

# Culdrose Medical Centre

## Quality report

RNAS Culdrose,  
Helston,  
Cornwall,  
TR12 7RH

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1 November 2018

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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 from our ongoing monitoring of data about services, and information given to us from the provider, patients, the public and other organisations.

## Ratings

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

# Chief Inspector's Summary

## **Culdrose Medical Centre is rated as Requires Improvement overall**

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? - Requires Improvement

We carried out an announced comprehensive inspection of Culdrose Medical Centre on 1 November 2018.

Defence Medical Services (DMS) are not registered with the CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014 and are not required to be. Consequently, DMS services are not subject to inspection by the CQC and the CQC has no powers of enforcement. This inspection is one of a programme of inspections that the CQC will complete at the invitation of the Surgeon General in his role as the Defence Authority for healthcare and medical operational capability.

### **The overall findings from the inspection:**

- There was an open and transparent approach to safety. All staff knew how to raise and report an incident, but not all had been given the tools to use the system to do so. We saw some inconsistencies with the management of significant events with no clear indication that a root cause analysis had been completed and actions identified to address what had occurred, or actions put in place to reduce the likelihood of re-occurrence.
- The practice had some systems in place to minimise risks to patient safety. However, areas of governance and staff management required review to ensure the effectiveness of these systems. For example, systems in relation to: safety alerts; infection control including the management of sharps bins; management of patients on high risk medicines; management of laboratory results and safety of staff.
- There was good evidence to show collaborative working and sharing of best practice to promote better health outcomes for patients.
- Staff were proactive in helping patients to live healthier lives but these processes required better overarching management.
- There was evidence to demonstrate quality improvement was embedded in practice, including a programme of clinical audit and quality initiatives used to drive improvements in patient outcomes.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.

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- Review of appointment availability showed access to GPs and nurses was good, with urgent appointments available the same day.
  - Information about services and how to complain was available.
  - The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.
  - There was a clear strong leadership structure and staff felt engaged, supported and valued by management.

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

- The practice participated in a monthly aviation medicine dial-in; this was a telephone conference held by aviation trained GPs and the flight safety team at another local military medical centre. All the doctors (including locums who were undertaking aviation training) had protected clinic time to dial-in. This was an opportunity for clinicians to update on air safety incidents related to aviation medicine, and any aviation medicine updates such as changes in policy.
- Multi-disciplinary clinics for managing patients with musculoskeletal (MSK) injuries were held. There were two types; one referred to as PRIMO that included the patient, physiotherapist, Exercise Rehabilitation Instructor and the Medical Officer. The second clinic type (PRIMO plus) also included an aviation medicine consultant. Three examples of clinical notes were seen and it was clear the clinic assisted the patient's optimal progression along their care pathway. We also saw a lower limb functional assessment was completed by clinicians for aircrew in a flying simulator as part of the process for assessing fitness to fly. A standardised form was seen, with clear objective assessment categories.

**The Chief Inspector recommends:**

- Measures should be put in place to ensure that all staff have sight of any Medicines and Healthcare Products Regulatory Agency (MHRA) alerts and other safety updates.
- Implement a safe system to manage patients who are prescribed high risk drugs, specifically the use of shared care protocols where appropriate.
- Consent for intimate examinations is recorded in line with best practice.
- Review the arrangements for providing an alarm system in the practice.
- A review of formal governance arrangements including systems for assessing and monitoring risks should be embedded and understood by all staff. This should include management of test results.
- Assurance should be in place to show all staff are aware of their roles and responsibilities.

**Professor Steve Field** CBE FRCP FFPH FRCGP  
Chief Inspector of General Practice

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## **Our inspection team**

The team that inspected Culdrose Medical Centre included a CQC lead inspector and a team of specialist advisors including a GP, a practice manager, a nurse and a physiotherapist.

## Background to Culdrose Medical Centre

Culdrose Medical Centre provides an integrated service of primary care, occupational health care and physical rehabilitation services as well as providing emergency cover to the airfield whenever flying operations are taking place. The patients are aircrew and support staff from the air station including phase 2 trainees, some of whom are under 18 years of age.

