East of Scotland Combined Medical Practice

Leuchars Medical Centre, Fife, KY16 0JX

Condor Medical Centre, Arbroath, DD11 3SJ

Defence Medical Services inspection report

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

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

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Summary

About this inspection

We carried out an announced comprehensive inspection of East of Scotland Combined Medical Practice on 18 and 19 August 2025.

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

Are services safe? – inadequate

Are services effective? – inadequate

Are services caring – good

Are services responsive to people's needs? – good

Are services well-led? – inadequate

CQC does not have the same statutory powers with regard to improvement action for the Defence Medical Services (DMS) under the Health and Social Care Act 2008, which also means that the DMS is not subject to CQC's enforcement powers. However, as the military healthcare regulator, the Defence Medical Services Regulator (DMSR) has regulatory and enforcement powers over the DMS. DMSR is committed to improving patient and staff safety and will ensure implementation of the observations and recommendations within this report.

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

At this inspection we found:

- Feedback showed patients were treated with compassion and respect, had access to the service and were involved in decisions about their treatment and care. However, on review, it was evident that negative feedback had not been captured and acted on.
- Safeguards in place included close working with the welfare team and local safeguarding team to support vulnerable patients. However, staff training was found to be out-of-date.
- Despite finding many issues that required action, it was clear the practice did have a patient-centred culture. However, the governance structure was not effective enough to support it and led to gaps where treatment requirements were unknown or not managed effectively.
- The continued turbulence with senior leadership at the practice had resulted in confusion over lead roles, a vacuum of responsibilities that were often not suitably covered and a widening gap between military and civilian staff. The leadership approach was not collaborative and inclusive and there was scope to optimise the relationship with the regional headquarters team.

- The combining of Leuchars and Condor Medical Centres had been implemented with the aim of increasing resilience across the 2 sites. However, the full benefits of this were yet to be seen, a significant barrier being the IT incompatibility across the 2 sites.
- The approach and systems relating to risk assessment/management and health and safety required improvement and staff with lead responsibilities required role-specific training.
- A system was in place for managing significant events, but we received mixed reports about its effectiveness. Significant events were discussed at healthcare governance meetings.
- The practice worked collaboratively with internal units and external organisations to enhance the safety, welfare and wellbeing of patients.
- The arrangements for managing medicines required strengthening, in particular the management of high-risk medicines.
- Consistent Read coding was not in use. Multiple condition codes for overlapping conditions had been applied and so caused a lack of clarity around diagnosis. This was compounded by diary dates often missing for conditions that need monitoring or present for those which no longer need monitoring.
- The monitoring of patients with long-term conditions was not consistently being undertaken with consequent missed opportunities to prevent disease progression. The system was part dependent on staff knowing individual patients which was not a sustainable method. However, once patients' needs had been identified, the evidence was that management of long-term conditions was mostly done well.
- Quality improvement projects were undertaken and there was evidence they supported improvements in patient care.
- Although visibly clean on the days of inspection, a recent regional audit had identified issues with the cleanliness of the premises.

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

- Practice staff had gone the extra mile on a number of occasions to provide an enhanced level of care. Of note, for a patient with a cardiac condition.
- The Business Support manager and administration teams at both sites were experienced and aware of the connectivity issues (external links) DPHC faced in Scotland (highlighted on the risk register and through ASERs) when referring to the NHS when communicating with two separate NHS Boards (Fife and Tayside). The teams mitigated issues wherever possible and had good communication and networking with healthcare providers (NHS Fife/Tayside HSCP) to help ensure that patients were seen within the relevant timeframes.

The Chief Inspector recommends to DPHC:

- Given the current dynamics at the practice, consider how this impacts the practice's effectiveness as a training practice.

- Conduct an urgent review of the skills and qualifications of the nursing department to ensure that no staff member is working outside of scope and that all competencies can be assured.
- Carry out an urgent and thorough review to determine and address the root causes of high levels of sickness absence, staff turnover and formal grievance procedures being experienced within the practice.
- Review the combining arrangements to consider whether the benefits of combining can be realised where patient lists cannot be merged. Consider whether a network is better able to deliver the desired benefits.
- Outline tried and tested workarounds for medical teams in Scotland where direct access to Lablinks is not available and disparate access arrangements to hospital systems presents an issue. This with a view to ensuring safe management of samples, tests and hospital letters.

The Chief Inspector recommends to the practice:

- Strengthen safeguarding arrangements to ensure staff are in-date with training, familiar with reporting processes, and there is an effective system to identify and manage patients where there are safeguarding concerns.
- Chaperone arrangements should be strengthened to include staff training and the recording of when a chaperone has been offered.
- Review how staff in the PCRF and those belonging to the unit who carry out duties in the practice have their professional registration and employment checks managed ensuring all are in-date or have been risk assessed.
- Infection, prevention and control training to be updated for all staff and effective communication established to ensure issues are discussed with all appropriate staff. Those with lead roles should be provided with role-specific training.
- Cleaning arrangements to be reviewed as a matter of urgency and adapted to ensure effective cleaning is sustained on a frequency that meets with nationally recognised standards.
- Revise and strengthen arrangements to ensure items of stock including medicines and person protective equipment are regularly checked and these checks documented.
- Ensure that equipment in the PCRF has clear signage and is quarantined when not in-date for servicing and added to the risk register when appropriate.
- Implement a plan for managing the outbreak of an infectious disease at Leuchars and ensure staff are trained in how to respond.
- Implement robust processes to gain assurance of clinical competency and ensure clinicians are not working outside of their scope of practice.
- Review the leadership arrangements in the PCRF taking into consideration the potential risks identified within the team from a gap in the leadership.
- Review the emergency medicines held to ensure they are in line with DPHC policy and where required, authorised by the Regional Clinical Director. Ensure that staff are appropriately trained to administer the emergency medicines held.

- Ensure staff have completed (and are in-date for) the appropriate training for responding to a medical emergency.
- Prioritise addressing issues with the summarising of clinical records that present a potential significant risk.
- Address the backlog of patients overdue for a medication review and implement a system to ensure these are completed inside the required timeframe.
- Address the processes around chronic disease management to create an effective, sustainable system that supports the effective delivery of appropriate and timely assessment and treatment.
- Ensure suitable inductions are provided to newly appointed staff.
- Formulate a plan to address the low levels in mandatory training completion rates.
- Improve the recording of both implied and verbal consent being obtained from the patient.
- Maintain a contemporaneous accurate record to show patients who have attended for AAA, bowel & over 40s screening. This with the aim of offering additional support and encouragement to those who do not attend.
- Standardise and revise the searches used to identify carers.
- Strengthen governance processes including:
    - Peer review of notes for all clinicians
    - Regular risk assessment of substances hazardous to health
    - Utilisation of the specimen sample register
    - Terms of reference that require completion or updating
    - Monitoring of the vaccination fridges
    - Completion of Patient Group Directions
    - Management and monitoring of patients on high-risk medicines
    - Risk assessment and management of known risks
    - Effective use of the audit programme to drive improvement
    - Oversight of vaccination status for staff and patients
    - Management of safety alerts
    - The business continuity plans for both sites
    - Data security standards are being met.

Professor Bola Owolabi

Chief Inspector of Primary and Community Services.

Our inspection team

The inspection team was led by a CQC inspector and supported by a CQC regulatory officer. The specialist advisors included a primary care doctor (working remotely), 2 practice nurses (1 working remotely), pharmacist, physiotherapist (working remotely), exercise rehabilitation instructor and practice manager. A newly recruited specialist advisor shadowed the inspection as part of their induction.

Background to East of Scotland Combined Medical Practice

Leuchars Medical Centre fully combined with Condor Medical Centre in May 2025 to form East of Scotland Combined Medical Practice (referred to as the practice throughout the report). The medical centres are 25 miles apart.

