Culdrose Medical Centre

Quality report

RNAS Culdrose
Helston
Cornwall
TR12 7RH

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13 November 2019

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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 given to us by the practice and patient feedback about the service.

Ratings

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

Chief Inspector's Summary

This practice is rated as good overall

The key questions are rated as:

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

We previously carried out an announced comprehensive inspection of Culdrose Medical Centre on 1 November 2018. The practice was rated as requires improvement overall, with a rating of requires improvement for the key questions of safe, effective and well-led. Caring and responsive were rated as good.

We carried out this announced follow-up inspection of Culdrose Medical Centre on 13 November 2019. 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.

At this inspection we found:

- The practice was well-led and leaders demonstrated they had the vision, passion and integrity to provide a patient-focused service that sought ways to develop and improve.
- An inclusive team approach was supported by all staff who valued the opportunities available to them to be part of a patient-centred service.
- There was an open and transparent approach to safety. An effective system was in place for managing significant events and staff knew how to report and record using this system.
- Clinical records were consistent in terms of the quality of record keeping.
- There were gaps in processes to identify, understand, monitor and address current and future risks in the oversight of medicines management.
- Staff were aware of current evidence-based guidance. They had received training so they were skilled and knowledgeable to deliver effective care and treatment.
- The practice worked collaboratively and shared best practice to promote better health outcomes for patients.
- There was evidence to demonstrate quality improvement was embedded in practice, including an annual programme of clinical audit used to drive improvements in patient outcomes.
- The practice proactively sought feedback from staff and patients which it acted on. Feedback showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.
- Information about services and how to complain was available.

- Equipment at the practice was sufficient to treat patients and meet their needs.

Notable Practice

- The PCRF staff had instigated an improvement strategy for patients leaving the service due to ill health to ensure they continued to get the rehabilitation they needed.

The Chief Inspector recommends:

- Review systems and processes for medicines management to ensure they are fully effective and being followed.

Dr Rosie Benneyworth BM BS BMedSci MRCGP
Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

The inspection team was led by a CQC inspector**.** The team comprised specialist advisors including a GP, practice nurse, practice manager, physiotherapist and pharmacist.

Background to the Culdrose Medical Centre

Culdrose Medical Centre (referred throughout the report as 'the practice') provides an integrated service of primary care, occupational health care and physical rehabilitation services as well as providing emergency cover to the airfield 24 hours a day. 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 works with RAF St Mawgan (SMG) Medical Centre by sharing management teams and by providing rehabilitation services, emergency medical cover and primary care for their patient population (400) when the SMG civilian medical practitioner (CMP) is away.

In addition to routine primary care 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 Primary Care Rehabilitation Facility (PCRF) is spread over two sites; the main site is co-located within the practice and three rooms within the gym, sharing the main unit gym space.

The practice has its own dispensary.

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 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 staff team

Position	Numbers
Principal Medical Officer (PMO)	one

Medical Officers (MO)	seven
Civilian practice nurses	Two (one full time, one part time)
Military practice manager	one
Medical assistants	eleven
Pharmacy Technician	one
Physiotherapist	Two and a half - full time equivalent (FTE)
Exercise Rehabilitation Instructor (ERI)	Two (FTE)
Administrators	eight
Administrator (PCRF)	one

Are services safe? | Requires improvement

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

Following our previous inspection, we rated the practice as requires improvement for providing safe services. We found gaps in processes to keep patients safe including: infection prevention and control (IPC); management of test results; the management of Medicines and Healthcare products Regulatory Agency (MHRA) alerts, medicines management, including shared care agreements; the management of significant events and the lack of an alarm system.

At this inspection we found the recommendations we made had mostly been actioned. Some further action was required. The practice is still rated as requires improvement for providing safe services.

Safety systems and processes

Systems were established to keep patients safe and safeguarded from abuse.