The practice is open on Monday to Friday 08:00 to 12:30 and 13:30 to 16:30 and from 17:00 to 18:30 for urgent cases 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 practice has its own pharmacy which is open 08:00 to 16:30 Monday to Thursday and 08:00 to 15:00 on a Friday.

The Primary Care Rehabilitation Facility (PCRF) is spread over two sites; the main site which is co-located within the medical centre, and also separately three rooms within the gym, sharing the main unit gym space.

In addition to routine GP services, the practice 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 practice team comprises a mix of military and civilian staff. The core team includes three military GPs, one full time equivalent (FTE) civilian GP (split between two civilian medical practitioners (CMPs) and one locum), two band 5 nurses; a pharmacy technician; 2.5 FTE physiotherapists and two exercise rehabilitation instructors. The practice is managed on a day-to-day basis by a full-time practice manager supported by seven medics (the work of a military medic is similar to that of a health care assistant in NHS GP practices but with a broader scope of practice), five civilian administrators, two civilian receptionists and two civilian managers (one of these posts has been vacant for 13 months) .

### Are services safe?

### Requires improvement

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

#### Safety systems and processes

The practice had systems to keep patients safe and safeguarded from abuse. However, some improvement was required.

- Measures were in place to protect patients from abuse and neglect. Arrangements for safeguarding reflected relevant legislation and local requirements. The practice had both adult and children safeguarding policies in place and each clinical room had an easy to follow referral guide for staff. The Principal Medical Officer (PMO) had made positive steps to communicate with the local community and had sent a letter of introduction as the safeguarding lead to all local NHS practices, the hospital trust and the local safeguarding board.
- The practice did not use non-clinical staff as chaperones, however chaperone training for all staff was on the training plan. The chaperone policy was in place and widely on display throughout the practice.
- Measures were in place to highlight and monitor vulnerable patients, including the use of Read codes on electronic patient records. A central register of vulnerable patients was not held by the practice, although a search was available on Defence Medical Information Capability Programme (DMICP). This identified three patients who all had alerts within their records.

Vulnerable patients were discussed at healthcare governance and clinical meetings. They were also discussed with the chain of command at carers meetings/welfare meetings.

- The full range of recruitment records for permanent staff was held centrally. However, the practice manager could demonstrate that relevant safety checks had taken place including a DBS check to ensure staff were suitable to work with vulnerable adults and young people. DBS checks were renewed every five years. They also monitored each clinical member of staff's registration status with their regulatory body. All staff had professional indemnity cover. Information was in place to confirm staff had received the relevant vaccinations required for their role at the practice.
- The practice maintained good standards of cleanliness and hygiene. We observed the premises were clean and tidy. There were cleaning schedules and monitoring systems in place. The lead person responsible for infection control was a nurse who worked out of another military practice who visited Culdrose Medical Centre on a weekly basis. There was a named deputy. Not all staff had completed IPC online training. The most recent audit (August 2018) identified a significant number of issues that needed addressing. An action plan was in place though not all staff were aware of it. The pharmacy was not included in the audit. We saw sharps boxes throughout the practice that had not been dated in line with best practice guidance
- Deep cleaning was completed. The practice had two dedicated cleaners, both were trained to clinical cleaning standard. The cleaning was monitored against the current cleaning contract/schedule and the supervisor completed a monthly walk round with the nursing team/business manager where cleaning standards were checked.
- Systems were in place to ensure facilities and equipment were safe. Electrical safety checks were undertaken in accordance with policy. Fire safety, including a fire risk assessment, fire plan, firefighting equipment tests and fire drills were all in-date. Portable appliance and clinical equipment checks were up-to-date and records maintained.

## **Risks to patients**

There were adequate systems to assess, monitor and manage risks to patient safety but some clarification of responsibilities was necessary to reduce risk.

- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. Staff, including reception staff, had received medical emergency training in the last 12 months, for example in burns scenarios and casualty management.
- There was a swimming pool located in the gym building and hydrotherapy classes took place under the guidance of an exercise rehabilitation instructor. There was always a lifeguard present at the same time as a rehabilitation class and this was seen on inspection day. There was no Automated External Defibrillator (AED) present at the poolside, the nearest one being in the nearby main gym.
- There was a documented approach to the management of test results. There was a local policy in place but some elements and responsibilities were not known to all staff. The nursing team recorded all outgoing samples in a register but the medics had the responsibility of tracking and recording that each sample had been received back into the practice. The samples register had outstanding results showing (June 2018) as new medics were not aware of their responsibility. We did see the nursing team had been tracking results via DMICP and had been chasing and actioning. Clarification of responsibility for the samples register was needed and an audit to ensure its effectiveness.

## Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- Summarisation of records was completed on DMICP and were flagged for the nurse and/or doctor to review.

## Safe and appropriate use of medicines

The arrangements for managing medicines and vaccines were well managed. This included arrangements for obtaining, recording and handling of medicines. However, some areas needing improvement;

- The PMO was the lead for medicines management within the facility. A registered pharmacy technician provided dispensing services from the medical centre. In the absence of the pharmacy technician, the dispensing was outsourced to a local pharmacy.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use. All staff who administered vaccines had received the immunisation training as well as the mandatory anaphylaxis training.
- Dispensed controlled and accountable drugs were second checked by another person; this is in keeping with the DPHC policy. Monthly and quarterly checks were completed. The controlled drugs keys were held in a secure key safe, access to this was limited.
- Repeat prescriptions were only accepted by email or in person and were reviewed regularly with the patients. Repeat medicines were processed within 48 to 72 hours.
- All prescription pads were stored in the dispensary which was locked at all times and entry was restricted. All forms were booked out from the bound register and signed out by individual prescribers.
- There were procedures in place for the review of high risk medicines. For example, the monitoring of disease modifying anti rheumatic medicines which were initiated by secondary care. The practice took bloods regularly, checked the results, gave short prescriptions and put alerts on the clinical system and had a system of management in place. However, we identified three patients who were prescribed high risk medicines by secondary care but did not have a shared care agreement in place. We discussed this with the PMO who agreed they would ensure these were put in place.
- Standard operating procedures (SOPs) were in place to support a safe dispensing practice. There was a system for staff to record that they had read and understood them.
- There was some confusion as to the responsibility of managing safety alerts. Staff identified the pharmacy technician, group mail box and practice manager as receiving email updates from the regional pharmacist. The pharmacy technician was in fact responsible and accessed the MHRA web site weekly. They completed any actions required including DMICP searches and recalls. We saw that alerts had been seen and actioned but we were unable to see that this was failsafe and complete as an assumption was made that another member of staff was recording alerts on a register. We saw the register was incomplete with large periods of time with nothing recorded.

In the absence of the pharmacy technician, it was unclear who was responsible for managing safety alerts.

- PGDs (Patient Group Directions) and PSDs (Patient Specific Directions) were in use to allow non-prescribing staff to carry out vaccinations in a safe way. PGDs were appropriately managed as staff who had received training and authorisation by the SMO had been recorded. All had completed their relevant vaccine administration training.

### **Track record on safety**

The practice had a good safety record, but improvements were needed to ensure safety.

- The practice manager was the lead for health and safety and had completed training relevant for the role. Risk assessments pertinent to the practice were in place including patient handling, needle stick injury, lifting and handling and lone working. The PCRf had a specific risk assessment for the safe use of needle acupuncture.
- There was no alarm system in the practice and staff did not have individual alarms to summon assistance in the event of an emergency.

### **Lessons learned and improvements made**

The practice reported incidents and were supported to do so. Systems needed improvement to ensure learning and improvement was identified and shared.

- There was an electronic organisational-wide system (referred to as ASER) for recording and acting on significant events, incidents and near misses. All staff knew how to raise and report an incident, but not all had been given the tools to use the system to do so. We saw some inconsistencies with the management of significant events with no clear indication that a root cause analysis had been completed and actions identified to address what had occurred, or actions put in place to reduce the likelihood of re-occurrence. There was a scheduled weekly meeting to review ASERs and to feed into the main healthcare governance meeting. ASER trend analysis had not taken place.

<b>Are services effective?</b>	<b>Requires Improvement</b>
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We rated the practice as requires improvement for providing effective services.