Located across 2 NHS regions, Tayside and Fife, and based in the Defence Primary Healthcare (DPHC) Scotland and Northern Ireland Region, the practice provides routine primary care and occupational health care service to a combined patient population of approximately 1,470 military personnel and entitled civilian patients. Families (including children) living within a 5-mile radius of the Leuchars Station boundary can register as patients. Condor houses 45 Commando Royal Marines whilst Leuchars is predominantly an Army base with 2 main units; the Scots Dragoon Guards and 2 Battalion Royal Electrical and Mechanical Engineers. In addition to Army personnel, the Station contains an active airfield and around 60 RAF personnel. Furthermore, both sites have Military Provost Guard Service staff and other smaller units.

The Primary Care Rehabilitation Facility (PCRF) is an integral part of the medical centre at both sites and provides service personnel with a physiotherapy and rehabilitation service. Notably, military patients at Leuchars benefit from a refurbished hangar with an impressive rehabilitation suite. The medical centre at Leuchars also has its own dispensary and provides some support to Condor who outsource prescriptions.

A new building at Leuchars is scheduled to be fully operational in early 2026.

Leuchars Medical Centre is open from 08:00 to 16:30 hours Monday to Friday with the duty doctor providing urgent advice via a duty mobile between 16:30 and 18:00 hours. Wednesday afternoons are protected for training, but patients can still access services by telephone and urgent patients can be seen. Outside of these hours, patients are signposted to the NHS111 service or 999 service.

Condor Medical Centre is open from 13:00 to 17:00 hours Monday, 08:00 to 17:00 hours Tuesday, Wednesday, Thursday and 08:00 to 12:00 hours Friday with Leuchars providing cover outside of these hours.

Practice staff

Doctors	1 Senior Medical Officer (SMO) 3 Ministry of Defence GPs (MOD GPs) 1 Regimental Medical Officer (RMO) – not a DPHC asset. 1 General Duties Medical Officer (GDMO) – 45 Commando Medical Officer – not a DPHC asset. 1 General Duties Medical Officer (GDMO) – 2-year placement started April 2025. 1 Foundation Doctor Year 2 – 4 month placement. Start date August 2025 New Entrant Medical Officer (NEMO) placement until 29 August 2025
Nurses	1 Senior Nursing Officer (SNO) 2 civilian nurses (Band 6) 2 civilian nurses job share (Band 5) 1 Scots Dragoon nurse – not a DPHC asset 1 healthcare assistant
Medics	Condor – 10 Pre-hospital Treatment Team (referred to as PHTT) medics (not DPHC assets) Leuchars – 8 medics (not DPHC assets) Condor – 1 medic (non DPHC asset)
PCRF	1 military physiotherapist Officer in Command (OC) PCRF 2 civilian physiotherapists 1 civilian exercise rehabilitation instructors (ERI) 2 military ERIs) – unit not DPHC assets
Pharmacy technicians	1 civilian pharmacy technician

	1 military pharmacy technician
Practice manager Deputy practice manager	1 military 1 military
Administrators	1 civilian business support manager 5 E1 administrators 1 E2 administrator – part-time

*In the armed forces, a medic is a soldier who has received specialist training in field medicine. It is a unique role in the forces and their role is similar to that of a health care assistant in NHS GP medical centres but with a broader scope of medical care.

Of note, the practice had some long-term absences and gaps:

SMO – long-term absent

SNO – long-term absent

Band 6 Nurse Leuchars – long-term absent

OC PCRF – deployed from August 2025

DPHC Medic Condor - gapped

Are services safe?

We rated the practice as inadequate for providing safe services.

Safety systems and processes

The Senior Medical Officer (SMO) was the named safeguarding lead and the acting Senior Medical Officer A/SMO deputised in their absence. Revised by the Senior Nursing Officer (SNO) in 2025, a practice-wide safeguarding policy for adults and children was in place. The practice covered 2 different statutory services for reporting safeguarding concerns. Doctors could access the local council websites to make these referrals and that they had access to a paediatrician via the 'Consultant Connect' system if they needed to discuss cases.

The staff induction pack covered safeguarding arrangements. However, the staff training database was inaccurate and required updating to reflect the correct personnel and records of training. During the inspection we established that 9 members of staff were out-of-date for their training including a physiotherapist and a nurse from the unit who supported with triage. The acting safeguarding lead was showing as out-of-date with level 3 training on the training database but confirmed after the inspection that they were in-date and that the database would be updated.

At Leuchars, staff stated that safeguarding information was conveyed to new or locum doctors as part of their induction. We asked what level of training the nurses were trained to, but the detail could not be provided. Staff were aware that the safeguarding lead was the A/SMO but were unsure who to go to in their absence. There was safeguarding information available in 2 of the treatment areas at Leuchars and the regular doctors accessed the information online (most practices have contact details in all treatment/consultation rooms as a minimum so that all clinicians using the room have the information readily available).

At Condor, there was the option to refer 'patients of concern' to the 'officer of the day' if the patient was actively at risk. The national on-call advice line for safeguarding concerns was displayed in all treatment rooms. Posters displayed inside and outside of the medical centre provided the station welfare officer's contact details.

Staff in the Primary Care Rehabilitation Facility (PCRF) were trained to level 2 (except for the recently deployed Officer in Command physiotherapist who had completed level 3) safeguarding and were not aware that there was now a Defence Primary Healthcare (DPHC) requirement to complete level 3.

Although action had been taken when needed to report safeguarding concerns to the appropriate authorities, there was a risk that patients who were vulnerable may be missed. There was no robust process in place to track patients and the clinical operating system (known as DMICP) highlighted that there were gaps between multidisciplinary team (MDT) meetings and patients for whom no record of discussion had been made for months. The DPHC standard operating procedure (SOP) required reviews to be carried out monthly. Codes had not been removed when needed and alerts were not always in place against

the patient record. There was a register but this was not current as the patients we reviewed from the list had left the practice. The summarising and registration processes were not always picking up vulnerable patient status.

A monthly meeting was held to discuss patients with complex needs and 'patients of special interest' that included adults, families, children with safeguarding concerns, high risk medicines, palliative care patients and serving personnel under 18 years of age. This meeting was used to discuss vulnerable patients/safeguarding issues and included doctors, nurses and the Business Support Manager (BSM). In addition, there was a weekly doctor/physiotherapist meeting at Leuchars where patients of interest were discussed. The doctors added clinically complex patients to the list to be discussed. Minutes were shared with doctors unable to attend. There was a register for 'patients of special interest' but when reviewing a sample of patients' notes on this register, we found that the patients had left the practice. The practice managers at both sites were unaware of the processes in place to monitor serving personnel aged under 18 years and care leavers. Both were DMICP administrators but had not received any training or guidance.

We were given a good example of a vulnerable individual being identified by an exercise rehabilitation instructor (ERI) and subsequently referred to the nursing department.

Commander Case Conference (previously unit health committee) meetings were held at both sites with the Chain of Command (CoC), welfare and padre with a nominated doctor for each site. Patients not in these units were discussed with the CoC in individual MDT meetings when appropriate. At Condor, the A/SMO kept a master list (in DMICP) of patients of interest.

A chaperone policy was in place and had been reviewed by the SNO in 2025. Although there was a poster informing of chaperones in the waiting area, in some of the clinical rooms and referenced in the patient information leaflet, there was no list to identify staff trained as chaperones, a requirement stipulated in the SOP. The A/SMO stated that chaperones were offered as per the DMICP SOP but Read coding and/or recording the offer was inconsistent among clinicians. The mandatory DPHC audit was last conducted in February 2025 and showed that:

- 2 of the 4 patients where the offer of a chaperone was indicated had this recorded in the records.
- The name of the chaperone was not recorded on any of the occasions when a chaperone was used.
- The chaperone policy was available to patients
- Chaperones were not being offered for all intimate examinations regardless of the gender of the healthcare professional.
- The requirement to offer a chaperone had been discussed at practice meetings and highlighted to all clinical staff as well as the failure to use Read codes.
- It was recommended that re-audit be conducted in 6 months. This was included in the practice diary to be conducted in August 2025.

This presented a risk to both patients and clinicians. Chaperoning is a specific skill in which the person undertaking the role needs to be aware of the normal requirements for

an examination and are confident speaking up if there are concerns. There was little assurance provided that staff were trained to do this and the last training session was held in March 2023.