- A framework of regularly reviewed safety policies was in place and accessible to staff, including locum staff. Staff received safety information about the practice as part of their induction and refresher training.
- Measures were in place to protect patients from abuse and neglect, including adult and child safeguarding policies. Staff had received safeguarding training and update training at a level appropriate to their role.
- A safeguarding lead and deputy were identified for the practice. Safeguarding arrangements and local contact details were displayed in clinical rooms for staff to access.
- Coding and alerts were used to highlight vulnerable patients. A vulnerable patient register was held on the electronic patient record system (referred to as DMICP) with six adults identified at the time of the inspection. The needs of service personnel assessed as being vulnerable were discussed at a carers meeting with the welfare team, chaplains and executive branch of the base.

- The practice did not use non-clinical staff as chaperones although chaperone training for all staff was on the training plan. The chaperone policy was in place and widely on display throughout the practice.
- The full range of recruitment records for permanent staff was held centrally. However, the practice could demonstrate that relevant safety checks had taken place at the point of recruitment, including a Disclosure and Barring Service (DBS) check to ensure staff, including locum staff, were suitable to work with vulnerable adults and young people. DBS checks were renewed every five years.
- Arrangements were in place to monitor the registration status of clinical staff with their regulatory body. All staff had professional indemnity cover. Information was in place to confirm staff had received all the relevant vaccinations required for their role at the practice.
- There was an effective process to manage infection prevention and control (IPC), including a lead and deputy lead for IPC who was appropriately trained for the role. The staff team was up-to-date with IPC training. The practice completed an annual IPC audit in September 2019.
- PCRF clinicians practised acupuncture and arrangements were in place for the safe provision of this treatment, including an acupuncture health screening assessment and patient information sheet.
- Environmental cleaning was provided by an external contractor. Cleaning schedules and monitoring arrangements were established.
- A deep clean of the premises took place annually. We identified no concerns with the cleanliness of the premises.
- A member of staff had the lead for the safe management of healthcare waste. Consignment notes were retained at the practice and an annual waste audit was carried out in July 2019.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

- There had been a significant change of staff within the past few months with a new PMO, practice manager, two medical officers two administration staff and medics recently joining the practice. Staff we spoke with said staffing levels were low and at times were not always adequate to meet the needs of the patients. We saw there was an effective approach to managing staff absences and for responding to epidemics, sickness, holidays and busy periods. Recruitment was ongoing, and interviews were being held this month to fill the two nursing posts. The practice hoped to be fully staffed by early 2020.
- There was a mix of military and civilian staff. A comprehensive induction programme was in place as well as comprehensive desktop instructions to familiarise temporary staff with systems and processes.
- The practice was equipped to deal with medical emergencies. An emergency kit, including a defibrillator, oxygen with masks and emergency medicines were accessible to staff in a secure area of the practice; all staff knew of its location. Weekly and monthly checks were in place to ensure the required kit and medicines were available and in-date. Staff were up-to-date with the required training for medical emergencies. They participated in regular training relevant to emergency situations. Staff had recently received training in the recognition and management of sepsis. Posters about sepsis were displayed throughout the practice.

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.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. There was a documented approach to the management of test results.
- A process was established for scrutiny and summarising of patients' records and this was monitored by the practice manager. On arrival, new patients were required to complete a patient registration form and they were also encouraged to book a new patient appointment with a clinician. A clinician was responsible for summarising the notes in DMICP. At the time of the inspection there was no backlog in summarising notes.
- Staff told us that there was infrequent loss of connectivity with DMICP and that issues never lasted more than an hour. Therefore, the impact on patients was minimal. There were two laptops available that could be used to access a different IT system if required.
- Referrals to other departments and external health care services, including urgent referrals, were managed by administrative staff. They responded to requests from the doctors and booked patient appointments. If an appointment was not available based on patient availability, then the administrator followed it up on behalf of the patient. Referrals were logged and monitored. Physiotherapists monitored the referrals they made to the Regional Rehabilitation Unit (RRU) and other services.

