Culdrose Combined Medical Practice

Defence Medical Services inspection

This report describes our judgement of the quality of care at Culdrose Combined Medical Practice. It is based on a combination of what we found through information provided about the service, patient feedback and through interviews with staff.

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

Contents

Summary

About this inspection

We carried out this announced comprehensive inspection on 2 April 2025. We visited both sites, Culdrose and St Mawgan. As a result of this inspection the practice is rated as requires improvement in accordance with the Care Quality Commission's (CQC) inspection framework.

The key questions are rated as:

Are services safe? – requires improvement
Are services effective? – requires improvement
Are services caring? – good
Are services responsive? – good
Are services well-led? – good

The Care Quality Commission (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 one of a programme of inspections that the CQC will complete at the invitation of the DMSR in their role as the military healthcare regulator for the DMS.

At this inspection we found:

The leadership team had a clear understanding of key issues and the work on combining was continually ongoing.

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.

Our review of records and processes to monitor care showed patients received effective and timely clinical care.

The practice had a system to identify the training needs for individual staff. However, there was a need for greater clarity around the status of mandated training courses completed. An effective system ensured that staff held the appropriate professional registrations.

Patient feedback about the service was positive. It demonstrated patients were treated with compassion, dignity and respect.

Appropriate measures were in place to minimise the risk of infection. Infection prevention and control audits were regularly undertaken. Staff training in infection prevention and control must be completed by all staff.

There was a culture of improving the service through audit and quality improvement. All mandated audits had been completed. This could be further strengthened by clinical audit.

The practice has had significant staffing issues so there has been no permanent pharmacy technician to drive continuous improvement. The current locum pharmacist was working to improve and rectify processes to comply with policy. Some medicines management required improving, including the management of controlled drugs, ensuring physical stock levels reflect what is recorded on DMICP including the emergency trolley.

Staff spoke highly of the culture within the team and described an inclusive and supportive leadership management style.

Staff understood the Mental Capacity Act (2005) and how it applied in the context of the service they provided.

Information systems and processes were in place to deliver safe treatment and care. There was a backlog of summarising that was being addressed with an action plan.

The practice had good lines of communication with the units and welfare teams to ensure the wellbeing of patients. Extensive links had been developed both internally and externally to enhance the support provided to patients and staff.

Governance systems underpinning the safe running of the practice were up-to-date.

ASER, the organisational-wide system for reporting significant events was effectively used and changes were made as a result of incidents.

We found the following areas of notable practice

The exercise rehabilitation instructor (ERI) developed a booklet for monitoring health factors (sleep, stress, nutrition) to support recovery. This booklet was reviewed as part of patient clinical reviews and if further support was required there were established links (e.g. with the weight management nurse).

The PCRF introduced an app to book individual programme rehabilitation sessions to make booking easier for patients, as well as less administration for the PCRF staff. The staff reported positive feedback from patients as was so much easier to book in.

‘Cadre Considerations’ was a system set up on the SharePoint which allowed any member of the team to record anything of interest to a specific cadre. It was set up for all staff groups and could be added to by any member of the team. Staff all commented how useful it was and was an easy way to communicate up to date information.

It was recognised the ‘multi-user’ email addresses were complicated and open to error on transcribing. A medic developed a card system containing individual departmental email addresses to hand out at reception, again to reduce the difficulties patients had reaching various departments.

The Chief Inspector recommends to Culdrose Combined Medical Practice

A review of the mandatory training programme should be undertaken to ensure staff have completed the Defence Primary Healthcare (DPHC) required training to deliver effective care and treatment.

Ensure all staff complete training relevant to their role in recognising the deteriorating patient/sepsis.

Ensure all staff continue to receive training at a level appropriate to their role in how to interact appropriately with people who have a learning disability and/or autism.

Continue to address the back log in the summarisation of patients' medical notes.

All emergency medicines held on the emergency trolley must be added to DMICP and monthly time expiry reports run.

A complete stock check, involving the controlled drugs register, DMICP and physical stock must be completed for all controlled and accountable drugs and a complete stock check of DMICP and physical stock must be completed for vaccines and all dispensary stock.

The Chief Inspector recommends to the base.

Continue to work with the medical centre to provide accessible access at Culdrose Medical Centre.

The Chief Inspector recommends to DPHC:

Continue to monitor current staffing levels (medics and dispensary staff) are sustained to maintain governance requirements and to safeguard the health, wellbeing and morale of staff.

Aidan Fowler

Interim Chief Inspector of Healthcare, covering Secondary and Specialist Care and Primary and Community Care

Our inspection team

The inspection team was led by a CQC inspector. The team included specialist advisors including a primary care doctor, practice manager, physiotherapist, exercise rehabilitation instructor and a nurse. A pharmacist specialist advisor visited on the 10th of April.

Background to Culdrose Combined Medical Practice

Culdrose Combined Medical Practice provides an integrated service of primary care, occupational health care and physical rehabilitation services to the population of RNAS Culdrose and RAF St Mawgan, as well as providing emergency cover to the Culdrose airfield 24 hours a day. The patient population of approximately 1600-1700, across both sites, consists of aircrew and assorted facilitators, support staff at Culdrose, and a range of Royal Navy, Army and Royal Air Force general service personnel at RAF St Mawgan. Culdrose has a steady flow of phase 2 trainees, both aircrew and junior technicians, some of who are under 18 years of age. RAF St Mawgan has a regular flow of attendees on courses who may require unscheduled care.

In addition to routine primary care services, the medical centre provides a range of other services including minor surgery, immunisations, sexual health, smoking cessation, cervical cytology, over 40's health screening and chronic disease management. Maternity services are provided by NHS practices and community teams.

The Primary Care Rehabilitation Facility (PCRF) is spread over 2 sites; the main site is co-located within the medical centre and 3 consulting rooms within the gym (it has its own dedicated, partitioned gym area). The medical centre has its own dispensary at the Culdrose site.

The practice is open Monday to Friday 08:00 hours to 12:00 hours and 13:30 hours to 16:30 hours, with shoulder cover until 18:30 hours for emergencies only. Between 18:30 hours and 08:00 hours, weekends and on bank holidays, patients are diverted by a telephone message to NHS 111 services.

The two sites previously shared resources and personnel, as well as assisting the ongoing tasks of both host units such as airfield cover and support to courses, before formally merging into the "Culdrose Combined Medical Practice", for which full operational capability was declared in June 2024.

The staff team

Culdrose

Principal Medical Officer (PMO)	One
Deputy Principal Medical Officer	Three (1 full time equivalent split between two individuals as a job share, one MOD GP working at St Mawgan but currently off work long time)
MOD Doctors	Two (one DPMO and one RAF Deputy Senior Medical Officer)

Practice manager	One
Business Manager	One (civilian)
Senior Nursing Officer (SNO)	One
Nurses	Three – two based at Culdrose site (one long term absence), one fulltime equivalent at St Mawgan site shared between two nurses
Exercise Rehabilitation Instructors (ERI)	Two (one post vacant)
Physiotherapists	2.4 (full time equivalents shared between three physiotherapists)
Administrators	Eight full time equivalent roles, twelve individuals in post due to some job shares
Medical Assistants	Two POMA's (one post currently vacant) Two LMA's (one based at St Mawgan, one post currently vacant) Eight MA's (four vacancies)

*A medic is a unique role in the forces and their role is similar to that of a health care assistant in NHS GP practices but with a broader scope of practice.

Are services safe?

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

Safety systems and processes

The practice worked to the Defence Primary Care Healthcare (DPHC) Tri-Service safeguarding policies. All staff within both the practice and the Primary Care Rehabilitation Facility (PCRF) had received up-to-date safeguarding training at a level appropriate to their role. There was a safeguarding adults and children's standard operating procedure (SOP) in place, both contained external contact details for the local and district area and both contained an easy-to-follow flow diagram to support staff when required. These were located within SharePoint and links were available via the joint management tool and via the SharePoint home page.