Most DPHC staff held appropriate Disclosure and Barring Service (DBS) and Protecting Vulnerable Groups (PVG) certificates on the staff database. Professional registrations required were in place and documented on the staff database, this was managed by the BSM. Non-DPHC staff in the PCRF were not currently holding the required disclosure certificates for Scotland. There was no evidence that the ERIs had been placed on the personnel risk register with evidence of PVG application submitted and the A/SMO (and/or Regional Clinical Director dependent on the regional policy) to evaluate the risk to determine if tolerable. In addition, the professional registrations of some PCRF staff were showing as out-of-date, recorded as completed at a date in the future and not applicable.

The practice managers and nursing team were not aware of a specific staff vaccination register (this may be held by the SNO who was not available at the time of inspection). The information would be available from DMICP and individual staff if required. Hepatitis B status was reviewed as part of the recruitment process for all clinical civilian staff and held by line managers. However, it was not clear who held the information for the Band 5 nurse and healthcare assistant as no evidence was available. Evidence for the vaccination of locum staff was submitted by the agency.

Regimental Aid Post (RAP) and the Pre-Hospital Treatment Team (PHTT) staff did not all hold appropriate DBS/PVG certificates recorded on the staff database. There were several discrepancies with both due to deployability and the management of the database. RAP and PHTT are not DPHC staff and are ‘owned’ by the unit. However, they do perform clinical duties in the medical centres and are therefore required to have the same recruitment checks as DPHC staff.

In advance of the inspection, we were informed of an infection prevention and control (IPC) nurse lead at Leuchars and an IPC link practitioner for the Condor site. However, when asked, the named individual at Leuchars stated that they were not the lead and we were subsequently informed that the lead was the SNO. The named lead at Leuchars did not attend the quarterly IPC link practitioner meetings run by the DPHC IPC lead. However, they told us that they regularly monitored the DPHC IPC SharePoint page for any updates, referred to the national IPC manual for Scotland, consulted the DPHC IPC compendium and was awaiting a place for the IPC link practitioner’s course.

The IPC link practitioner at Condor attended the quarterly IPC meetings and regional meetings (where IPC matters were discussed) and received updates from the Regional Nurse Advisor. They also subscribed to health alerts relating to exotic disease outbreaks. There was no formal IPC training at Condor but spot checks on the quality of handwashing were reportedly carried out for clinical staff (there was no formal documentation).

IPC was part of the staff induction. However, 19 staff were out-of-date with mandated IPC training and this did not correspond with the staff database that stated 12 staff required training. There was evidence that audits had been carried out in 2025. For example, an audit action log had been started in May 2025 and 12 entries were recorded. A sharps management audit had been carried out at Condor in July 2025. Action plans had been drawn up post audit but it was not clear on how these had been progressed. We identified

a number of minor issues with the building (blown seals on the floor and flaking paint) but these did not present an immediate risk. Disposable privacy curtains were in place and in-date with cleaning/replacement.

IPC was not a standing agenda item at the practice meetings so there was no clear channel of communication with the wider team to discuss any issues. A regional audit of the premises had been carried out 2 weeks prior to the inspection so we requested a summary of the findings which reported that the facility was dirty and that bins were overflowing.

The PCRF IPC lead at Leuchars was the Band 6 physio. They had not completed the IPC link practitioner training but had completed the annual audits in November 2024. A selection of these were checked and they had been completed fully and signed as compliant. Acupuncture was provided by the physiotherapy team and IPC measures were followed for this procedure, including the safe disposal of needles. An in-date risk assessment for acupuncture was available.

Hand washing technique posters along with first aid measures to manage sharps/body fluid exposure were displayed.

At both sites there was a daily cleaning schedule for each room. However, the cleaning contract had not been updated since 2022 and the contracted 4 hours of cleaning, for both the medical and dental centres, was insufficient to carry out a twice daily clean of high-risk areas. For example, the cleaning contract at Condor was 4 years out-of-date and stipulated 37 hours of cleaning per week but only 20 hours were being provided. Clinical rooms and toilets should have twice daily cleans to meet with NHS standards but this was not happening (there were 7 toilets and 6 treatment rooms). There was no evidence of when carpeted areas were last cleaned. Furthermore, there was no evidence of deep cleaning or monitoring of contracts at either site.

The cleaning cupboard at Leuchars was visibly dirty with various items stored on the floor, including mop heads (mops should be stored with mop head positioned upwards to facilitate complete drying and discourage bacterial growth). Rooms within the medical centre were not colour coded, there were items such as an electrocardiogram machine blocking a fire exit (this was moved on the day and we were assured it was not normal to be kept there) in the corridor and the preliminary examination room was visibly dirty and had a bucket in it containing a collection of dirty cloths. At Condor, the standard of cleanliness was higher.

The practice manager at Condor actively engaged with the Quartermaster on site regarding ongoing issues with cleaning. At Leuchars, it was anticipated cleaning would improve following the move into the new building, scheduled for January 2026. However, this would require a review and update of the contract, better management and monitoring of the cleaning standards and clear accountability.

The PCRF at Leuchars used a gym in a hanger. This had no external cleaning and was cleaned entirely by PCRF staff. The PCRF staff had a clear cleaning schedule for the hanger (and PCRF) in their SOP and staff reported no concerns with standards of cleaning. Some equipment was out-of-date for servicing and although we were told these items were not being used, there was no clear signage in place or evidence of quarantine

procedures being followed. We highlighted that signs should be placed on the equipment to identify it as quarantined and not for use until servicing has been completed, and, that records should be made on the issues log regarding an unusable asset that may affect patient care.

Clinical waste was managed in accordance with current policy (lockable yellow bin) at both sites. However, the bin at Leuchars was not secured. A pre-acceptance audit was completed for both sites in June 2025. Consignment notes were retained and the practice managers had access to the contractor's online waste log. Sharps boxes were labelled, dated and disposed of appropriately. A legionella log was managed by the practice managers and taps regularly flushed.

There were only 2 spill kits at Leuchars which was not sufficient for the number of clinical rooms. Both were located downstairs and not easily accessible for clinicians who used rooms upstairs.

At Leuchars, there was no clear plan for managing the outbreak of an infectious disease. When questioned on the 'outbreak plan', staff we spoke with were unable to provide sufficient information on the plan or details of where the plan was held. It was suggested that an infectious patient would be asked to wait in their car as there was no designated area for infectious patients. This would pose a significant safety issue, as the patient could deteriorate and this not be noticed if they were out of sight. A plan was sent by the practice post inspection. Although overdue a review in August 2023, the plan did refer to actions that should be taken in the event of a communicable disease outbreak. Patients would be sent home where possible or kept in isolation in a temporary bedding down facility within Leuchars Station.

Although not formalised, there was an 'outbreak plan' at Condor. Information including signs and symptoms would be relayed to reception if there was a local outbreak of an infectious disease. This would allow reception to identify any infectious patients to ensure they were isolated from others. As with Leuchars, Condor did not have a designated area for infectious patients but could enter them through a separate entrance (via the ambulance entrance) and administer treatment in a room that could be accessed without transiting through the building.

Risks to patients

Staff were content with patient care and the services offered. However, there were significant gaps within the leadership and management structure in the absence of the SMO and SNO. Some staff reported a reliance on the unit staff to run total triage and availability often changed. Concerns were raised by a number of staff about clinicians working outside of scope of practice. For example, a clinician had carried out an ear irrigation but there was no evidence that they had completed the required training (it was reported to us that the patient returned with ear pain and the doctor stated they were too busy to see the patient and they were advised to attend 2 days later for a doctor's appointment). Although challenged as incorrect by the acting leadership, we were also told that the healthcare assistant had run duty nurse clinics and triage. A member of staff on placement had recently been removed and relocated by Regional Headquarters (RHQ) after the individual was found to be undertaking audiometry unsupervised (trainees are

required to be supervised at all times). We noted that no ASER nor Duty of Candour had been raised.