Safe and appropriate use of medicines

The practice did not have fully reliable systems for the appropriate and safe handling of medicines.

- A lead and deputy were identified as the subject matter experts for medicines management with the day-to-day management of medicines delegated to a pharmacy technician.
- Arrangements were established for the safety of controlled drugs (CD), including destruction of unused CDs. We saw that monthly and quarterly checks were carried out although some checks were missing (June and September 2019). Medication requiring refrigeration was monitored twice a day to ensure it was stored within the correct temperature range. We noted that records showed temperatures out of range on several occasions but no actions had been taken.
- The practice's arrangements for the monitoring of prescription stationary required review. Prescriptions were stored in the dispensary and recorded in a bound book. The book did not detail the balance of forms held, only serial numbers, making it difficult to ascertain that stock was correct. There were no visible stock checks recorded. Prescription stationery for CDs were not checked. Following the inspection, we were given assurances that formal checking processes had been put in place.
- There was no evidence of monthly or quarterly checks by internal/external officers since records began in 2015. The pharmacy technician could not recall a visit by a regional pharmacist in 2019.We were advised following the inspection that a formal visit from the regional pharmacist had been arranged.

- Blood glucose monitoring equipment was available but was not being used correctly. The strips used were incorrect for the meter used. There were no records of control tests being carried out to check functionality. Following the inspection, we received evidence to show this had been addressed and was now being managed appropriately.
- Patient Group Directions (PGD) had been developed to allow appropriately trained nurses to administer medicines in line with legislation. The PGDs were current and signed off. However, we noted that medicines supplied for PGD use were not recorded and accounted for appropriately by the nursing staff.
- Requests for repeat prescriptions were managed in person or by email but also by telephone which was not in line with policy. A process was in place to update DMICP if changes to a patient's medication was made by secondary care or an out-of-hours service.
- A process was established for the management of and monitoring of patients prescribed high risk medicines (HRM). A register of HRM used at the practice was held on Sharepoint and all doctors had access to this. Alerts, coding and monthly searches were used to identify and manage patients on HRM, although we noted there were no recall dates recorded within the register. We were assured following the inspection that the register had been amended and recall dates inputted. Shared care agreements were in place for the patients that required them.
- Whilst written procedures (SOPs) were in place to support safe dispensing practice, we found that some processes detailed in a SOP were not being followed. For example, temperature monitoring, especially the medics room, and date checking in the dispensary. There was no system to monitor compliance with the SOPs.
- The management of medicines was subject to regular audit. For example, an antibiotic prescribing audit was completed in July 2019.

Track record on safety

The practice had a good safety record, although some improvements were needed to ensure the up to date risk assessments were in place.

- Measures to ensure the safety of the facilities and equipment were in place. The practice manager was the lead for health and safety. Electrical and gas safety were up-to-date. Arrangements were in place to check the safety of the water. A fire risk assessment of the building was undertaken annually. The fire system was tested each week. Staff were up-to-date with fire safety training and were aware of the evacuation plan.
- Equipment checks, including the testing of portable electrical appliances were in-date. The PCRF provided evidence that the equipment held at the various gyms used to treat patients had been serviced.
- An alarm system was in place in the practice and the gym and was tested weekly.
- Risk assessments pertinent to the practice were in place but were held with assessments and information that was out of date making it difficult to find the most up to date information. Not all staff had read these. We received information following the inspection that the practice had begun to work on this.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff used the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events, incidents and near misses. All staff had electronic access to the system, including locum staff. Staff provided several varied examples of significant events confirming there was a culture of effectively reporting incidents. Whilst we saw incidents reporting was encouraged, further work was needed to ensure that the root cause analysis was thorough, and that learning was captured prior to closure. There was a scheduled weekly meeting to review ASERs and they were also reviewed at practice and management meetings if required; these were minuted. Improvements were made as a result of investigations into significant events. For example, the management of results had improved, including introducing a sample log and training staff in the correct processes to follow.
- The pharmacy technician was responsible for managing medicine and safety alerts. These were cascaded from regional headquarters or directly from the Medicines and Healthcare products Regulatory Agency (MHRA) to the practice mailbox. The system was only checked for alerts each week and were then logged on a spreadsheet. Alerts were emailed to staff with a read receipt, they were also discussed at the practice meetings. On the day of the inspection we noted that the spreadsheet did not contain all current alerts. Following the inspection, we received evidence to show that searches were being undertaken daily.