The Principal Medical Officer (PMO) was the safeguarding lead and had access to the DPHC level 3 safeguarding peer support / supervision meetings which occurred on the first Monday of each month. They had engaged with the local authority the "Our Safeguarding Children Partnership' for Cornwall and the Isles of Scilly (OSCP)" and registered for the "Working Together to Safeguard" training in June this year.

All doctors were encouraged to engage with the regional safeguarding training and learning opportunities, for example one doctor had completed interactive multidisciplinary team level 3 adult safeguarding training: "Understanding the Nature and Dynamics of Domestic Abuse and Sexual Violence" delivered by Safer Futures Cornwall. They had also attended "Child Safeguarding-stopping me seeing the people I love, child sexual exploitation" delivered by the Safeguarding Children Partnership for Cornwall and the Isles of Scilly and attended the 'lunch and learn' online session, which included members of the hospital team and community psychotherapists, exploring the application of the Mental Capacity Act across all stages of life, facilitated by the integrated safeguarding team.

Practice staff had a local app on their mobile phones and devices, signposting them to safeguarding agencies and there were safeguarding posters around the practice.

New doctors/locums and nurses were made aware of safeguarding arrangements during the first week of their induction and this included the requirement to read 'our safeguarding local working practice', which also identified the practice safeguarding leads. Locum doctors were invited to attend complex care meetings where safeguarding issues were discussed.

There were very few patients aged under 18 based at RNAS Culdrose, the small number were always identified at registration and coded with an alert attached to their clinical record. Regular searches were undertaken on DMICP (electronic patient record system) for patients under the age of 18, care leavers and carers. There was a monthly meeting held where vulnerable patients were discussed. The "Management of Vulnerable Patients" local working practice detailed the process by which they identified, monitored and supported vulnerable patients and care leavers.

The Culdrose executive maintained a register of individual concerns (RIC) which was discussed at a monthly carers meeting and included a representative from the medical centre. At this meeting patients of concern could be discussed, with their consent (this would be recorded on their clinical record), other representatives, for example from the executive department, welfare and the chaplaincy were also present. Whilst the duty team did not have direct responsibility for out of hours medical care, which was provided by NHS 111, as part of a local agreement with the unit, the station orderly officer on duty had been given permission to contact the duty medic or doctor to help provide support and guidance in the case of one of those individuals presenting in distress out of hours.

Notices advising patients of the chaperone service were displayed in each room, including the names of the staff that were trained, in the practice leaflet and in the reception area across both sites. Gender specific chaperones were available throughout the working day. A local working practice (LWP) policy was in place as guidance for chaperone use. An annual chaperone audit was undertaken.

Staff who acted as chaperones had received a Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

The full range of recruitment records for permanent staff was held centrally. The practice could demonstrate that relevant safety checks had taken place for the staff at the point of recruitment, including a DBS check to ensure staff were suitable to work with vulnerable adults and young people. One member of staff had no DBS recorded and 1 was out-of-date. We asked the practice and upon further scrutiny we saw 1 was a member of staff who had been off long-term with illness, (the practice removed their entry on the spreadsheet until they knew if they were to return to practice). The other absent entry was a new joiner and they have now updated the log and were in-date.

All staff had crown indemnity and all clinical staff held a professional registration which was recorded on the staff database.

There was a dedicated lead for infection prevention and control (IPC) and they had completed the IPC link practitioner training. The staff training database indicated 3 members of clinical staff required the annual DPHC mandated IPC refresher training.

Measures were taken to minimise the spread of infectious diseases. Individual nurses used separate clinical rooms. There was a standard operating procedure in place and an LWP for the management included tracking designed to look at communicable disease trends.

The senior nursing officer (SNO) conducted the annual IPC audit as per the annual audit schedule. All findings were recorded in the audit tool and any issues/ recommendations were discussed at the subsequent practice meetings. Risks were recorded in the practice healthcare governance risk register workbook. The previous audit highlighted compliance issues with bins (clinical / non-clinical) and the patient privacy curtains, in that they were non-compliant with IPC standards. This was identified and highlighted in the risk register and alternatives sourced.

The cleaning contract was managed by the practice manager. The contract included 2 annual deep cleans and daily routine clinical cleaning conducted by contractors. Clinical staff were responsible for cleaning desktops and equipment such as keyboards and patient plinths between consults. The contractor conducted supervisor visits at both sites regularly to ensure compliance with cleaning standards and were responsive to issues that arose, this was highlighted at St Mawgan's site where an issue with cleaning personnel was identified. The situation was placed under review and the problem rectified in 4 days.

The management of healthcare waste was in line with policy. Clinical waste was bagged, secured and marked with the practice code before being recorded in a waste log held in a dry store. Consignment notes were held at both sites and clinical waste audits completed. We noted the external yellow bins were not secured but they were awaiting delivery of a chain and lock.

Acupuncture was practiced at both sites and sharps bins were present for safe disposal of needles. A medical questionnaire and consent form was completed and scanned on to patient notes and a patient information leaflet was in place. The defence acupuncture audit had been completed annually to ensure comprehensive documentation.

Servicing of physical training equipment was managed by the exercise rehabilitation instructor (ERI). All equipment over the 2 sites was in-date and was being managed well including weekly checks to ensure equipment was working properly and cleaning checks at the end of each day.

The cleaning contract had been amended, with a change of use agreement in place, to meet clinical cleaning requirements within the annexed PCRF space within the station gymnasium. A statement of need (SON) had been submitted to DPHC for IPC compliant flooring. However, this was still outstanding due to funding constraints. We recommended that this be hastened and monitored.

Risks to patients

There was an effective system to assess, monitor and manage risks to patient safety. There were arrangements for planning and monitoring the number and mix of staff needed. Currently the practice had a 0.8 (whole time equivalent) MOD doctor vacancy due to long-term absence, this was managed with long-term locum support. This helped with the primary healthcare needs but caused problems with the delivery of occupational health requirements as this required specialist training such as aviation medicine. The care delivery at St Mawgan had been disrupted and there had been some difficulties fulfilling unit specific tasks, this had now improved with an MOD doctor providing locum cover 2 days per week. It was proposed that some long-term rebalancing of workforce across both sites would be implemented. There was a comprehensive whole practice rota with weekly management planning and diary meetings for continuous re-evaluation of processes and adaptation to accommodate challenges. For example, the combining of rotas into a single whole practice rota identifying key pinch points.

There was currently a shortage of medics (5) and this had impacted in their ability to support unit outputs and not all could provide airfield duties. There were significant limitations to DPHC priorities requiring a continuous risk assessment to support critical

outputs. For example, aspects of force protection, audiometry, and health checks required prior to deployment. We discussed this with the Regional Clinical director (RCD), they were actively trying to find a solution and were looking at relocating medics from different locations to meet demand. This was highlighted on the risk register.

Within the PCRF there were enough physiotherapists to meet patient needs. Staff worked across both sites (one physiotherapist covered St Mawgan for continuity). The lack of ERIs at times impacted on patient care, the ERI was present at St Mawgan 2 days per week. If patients had to see the ERI on those days they had to travel the 2 hour round trip journey (longer in the summer months).

The SNO confirmed there were currently sufficient nurse hours to meet the current populations needs. The recent hiring of a locum nurse had improved routine nurse appointment times. Arrangements were in place to ensure the practice had sufficient nurse cover during periods of staff absence. For example, the practice rota was used to co-ordinate leave across both sites, staff said they were happy to work at either site.

Only doctors that had completed aviation medicine training (MAME) provided cover to the airfield out of hours. The doctors were trained for battlefield advanced trauma life support (BATLS), this was a requirement for airfield cover.