### **Effective needs assessment, care and treatment**

The practice assessed needs and delivered care in accordance with relevant and current evidence based guidance and standards.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from National Institute for Health and Care Excellence (NICE) and used this information to deliver care and treatment that met patients' needs. We saw evidence which showed there were processes in place to review updates, discuss these with clinical colleagues to ensure evidence-based best practice was updated in line with amendments. Audits were undertaken stemming from NICE recommendations, for example, for the management of epilepsy.

### **Monitoring care and treatment**

The practice had a good chronic disease management plan in place managed by the practice nurses. Patients were recalled appropriately and patients received effective, individually personalised care.

The practice used data collected for the Quality and Outcomes Framework (QOF) to monitor outcomes for patients. QOF is a system intended to improve the quality of general practice and reward good practice. It is used across many NHS practices. The Defence Medical Services (DMS) have a responsibility to deliver the same quality of care as patients expect in the NHS. The QOF provides a useful way of measuring this for DMS. Because the numbers of patients with long term conditions are often significantly lower at DPHC practices, we are not using NHS data as a comparator.

The practice provided the following patient outcomes data to us from their computer system on the day of the inspection:

- There were five patients on the diabetic register. DMICP records for these patients showed that cholesterol levels had been measured for all and four were 5mmol/l or less. All patients, their last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.
- There were 36 patients recorded as having high blood pressure. Thirty-four had a record for their blood pressure taken in the past nine months. Thirty-four patients had a blood pressure reading of 150/90 or less.
- There were 17 patients with a diagnosis of asthma. Fourteen patients had an asthma review in the preceding 12 months which included an assessment of asthma control using the three Royal College of Physicians questions.
- There were 22 patients being treated with depressive symptoms. We looked at the clinical records of six patients identified on the system as being treated for depressive symptoms. Of these, 19 had a review between 10 and 56 days after diagnosis. We were assured their care was being effectively and safely managed, often in conjunction with other relevant stakeholders such as the welfare team and the Department of Community Mental Health (DCMH).

Information from the Force Protection Dashboard, which uses statistics and data collected from military primary health care facilities, was also used to gauge performance. Service personnel may encounter damaging noise sources throughout their career. It is therefore important that service personnel undertake an audiometric hearing assessment on a regular basis (every two years). Data we were provided with for the Group Practice showed:

- 79.4% of patients had an audiometric assessment within the last two years compared to 86% regionally and 85.5% for DPHC nationally. The practice had recognised this as a shortfall and identified it was mostly due to the audiometric booth being broken for two weeks. There was a plan in place for improvement and to catch up with this.
- There was evidence that clinical audit was taking place. Audit activity was recorded and monitored by the practice managers through the healthcare governance (HCG) workbook, a system that brings together a comprehensive range of governance activities, including the risk register, significant events, Caldicott log, building fault log, quality improvement and audit.
- An audit calendar was in place that identified the audits to take place going forward but this was not accurate as audits that had been undertaken had not been included. Clinical audits

undertaken for the practice included: a minor surgery audit, long term condition audits, prescribing audits, and chronic disease management.

### **Effective staffing**

Evidence reviewed showed that not all staff had the skills and knowledge to deliver effective care and treatment.

- The practice could not demonstrate how they ensured role-specific training for relevant staff. For example, nurses had not had extended training in long term conditions such as asthma or diabetes.
- Not all staff had received updated infection prevention and control training.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The practice demonstrated a positive training ethos. Staff told us they were supported to develop their skills and encouraged to participate in training. All GPs were supported to undertake the Military Aviation Medicine Course including locum GPs, ensuring all patients received safe effective care.
- The practice had an induction pack which covered mandatory and role specific induction for all clinical and administrative staff and locums. We saw that not all staff had not completed a full induction.
- Staff had access to one-to-one meetings, appraisal, coaching and mentoring, clinical supervision and support for revalidation. Clinical staff were given protected time for professional development and evaluation of their clinical work.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

### **Coordinating care and treatment**

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- We found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services. We saw an example where a patient with a rare and highly infectious disease presented to the practice. The practice liaised with all healthcare professionals in the area and shared knowledge and good practice.
- The practice participated in a monthly aviation medicine dial-in; this was a telephone conference held by aviation trained GPs and the flight safety team at another local military medical centre. All the doctors (including locums who were aviation trained) had protected clinic time to dial-in. This was an opportunity for clinicians to update on air safety incidents related to aviation medicine, and any aviation medicine updates such as changes in policy.