Are services effective?	**Good**

We rated the practice as good for providing effective services.

Following our previous inspection, we rated the practice as requires improvement. There were gaps in the provision of effective services including: staff training; staff induction and recording consent.

At this inspection we found all the recommendations we made had been actioned.

Effective needs assessment, care and treatment

The practice had processes to keep clinicians up to date with current evidence-based practice.

- Our review of patient records demonstrated that clinicians carried out assessments and provided care and treatment in line with national standards and guidance, supported by clear clinical pathways and protocols. Arrangements were established to ensure staff were up-to-date with current legislation, research and guidance, including NICE (National Institute for Health and Care Excellence) and the Scottish Intercollegiate Guidelines Network (SIGN). These were discussed at the weekly meetings for clinicians and, if relevant, with the wider staff team at the practice meetings and health care governance meetings.
- Staff were also kept informed of clinical and medicines updates through the Defence Primary Health Care (DPHC) newsletter circulated to staff each month.
- The PCRF team referred to the Defence Rehabilitation website for best practice guidance. For example, ERIs used it for guidance on equipment management, training and best practice guidance.

Monitoring care and treatment

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.

- A lead doctor was identified for each long-term condition with a lead nurse overseeing the management, including recall, of patients with long term conditions.
- We found the care of patients with long-term conditions was good. For example, patients with diabetes, hypertension and asthma. There was an experienced member of staff who was responsible for long-term condition management. They carried out regular searches, recalling patients when appropriate. We looked at a selection of patient records and were assured that clinicians were consistent in how patients were reviewed.
- We looked at a range of clinical records and were assured that the care of patients with a mental illness and/or related symptoms was being effectively and safely managed. Appropriate templates were used to assess patients and plan their care.
- Clinicians worked closely with the Department of Community Mental Health (DCMH) and referred patients when required.
- 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). Audiometric assessments were in date for 78% of patients.
- A patient database was used effectively to monitor injury trends and access to PCRF. It was used to share information with unit commanders at the UHC meetings. This supported units to understand the specific injuries associated with the operational activity of the unit and thus explore ways to minimise injuries based on specific trends.
- Quality improvement, including clinical audit, was clearly embedded in practice and seen as the responsibility of all staff. The PCRF was integrated in the wider audit programme for the practice. A lead for audit was identified and an audit programme was established for 2019. The audits we looked at showed the practice acted on the outcomes to improve the service. For example, an audit on patients who presented with ankle pain identified that they were not always getting access to the correct care. An action plan was developed that included instructions for any patients presenting with ankle pain were to be seen by the physiotherapist in the first instance.
- An asthma audit identified that staff were not using the correct asthma template to capture the correct information when assessing patient's needs. As a result, learning and discussion was had and now all staff use the correct template; this was seen in patients notes on the day of the inspection.

Effective staffing

Continuous learning and development were promoted for staff. The staff database was monitored by the practice manager to ensure staff were up-to-date with training and development.

- A generic and role-specific induction was in place for new staff to the practice. All staff, including a recently inducted member of staff, described a comprehensive and supportive induction. This included supernumerary time and supervised practice.