Consistent gaps (notably the Officer in Command or 'OC' PCRF through military commitments) had left a reduced function for patient appointments and a leadership gap for the combined PCRF. A request for locum support was made but had been declined by RHQ due to budgetary constraints. The Band 6 physio has had a temporary uplift to Band 7 to recognise the additional responsibilities they had taken on, but no protected time in their diary to manage the additional workload of covering for the OC and to absorb the additional caseload. There was concern that wait times would increase. There was a 2 week wait for appointments at the time of inspection, just within the key performance indicator of 10 day but serving personnel were returning from block leave so demand on appointments was expected to increase.

Checks of the medical emergency trollies included when a trolley had been opened. However, the quantities for the emergency drugs were not in line with DPHC policy. There were no risk assessments for the medicines that were not on the core list held at Condor. There was also an additional doctors grab bag to treat patients if there was an emergency on camp (due to the relative long time for the ambulance to arrive at the station). The doctor's emergency bag held additional medicines but these had not been risk assessed (as stipulated in DPHC SOP 4-7-1) nor authorised by the Regional Clinical Director. Several items in the trolley were removed because they were out-of-date.

There was an emergency SOP for Leuchars PCRF which included actions to be taken if the emergency occurred in the hanger (remote from the main practice building). The SOP had a flow chart that was displayed in the PCRF and in the hanger.

Basic Life Support training, anaphylaxis and the use of an AED training (mandated training for all staff) had taken place at Leuchars in May 2025 but there was a number of absentees. There was no record of any equivalent training at Condor, the next training was scheduled for September 2025. However, the doctor was trained in immediate life support (including a special course for children), the nurse had completed advance life support training and unit staff were also trained in life support. There was no record of sepsis training although a session had been scheduled for September 2025.

Eighteen staff members were out-of-date for heat injury prevention training across both locations (the last heat illness training was recorded in July 2023 at Leuchars). There was evidence that the practice has managed heat injuries and this made it imperative that all clinicians were trained as per the mandatory DPHC policy. Injury training role play and a walk through of treatment algorithms was said to have been done in the practice in the last 12 months. Deployable medics had been trained on heat illness (and the DPHC medic completed this in case they were deployed). The practice had liaised with the DPHC expert in cold injuries in response to a patient need and were able to describe cases of relevance including occupational management. There was no specific triage algorithm for babies and children but they would be seen or triaged by 1 of the 2 doctors who were trained in paediatric immediate life support.

There was little evidence of scenario-based or moulage training recorded at either site. However, we were told that emergency trolley familiarisation had taken place at Condor and both sites had reviewed their emergency kit bag and resuscitation equipment during a

table top exercise. During this review the A/SMO quizzed the team and tested their knowledge on resuscitation. This led to identifying the need for connector tubes for i-gels. PCRF staff at Leuchars had attended a heat illness scenario training session led by the SMO.

CCTV was used to observe the main waiting area at Leuchars although there was a secondary area for patients awaiting audiometry that was not monitored. The reception/waiting area at Condor had recently been refurbished but there was a secondary waiting area (previously the area used for patients waiting for dental treatment) that had no monitoring. No risk assessment had been carried out.

Information to deliver safe care and treatment

Staff reported some concerns with IT outages. However, DMICP Leuchars and Condor had been partially combined which was causing significant difficulty for staff at Condor who had to access Leuchars DMICP for the appointment book (to leave and arrive patients) but then had to log back into Condor DMICP to do consultations. As a result, practitioners were having to write down patient details on paper. This constituted a Caldicott risk and also introduced an additional layer of risk due to possible human error. In the event of an outage, the business continuity plan was followed. Although the patient lists were not merged, clinic lists could be accessed from both sites and this would be used to support any DMICP outage. Unplanned power outages would be managed by reverting to emergency appointments and using packs of paper forms which would be uploaded to DMICP at a later point. If the outage was enduring, patients would be directed to another practice (Leuchars and Condor would be the first option if available) or telephone triage.

For the PCRF, there were separate continuity plans for Leuchars and Condor, neither of which had been reviewed recently, and the Leuchars plan did not mention the PCRF area which was in a separate building. The guidance within the plans was unclear as to what should happen during an outage. PCRF staff were unable to recall a recent outage but reported they would see patients as normal, keep paper notes, and enter these on DMICP at the earliest opportunity.

The summarisation of patient records was a significant issue at Leuchars. When combined with evidence from the safeguarding searches, there was a risk that patients had chronic conditions that were being missed/managed inappropriately. This presented a higher risk in civilian adults and children who had not previously been registered with a DPHC practice and whose notes had to come from the NHS. Although the practice was aware of this risk and had made some attempts to mitigate it, it was not clear to what extent this had been successful or if this risk was captured in the practice risk register. Across both sites, a total of 26% had not had a notes summary conducted in the preceding 5 years (this was higher at Leuchars with 31% of the patients having not had this done) and 4% of patients had no record of any notes summary having ever been done. A total of 488 patients had registered with the practice in the preceding 12 months. Of these, 42% did not have a new patient template recorded in their notes in the preceding 12 months (higher at Condor where the total was 49%). Of the newly registered patients, 46% had not had their notes summarised within 12 months of registering (higher at Leuchars where the total was 57%).

Notes from the NHS were delayed in reaching the practice for patients who were newly registered entitled family members.

At Condor, a nurse summarised patient notes on joining the practice to pick up any chronic diseases, mental health issues, significant past history and caring responsibilities. The process included a tidy up of patient notes and combining problems that had been recoded multiple times. Patients were then recalled for any outstanding appointments. However, there was a backlog of summarising.

Arrangements were in place for auditing the consultation records of doctors. This was done informally between 2 of the doctors who swapped sites each week (on a Thursday) and held a handover call at the end of each Thursday. Other opportunities for peer review were during the complex patient meetings. A peer review audit was done annually with doctors reviewing 10 sets of notes from a colleague using a template and then holding a debrief to discuss the findings. A copy of the audit was provided and included a good summary of findings. However, it did not include any evidence of peer review being carried out at Condor and 1 of the peer reviews had been carried out by a junior doctor which steps outside of the usual review arrangement as they may not have the experience to ensure that the notes were completed accurately.

There was no evidence of regular auditing of nurses or medics record keeping. There was no peer review between nursing staff at Condor and Leuchars, despite being ‘1 practice, 2 sites.’

The review of record keeping informed us that clinical supervision had been offered but not all staff believed that it would be of benefit (no further details were given). A schedule was in place for the physiotherapists to audit each other’s notes on an annual basis and to also audit the ERIs’ notes. The last notes audits seen were completed in September 2024 for physiotherapist’s notes, and October 2024 for ERI notes, all of which were at a good standard overall. The rehabilitation master template was completed on all sets of notes checked. PCRF staff used Read codes for presenting problems and this was evident on the notes checked but outcome measures when used were inputted by scanning rather than via the template. This meant that they were not Read coded, could not be searched and did not appear on the Defence statistics’ dashboard.

Processes were in place for sample management. Each site had 1 standalone NHS Tayside terminal which allowed them to access blood results and hospital letters. Practices in Scotland cannot receive results via Lablinks direct to DMICP so the NHS terminals allowed rapid access to results rather than waiting for paper results to be sent via post. Requests for tests were made by the clinician through DMICP. The SNO had implemented a sample register in April 2025 to record and track each request. However, this was not being maintained and, at both sites, there were examples found of results being missed.

At Condor, the practice nurse checked the register daily and printed out all results which were given to the doctor for review and action. We were told that the results were not transcribed onto DMICP as coded results because the doctor knew all the patients well and there was insufficient nurse capacity. This presented clinical risk due to ease of access to results and the potential to miss results that required action when having to trawl through a lot of scanned documents at times to find that results had been completed. A review of the patient records highlighted that the doctor had free texted results in and

occasionally coded them. We fed back that the reliance on an individual clinician at the practice knowing their patients and results presented a risk should the patient see another clinician at the practice or when moving to another medical centre (as frequently happens in the military).