- Clinical meetings to discuss patients were held each month between the physiotherapists and doctors. PCRf staff referred patients to other clinics if it was deemed appropriate to their rehabilitation, such as the multi-disciplinary injury assessment clinic (MIAC) at RRU Plymouth.
- The PMO and a representative from the PCRf attended Unit Health Committee (UHC) meetings to update unit commanders on medically downgraded patients. In addition to UHC meetings, the PMO attended welfare meetings where the needs of vulnerable patients, including patients with mental health needs, were discussed.

### **Supporting patients to live healthier lives**

Staff were proactive in helping patients to live healthier lives.

- Records showed, and patient feedback confirmed, that staff encouraged and supported patients to be involved in monitoring and managing their health. Staff also discussed changes to care or treatment with patients as necessary.
- The practice supported national priorities and initiatives to improve the population's health including, stop smoking campaigns and tackling obesity. The practice had introduced over 40s' checks, the numbers eligible were 441 patients, all were invited to attend for a check and in the first month 33 had been completed. This work was ongoing.
- Patients had access to appropriate health assessments and checks. We saw that the practice undertook searches and had established links with the Southwest Bowel Screening programme. Once a patient had been notified of the opportunity for screening there was no mechanism in place to confirm if patients had accepted or declined screening. Equally searches were undertaken for patients eligible for breast screening. We saw again there was effective recall and reminders sent to patients but there was no end process to capture those patients that failed to attend or did not respond.
- All new patients were required to register with the practice and to complete an administrative arrival form (to check contact details, outstanding hospital appointments and repeat medicines etc.) and complete a health questionnaire. They were then offered a new joiner medical screen with the nursing team. The questionnaire was summarised and health record updated. Patients who declined new joiner appointments were followed up by the nursing team.

It is important that military personnel have sufficient immunity against the risk of contracting certain diseases. The World Health Organisation sets a target of 95% for vaccination against diphtheria, tetanus, pertussis and polio and measles, mumps and rubella. The following illustrates the current 2018 vaccination data for the practice patient population. The practice was unable to provide comparators to regional and national statistics.

- 83% of patients were recorded as being up to date with vaccination against diphtheria.
- 83% of patients were recorded as being up to date with vaccination against polio.
- 83% of patients were recorded as being up to date with vaccination against hepatitis A.
- 98% of patients were recorded as being up to date with vaccination against tetanus.
- 64% of patients were recorded as being up to date with vaccination against typhoid.
- The practice was unable to provide the statistics for Hepatitis B

The typhoid vaccine has a lower uptake than other vaccinations. Current guidance states that DMS practices should offer the typhoid vaccination to personnel before deployment and not to routinely vaccinate the whole population.

## Consent to care and treatment

Staff did not always record patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits. We reviewed patient records and saw that written consent was sought when minor operations were undertaken. However, no consent was recorded for intimate examinations and these were not Read coded, the audit had not picked up this oversight.

<b>Are services caring?</b>	Good
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**We rated the practice as good for caring.**

### Kindness, respect and compassion

- We received 27 CQC comment cards completed prior to the inspection. All feedback in relation to how patients were treated by staff was positive. A theme identified overall was that patients felt respected and well cared for, with all staff being friendly, approachable and respectful. The patient survey showed 94% of patients would recommend the practice to friends and family,
- The practice had an information network available to all members of the service community, known as HIVE. This provided a range of information to patients who had relocated to the base and surrounding area. Information included what was available from the local unit and from civilian facilities, including healthcare facilities.

### Involvement in decisions about care and treatment

Staff supported patients to be involved in decisions about their care.

- An interpretation service was available for patients who did not have English as a first language and all staff we spoke with were aware of how to access it.
- The Patient Experience Survey showed 97% of patients at Culdrose Medical Centre felt involved in decisions about their care. Feedback from the CQC patient feedback cards supported this positive outcome.
- Processes were in place to identify patients who also had a caring responsibility so that additional support or healthcare could be offered if needed. At the time of the inspection there were no carers identified by the practice. The practice identified carers either through the Chain of Command, welfare meetings or by requesting that carers make themselves known using signage in the practice reception. They did not ask the question on the new joiners' paperwork/health questionnaire but said they would do so moving forward. A review of the carers search within DMICP showed three patients Read coded as carers but none of the three had any alerts recorded to flag to reception staff or clinicians.