- Mandated training was monitored, and the staff team was in-date for all required training. A programme of ongoing development training was in place with in-house and external training sessions available to staff each week. Clinicians were also supported with continual professional development (CPD) and revalidation through protected time each week.
- The practice demonstrated a positive training ethos. Staff told us they were supported to develop their skills and encouraged to participate in training. All doctors were trained in the Military Aviation Medicine Examination course (MAME) including locums, Two doctors also had a Diploma in Aviation Medicine ensuring all patients received care from suitably qualified clinicians.
- A process of clinical supervision was in place for PCRF staff and a supervision log was maintained. A SoP was in place for PCRF staff and it covered protected time of up to five days each year for goal specific training in accordance with individual staff objectives.
- Peer review between clinicians was being set up through with a view to further ensuring that guidelines were followed. Regional meetings and forums were established for staff to link with professional colleagues in order to share idea and good practice. For example, nurses were supported to attend the regional nurse's forum to link with their colleagues.

Coordinating care and treatment

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

- The clinical records we reviewed showed appropriate staff, including those in different teams, services and organisations were involved in assessing, planning and delivering care and treatment.
- 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 practice. 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.
- 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. They had good relationships with the regional podiatry service who held regular clinics at the practice.
- The PMO 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.
- The practice was trying to establish links with local NHS providers. We saw several examples where care plans were shared with secondary care providers. The PMO described how they had tried to refer a patient to an eating disorder clinic but had come up against barriers due to the patient not being an NHS patient. The PMO then referred the patient to DCMH who supported the patient further.
- The senior ERI was leading a regional ERI group that met several times a year providing arena forum for sharing professional issues and best practice for rehabilitation instructors.
- A SoP was in place outlining the process to follow for patients leaving the military. Doctors provided patients transitioning from the military with a release medical. They also referred patients to the welfare team for support with the transition, and if appropriate to the Department

of Community Mental Health (DCMH). Patients were signposted to SSAFA, a UK charity providing welfare and support for serving personnel in the British Forces, veterans and military families.

- The PCRF staff had instigated an improvement strategy for patients leaving the service due to ill health. Previously patients undergoing physiotherapy or rehabilitation had the potential to be 'lost' once this decision had been made. By formation of a multi-disciplinary clinic and improved communications between the employment board, the practice and the PCRF patients continued to be involved in their care pathway and rehabilitation, up to their leaving date.

Helping patients to live healthier lives

Staff were proactive and sought options to support patients to live healthier lives.

- Clinical records showed 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.
- Health promotion displays were available in patient areas. These were dated and refreshed in line with the strategy. At the time of the inspection there were displays about sepsis.
- Health fairs were held on the base unit gymnasiums and the practice was represented by the nurses.
- There was no one at the practice nominated as the lead for sexual health nor had any staff completed the required training for the role (referred to as STIF). A STIF trained nurse from SMG held a sexual health clinic at the practice once a week for those patients that required it.
- Information was available for patients requiring sexual health advice, including sign-posting to other services. Where appropriate patients were referred to local genitourinary clinic for screening. Condoms were available at the practice. In the foyer, information about local sexual health pathways was displayed for patients.
- The ERI was interested in assessing patients holistically to enhance full recovery. They were developing a form for patients to complete to monitor sleep, mood and activity during their rehabilitation. This was new and not fully embedded but audit was planned to capture its impact.
- Patients had access to appropriate health assessments and checks. Regular searches were undertaken for patients eligible for bowel and breast screening and appropriate action taken if patients met the criteria. There was a policy to offer telephone or email reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using public health information posters and they ensured a female sample taker was always available. We saw records that confirmed that 99% of women had received screening or were waiting to be called.

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. Based on clinical records, the following illustrates the current vaccination data for military patients:

- 97% of patients were recorded as being up to date with vaccination against diphtheria.
- 97% of patients were recorded as being up to date with vaccination against polio.

- 96.5% of patients were recorded as being up to date with vaccination against hepatitis B.
- 96% of patients were recorded as being up to date with vaccination against hepatitis A.
- 97% of patients were recorded as being up to date with vaccination against tetanus.
- 80% of patients were recorded as being up to date with vaccination against typhoid
- 98.5% of patients were recorded as being up to date with vaccination against MMR
- 98% of patients were recorded as being up to date with vaccination against meningitis.