At Leuchars, we were told that the nurses reviewed and coded the results on the standalone terminal but it was reported that they did not have enough nurses to do this daily (as it was time consuming) and therefore the urgent results were prioritised. The practice received postal results each day which were placed into the duty doctor's tray for review prior to scanning and tasking to the requesting doctor. We questioned the capacity for nurses to code results if unable to review them all due to time constraints. The practice indicated there was a risk of a transcription error for results if they were coded onto DMICP. We discussed that the benefits may outweigh the risks if no process (such as a double check of those entered onto the system) was in place. Coding of results also allowed for trend analysis to be conducted.

Hospital letters were received in the post but could be accessed via the stand alone portals for NHS Tayside if needed. This helped mitigate against not receiving timely letters from the NHS. There was no IT connectivity with NHS Fife and this had been flagged as a risk.

A well-coordinated system was in place for managing referrals, including urgent and 2-week-wait (2WW) referrals, which were managed primarily by the BSM at Leuchars (who had previously been hospital liaison) and a hospital liaison administrator at Condor using Scottish Care Information Gateway. The administration teams and clinical staff had a very good understanding of the IT connectivity issues DPHC faced in Scotland (highlighted on the risk register and through ASERs) when referring to the NHS and mitigated the risks appropriately. The DPHC referrals' tracker was being used to good effect to track patient referrals at both sites. Referrals to internal secondary care providers such as Department of Community Mental Health and Regional Occupational Health Team were also monitored.

The PCRF team managed their own referrals. There was no formal tracking of referrals to the Regional Rehabilitation Unit but staff used their administration task lists to regularly review their caseloads and discussed any cases that needed onwards referral at their multidisciplinary team meetings (held weekly).

Safe and appropriate use of medicines

The A/SMO was the lead for medicines management and the pharmacy technicians (PT) were responsible for the day-to-day operation of the dispensaries. However, this was not reflected within the terms of reference (TORS). The delegation of the responsibility was not apparent from the SMO's TORs. The SMO's TORs were out-of-date and reflected the TORs in the name of the current RCD signed by the former RCD who had left the service over 2 years ago.

Dispensary and controlled drugs (CDs, medicines with a potential for misuse) keys were stored securely although the cabinet did not comply with the 'Misuse of Drugs Act 1973 Safe Custody.' Effective measures, including the use of logs, were established and key

holders were nominated. The delegation for CDs from the Commanding Officer was to the SMO who had not been in work since January 2025. We highlighted that this needed to be changed to the A/SMO. The PTs were aware of requesting identification from persons collecting CDs on behalf of the patient. All CDs issued that we checked had been collected in person by the patient. Entries into the CD register were complete and matched the receipts on DMICP.

A doctor's 'grab' bag was kept at the Condor site to treat patients if there was an emergency on camp. The same principles needed to be applied as the emergency drugs (because additional emergency drugs were kept in the bag). We highlighted that the SMO must complete the risk assessment (as laid out in the DPHC SOP for emergency drugs) and have authorisation from the RCD.

Military prescriptions (Fmed 296) were appropriately managed and stored securely. Prescription stationary was monitored and records kept of serial numbers on delivery and also when distributed through the practice.

CDs and accountable drugs were very well managed practice-wide, including up-to-date account manager delegated authority forms. Access to these medicines was broadly in line with legislation. Checks were completed monthly in accordance with the DPHC SOP and the destruction of CDs was witnessed appropriately with the destruction certificates retained.

The pharmaceutical fridges in both locations were locked but with the key still in the lock, thus effectively open. Items at both sites were stored on the base of the fridge. All refrigerated items must be on shelves and not the base of the fridge nor touching the sides to ensure adequate airflow and maintaining a uniform temperature. A record of fridge cleaning dates was in place. Data loggers and external thermometers were calibrated and in-date. Temperatures were monitored as required and records showed all were in range. Medicines dispensed for a patient from an outsourced site from February 2025 was being stored in refrigerator but should have been discarded if not required. The treatment room refrigerator at Leuchars had an empty specimen carriage box stored within it. Specimens/samples must not be stored in the same refrigerator as pharmaceutical products. This was removed on the day.

At both Leuchars and Condor there were numerous items in the doctors' rooms, treatment rooms and in the dispensary that had expired (a considerable amount of expired medicines were found at Leuchars). Some had expired recently however there were items that had expired in December 2023 and June 2022. Expired equipment included personal protective equipment in every room, moisturiser in most rooms, swabs, wound dressings (some had expired in August 2021), blood bottles, cervical cytology brushes, pregnancy tests (expired in August 2024). There were no control checks noted for the glucose monitors at both locations. Staff explained that the meter was turned on and off for the check. However, control checks must be performed weekly and recorded.

One of the nurses had been signed off as a non-medical prescriber and the required authority was in place. Patient Group Directions (PGD) to administer medicines were used but the authorisation dates were not being monitored to ensure they were in-date. We scrutinised the records of the 2 nurses (out of 3 nurses checked) to find that none of the vaccinations (for which the PGDs had expired) had been administered since expiring.

Training was current for clinicians who used PGDs and annual vaccination and immunisation training had been completed. PGD stock was held in the dispensaries and it was in-date and labelled appropriately. Auditing of PGDs had taken place in September 2024 and no concerns were identified. However, the correct format for recording PGD audits was not being used. It was reported to us that PGDs had been signed in February 2025 by the SMO but were told that some staff named on the PGDs had not worked at the practice since December 2024.

Patient Specific Directions (PSD) were not used unless there was any doubt on the PGD training of staff. In such circumstances, a PSD was not required as the doctor prescribed for specific nurses and medics to administer. However, the nurses were administering from the electronic record and not from the signed Fmed296 prescription, which was not in accordance with DPHC policy.

Effective arrangements were in place for repeat prescription requests, including via email Repeat prescriptions were processed within 48 hours or sooner if workload permitted. However, arrangements to recall the patient if a medicines review was required needed strengthening. A search on DMICP showed a total of 223 patients were on repeat medicines. We checked 3 patients and all were overdue a medicines review.

There were multiple risks of potential harm in relation to how the practice managed patients on high risk medicines (HRM). These included: missing alerts, missing/incorrect codes, missing shared care agreements, patients not having the required monitoring, medicines being omitted from the prescribing screen risking drug interactions/inappropriate prescribing, patients not being offered appropriate vaccinations, and nationally recognised guidance on safe prescribing not being followed. There was variable evidence about the quality of medication reviews being undertaken and variable evidence that abnormal results were being acted on.

The practice conducted an audit of patients on HRM in May 2025. This audit showed that all patients who required it had a shared care agreement in place on DMICP and that all patients were in-date for monitoring and had a Read code and alert on their records. The audit recommended that patients who were no longer on a HRM were removed from the register. The audit included all patients on the HRM register but clinical searches carried out as part of the inspection highlighted that the register was not current and did not include all patients on an HRM.

Prescriptions were signed before dispensing and were issued with the patient information leaflet. In addition, the PTs held all the relevant medicine information and warning cards. Prescriptions awaiting collection were held securely and patients followed up when not collected. Patients who failed to collect their medicine within 3 days, such as antibiotics, were contacted by the PT and the matter highlighted to the prescribing clinician. A record was made on DMICP using the ‘not collected’ clinical code.

There was a local working practice (LWP) for handling external correspondence including privately obtained prescriptions and secondary health care medicines. Once scanned and recorded on DMICP, all documents were referred to the duty doctor. In some circumstances, hard copies were passed directly to the duty doctor for action prior to scanning. This was reflected in the LWP.

The pharmacy technicians were aware of the valproate and topiramate (medicine to treat epilepsy, migraine and bipolar disorder) search. However, the search which was on the DMICP shared searches had not been carried out. There was no evidence of previous searches. This needs to be carried out monthly due to the transient nature of the populations within DPHC medical centres. The search was completed on the day of inspection and this highlighted no patients were prescribed either of these medicines.