### Privacy and dignity

The practice respected the privacy and dignity of patients.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. Clinic room doors were closed during consultations.
- The layout of the reception areas meant that conversations between patients and reception could not be easily overheard. Reception staff said that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

**Are services responsive to people's needs?**

**Good**

**We rated the practice as good for providing responsive services.**

### **Responding to and meeting people's needs**

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- Staff understood the needs of its population and tailored services in response to those needs.
- The facilities and premises were appropriate for the services delivered and to meet patient need. An access audit as defined in the Equality Act 2010 had been completed for the premises and reasonable adjustments had been made based on the patient population need. The practice could support patients who were wheelchair users or who had limited mobility. The practice had designated parking spaces for these patients.
- Multi-disciplinary clinics for managing patients with musculoskeletal (MSK) injuries were held. There were two types of these that included the patient, physiotherapist, ERI and the Medical Officer (PRIMO). The second clinic type (PRIMO plus) also included an aviation medicine consultant. Three examples of clinical notes were seen, and it was clear the clinic supported the patient to progress along their care pathway
- A lower limb functional assessment was completed by clinicians for aircrew in a flying simulator as part of the process for assessing fitness to fly. A standardised form was seen, with clear objective assessment categories.

### **Timely access to care and treatment**

- The practice was open Monday to Friday 08:00 to 12:00 and 13:30 to 16:30 and from 16:30 to 18:30 for urgent cases only. After this time patients were directed to the NHS 111 service.
- No extended hours were routinely offered but bespoke appointments could be made for shift workers or anyone that could not attend in core opening hours. A duty medic was on call 24 hours a day at 10 minutes notice for any aircraft incidents.
- There was good access for all patients including an early morning triage for urgent care. We saw some good examples of clinics being arranged to facilitate the flying crew elements of the patient group, such as vaccination clinics arranged for Friday afternoons so that there were no flying restrictions placed on aircrew during the week. The practice ran bespoke clinics for force preparation for deploying squadrons.
- The PCRF were unable to produce recent dashboard statistics even with liaison with their Regional HQ (the most recent ones they could show were January to March 2018). We visually checked the DMICP diary and appointments were available within 10 working days and patients with urgent needs could be seen on the day.

- Details of how patients could access the GP when the practice was closed were available through the base helpline. Details of the NHS 111 out of hours service was also displayed on the outer doors of the medical centre and in the practice leaflet.
- The patient experience survey showed that 79% of patients at the practice were satisfied with the location of their appointment and 11% did not respond to the question.

### **Listening and learning from concerns and complaints**

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information was available and displayed to help patients understand the complaints process.
- The practice worked with the DPHC complaints policy and procedure. The practice manager was the designated responsible person for handling all complaints. We saw the practice leaflet contained the direct telephone number and email address to contact them if required. There was a very comprehensive and well laid out poster display for both staff and patients in the main corridor of the practice.
- The patient survey undertaken in October 2018 showed 100% of patients asked (34) felt that their concerns, compliments and suggestions were listened to.
- A log of both written and verbal complaints was maintained. Culdrose Medical Centre had received four complaints since August 2017, all of which had been effectively managed with no emerging theme.

<b>Are services well-led?</b>	Requires improvement
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**We rated the practice as requires improvement for providing a well-led service.**

### **Leadership capacity and capability**

We found the management team had the capacity, experience, skills and tenacity to deliver high-quality, sustainable care. Everything we saw on the inspection day, and communications with the practice following the inspection, supported this.

- There was a clear leadership structure and staff felt supported by management. Staff told us the practice leaders were approachable and always took the time to listen to all members of staff.
- There was a comprehensive meetings programme in place and the practice held regular whole team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. We noted team away days were regular.
- All staff were involved in discussions about how to run and develop the practice, and the PMO encouraged all members of staff to identify opportunities to improve the service delivered by the practice.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (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). This included support training for all staff on communicating with patients about notifiable safety incidents. The leaders encouraged a culture of openness and honesty.