Basic Life Support (BLS) and Immediate Life Support (ILS) were held as an essential requirement with training funded and accommodated to ensure staff members could attend. The training record was not clear as to which staff had completed basic life support, anaphylaxis and automated external defibrillator (AED) training.

Information about sepsis was displayed in various areas of both practices. The training record indicated that not all staff had received training in sepsis, although this was not mandated.

Emergency scenarios were undertaken by all staff on a regular basis with moulage and resuscitation training scenarios incorporated into the training schedule. The most recent scenarios included response to a casualty on the station, a hot debrief took place immediately afterwards looking at how it was handled and identifying any learning points, this subsequently led to a training exercise to address lessons learnt. The team also attended a post-crash multi agency tabletop exercise earlier this year which included external groups (police, fire, NHS and post-crash team).

Unplanned admissions to hospital were managed well, including effective communication and monitoring between the practice and the hospital itself. Upon discharge from hospital the patient was given a follow up appointment with a doctor.

All staff knew where the emergency medicines were located at both sites. We found all medicines on the emergency trolleys were appropriate and in-date and a risk assessment was in place.

Ambient temperature monitoring was being completed in accordance with the DPHC SOP for temperature monitoring. Oxygen was held and was accessible with appropriate signage in place. There was an AED kept at each site.

The layout of both waiting rooms allowed patients to be observed whilst waiting for their appointment.

Wet globe bulb testing was conducted multiple times throughout the day to confirm environmental factors were suitable to complete rehabilitation. Fans had been purchased to mitigate high temperatures. These temperatures were recorded daily.

Information to deliver safe care and treatment.

An SOP was in place for the management of the summarisation of patients' records. However, the practice was aware that this was not being managed effectively nor in a timely way. On the day of the inspection, we found that approximately 700 military notes had previously not been summarised, this had been reduced down to 400. A plan was in place with support from the Regional Clinical Director in using 2 doctors working remotely to address the backlog. All new patients' notes were being summarised straight away.

Clinicians used peer review to measure and ensure quality of care delivery across most of the staff team at the practice. Annual peer review for doctors was conducted in line with DPHC policy, using the NHS England peer review audit template, results were discussed within the doctors' meeting and shared with regional headquarters. The most recent peer review of the PMO's clinical records was undertaken by one of the MOD doctors, a former PMO of the practice, to maintain objectivity.

Within the PCRF peer review for physiotherapists was booked in every 3 months and joint sessions were held with other PCRFs in the region. Mentorship to PCRF physiotherapists was provided by the new regional Band 8 physiotherapist, the physiotherapists told us this was extremely valuable support.

There was a formal process in place for the ERI to receive formalised peer review, clinical supervision and mentoring on musculoskeletal assessment skills. Notes audits were completed annually.

Medics were overseen primarily by the doctors, they managed their training and competencies and conducted record audits of DMICP consultations. There was a formal process in place for the peer review of nursing records. Monthly clinical supervision and protected time for continual professional development was in place. Audits of recorded consultations were conducted and discussed with the registered nurse and activity was conducted in compliance with Nurse and Midwifery Council standards for maintenance of registration.

Staff confirmed that access to patient records was only occasionally a concern and did not pose a significant risk to continuity of patient care. In the event of a DPHC-wide outage, the practice would refer to the business continuity plan (BCP), seeing emergency patients only and routine clinics maybe cancelled, this was last reviewed in September 2024. There was a BCP activity tracker within the joint management tool to audit all outages and shortfalls in services. There was also a 'Battle Box' containing supporting documents to maintain outputs. If there was a loss to infrastructure then they would relocate to PCRF building. If this was lost then St Mawgan was the operating option and vice versa.

The management of referrals was failsafe. The practice was using the new Defence Primary Healthcare (DPHC) centralised process for referral management. This provided a variety of functions to support the monitoring of referrals, including an alert to prompt follow-up and the ability to transfer details of the referral if the patient moved to another practice. All administrative staff were trained in referral management. Referrals included internal and external referrals for hospital appointments (urgent and non-urgent) and the Department of Community Mental Health.

In July 2024, ASER trends were noted with regards to rejected samples, whether due to labelling (some still handwritten), timing of samples (too late in the day for processing), samples going missing between the practice and the laboratory, incorrect bottles, as well as some which were rejected without obvious reasons. The SNO and a representative from the NHS hospital met together and they looked into the detail. Issues found included poor bagging of samples, everything being requested on one form when they were required to go to different destinations, labelling issues and illegible handwriting which meant they could not be processed. As a result, improvements were made including, purchasing a label printer, bags for transit and the development of a combined site sample tracker to ensure samples were still being monitored when staff were absent. This resulted in a best practice ‘purple’ ASER after another combined practice in the region wanted to adopt the same processes. The process by which the SNO “followed the journey” of the samples was critical to understanding how it worked and ensured they adapted to improve the process.

All pathology results came into a group inbox to be processed by the duty doctor, who would notify the requestor, or action if an urgent response was required. Cytology results were managed by nursing team. The process for communicating results was captured in an LWP. Urgent or critical results would be acted upon by the duty doctor.

Safe and appropriate use of medicines

Due to pharmacy technician recruitment issues, a locum pharmacist was currently working in the dispensary. Through discussion, it was confirmed that they felt respected, supported and valued. The current locum pharmacist was working to improve and rectify processes to comply with DPHC SOPs. Currently all routine medicines were being outsourced to the community pharmacy whilst medicines management activities were being re-established. Acute or urgent prescriptions were being dispensed by the locum pharmacist in the Culdrose dispensary.

One of the doctors was the medicines management lead. The locum pharmacist had a set of standard Military Medical Personnel (MMP) agency terms of reference (ToRs) for a Band 8 pharmacist. Whilst it was a generic ToR for agency pharmacists, most of the roles and responsibilities included in the ToRs could be applied to the Culdrose dispensary. It was confirmed that the pharmacist was listed on the General Pharmaceutical Council register as a practicing pharmacist.

The locum pharmacist had access to the electronic organisational wide system (referred to as ASER) system and demonstrated that they could log in and record a significant event Through discussion of the latest 2 significant events, it was evident they understood the importance of reporting and was able to describe the correct process in line with policy.

Evidence was seen of effective processes for the management and action of Medicines and Healthcare products Regulatory Agency (MHRA) and National Patient Safety alerts. There was an in-date electronic alert register and the practice had a system in place to ensure that they were receiving, disseminating, and actioning all alerts and information relevant to the practice. The register documented what action (if required) had been taken.

We saw monthly searches were regularly undertaken on DMICP to identify any patients prescribed sodium valproate (used for epilepsy, bipolar or migraine) or topiramate (used to treat seizures). Evidence was seen of effective communication with the prescriber on identification of any new patient identified. The locum pharmacist was aware that sodium valproate must be dispensed as a full pack and was able to locate the patient information leaflets if required for future patients.

Patient Group Directions (PGDs) had been signed off to allow appropriately trained staff to administer and or supply medicines in line with legislation. Medicines that had been supplied or administered under PGDs were in-date. There was a cupboard holding over-labelled nicotine replacement therapies and primary care treatments for supply using PGDs. All over-labelled medicines were found to be in-date across the 2 sites. At St Mawgan there were no address labels being added to the over-labelled medicines. All over-labelled medicines need an address label. This was rectified within 48 hours of the visit.

A PGD audit had been completed in the last year and it was confirmed that the findings from the audit had been reviewed with the nursing team. Evidence was seen that the nurses had completed the required PGD training. A spot check of DMICP confirmed that the PGD template was being used.

Patient Specific Directives (PSDs) were rarely used in the practice. The practice has used 2 PSDs in February 2025. A spot check of the notes found that the DMICP records had been coded correctly, but some fields were found to be missing. For example, the PSD clinic dates and signature of the medic authorised to use the PSD.