Track record on safety

The practice managers were the health and safety leads for their respective sites and the BSM was the deputy at Leuchars. Neither the practice manager nor the BSM had completed the required health and safety training nor any formal training around risk management. Building custodians were identified for both sites along with leads and deputies for fire safety and the environment, fire and health and safety (referred to as SHEF). When asked, the practice managers and BSM were unsure when the risk register and issues log were discussed formally but they were a standing agenda at the combined healthcare governance meetings. Health and safety policies were displayed at both sites. There was no record of attendance at the regular station safety meetings with the host unit at Leuchars. The Condor practice manager had a unit health and safety assessment in August 2025.

The practice had registers for both current and retired risks; similarly, there were current and retired issues logs although the 4Ts (transfer, tolerate, treat, terminate) approach was not being adopted fully. These registers were all held on the HcG workbook. The risk register was made up of 3 sites (EOSCMP, Leuchars and Condor) despite being a combined set up.

A review of the register highlighted that risk management required strengthening. For example, there was evidence within the workbook of a risk (lack of inter-connectivity with NHS Tayside and Fife on all available platforms) being escalated in February 2025 by a member of staff who had not been at work since January 2025. There were no updates within the log to confirm that the escalation had been accepted.

A range of 14 risk assessments (RAs) included lone working, general office, clinical and patient areas. These assessments were poorly constructed, mixed between generic and specific without clear direction. The RAs were all dated 6 May 2025 and completed by the practice manager at Leuchars for the combined sites without A/SMO's sign off. Specific RAs were required for both sites and had not been completed in line with DPHC policy and the Joint Service Publication (JSP). JSPs are the official sources of policy and guidance for the UK Armed Forces.

A list of control of substances hazardous to health (COSHH) items held within a register was not compliant with MOD policy and COSHH risk assessments dated 2016 were held on SharePoint without signatures or review dates.

Processes were in place for the regular monitoring of utilities and equipment at both Leuchars and Condor. Electrical safety checks were up-to-date. There was no mains gas at either site. Legionella risk assessments had been completed and the safety of water was regularly checked and recorded. Annual equipment checks (referred to as LEA) were

up-to-date and no issues had been highlighted. Electrical equipment testing was completed for Leuchars in March 2025 and for Condor in April 2024.

Up-to-date fire risk assessments for all buildings used by the practice were in place. Weekly and monthly checks of the fire alarm system and firefighting equipment were up-to-date. A fire service check and fire evacuation drills were carried out annually.

Wet bulb globe testing was carried out in the PCRF at Leuchars and by the unit at Condor to ensure the climatic environment was safe for physical training.

At Leuchars, there was no fixed alarm system in the practice but handheld alarms were available in some clinical rooms. These were checked periodically for audibility and staff response, although these checks were not documented. There were no alarms at Condor but we were told they had been ordered. The disabled toilets at both sites had an alarm system in place.

In the PCRF, staff reported that personal alarms (which were the solution to no emergency alarm system) could only be heard if there was someone else in the building and given the separate PCRF and gym at Leuchars, it was common for the physiotherapist or ERI to be the only clinician in the building. This was on the risk register, but the last update was in October 2024 and stated that RHQ rejected the lone working SOP/risk assessment as intolerable risk. PCRF staff at Condor did not have an alarm system and worked at the far end of the building away from other staff. This was not on the risk register and no action had been taken to mitigate.

Lessons learned and improvements made

The practice worked to the DPHC policy for reporting and managing significant events, incidents and near-misses, which were recorded on the ASER system (organisational-wide process for reporting significant events). Staff spoken with could demonstrate how to access the ASER portal but the staff database showed that only 45% were in-date with training. ASERs were a standing agenda item at healthcare governance meetings.

Feedback from staff on the ASER process was mixed and we were not reassured that a comprehensive practice-wide ASER log was in place that included the details of the team who undertook the root cause analysis (RCA) for each incident reported, lessons learned, details of the meeting where the ASER was discussed and a closure date. Some staff told us the RCA was done in an open transparent way; others said that they were not included in the process. We did see examples of when the ASER process was followed but also heard of examples when no ASER was raised or when an ASER had been closed inappropriately.

Staff we spoke with during the inspection provided numerous examples of ASERs. There was little evidence of discussion held and any changes made as a result although we were given an example of when the scanning process was changed as the result of an ASER. A second example we were given showed that the practice had raised a sentinel event (a serious incident that requires urgent investigation) following a break-in at Condor when medicines were stolen.

We were shown a register and given an example of a stool sample that had gone missing and told that an ASER had been raised. However, the register showed the missing sample was not annotated and the only comment was ‘seen for GP.’ We highlighted during the inspection that the register needs to be annotated with the correct details. This detail was also missing from the ASER log so it was clear processes were not streamlined or being followed.

A process was in place for managing notices from the Medicines and Healthcare products Regulatory Agency. Alerts were logged on a register and actioned in a timely way by the pharmacy technician. There was a link to the spreadsheet and pharmacy alerts were raised and discussed at clinical governance meetings. However, the latest National Patient Safety Alert (NPSA) had not been recorded as the email from RHQ had not been received. The pharmacy technician was aware of the NPSA for sodium valproate but the inbuilt DMICP (for valproate and topiramate, medicines used to treat epilepsy) search had not been carried out. We carried out the search on the day of inspection and no patients were prescribed either medicines.

Are services effective?

We rated the practice as inadequate for providing effective services.

Effective needs assessment, care and treatment

The acting Senior Medical Officer (A/SMO) communicated policy changes and updates from NHS Tayside to the wider practice team. We were shown an example of these updates having been received via email. In addition, developments in clinical care were issued to the team via the Defence Primary Healthcare (DPHC) updates. We could not see any evidence of clinical guidelines having been discussed at internal meetings.

Primary Care Rehabilitation Facility (PCRF) staff had access to the guidance on the Defence Learning Environment. Relevant departmental clinical updates were also shared and/or discussed at the PCRF weekly meeting. PCRF staff were aware of best practice guidelines from Defence as well as National Institute for Health and Care Excellence (NICE) guidelines where appropriate.

PCRF staff at Leuchars reported using strength measures rather than patient-reported outcome measures but had not done any evaluation to demonstrate how this approach measured performance. PCRF staff used the musculoskeletal health questionnaire (MSK-HQ) patient-reported outcome measure at the initial appointment, but this was scanned on by administration staff rather than being inputted via the rehab template, so it was hard to use for trend analysis (and was not repeated at other timepoints in their care) and was not Read-coded for statistical analysis.

It was evident from the clinical records we reviewed that Rehab Guru (software for rehabilitation exercise therapy) was predominantly used for rehabilitation exercise programmes. Physiotherapists accepted patients onto their caseload after the initial appointment had been booked and this provided them the opportunity to call and follow up on individuals who had yet to book their appointment. Caseloads were reviewed on a regular basis. There was a range of group classes including hydrotherapy, individual programmes, Pilates, and generic group training for those on fulltime rehabilitation. Space and equipment were adequate to facilitate best practice rehabilitation (excluding the situation with the un-serviced equipment).

Step 1 of the DPHC mental health pathway was delivered at the practice and patients with a mental health need were added to the vulnerable patients register if appropriate. With reference to the Department of Community Mental Health (DCMH) referral checklist, patients were referred who needed intervention beyond step 1. We reviewed the registers at both sites for patients with mental health needs using the single condition and depression registers. We reviewed a sample of 4 patients from the registers; 2 were being managed appropriately, 1 had no evidence of a mental health condition and 1 had not been managed appropriately. Although a referral had since been made, it was initially delayed and the standard operating procedure (SOP) for managing vulnerable patients had not been followed.

Monitoring care and treatment

Although leads were identified for long-term conditions (LTCs), the responses from staff when asked highlighted a lack of clarity on responsibilities. LTC searches were carried out in the practice monthly using DMICP chronic disease register searches. A doctor then reviewed the patients to determine if they needed to be recalled. It was unclear how recalls were undertaken for patients who needed it. We were told the nurse invited the patient in to see the nurse, then the doctor for their LTC review, but in the sample of notes reviewed, there was no evidence of invitations being sent. The A/SMO informed us that administration staff were tasked to ring the patient as the previous Senior Nursing Officer (SNO) had removed the ability to free text on invitations sent by text message. The nurse at Condor was not permitted to do any LTC clinics without a doctor in attendance but was not able to provide a reason why.

