

the inspection that carers would be sent an invitation for a health check and the staff team had been briefed about this requirement. Information for carers was displayed on the patient notice board and included in the practice information leaflet. An audit of carers was carried out for 2025.

Privacy and dignity

Patient consultations took place in clinic rooms with the door closed. If headphone sets were used for telephone consultations then the patient's ID was checked prior to any information being disclosed. Privacy curtains were available in all clinical rooms for intimate examinations. Measures were in place for patients to speak with the receptionist discreetly.

Cubicles in the Primary Care Rehabilitation Facility (PCRF) just had privacy curtains which posed a confidentiality challenge. However, a radio the background was used to mitigate this. A room in the PCRF with privacy curtains was available for pelvic health examinations with a sign placed on the door to inform people not to enter the room also available. This room could also be utilised when a patient requested a more private setting. Facilities were available in the gyms used for rehabilitation to provide privacy for patients.

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

Are services responsive to people's needs?

We rated the practice as good for providing caring services.

Responding to and meeting people's needs

We found that the practice was responsive to the needs of patients and occupational requirements with clinics co-ordinated to meet those needs. Total triage prioritised patient needs with same day appointments for those with an urgent need and telephone consultations for patients located remotely. Through the use of DMICP alerts, vulnerable patients and carers were promptly identified and prioritised for an appointment. Extended appointment times could be facilitated. Depending on patient preference, the practice used various communication methods to share information, such as test results and appointment letters.

DMICP searches were undertaken to identify personnel with outstanding occupational healthcare needs. This pro-active approach was beneficial to the patient and the Chain of Command as it reduced pressure on operational preparation. Vaccination clinics were arranged depending on the needs of the unit with the practice facilitating clinics for up to 300 patients at short notice. During the Royal Edinburgh Military Tattoo event there had been an influx of soldiers, including bands who rehearse at night. The practice ensured appointment availability in the afternoon so that personnel had access to care before they start their night shift.

In line with the Equality Act 2010, an access audit for the premises was completed in October 2024. The premises could accommodate people with mobility needs as it was spacious with accessible parking spaces, an automatic opening front door, 2 accessible toilets and a hearing loop. Signage was clear throughout the building.

Even though no patients were transitioning at the time of the inspection, a transgender health care protocol was in place dated March 2025. Alerts for non-binary patients were included on their DMICP record. Accessible gender-neutral toilets were available.

Although staff had received training in attention deficit hyperactivity disorder in August 2025, not all staff had completed training in how to interact appropriately with people with a learning disability and/or autism. Three clinicians had completed this training in accordance with the DMSR Healthcare Defence Code of Practice (DCOP).

Timely access to care and treatment

Supported by a standard operating procedure, a process of Total Triage was in place. Total Triage was duty doctor-led and involved a nurse, medic and administrator. It was held from 08:00 to 10:00 hours and again from 13:30 to 14:30 hours. Staff described how Total Triage had been instrumental in creating an efficient appointment system as patients with an urgent health care need were prioritised for a same day appointment with a doctor or nurse. Total triage also determined if a face-to-face consultation was required. A 2-way

text message system had been introduced. Using this process meant patients could send texts to book appointments. They could also telephone the practice or submit an eConsult.

Depending on the output from Total Triage, routine appointments with a doctor and nurse could be facilitated within 1-3 days. Medics could see a patient on the same day and there was a 2 day wait for an appointment with the health care assistant. Occupational health medicals could be facilitated within 7 days.

Patients with an urgent need could see a physiotherapist within 2 days and follow up appointments could be accommodated within a week. Usually it was 5 days for a new patient routine appointment. At the time of the inspection, the wait was 20 days due to increased referrals as regiments had returned from deployment. Exercise rehabilitation instructors had capacity to see patients within 2 days.

The Direct Access Physiotherapy (DAP) pathway was available for patients to use. There was an equal number of referrals received from doctors and DAP. The Primary Care Rehabilitation Facility (PCRF) team indicated that they could meet demand. We noted from our review of records that a form for DAP was not being completed as recommended by policy.

Waiting times for the Multidisciplinary Injury Assessment Clinic varied between 2 days and 4 weeks as the Edinburgh Regional Rehabilitation Unit (RRU) covered 3 sites. This variation did not have a negative impact as the RRU had protected appointments for urgent referrals. The PCRF also had weekly meetings with the RRU to discuss patients prior to referral.

A duty nurse was on call for out-of-hours triage from 16:30 to 18:00 hours each weekday and had access to the duty doctor if needed. Access to NHS health care out-of-hours from 18:00 hours midweek and at weekends/public holidays was displayed on Part One orders, the practice door and in the practice leaflet.

Listening and learning from concerns and complaints

The practice manager and business services manager were the leads for complaints, which were managed in accordance with the Defence Primary Healthcare complaints policy and the practice standard operating procedure. A structured complaints log including actions and learning was maintained. Complaints about clinical care were referred to the Senior Medical Officer.