There were currently no independent prescribers in the practice. The SNO was in the process of completing the course.

Staff were able to discuss and demonstrate a robust process for the management of secondary care prescription requests.

The duty medic provided shoulder cover out of hours. Through discussion with the medics and review of the duty medic pack it was assured that the duty medic could access the emergency pain relief if required in an emergency. There was a clear audit trail for any entry to the dispensary out of hours.

The dispensary had a bound book to record the receipt and supply of prescription forms received into the practice and stored in the dispensary. It was discussed on the day of the visit that the book would need to be updated to include date of receipt, the quantity received, running total and the signature/initials of the person receipting them. Evidence was seen that prescriptions were issued by serial number and clinicians had signed and dated the receiving of them.

There were good processes in place for the requesting and issuing of repeat medication. Due to the recruitment issues and vacant pharmacy technician's post, the repeat prescriptions were managed by the prescribers. Whilst there was a locum pharmacist working in the dispensary, all repeat prescriptions were being outsourced through the community pharmacy. We noted that prescriptions outsourced to the community pharmacy in Newquay were not always being sent to a secure NHS email address, this was actioned on the day of the visit. Both sites kept a log for outsourcing prescriptions to the community pharmacy. We noted that the spreadsheet held patient names and the medicines they were prescribed. For confidentiality reasons, the names of the patients were deleted and DMICP numbers would be used in future.

The procedure for medication review for patients with long-term conditions was good. The locum pharmacist showed good awareness of their responsibilities and knew when requests should be tasked to a senior clinician. The process for handing out prescriptions to patients was discussed and witnessed and included comprehensive medication counselling and giving the patient the correct information leaflet, this was in-line with the DPHC policy. The dispensary held appropriate warning cards.

It was evident that the high-risk medicines (HRM) register supported the safe and comprehensive management of patients prescribed HRMs. Through discussion it was confirmed that the practice was using the current and updated HRM searches on DMICP. Appropriate HRM and shared care alerts were raised on patient's DMICP records and appropriate and timely blood monitoring had been undertaken. The practice had a comprehensive HRM SOP and a thorough and detailed HRM monitoring audit had been completed recently.

Controlled and accountable medicines were kept in the dispensary in a cabinet. The controlled drugs (CD) cabinet was compliant with the Misuse of Drugs (Safe Custody) 1973 Regulations at St Mawgan but not at Culdrose. As the cabinet at Culdrose was held on a secure military base, the current cabinet was considered adequate. At St Mawgan, CDs were not accounted for on DMICP. At Culdrose, a spot check of physical stock, DMICP and documentation in the controlled drugs register found an error in the accounting of CDs on DMICP. A three-point check of DMICP, the controlled drug register and physical stock must be completed for all controlled and accountable medicines. It was acknowledged that the errors identified were legacy errors from a period when the practice was experiencing difficulties recruiting and retaining locum pharmacy technicians. It was recognised that the current locum pharmacist was working to address all these legacy errors and that this would take time to rectify.

Documentation in the CD register was clear and legible and in accordance with policy. The specimen signature log in the CD register had been completed accurately by all those involved in the accounting of the controlled and accountable medicines.

Internal monthly and external quarterly checks were mostly being completed in line with policy for all controlled and accountable drugs held as dispensary stock. There were 3 missing checks identified during the last 12-month period across both sites.

Evidence was seen that the annual CD audit and the annual self-declaration had been completed. A review of the most recent destruction certificate confirmed that accountable and CDs were being destroyed in accordance with policy.

The dispensary has a CD/accountable medicine key safe log and a key safe to keep the keys. The CD keys were kept separate from the dispensary keys There was a CD access process if the cupboard needed to be accessed out of hours.

All staff knew where the emergency medicines were located and there was evidence that the medicines in the emergency trolley had been checked monthly. Both trollies were secured with a serialised tag and there was a log for access to the trolley at both sites. On the day of the visit, the serialised tag corresponded with the serialised tag in the logbook. Evidence was seen that ambient temperature was being completed in accordance with the DPHC SOP for temperature monitoring. The emergency medicines risk assessment had been completed as per policy. A stock check of the trolley found all medicines and medical consumables to be in-date. The emergency medicines at St Mawgan were not accounted for on DMICP, so no time expiry reports were being completed to manage the stock.

The oxygen cylinders on both sites were at least half full and in-date. Appropriate Hazchem signage was displayed on the doors holding the oxygen and Entonox (a pain-relieving gas).

All vaccines were in-date and evidence was seen that the vaccines are being correctly rotated in the pharmaceutical fridge. There was sufficient space around the vaccine packages for air to circulate. No food or specimens were held in the pharmacy fridges.

Evidence was seen of twice daily monitoring of the pharmaceutical fridges and the external thermometers were in-date.

A random spot check of stock found discrepancies in the accounting of vaccines. Again, it was acknowledged that the errors identified were legacy errors from a period when the practice was experiencing difficulties recruiting and retaining locum pharmacy technicians. It was recognised that the current locum pharmacist was working to address all these legacy errors and that this would take time to rectify.

A spot check of the prescription only medicines found all medicines to be in-date. There were medicines on the shelf that were due to expire in April 2025 that had not been highlighted as short dated. These were removed from the shelf on the day of the visit. This was likely to be because time expiry reports were not being completed. The locum pharmacist was working on rectifying the legacy stock discrepancies. Through discussion it was agreed that the team would complete a full stock check of the dispensary medicines and then complete monthly time expiry reports in the future.

Expired medications were destroyed using the appropriate pharmaceutical waste bins.

Track record on safety

The business manager was the risk manager and had completed the Institute of Occupational Safety (IOSH) course. Risk assessments were in place but were signed off by a non-trained assessor and the business manager as the risk holder. We discussed the possibility of the business manager becoming the assessor and the PMO to hold the risk as a more efficient way of managing risk overall. The practice manager was the risk manager and had not yet completed an IOSH course.

Taking account of the ‘4 T’s process’ (transfer, tolerate, treat, terminate), the risk register was detailed and reviewed each month at the healthcare governance meetings. The main risks identified were identified within the IPC audit and had been escalated appropriately.

A range of regularly reviewed clinical and non-clinical risk assessments was 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.

Measures to ensure the safety of facilities and equipment were in place. The station conducted inspections and held the details on a spreadsheet, health and safety audits were completed and sent back to the health and safety team. Electrical safety checks were up-to-date. Water safety checks were regularly carried out. A legionella risk assessment had been completed and was due again in June 2025.

A fire risk assessment of the building was undertaken annually. Firefighting equipment tests were current. Staff were up-to-date with fire safety training and were aware of the evacuation plan.

Portable appliance testing had been completed at both sites.

Both locations had had a mixture of fixed and portable alarms that were tested regularly, all staff held personal alarms.

Lessons learned and improvements made

Staff worked to the DPHC policy for reporting and managing significant events (SE), incidents and near-misses, which were recorded on the electronic organisational wide system (referred to as ASER). They were discussed at the ASER meeting every month but sooner if more urgent. An ASER register was maintained. All staff had completed ASER training to access the system. All staff we spoke with knew how to raise an SE or incident. ASERs were only closed after discussion at the ASER meeting.

We saw 2 examples of recent ASERs. One was regarding repeat medications for patients at St Mawgan, they were being dispensed from Culdrose on a weekly basis, prescriptions were sent over and a driver delivered the medicines on a Wednesday. A series of ASERs raised concern that this process was not working. As a result, the process was paused and medication was dispensed from a pharmacy locally. Design of new process was in place but awaited appointment of a permanent pharmacy technician at Culdrose.

The practice manager was ASER lead undertook a 6-month trend analysis. ASER and trend analysis occurred at same time as complaint analysis to look for anything overlapping. For example, an eConsult arose within both, it was submitted late on a Friday and was not actioned, the process was amended to ensure this did not reoccur.