The practice last ran the DMICP shared searches for the LTC combined register in August 2025 prior to the inspection. There was no evidence that the practice had run the validation searches annually as laid down by the DPHC SOP. Therefore, patients who did not have the appropriate Read code for a chronic disease could be missed. Validation searches are recommended to ensure patients have the appropriate code and would therefore be picked up in the chronic disease register searches. As part of the inspection, we carried out a range of validated clinical searches on DMICP and reviewed a sample of patients to gain assurance that they were being well managed. Our findings were:

- There were discrepancies found between the chronic disease register searches and the validation searches. For example, the single condition register search showed 38 patients at Leuchars with a diagnosis of high blood pressure but the validation search showed there to be 44. A second example was patients with abnormal liver function tests at Leuchars. Twenty-four patients had the correct code and therefore showed up on the register searches whereas there were 42 patients on the validation search. Whilst not all of these patients would need a LTC code and monitoring, there was insufficient evidence the practice had reviewed the patients to determine if coding and monitoring was appropriate.
- Coding in the main was inconsistent and multiple codes used for the same condition caused a lack of clarity around diagnosis. This was compounded by diary dates that were often missing for conditions that required monitoring or present for those that no longer need monitoring or had been superseded.
- The lack of coding of blood results was shown to have led to patients not having been followed up/diagnosed appropriately. For example, a patient with a raised (pre-diabetes level) HbA1c (a blood test to show average sugar levels) had not had this followed up.
- Twenty-three patients were found on the register search as having diabetes. Although there were examples of some patients being well-managed, of the 8 we reviewed, recall dates for foot checks were not always in line with the DPHC SOP. One patient had 4 different Read codes applied (3 of which had been entered by the same doctor on the same day), 1 recently diagnosed patient had no mention of the need for a fasting blood sugar check after 6 weeks. We noted that the management of patients with diabetes at Condor was more robust than at Leuchars.

- We reviewed 3 patients diagnosed with high blood pressure and, although some recall diary dates and Read codes were missing, there was evidence of good quality, templated annual reviews.
- Patients with mental health needs were generally being supported extremely well. There was a notable exception where there was a perceived delay in making the Child and Adolescent Mental Health Services referral.

Weekly meetings were held within the PCRF to discuss ongoing care for patients on their caseload. A review of patient records was carried out for patients who had been under care for a period of 3 months without contact.

Data for audiometry assessments provided after the inspection showed that 84% of the patient population were in-date.

There was little evidence of audit being used to drive quality improvement although the Healthcare Governance (HcG) workbook contained an audit calendar with a range of audits planned each month and links to completed audits. Evidence was seen in the minutes of the HcG meeting from June 2025 that completed audits were discussed as part of a standing agenda as well as plans for those plus planned quality improvement projects (QIPs). The minutes did not mention key outcomes for the audits or plans for change where this was needed. The minutes of the August 2025 meeting stated audits were not discussed. There was 1 example of an audit on Type 2 diabetes in adults completed in March 2025. Although areas for change were discussed, it was unclear what action had been taken following the audit and no second cycle had yet been done (the audit did not state when this should be undertaken). However, it was reported that this audit had been repeated annually since 2017 and recommendations and notes made in regard to updated clinical guidelines.

Aside from infection prevention and control there was no evidence of recent nurse audits being completed at either site (on the audit diary, no nurse audits had been completed in 2024). Audits outstanding for completion included yellow fever, flu vaccine uptake, nurse peer review and bowel screening.

There was evidence of DPHC mandated audit activity for notes keeping, minor surgery, carers, consent/chaperone and high-risk medicines. The audits were generally of good quality with a range of appropriate topics being covered. However, it was not clear how the lessons identified/changes required had been implemented with the minutes of meetings lacking this detail. We were not provided with evidence of completed audit cycles and, although reference was made in some audits of previous findings, there was no direct comparison of results between the 2 cycles.

Effective staffing

The practice had implemented the DPHC mandated induction programme which included role specific elements that extended to the PCRF. There was an induction pack available but it had not been introduced until June 2025. The staff database indicated that all staff had completed an induction but only 2 completed ones were made available when copies were requested. In addition, the practice manager at Condor had not received any induction and the role-specific inductions held on SharePoint related to another military

medical centre in the region. We noted that 2 nurses had no evidence of any induction having been completed. Locum doctors would normally work from Leuchars with 1 of the Leuchars' doctors backfilling at Condor if required. This allowed mentorship for the locum if new to DPHC. A copy of the induction pack for doctors was provided and, although dated November 2022 (it was unclear if this had been reviewed since then), the content was appropriate. Terms of reference (TORs) had not been signed by nurses at either site. It was reported that in some cases, these had been provided but staff refused to sign. No reason was given.

There was no formal induction process for the non-DPHC ERIs working at Condor PCRF. The Band 6 physiotherapist at Condor had responsibility for the clinical management of the non-DPHC ERIs according to their TORs. However, the physiotherapists reported having raised this as inappropriate as they had no way of holding them accountable as they were not within their Chain of Command. There was no record of mandatory training for the non-DPHC ERIs on the practice database, so there was no oversight of whether or not they had completed this.

The practice managers and Business Support Manager (BSM) monitored the status of mandatory training. However, the database was not accurate and was not being maintained in accordance with DPHC policy and direction. Compliance with mandatory training was low with all staff including both practice managers out-of-date with training or having no record of training courses having ever been completed. Examples included infection prevention and control training where 46% (23 out of 50) of staff were recorded as in-date on the database but 19 of those were found to be out-of-date. Eighteen staff were out-of-date for heat injury prevention training, 55% were out-of-date with ASER training and 50% of staff were out-of-date for basic life support training. Although not mandated by DPHC, there was no record of sepsis awareness training. The practice manager and BSM at Leuchars stated that the governance workload and processing of paperwork impacted on the ability to complete mandatory training. This was evident by gaps within the database. Staff training had previously been managed and overseen by the Officer in Command (OC) physiotherapist but this responsibility had not been reallocated in the absence of the SMO and staff were unsure on who was currently responsible.

Staff had not completed the training in how to interact appropriately with people who have a learning disability and/or autism but had been invited to an NHS Education for Scotland seminar on 'exploring communication resources developed by the Learning Disability Drivers' in September 2025. There was little evidence provided of in-service training (IST). The practice managers required health and safety and risk training. The PCRF were an exception and held in-service training quarterly, regular peer review and spoke of positive development since the combining and being line managed and appraised by the OC PCRF. However, the non-DPHC ERIs had reported not completing any clinical development programme in the last 12 months (they were not in attendance at the time of inspection to ask for evidence, so this was reported by other PCRF staff).

Doctors were supported to stay current with specialist roles; for example, doctors who were Military Aviation Medical Examiners (referred to as MAME). Four junior doctors recently joined the team at Leuchars and 2 at Condor. Staff spoke of the considerable work involved in teaching and checking consultations but the doctors stated that they enjoyed providing training. They told us that the time taken with junior doctors reportedly

made it difficult for nurses to sit in with doctors for training. Not all clinicians received specific formal training on delivering paediatric care. However, both the SMO and the A/SMO had completed paediatric immediate life support training. This was above the mandated level of training in DPHC and was evidence that the practice had thought about the fact they look after children and need to be trained for this.

There was little evidence that the clinical lead had undertaken a review of whether personnel were suitably qualified and experienced. There were positive comments made on the SNO's recent review of this in the nursing department but there was also evidence that these efforts had been undermined. One member of staff who claimed to be the acting SNO was still on probation and had not long qualified so we shared concerns that assurances of clinical capability needed to be more robust. We were told how some competencies had been met by watching webinars or on-line courses that were not a recognised or affiliated qualification or a training course. A check of the database showed competencies (including safeguarding) had not been included.