Four complaints relevant to the medical centre were received in the last 12 months and had been appropriately managed to the satisfaction of the complainant. Minutes showed that complaints and compliments were a standing agenda item at practice and healthcare governance meetings. Themes were monitored through the annual complaints audit.

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

Are services well-led?

We rated the practice as good for providing caring 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."

In addition, the practice had collaboratively developed a local vision/mission statement drawing on DPHC healthcare priorities, staff input and patient feedback. It was defined as:

> "To be a trusted and resilient medical practice that empowers our patients and strengthens our organisation by delivering innovative, patient-focused healthcare. We aspire to set the standard for safe, effective, and adaptable medical support that enhances readiness, promotes wellbeing, and sustains the fighting power of those we serve."

When developing strategy or making service changes, the senior leadership team (SLT) assessed the health needs and demographics of the patient population alongside patient and key stakeholder feedback. Engagement with patients, staff, the Chain of Command and external agencies supported with strategic decision making. We were advised all planned changes were risk assessed for patient and staff impact. Business plans were discussed and only approved once the benefit to the patient population was clear.

The Primary Care Rehabilitation Facility (PCRF) had a specific developmental plan which fed into the wider strategy and business plans. An example of this was engagement with the garrison in relation to setting up the same gym sessions that are delivered at other garrisons to ensure equity of service provision.

Practice staff had a good relationship with the garrison leaders regarding environmental sustainability and the recycling of waste. Recycling was encouraged and the use of QR codes and electronic information rather than printed information. Some rehabilitation assessment documents had been laminated so they were reuseable. A 'device shut down' checklist had been introduced in all rooms to remind staff to reduce energy waste. Recycling and waste segregation were in place and remote consultation options helped reduce unnecessary travel. Printer toner and cartridge recycling schemes in place. There was a designated bike parking area for staff and patient use.

Leadership, capacity and capability

The SLT was highly experienced and sufficiently staffed. The team consisted of the Senior Medical Officer (SMO), lead physiotherapist, Senior Nursing Officer (SNO), practice

manager and business services manager. Although collaborative working was embedded, each of the SLT had clearly defined roles, responsibilities and reporting lines. Staff spoke highly of the leadership team in terms of visibility, availability and provision of support. We heard that the SMO and SNO visited the staff in each department regularly. The SNO planned to introduce a 'staff coffee hour' meaning each department will be allocated an hour a week to for an informal chat.

The SLT spoke well of DPHC Headquarters and highlighting that the practice was very well supported by the regional team. For example, the PCRF lead attended a regional management meeting hosted by the Regional Clinical Director (RCD). The RCD visited the medical centre and PCRF when they first took up post.

The SLT were conscious of the need for succession planning especially as key leaders were military and subject to deployment/rotation. The SLT had created a structure with roles evenly spread across the team so the loss of a staff member would minimise the impact on the SLT. These included heads of department roles, designated deputy roles and centralised governance systems. The introduction of a business services manager post had supported with minimising the loss of capability/corporate knowledge when the practice manager is posted. Standardised protocols and local standard operating procedures policies were in place to support leaders new to the practice. Leadership capability was enhanced by formal training, regular governance meetings and higher command oversight.

Culture

It was clear from patient feedback, interviews with staff and the welfare team there was a patient-centred culture at the practice. This was also evident from our observation of how patients were greeted at the reception. Staff understood the specific needs of the patient population and tailored the service to meet those needs. For example, the pro-active approach to coordinating vaccination clinics to accommodate the needs of units.

Staff spoke highly of the culture and strong collaborative teamwork. They felt respected, supported and valued. Everyone had an equal voice, regardless of rank or grade. Both formal and informal opportunities were in place so staff could contribute their views and ideas about how to develop the practice. The 2025 staff satisfaction survey highlighted positive team cohesion and staff scored high in terms of job satisfaction. Excellent comments were submitted about working at Redford Medical Centre. It was clear the survey was reviewed and concerns actioned. For example, the survey highlighted some team cohesion issues and this was promptly addressed.

To maintain positive wellbeing for individuals and the team, the weekly 'Wellness Thursday' provided staff with the opportunity to focus on their own needs. Team building or 'White Space' events were held regularly and staff said they enjoyed the recent 'pamper afternoon'. The SLT funded the tea and coffee for the staff team. Since taking up post, the SMO re-introduced Wednesday sports afternoons for eligible personnel. The SLT had developed a relaxing atrium area for staff to use for lunch and breaks. Since its development, staff had started to have breaks together rather than staying in their rooms.

The SLT promoted an open-door policy and encouraged staff to share their views at meetings. Staff said they were comfortable raising any concerns and were familiar with the whistleblowing policy. They 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 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. A duty of candour log was maintained.

Governance arrangements

Formal and informal communication channels were established including both a practice and healthcare governance meeting. Minutes showed these meetings were well attended by staff. In addition, each of the clinical teams and the administration team held monthly meetings and the doctors meeting was held each week. The SNO attended the doctors meetings, which supported integration with the nursing team and the maintenance of effective working relationships. The heads of department met each month. Staff advised that they found the daily informal ‘huddle’ useful to discuss current issues and share and relevant information.