Are services effective?

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

Effective needs assessment, care, and treatment

Clinicians had opportunities to attend regional forums, such as regional governance meetings and nurse development forums. All doctors were signed up to receive the National Institute for Health and Care Excellence (NICE) and the Scottish Intercollegiate Guidelines Network (SIGN) clinical update emails. Defence Primary Healthcare (DPHC) standard operating procedures (SOPs) were shared with all staff via emails as updates happened. NICE alerts were also shared via the Senior Nursing Officer (SNO) newsletter as a means of continued update and discussion points for team members who may have been absent.

Updates were discussed in the clinicians meetings, practice meetings, doctors meetings and chronic disease update meetings. A recent example discussed with the team was the new asthma management guidelines. Additionally, nurse meetings involved a review of patient consultations in areas of updated practice, as a means of clinical supervision and wider learning opportunities. Clinicians also attended a complex care meeting every month. We were told it was useful across both sites since the merger as it was a good opportunity for sharing relevant information and encouraged learning opportunities as the population at risk at the 2 sites had differing health care requirements.

Across both sites, Primary Care Rehabilitation Facility (PCRF) staff had appropriate clinical spaces and resources to deliver care, including appropriate rooms for individual assessments over at the rehabilitation gyms. There were 3 clinical rooms within the medical centre at Culdrose with a small gym that was well equipped. The separate rehabilitation gym was about 5 minutes' walk away with a dedicated rehabilitation space that again was very well equipped with equipment, educational smart screen and an exercise area. At St Mawgan there was a small well-equipped gym and appropriate space for private clinical assessments.

Clinicians from the PCRF had multidisciplinary (MDT) meeting every 2 weeks, and every 6 weeks the patient support group meets (PSG) (PSG was a unit liaison support group who supported patient's occupational return). Staff also attended the regional in-service training at Plymouth Regional Rehabilitation Unit where there was feedback on guidelines and updates.

The PCRF used rehabilitation outcome measure testing to ensure patients were ready to return to full duties, this was documented fully by all clinicians. Our review of PCRF patient records confirmed the physiotherapists used the Musculoskeletal Health Questionnaire (MSK-HQ) and Functional Activity Assessment (FAA). Both the MSK-HQ and FAA were standardised outcome measures for patients to report their symptoms and quality of life. The MSK-HQ was used at the initial appointment and on discharge of the patient. 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 exercise list provided was also documented in the patient's record.

Patients with mental health needs were managed and supported in line with standard practice. The Department of Community Mental Health (DCMH) had provided doctors with guidance in Step 1 of the mental health intervention programme. If referred to the DCMH, the patient had an initial assessment within 3 weeks or within 24 hours if urgent.

Welfare support was well established with patients having enhanced access through strong ties with station welfare groups on both sites including the Padre, the PSG and the station executive. Patients could also be signposted to support groups such as Navy Step 1 wellbeing courses, self-help tools and the RAF Benevolent Fund Listening & Counselling Service.

Monitoring care and treatment

The nursing team had a significant role in the management of long-term conditions (LTCs) and was involved at all stages, including patient tracking, monitoring and education. Chronic disease leads were allocated to each speciality, to ensure compliance with treatment protocols and guidance and afforded clinical supervision opportunities. They audited the service and patient lists to achieve full compliance where able. A monthly recall system was in place, with quarterly register checks conducted to capture any deficits. Monitoring was broken down into specific areas to mirror NHS screening activity and ensure parity of service.

New chronic disease templates were used and diseases coded appropriately in patient's notes. Patients were notified via text and they were invited to book in with nurse. Following the initial appointment, a follow up was made with the appropriate clinician for review including advice and guidance.

There were 4 adult patients on the diabetic register. For 3 patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For 4 patients with diabetes, the last blood pressure reading was 150/90 or less which is an indicator of good blood pressure control.

Fifty-one patients were identified as having hypertension (high blood pressure) and 41 had a record confirming their blood pressure was checked in the past 12 months. Fifty patients had a blood pressure recording on 150/90 or less.

Thirty-four patients had a diagnosis of asthma and 33 had an asthma review in the preceding 12 months. A consistent asthma review template was being used.

Audiometry assessments were in date for 82% 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. Over 40 health checks were not a DPHC priority in line with operational activities. However, these were completed opportunistically or by direct patient request. The practice were not able to actively recall patients for the checks due to staffing constraints but every effort was made to review these patients when possible.

The practice manager oversaw quality improvement activity, including clinical audit, all staff were involved in the audit process, there was an audit calendar in place. Audits were

discussed at monthly governance meetings. Nearly all audits had completed more than one cycle. Most recently the following audits had been undertaken.

- Anti-biotic prescribing
- Chaperone
- Cytology
- Long-term condition assurance audits
- Infection prevention and control

Within the nursing team the audits reviewed were mostly administrative. Audit activity could be improved by the nurses by conducting targeted clinical activity audits. Advice was given on the compilation of an audit designed from NICE guidance and a suggestion offered on looking at an LTC activity given the significant input that the nursing team had.

Within the Primary Care Rehabilitation facility (PCRF) recent audits were;

Women's health audit patients eligible for women's health physiotherapy were contacted to see and offered to be seen, the audit was used to highlight to doctors the need for timely referral to physiotherapy for eligible patients (ante-natal, post-natal). A second cycle had not yet been completed.

Aircrew audit - this assessed whether aircrew on courses at Culdrose attended physiotherapy as required. Findings of the audit led to a wish to implement direct access physio (DAP) for aircrew, though this was dependent on a PCRF clinician becoming trained in aviation medicine.

A best practice audit was completed to evaluate if appropriate patient recorded outcome measures (PROMS) were completed for anterior cruciate ligament patients, the outcome of the audit was to remind clinicians to complete appropriate PROMS for patients. A re-audit was required.

An individual programme (IP), designed by the military exercise rehabilitation instructor (ERI), was designed to use with the patient to achieve their rehabilitation goals, essentially it was their own programme to work on. There were sections within the IP to encourage patients to collect and reflect information about their sleep, mood, and nutrition. The ERI also signposted patients to the medical centre for weight management if they thought this would be helpful.

A quality improvement project (QIP) register was also maintained, QIPs were discussed regularly at whole staff meetings. A new QIP register had been recently introduced, some adjustments were needed to align the QIP process with Defence Primary healthcare policy.

Effective staffing

There was an extensive and bespoke induction programme, with a separate induction for locum staff. There was an induction register on SharePoint. Both Defence Primary Healthcare (DPHC) and workplace inductions were recorded on the staff database. The

practice manager monitored induction to completion and induction checklists were retained. There were also comprehensive tabletop instructions available for all departments. Any new doctor not used to work in DPHC or unfamiliar with the DMICP (electronic patient record system) would be given the opportunity of shared clinics with another clinician and nominated clinicians to be available for questions. Nurses were given individualised mentorship allowing them to be supernumerary in the interim.

We looked at recently inducted staff records and noted that records had been completed to show that staff understood what was required of them.

At the time of the inspection, it was not fully clear how many of the staff team were in-date for mandatory training with the training log showing 70% of training had been completed. There were gaps in the training log with some staff having none of the mandatory courses recorded as completed. For example;

- 8 staff were recorded as having not completed basic life support and AED training, 4 were new joiners and the date of their last training has not yet been confirmed, 4 remained out-of-date. Basic life support and AED training was until recently face-to-face training only. Accessing a training AED from regional headquarters and staff availability had delayed completion prior to this being available online. It was only amended recently to include online training when the training policy and passport was updated at the end of March 2025. This had now been actioned and staff were requested to complete.
- 12 staff had no anaphylaxis training recorded (nurses, medics, and doctors)
- 4 did not have it recorded; 3 were new joiners and 1 was administrative staff. The remaining 8 (of 12) were out-of-date within the last 6 months. They had been contacted and instructed to complete as soon as possible.
- 11 staff were recorded as having not completed/not recorded level 2 safeguarding training but had completed level 3. The training policy was recently amended at the end of March 2025. Previously, safeguarding level 1 and 2 we targeted to all staff except doctors and nurses and level 3 was for doctors and nurses. It has now been amended to safeguarding level 1 for non-clinical staff, level 2 for all staff and level 3 for role specific clinical staff. Due to this recent change, several clinical staff were now required to complete level 2. This was being actioned.