The unit commanders were responsible for ensuring their personnel kept up-to-date with vaccinations. They appropriately did this through the Joint Personnel Administration (JPA) system. The practice carried out an assurance check.

Consent to care and treatment

Staff sought 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.
- Where a patient's mental capacity to consent to care or treatment was unclear the doctor or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment. Informed consent was recorded in patient records.

Are services caring?	Good

We rated the practice as good for caring.

Kindness, respect and compassion

Staff supported patients in a kind and respectful way.

- Throughout the inspection we observed staff were courteous and respectful to patients arriving for their appointments.
- We received 26 patient Care Quality Commission comment cards in total. All of these were entirely positive about the service experienced. Patients praised the practice staff who they perceived to be very helpful, kind and caring. The two patients we spoke with were very complimentary about the friendly, considerate and caring attitude of staff.
- Results and comments from the October 2019 Patient Experience Survey (38 respondents) showed 30 patients said they would recommend the practice to their friends and families if they were able to. Four stated the question did not apply to them and four said they would not recommend because of the considerable commute from their home address.
- 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.

- Interpretation services were available for patients who did not have English as a first language and staff provided an example of when they recently used the service.

- The Patient Experience Survey showed 90% of patients were involved in decisions about their care. Feedback on the CQC patient feedback cards highlighted that patients felt involved in their treatment plan and doctors supported them with making informed decisions about their treatment and care.
- The practice proactively identified patients who were also carers. A SoP was in place to support the carer identification process. In addition, the practice information leaflet included a section inviting patients who were carers to identify themselves.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Screening was 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 area and waiting area meant that conversations between patients and reception staff would unlikely be overheard. If patients wished to discuss sensitive issues or appeared distressed at reception, they were offered a private room to discuss their needs.
- The practice could facilitate patients who wished to see a doctor or physiotherapist of a specific gender.

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 in May 2019 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; one referred to as PRIMO that included the patient, rehabilitation instructor and the Medical Officer (PRIMO). The second clinic type (PRIMO plus) also included an aviation medicine consultant. These had been infrequent since our last visit due to unavailability of doctors and a changeover of the regional occupational health consultant. However, a new planned schedule of regular clinics was seen starting in the near future.

Timely access to care and treatment

Patients' needs were met in a timely way.

- The practice accommodated patients with an emergency need and staff advised us that no patients were turned away and would be seen on the same day. Routine appointments could be accommodated within five days. Aviation medicals were available within one week.

- 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. The practice ran bespoke clinics for force preparation for deploying squadrons. We also saw the practice had delivered bespoke vaccination clinics for ship's crew at Falmouth.
- A direct access physiotherapy (DAP) service was in place for patients. Patients prioritised as urgent were given the next available appointment ideally within five working days and patients with a routine need were seen within 10 working days. This process worked well with access meeting demand. We spoke to two patients who said access to appointments was good, and that the care was responsive, and they felt involved in decisions about their care.
- Details of how patients could access a doctor 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 practice and in the practice leaflet.

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.

- Defence Primary Health Care had an established policy and the practice adhered to this.
- The practice manager was the designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. The PMO would investigate any clinical complaints.
- We spoke with two patients who told us that they felt comfortable and knew how to complain if the need arose. They confirmed that military rank would not be a barrier to them raising issues with the practice.
- In the survey, 99% patients who felt that they needed to know how to complain responded to say that they knew how to. Some patients felt that this question did not apply to them.

Are services well-led?	Good

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

Following our previous inspection, we rated the practice as requires improvement for providing well-led services. This was due to underdeveloped governance systems.

At this inspection we found that some action had been taken to address the concerns identified.