There was a clear, defined staff reporting structure in place and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. Up-to-date terms of reference were in place for all staff and referenced the secondary roles undertaken by staff. Staff with lead roles had protected time to carry out their additional duties.

The healthcare governance workbook (HCG) was the overarching system used to bring together a range of governance activities including the risk register, medicine alerts, audit, health and safety and quality improvement. It was comprehensive, easy to navigate and contained all the relevant information to illustrate how the practice was governed. All staff had access and contributed to updating the workbook. The SLT advised that staff engagement, patient feedback via surveys and the patient participation group were utilised to improve practice processes.

We identified gaps with some clinical governance systems including the process to ensure the recall of patients for cervical screening, retinal screening and the management of sample results. In addition, there were system gaps with the management of medicines.

A programme of quality improvement activity was established to monitor the outcomes and outputs of clinical and administrative practice. Audits were presented and discussed with staff at the practice meetings.

Managing risks, issues and performance

The practice identified risk through incident reporting, audits, patient feedback, staff input and environmental assessment. A live and a retired risk register was in place along with an issues log; all within the HCG workbook. Our review of the risk register showed current and future risks were well managed with the register regularly reviewed and trends monitored.

Although staffing levels were adequate, having suitably qualified and experienced personnel (referred to as SQEP) was the top risk on the risk register. The poor interoperability between Defence and NHS IT systems was also a recognised risk. We identified gaps with some of governance and clinical processes.

The leadership team mapped priorities against resources and risks. This was demonstrated through the management action plan (MAP). Each action had a designated lead and target completion date. Feedback on progress took place at the HCG meetings. - The DPHC 'Opal Status' was reviewed each month.

The business continuity plan (BCP) was reviewed in June 2025. Resilience and the BCP were regularly tested. Examples included IT/DMICP network outages and staff shortages. All staff were informed by email of BCP updates.

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

The SLT team was familiar with the policy and processes for managing staff performance including through supervision, appraisal and the use of individual development plan. Underperformance was managed in line with DPHC policy.

Appropriate and accurate information

The Health Assessment Framework (HAF), an internal system, was used by the practice as to monitor performance and as a development tool. The HAF was reviewed with staff at HCG meetings to reinforce good practice, highlight areas requiring improvements and encourage team-based problem solving.

An Internal Assurance Review was undertaken in June 2024. The practice was graded as having substantial assurance overall and substantial assurance for each of the domains.

Arrangements at the practice were in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. The SMO and practice manager were the leads for Caldicott, a set of principles regarding the use of confidential information. A Caldicott audit was undertaken each week. to ensure records were not being accessed inappropriately. Any concerns identified were addressed at the practice meeting. All staff had received training in information governance and the General Data Protection Regulation.

Engagement with patients, the public, staff and external partners

Options were available to prompt patients to provide feedback on the service. Patients could contribute to the DPHC patient experience survey via a QR code that was displayed around the building. A patient participation group was held. As only 3 patients joined the last group, the practice was looking at ways to promote the group and improve attendance. A 'you said, we did' board was displayed in the waiting to inform patients about changes made based on their feedback.

We had access to the most recent staff satisfaction survey and the feedback was positive. Staff reported that they were encouraged to provide feedback at the practice meetings, via one-to-one meetings and through appraisal.

The practice worked closely with the Chain of Command, welfare support services and other Defence services to ensure a collective approach with meeting the needs of the service personnel population. The SNO attends specific meetings, such as the Edinburgh Tattoo meeting, to discuss medical requirements to support proactive planning of medical provision for the event.

The GP trainee spent equal time working between Redford Medical Centre and a local NHS training practice. Many of the families of service personnel were registered at this local practice. The GP trainer attended the local trainers quarterly meeting. Redford Medical Centre had hosted local NHS training practices for 1 of these meetings which had supported with developing closer links with NHS colleagues.

Continuous improvement and innovation

The practice team was committed to continually improving the service and this was evident through quality improvement activity, including a comprehensive programme of audit and responsiveness to patient/staff feedback. Many of the clinical audits were on the third cycle.

In response to patient feedback, examples of improvements included:

- a change in the layout of the waiting room
- condoms were moved to the toilets rather than held in the waiting area
- because of poor mobile signal, measures were put in place to contact patients by other means, such as a landline, Teams or email.

In response to staff feedback, examples of improvements included:

- revision of the Total Triage area to maximise space and promote integrated working
- meetings are now more concise and shorter
- integration of the duty medic into total triage

- duty medic and duty nurse now work in same clinical room to provide clinical support for each other and supervision for the medic.

A range of quality improvement projects had been undertaken by the practice over the last 12 months. Examples included:

- peripatetic audiology which resulted in a significant improvement in audiology statistics
- improvement in the management of patients with hypertension, including identifying those with undiagnosed hypertension
- development of a dispensary protocol to clarify access to controlled drugs out-of- hours
- introduction of text messaging which has improved communication and access from young soldiers.