Protected time was allocated for mandatory training as well as continuing personal development (CPD). Doctors were encouraged to use 5 study days a year for CPD. A variety of activities had been undertaken by doctors including lifestyle medicine and dermatology courses. CPD webinars were organised and all the doctors had access to these including recordings if they were unable to attend. Nurses had access to role specific training, for example the SNO was currently undertaking non-medical prescriber training.

The doctors and nurses had all completed regular appraisal and revalidation. All clinicians were aware of the CPD requirements and used clinical meetings, mandatory training, and practice meetings to support with meeting this requirement. Clinical supervision took place regularly with good supportive cross working between both sites.

The PCRF team could access educational events both internally and externally. The rehabilitation team managed their own CPD in line with their regulatory body's requirements and had annual appraisals.

Coordinating care and treatment

Practice staff met with welfare teams and line managers to discuss vulnerable patients. Staff told us that they had forged some good links with other stakeholders, including links with the local NHS hospitals, INITIAL (outside contractor), the NHS colonoscopy team and the district nurses. Two MOD doctors also worked in a civilian practice and one of them represented the practice at the Local Medical Committee.

It was clear that the PCRF were an integral part of the practice. There were good streams of communication with staff in the PCRF, meetings were inclusive and governance structures integrated.

Referrals made by the physiotherapists were managed and tracked by an administrator on the referrals database. Clinical forums for multidisciplinary team discussions were in place to review patient treatment and joint care pathway planning. The average wait for Multidisciplinary Injury Assessment Clinic (MIAC) was 3 weeks.

The doctors conducted regular handovers to other practices (including NHS) appropriately, this usually took the form of direct discussion with an appropriate clinician. For patients leaving the military, pre-release and final medicals were offered and information given.

Helping patients to live healthier lives

The SNO was the named lead for health promotion. The practice provided significant time and effort into health promotion activity. We saw that nationally provided resources were being used as throughout the practice various stands and posters were on display which were current with the health promotion diary for NHS England.

The SNO attended unit healthcare committee meetings so that they could share information about what they felt was important and required to achieve better health outcomes for patients. It was hoped that moving forward squadron or department representatives could be present so they would have better understanding. The SNO had also created 12 posters that matched the DPHC NHS health campaigns, and these were displayed on health promotion board in the waiting room. The nurses also led health promotions at unit health fair events.

The SNO was the lead for sexual health and was had completed the sexually transmitted infections foundation course (STIF) to level 6. They had also secured funding for all the nurses at the combined practice to become STIF trained. Patients could also be referred to specialist sexual health services and to the sexual health consultant. Condoms were available from the practice.

There was a detailed local working practice to support NHS screening. All eligible female patients are on the national cervical screening database and were recalled by the nurse. The latest data confirmed an 97% uptake, the NHS target was 80%. Regular searches were undertaken to identify patients who required screening for bowel, breast, and abdominal aortic aneurysm in line with national programmes. Alerts were added to their DMICP record which allowed for opportunistic discussion with a health professional. DMICP searches had been created for all national screening.

Vaccination statistics were identified as follows:

- 97% of patients were in-date for vaccination against diphtheria.
- 96% of patients were in-date for vaccination against polio.
- 95% of patients were in-date for vaccination against hepatitis B.
- 95% of patients were in-date for vaccination against hepatitis A.
- 96% of patients were in-date for vaccination against tetanus.
- 96% of patients were in-date for vaccination against MMR.
- 81% 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. Written consent was taken for invasive procedures and implied consent for non-invasive examinations. Consent was audited annually.

Clinicians understood the Mental Capacity Act (2005) and how it would apply to the patient population group. They had received training recently in mental capacity. Clinicians were aware of both Gillick competence (young people under 16 with capacity to decide) and Fraser guidelines (advice/treatment focussed on a young person’s sexual health).

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect, and compassion

In advance of the inspection, patient feedback cards were sent to the practice, feedback was from patients that had been seen by the Primary Care Rehabilitation Facility (PCRF), the dispensary and the medical and administrative staff. A total of 16 patients from both sites responded and feedback was positive, reflecting a general theme of kind and caring staff. Patients experience questionnaires were promoted throughout the practice. These were via QR codes, on the waiting room table with a direct link to the survey and it was also on the signature blocks for all staff. The last survey audit showed all positive responses. One of the comments was a request for a water fountain in the waiting rooms, this had been since requested and was awaiting approval.

We were given several examples where staff went above and beyond to help and support patients. Of note:

A patient was posted in and attended the medical centre for routine force health protection screening. At this point it was discovered that's the patient had previously received no vaccinations and had refused them; this had been encouraged by their parent. A supportive conversation was conducted and a consultation with education on efficacy and safety was given, the parent was encouraged to attend and did so. The consult was conducted in a non-judgemental manner and the views of the patient were respected at all times. As a result, the patient accepted the vaccinations, and the parent was content with the information given.

A patient with type 1 diabetes, deployed at sea contacted the practice reporting an issue with the insulin administration management being offered by the on-board healthcare provider. The nurse spoke with the staff on the ship, giving advice and further education, as a result the patient received a care pathway that managed their condition and kept them deployed.

A patient who became unsuitable for service, felt isolated and alone in the remote location, started drinking, self-neglect and was not coping. The removal from service process would have taken quite some time. The Principal Medical Officer (PMO) was keen to help the individual out of service and back to their home support as a matter of urgency to prevent further deterioration to their mental health. This was done within weeks and they returned home where the local health service was contacted by the PMO to assume care while the Royal Navy continued to support from afar.

A patient was posted to Culdrose to be closer to their family due to personal reasons. This individual, although not sick, was unable to present for duty. The PMO met with the Chain of Command and the Station Executive to allow this individual as much time at home as was needed, again to prevent the development of stress and mental illness.

Patients could access the welfare team and various support networks for assistance and guidance. Information regarding these services was available in the waiting areas and the clinical staff were fully aware of these services to signpost patients if required.

Involvement in decisions about care and treatment

We saw 11 carers were registered at the practice and they had all received a review. There were also posters around the station asking carers to identify themselves. Monthly searches were undertaken to ensure any new carers were recognised. They were offered flu vaccines and health checks when appropriate. There was information for carers included in the practice leaflet and on the notice boards at both sites.

Supported by a standard operating procedure, a translation service was available for patients who did not have English as a first language.

Privacy and dignity

Consultations took place in clinic rooms with the door closed. Patients were offered a private room if they wanted to discuss something in private or appeared distressed. Telephone conversations were undertaken in private to maximise patient confidentiality.

The reception layout at Culdrose site provided minimal privacy for patients who were speaking to reception. Staff did all they could to mitigate this including background noise from the television or radio and offering patients a quiet room if they wanted to discuss something more personal. At St Mawgan the waiting room was in view of the reception and conversations could not be overheard.

Within the PCRF there were separate clinical rooms and the reception / administration rooms were also separate. If patients requested to see a male physiotherapist the nearest PCRF that provided one was in PCRF Drake (Plymouth).

All staff had completed the Defence Information Management Passport training which incorporated the Caldicott principles.

Are services responsive to people's needs?

We rated the practice as good for providing responsive services.