Leadership capacity and capability

- There was a new leadership team in place at Culdrose Medical Centre. The leaders at the practice were working hard to address areas that required improvement, but these were in their infancy. Significant work had begun to ensure that care for patients had improved since our last inspection although progress in some areas had been restricted due to gaps in manning. Staff spoke highly of how the practice was led. They said managers demonstrated a collaborative

approach to leading the practice and supporting staff. The regional management team worked closely with the staff team.

- Leaders were knowledgeable about issues and priorities relating to the quality of services. As a result, key risks were being addressed.
- There was flexibility within leadership roles to ensure continuity in each department.

Vision and strategy

Throughout the inspection it was clear staff were committed to providing and developing a service that embraced the mission and vision.

- 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 practice planned its services to meet the needs of the practice population.

On the day of the inspection, we found the practice was working to and achieving its aims.

Culture

The culture at the practice was inclusive and all staff were treated equally.

- An inclusive culture underpinned the approach of the practice. All staff had an equal voice, regardless of rank or grade.
- The PCRF was integrated with the wider practice, including an integration of governance systems. This integration could be enhanced further by including PCRF staff within the management and UHC meetings.
- Staff described an open and transparent leadership style and said they would feel comfortable raising issues. They felt respected, supported and valued. Both formal and informal opportunities were in place so staff could contribute their views and ideas about how to develop the practice.
- The practice clearly demonstrated a patient-centred focus. Staff understood the specific needs population and tailored the service to meet those needs.
- Openness, honesty and transparency were demonstrated when things went wrong. A no-blame culture was evident; complaints and incidents were seen as opportunities to improve the service.
- The practice was aware of how 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). However, there was no system in place to capture this information. Immediately following the inspection, we received evidence to show that a duty of candour log had been generated that the practice manager held and would review weekly.
- Leaders clearly demonstrated that the needs and welfare of staff were priority. Staff were encouraged and supported to be the best they could be through training and developing their skills. Supervision and appraisal were in place for all staff.
- The practice actively promoted equality and diversity and staff had received training in this area.

Governance arrangements

There was an effective overarching governance framework in place which supported the delivery of good quality care.

- There was a clear staffing structure in place and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. Terms of reference were in place to support job roles.
- An effective range of communication streams were used at the practice. A schedule of regular practice and team specific meetings were well established. The PCRF team were invited and attended all main practice meetings. The Deputy Principal Medical Officer (DPMO) was the lead doctor for the PCRF and held weekly meetings with the whole PCRF team, any issues identified were fed back into the Senior Management Meeting for further discussion.
- Audit was a routine method used to measure the effectiveness and success of clinical and administrative practice. A comprehensive audit programme was established with clear evidence of action taken to change practice and improve the service for patients.

Managing risks, issues and performance

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

- The practice manager and PMO understood the risks to the service and these were recorded on the risk register. However, this document needed regular review.
- 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 business resilience and there was a plan in place.
- There were gaps in processes to identify, understand, monitor and address current some aspects of medicines management. Following the inspection, we received confirmation from the practice that actions were being taken to begin to address these.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- An internal quality assurance tool, the DMS Common Assurance Framework (CAF) was used to monitor safety and performance for the practice and included the PCRF. The DMS CAF was formally introduced in September 2009 and since that time has been the standard healthcare governance assurance tool utilised by DMS practices to assure the standards of health care delivery within DMS.

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 also had a Patient Participation Group (PPG) which met regularly and were proactive in making positive changes based on patients' involvement and

suggestions. Following patient feedback we saw that a formal request had been submitted for the provision of fresh drinking water to be made available in the waiting room. We saw evidence that this request had been considered and supported by the practice and efforts were being made to get this done.

- Representatives from the practice 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.

Continuous improvement and innovation

The practice has worked hard to improve following the last inspection. They had produced a management action plan which they have been working through. We saw examples of the practice focussing on continuous learning and improvement. For example, The PCRF staff had instigated an improvement strategy for patients leaving the service that were undergoing rehabilitation.