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## **Vision and strategy**

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- The practice vision was “Culdrose will put patient safety at the centre of all we do using best practice to improve patient care and patient employability”.
- The medical centre planned its services to meet the needs of the practice population.

## **Culture**

The practice had a culture of good quality sustainable care.

- Staff stated they felt respected, supported and valued.
- The practice focused on the needs of patients.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they needed. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.

## **Governance arrangements**

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured that:

- An understanding of the performance of the practice was maintained. The practice manager used the Common Assessment Framework (CAF) as an effective governance tool.
- A programme of clinical and internal audit was used to monitor quality and to make improvements.
- The practice had a Quality Improvement Team consisting of different staff representatives from the practice. They met quarterly to discuss and action improvements.
- A comprehensive understanding of the performance of the practice was maintained. Practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice. The practice nurse monitored achievement against clinical indicators in QOF and reported if there were areas which required focus.

However, we saw that some areas of governance that required improvement;

- There was a clear staffing structure. However, we saw that not all staff were aware of their own roles and responsibilities. Not all staff were aware of policies that were related to their roles. For example, staff responsible for maintaining the laboratory sample register were unaware of the policy, could not locate it and were unaware they were responsible.
- There were insufficient arrangements in place for identifying, recording and managing risks and issues, and for implementing mitigating actions. For example, there were inconsistencies in the oversight of safety alerts, infection control and significant event reporting. There was an absence of defined registers within the practice, for example a vulnerable patient register, including carers.

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- Shared care protocols were not in place for patients taking high risk medicines.

### **Managing risks, issues and performance**

There were some clear and effective processes for managing many risks, issues and performance. However, we identified some areas where improvement was required.

- The practice manager and PMO understood the risks to the service and kept them under scrutiny through the risk register.
- Processes were in place to manage current and future performance. Performance of clinical staff was demonstrated through peer review, including review of clinical records.
- The Regional Rehabilitation Unit (RRU) undertook advisory visits to the PCRf.
- Plans were in place for major incidents and staff were familiar with how to respond to a major and/or security incident.
- There were gaps in processes to identify, understand, monitor and address current and future risks including risks to patient safety.
- Practice leaders did not always have oversight of national and local safety alerts, although complaints were comprehensively managed. Infection control required better management and patients on high risk medicines did not have shared care agreements in place.

### **Appropriate and accurate information**

The practice had appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- There were good arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

### **Engagement with patients, the public, staff and external partners**

The practice involved patients, staff and external partners to support high-quality sustainable services.

- A patient experience survey was undertaken throughout the year and a suggestion box was in the patient waiting room.
- The practice, including a representative from the PCRf, attended unit welfare meetings each month.
- Staff gave feedback through a staff survey, staff meetings, appraisals and one to one monthly discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.
- The practice had a Patient Participation Group (PPG) which met regularly and were proactive in making positive changes based on patients' involvement and suggestions. For example, the waiting area outside of the physio area was improved following patient feedback.

### **Continuous improvement and innovation**

There was evidence of systems and processes for learning, continuous improvement and innovation.

- Continuous improvement was embedded in the culture of the practice. There was a seamless integration between the PCRf and medical centre staff.
- Multi-disciplinary clinics for managing patients with musculoskeletal (MSK) injuries were held. There were two types of these that included the patient, physiotherapist, ERI and the Medical Officer (PRIMO). The second clinic type (PRIMO plus) also included an aviation medicine consultant. Three examples of clinic notes were seen, and it was clear the clinic added to the progress of the patient along their care pathway
- A lower limb functional assessment was completed by clinicians for aircrew in a flying simulator as part of the process for assessing fitness to fly. A standardised form was seen, with clear objective assessment categories.
- The practice had a Quality Improvement Team. This consisted of different members of the practice team with differing responsibilities, who met together every three months to discuss issues, suggestions, complaints, significant events with the aim to use any information gained from patients to drive improvement. We saw positive changes made following patient feedback including changes to a waiting area and additional information leaflets made available for patients to refer to.