Responding to and meeting people's needs

Patient feedback indicated that patients were satisfied with the responsiveness of the service. Total triage was used to streamline and shorten care timelines and apportion duty contacts appropriately. At the initial point of patient contact, the Triage Coordinator would perform an initial triage to place the patient in a call back 'bucket'. This would be by either the medic or doctor depending on the nature of the problem. Once triaged into 'buckets', a triage clinician would back call patients. Those marked as urgent would be called first, otherwise they will be called in time order. The potential outcomes of these calls were;

- Care completed (no face to face or follow up appointment required)
- Urgent appointment booked (with MO, nurse, medic or physiotherapist)
- Priority appointment with a doctor booked.
- Routine appointment booked (with doctor, nurse or physio)
- Doctor follow up appointment booked.

There were a range of services delivered to meet the needs of patients, for example, well women and men clinics, over 40's health checks, menopause advice and long-term conditions.

The practice was constantly ready to respond at very short notice to the occupational needs of patients. A large proportion of patients routinely had to be ready to rapidly deploy which presented challenges to ensuring patients were always medically ready. The practice team responded to this with speed and efficiency.

An Equality Access Audit as defined in the Equality Act 2010 was completed at both sites within the past year. Any points identified were discussed and put onto the issues register. A statement of need (SON) had been submitted in March as front door to the medical centre consisted of an outer and inner single door that had a very narrow entrance way. Patients using a wheelchair would not manage this, similarly anyone with mobility problems or using crutches would find this challenging. The medical centre had been liaising with the base infrastructure team to get an automatic door fitted, but to date no improvements had been agreed or planned for.

There was a transgender policy in place and on the notice board within the waiting room. The practice had gender neutral toilets.

The practice staff were aware of the mandated training for learning disability and autism introduced in April 2024. The practice had pro-actively progressed the mandated training to enhance staff knowledge about learning disability and autism. All staff were working to complete this training, although many were outstanding there has been several completed and some are ongoing.

Staff were familiar with the new Defence Primary Healthcare (DPHC) transgender standard operating procedure. A small number of patients were being supported with gender reassignment and their doctor regularly liaised with the secondary care services involved.

The practice responded to feedback from patients and the Chain of Command. For example, following concerns raised, the PCRF introduced an app to book individual programme rehabilitation sessions and make booking easier for patients. There had been positive patient feedback since this had been implemented. The nurses had a request that female urine collection funnels be provided when a urine sample was requested, the standard operating procedure was updated and changed to ensure a plastic funnel was issued with every urine sample pot.

Timely access to care and treatment

Details of how patients could access a doctor when the practices were closed were available through the station helplines and was outlined in the practice information leaflets and in the unit orders.

Waiting times for appointments, both urgent & routine were:

- Doctor – Urgent on the day or routine 1 day
- Nurse – Urgent on the day, bloods on the day, routine 2-3 days.
- Medic- total triage on the day, routine/prelims (pre deployment health checks) 4 weeks.
- Physiotherapy – new patient 5 days, follow up 2 days.
- Exercise rehabilitation instructor - 3-4 days.

The Direct Access Physiotherapy (DAP) pathway was available for patients to use, with the exception of aircrew.

The patient information leaflet, answerphone message and patient information board outside of the medical centre provided details about opening times and access to medical care out-of-hours.

Listening and learning from concerns and complaints

The practice manager was the lead who handled all complaints in the practice. The practice had implemented a process to manage complaints in accordance with the DPHC complaints policy and procedure, 4 complaints had been recorded within the past 12 months. Complaints were discussed in the monthly practice meetings.

Information was available to help patients understand the complaints system, including in the patient information leaflet and in the waiting rooms.

Are services well-led?

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

Vision and strategy

Staff we spoke with were clear that their remit was to support patients to benefit from the best possible healthcare outcomes which, in turn, supported operational capability.

The practice worked to the Defence Primary Healthcare (DPHC) mission statement which was:

> ‘DPHC is to provide safe, effective healthcare to meet the needs of our patients and the chain of command to support force generation and sustain the physical and moral components of fighting power’.

Our findings throughout the inspection clearly demonstrated that the practice was successfully meeting the principles of the mission statements. In relation to future and strategic planning, a practice development plan was in place. Information gained through patient and Chain of Command feedback was central to future planning. There were effective links with the units across both sites, the recent creation of the combined practice tested the ability to manage change given the rearrangement of service provision.

Communication was maintained throughout the merger to ensure patients understood the rational for change and how this would affect their access to the service. Patient feedback forms were used to manage this and scrutiny pre and post group set up showed that the feedback had significantly improved now the practices were combined.

Care was delivered to patients through an integrated multi-disciplinary approach. There was clear engagement and support from the practice to support the Primary Care Rehabilitation Facility (PCRF) priorities. Teams across both sites were proactive in health promotion support, lifestyle advice and access to mental health provision.

This practice appeared to focus on what made it unique and that was the location. There was clear reference to providing the Cornish experience to its team which was certainly attractive in recruiting staff and trainees to the practice. There was a definite ethos on education and training. They had historically supported General Duties Medical Officers and had now in January 2025 successfully gained General Practice Education Committee (GPEC) accreditation, the practice will welcome GP Registrars on a 50/50 agreement with local NHS practices.

To address environmental sustainability, recycling was encouraged and the use of QR codes and electronic information rather than printed information. Recycle bins were available. The use of prescribed inhalers was being reviewed to move towards the use of ‘greener’ products. There was a unit climate change team being developed and the practice aimed to fully support the challenges and changes with the aim to improve.

Leadership, capacity, and capability

The staff spoke of a supportive working relationship with the regional nurse advisor and the regional clinical director who visited regularly. The practice had weekly meetings with the area manager to discuss current risks and constraints, this was fed back to the operations manager and the regional headquarters, both were very supportive and invested within the practice team. The staff teams across both sites worked hard to deliver the best possible care to patients.

The original model of the merged practice accounted for 4 core doctor roles: the Principal Medical Officer (PMO) with over-arching responsibility for the whole practice and 2 military doctors deputising, working across both sites including both clinical and administrative sessions at St Mawgan, though predominantly at Culdrose, augmenting a permanent civilian doctor working 0.8 full time equivalent hours based solely at St Mawgan. The management team also scheduled in presence at both sites, with the practice manager, business manager and Senior Nursing Officer working across ross both sites routinely. This had been challenged by the long-term absence of the civilian doctor. However, regular cross site working continued to support this, and plans were being made proactively to future proof the workforce model.

The business manager was a civilian and as such was able to stand in for any periods of absence when the practice manager was away. They worked well together and both knew each other's roles well.

Succession planning was in place to ensure consistent leadership/practice management given the transient nature of the military workforce. Terms of reference and practice leads reflected who would cross cover in the absence of key individuals, current vacancies were being addressed by reallocating responsibilities. The deputy Principal Medical Officer (DPMO) was about to leave post in the next few weeks, a handover was already scheduled with their successor.

Culture

It was clear from patient feedback, interviews with staff and quality improvement activity that the needs of patients were central to the ethos of the practice. Staff felt that their contributions to the development of the service were valued. All staff attended the practice meetings where they could put forward suggestions or raise concerns.

When the PMO started in post, a staff survey was undertaken it showed there were frictions and some low staff morale. This seemed to be following a 6-month period of vacant senior leadership which had contributed. The practice undertook measures to address this. For example, regular whole staff development away days and staff socials were organised. The staff survey was run a second time earlier this year and showed marked improvement across all staff groups.

The PMO had instituted 6 monthly open discussions with all staff including doctors, administrators, medics, nursing staff and the PCRF, to provide open forums for direct feedback and discussion, which had in turn yielded positive results. One example of this

was the administrative team previously reporting back that they did not feel senior leaders checked in with them outside of work tasks, since then the PMO has ensured he interacted with them more frequently, at a follow up meeting this was noted as a positive improvement.

'Cadre Considerations' (CC) was a system set up on SharePoint which allowed any member of the team to record anything of interest to a specific cadre. For example, if the administrative team notice that doctors were referring to a clinic that had recently closed, they could insert a note on the CC, then when the doctors were having their next meeting, the document was opened and the list of points for their attention could be reviewed by the team. It was set up for all staff groups and could be added to by any member of the team.

Medics were provided with good clinical support to develop both their skill sets and also their career progression. Meetings were held with junior member to discuss morale which also provided an opportunity to access their wellbeing outside of whole practice meetings. Medics said they felt were motivated and supported and worked well together.

In addition to the whole practice meeting, there was a weekly "clear lower deck" to ensure any new arrivals were welcomed, any leavers were bid farewell and thank you, all compliments were shared openly amongst the team, and all had an opportunity to provide feedback and raise issues. The nursing team told us that the Friday review meetings had contributed to a resilient nursing team that were aware of emerging issues and could rapidly respond. 'Fireside chats' with doctors often took place as a means of an informal setting for open communication and discussion.

Staff said they would feel comfortable raising any concerns and were familiar with the whistleblowing policy, they had access to the whistleblowing local working practice as well as online and telephone civil service and MOD bullying and harassment helplines.

The practice manager was the lead for duty of candour, there were processes established to ensure compliance 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.

Governance arrangements

The practice was well supported by the regional team the Regional Clinical Director (RCD) was present throughout the inspection to offer and support or guidance as needed. There were close links and regular contact with all regional headquarters representatives, The PMO attended weekly clinical leads meetings with the RCD and whole regional team, there were regular visits from many different representatives including, to name but a few, the area manager and specific leads (nursing, physiotherapy and governance).

Communication across both sites was strong and an appropriate meeting structure and healthcare governance approach was in place. There was a healthcare governance workbook in place for monitoring governance activity. The practice used the joint management tool to good effect. This was the healthcare governance workbook related document which provided a standalone single point of contact for all healthcare

governance supported documents. It was kept up-to-date and all staff directly inputted to its management.

An audit programme was in place and we saw examples of clinical audits where repeat cycles were carried out to monitor standards and quality. Within the nursing team audit activity could be strengthened to include long-term conditions as they were the key staff involved in managing these patients.

There was a range of standard operating procedures (SOPs) in place for all key processes and these were kept under review. There was an SOP tracker in place which identified the document owner and the required review date for monitoring purposes.

A thorough rotation of a range of meetings was in place to ensure effective communication and information sharing across the staff team. Other meetings included heads of department, healthcare governance, clinical, administrative and the practice meeting.

An understanding of the performance of the practice was maintained. The system took account of medicals, vaccinations, cytology, and non-attendance.

The joint management tool was an accessible combined tool for accessing all governance activity, all audits both for the practice and the PCRF were visible.

For example:

- Integrated audit programme
- Joint meetings/forums for the whole practice
- Integrated systems i.e. health governance workbook

The nursing team was encouraged to attend and engage at all healthcare governance meetings affording insight into activity and arising issues. Mentorship and supervision were offered at all levels and started at induction with the emphasis on teamwork to meet differing challenges.

Managing risks, issues and performance

Risks identified for the service were logged on the risk register and kept under scrutiny through review at practice meetings. Risk assessments were in-date for the medical centre and PCRF. Significant events and incidents were discussed at practice meetings, including any improvements identified.

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

Staff who were not performing would be supported initially to identify any underlying cause and implement support structures. If performance did not improve then formal performance management processes, military or civilian, would be followed.

The business continuity plan was in place and this had been reviewed, it detailed the action to be taken in the event of loss of any services.

Appropriate and accurate information

Accessible to all staff, the practice used the healthcare governance workbook to manage and monitor governance activity. In addition, the Health Assessment Framework (HAF), an internal system, was used by the practice as a development tool and to monitor performance. The HAF was reviewed at HAF meetings chaired by the DPMO, any issues identified were used as a tool for improvement. The nursing team had significant HAF input and were engaged at the healthcare governance meetings to provide feedback on the domains. Question sets were allocated to nurse leads and protected administrative time was allocated for activity relating to completion of the HAF and its outputs.

An internal assurance review (IAR) was undertaken in February 2024. Limited assurance was identified around the lack of senior leadership (with no PMO/ DPMO), safeguarding and the staff survey confirming the impact on staff morale on the merger and senior absences. The practice had implemented an action plan detailing 62 entries, this was fully completed by June 2024. All of the issues identified had improved and work was ongoing to keep standards high and staff morale good.

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 Caldicott Principles, guidelines for the management of patient identifiable information, were displayed. The staff team had completed Defence Information Management Passport training which incorporated the Caldicott principles.

Engagement with patients, the public, staff and external partners

A patient experience focus group was in early development, the aim was to engage with the patients, listen to their ideas and from this further develop the services provided at the practice.

Relationships with external partners had notably improved the effectiveness of the services provided at the practice including improved sample management and the liaison with the woman's' health colposcopy. Liaison with the sexual health clinic had led to access to external training at the Royal Cornwall Hospital and the gaining of funding for sexual health courses. OFSTED inputted to the units and the practice team were part of the working group and worked with them to support any of the unit's patients that were aged under 18.

There was a good use of the station routine orders with entries for routine business and emergency information. SharePoint had a patient communication site that was used to give local information and included links and access to guides for patients. The practice also used the electronic sign at the main gate to advertise any urgent news and to inform unit personnel of events that the practice was promoting. The practice also used text messaging to communicate with patients.

Within the practice there was a 'You said we did' board. An example of changes made following patient feedback was the issues identified with dispensing medicines at St

Mawgan, this was raised by patients and resulted in cessation of practice and a complete review of the process moving forward.

Continuous improvement and innovation

The leadership team was committed to continually improving the service and this was evident through quality improvement activity. Several strategies were identified to enhance service quality and staff well-being. These included providing training opportunities and strengthening resilience across both sites with the cohesive staff team.

Some examples of note were:

Improvements in samples management. All processes were reviewed giving, consideration to the laboratories systems and the developing of strong communication pathways. A sample ‘journey’ review was conducted to highlight flaws in the system and any rectified, including sample storage items and sample labelling.

The SNO used their expertise in IT to improve the SharePoint site setup and overall presentation and ease of use for all.

Cytology reports were sent directly via LAB links removing requirement for paper copies and cutting down on waiting times for results.

A practice ‘samples tracker’ was created which efficiently monitored movement of samples across the group and the laboratory.

An infectious disease tracker and an updated sharps bin disposal contract had significantly improved activity in these areas.

There was a weekly SNO letter, which captured all new information presented in an easily digested format for all staff to read.

The medics took it upon themselves to seek out label printers for blood bottles to reduce error and the volume of unprocessed samples.

It was recognised the ‘multi-user’ email addresses were complicated and open to error on transcribing, a medic developed a card system containing individual departmental email addresses to hand out at reception, again to reduce the difficulties patients had reaching various departments.

Total Triage re-organisation, initially there was a nurse placed in the team each day, with time they identified that there was no need for a nurse to be present and that their time would be better used elsewhere. The process was under continuous review and refinement to make it a more effective process for all involved.

‘Cadre Considerations’ was a system set up on the SharePoint which allowed any member of the team to record anything of interest to a specific cadre. It was set up for all staff groups and could be added to by any member of the team.

Six monthly individual staff group meetings with the PMO were an opportunity for the team to feel valued, listened to and supported. This had notably improved moral throughout the staff team.

The ERI developed a booklet for monitoring health factors (sleep, stress, nutrition) to support recovery. This booklet was reviewed as part of patient clinical reviews and if further support was required there were established links (e.g. with the weight management nurse).

The introduction of an app to book individual programme sessions to make booking easier for patients, as well as less administration for the PCRF staff. The PCRF staff reported positive feedback from patients as was so much easier to book in.