The SNO had been reviewing the LTC process/register and had advised that one of the nurses should not be undertaking LTC reviews until competencies had been assessed and signed off. In the absence of the SNO, the nurse had been permitted by the doctors to undertake these reviews. We were not provided with evidence of a suitable framework to establish competencies and raised concerns to external stakeholders. A stop had been put in place by the SNO and all nurses were requested to show evidence of their training. A separate competencies training log was set up for the nurses. However, with the reported support of some of the doctors, members of the nursing team were resistant to this and deemed themselves competent. Again, we reported concerns with this to external stakeholders due to the risks associated with providing treatment and care without sufficient assurance that key nursing staff were suitably experienced and qualified.

The medics had been working to Patient Specific Directives prior to March 2025 and clinical oversight and direction was provided by the Regimental Medical Officer (RMO). It was not clear who was completing clinical oversight of the RMO. It was reported that a foundation medic on placement was removed from the facility as they should have been supervised in practice.

Coordinating care and treatment

A range of structures were in place to ensure the effective coordination of patients care. Patients with complex healthcare needs were discussed at the multi-disciplinary team (MDT) clinical meetings. In addition, weekly MDT meetings took place between the doctors, physiotherapists and ERIs. The PCRF held virtual meetings weekly with the Regional Rehabilitation Unit in Edinburgh to discuss cases so urgent patients could be highlighted and prioritised.

The practice had effective relationships with the station Commanding Officers and squadron/unit commanders so concerns about the health and wellbeing of patients were promptly addressed. Members of staff attended the Commanders Monthly Case Review (CMCR) meeting. The practice also had good links with internal Defence services including the DCMH, Regional Occupational Health Team and Regional Rehabilitation

Unit. PCRF staff attended CMCRs at Leuchars and reported having an active role in these. PCRF staff at Condor did not attend unit meetings at Condor at the request of the A/SMO.

The practice provided examples of extensive networking with the NHS including with:

- The Chief Medical Officer for Scotland.
- Links to local hospitals with Kirkcaldy and Ninewells both having MOD liaison officers.
- Local NHS teams had been invited to attend events on base to improve working relationships.
- GP lead for Angus/Tayside who had:
    - assisted the practice in getting NHS email addresses and access to the standalone systems for requesting bloods/ x-ray referrals electronically.
    - Produced a weekly newsletter for NHS Tayside which was shared with the practice and provided good visibility of local guidelines. The A/SMO summarised this and shared with the whole practice weekly. Copies were also sent to the RCD and Regional Pharmacist.
    - Advised of local continued professional development (CPD) opportunities which the doctors could access. For example, the doctors attended CPD on the maintenance and reliever therapy system for a specific inhaler. As a result they have moved their asthma patients onto the inhaler and written this up as a quality improvement project (QIP).
    - Links with community midwives whose clinics are hosted at Leuchars and therefore are available to speak with face-to-face if required.
    - Good links with health visitors with links to them via an ex-military practice manager who now worked in the NHS.
    - A QIP was undertaken by a nurse who had previously worked as a district nurse (DN) to improve liaison between the practice and the local DN team, particularly at Leuchars.
- Evidence was given of how the practice fostered relationships with the NHS to ensure patients are seen quickly, especially when needed for operational reasons. The NHS was viewed as being keen to help.

PCRF staff reported using physical trainer (PT) prescription chits for reconditioning and emailed PT staff to advise them that an individual had been discharged from rehabilitation.

DPHC guidance was followed for patients leaving the military including, pre-release and final medicals. During the pre-release phase, patients received a summary of their healthcare record and given information about registering with NHS primary care. A notes review highlighted that recording was of good quality and took into consideration ongoing care. The information available suggested that some but not all were provided with information about additional services. Furthermore, patients were advised about the Armed Forces Covenant, which is a guarantee that those who have served in the armed forces are treated with fairness and respect. An overview of the process for leaving the

service was displayed with a quick response or ‘QR’ code for patients to access more detailed information.

Helping patients to live healthier lives

The SNO was the named lead for health promotion. In their absence at Leuchars and due to reduced staffing levels, the health promotion calendar had not been followed in the past few months. The nurse at Condor managed health promotion and utilised the DPHC health promotion calendar and tailored it to the patient demographic. The health promotion board in Condor had been updated in August and was updated on a monthly basis. Funding had been utilised in 2025 to purchase breast and testicular cancer props for patients to practice feeling for lumps. There were various other health promotion displays and leaflets available, including information about the ‘My Health App’ and vaccinations. Resources for mental health wellbeing were displayed including a range of leaflets that covered topics such as mindfulness, stress and relaxation.

PCRF staff were involved in the unit health fair at Leuchars in 2025 and provided a stand looking at lifestyle factors that influence musculoskeletal injuries. They promoted resources and advice as the ERI had completed the Defence Health and Wellbeing Advisors course.

A Band 5 nurse at Leuchars provided advice and support for smoking cessation but it was not clear if they had qualified as a smoking cessation practitioner.

Processes were in place to ensure effective maternity care. Once pregnancy was confirmed, patients were referred to local community midwifery services who held clinics at Leuchars.

The SNO was the lead for sexual health and had undertaken the appropriate training (referred to as STIF). Although sexual health advice and screening for some sexual transmitted infections was provided, patients could self-refer or be referred to sexual health screening services at St Andrews Hospital, Fife. The nurse at Condor had sourced a QR code from public health Scotland which allowed patients to pick up free condoms and access sexual health advice.

The number of women who had a cervical smear in the last 3-5 years was 93%. In the absence of trained nurses, cytology was led by 1 of the doctors who ensured that when patients moved into Scotland from England, they were transferred onto the Scottish Cervical Call Recall System (SCCRS). This was done by sending a screen shot of the patient’s DMICP cytology record to the local Health Board. The SCCRS then generated a patient recall which arrived at the practice before being coded onto the clinical system and the patient was then sent a copy of the recall letter. The doctor coded the results once received and set the DMICP recall date. They also contacted the patient about results. Smears were carried out by 1 of the doctors. As the samples needed to go to Glasgow, they were passed to the local NHS practice for transport. The doctor conducted searches every 4-6 weeks to see who was due and also SCCRS had a list on line of patients due which could be seen when the doctor logged on. The doctor chased any non-responders.

At Leuchars, nursing staff we asked were unable to provide information on how patients were recalled for their NHS 40+ health screening. At Condor, a search was run every 4-6 months and patients recalled.

There was evidence that health screening data was collated by the BSM through searches to identify and recall patients eligible for the national screening programmes. Following the inspection, we were sent evidence that recall letters had been sent. However, the dates on those for breast screening were dated after our visit.

Although the Chain of Command and individual service personnel were responsible for keeping up-to-date with their occupational required vaccinations, military practices normally monitor the vaccination status and manage the patient recall. A review of the DMICP system highlighted that searches had not been run for 12 months. We requested information in advance, asked on the day and when not available, requested for them to be submitted in the days following the inspection but nothing was received. Therefore, we were unable to establish the vaccination statistics for eligible service personnel. Children were not routinely vaccinated in the practice; they were only vaccinated for travel purposes. The child vaccination programme was completed within the NHS. We encountered the same issue with obtaining the current status of childhood immunisations but were provided with the following data after the inspection:

The World Health Organisation targets a 95% vaccination rate for routine childhood immunisations.

The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e., three doses of DTaP/IPV/Hib/Hepatitis B) was 100%

The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e., received Pneumococcal booster) (PCV booster) was 100%

The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e., received Hib/MenC booster) was 87.5%

The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) was 100%

The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) was 92.3%.

Consent to care and treatment

The recording of implied and verbal consent was inconsistent. Of the 5 nurse's records at Leuchars we checked, only 2 had consent documented. All 5 had consent recorded for the nurse's notes at Condor. The DPHC mandatory audit was completed in February 2025 and showed that only 60% of patients had consent recorded when required. It was noted that this was mainly due to the incorrect use of templates where tick boxes for recording of consent had not always been used.

A minor surgery audit completed in August 2025 showed that:

- The minor surgery template was used for 7% of procedures (personal choice of the doctor who prefers free text narrative). However, there was evidence of contemporaneous clinical notes covering the same topics.
- Consent was shown to be present in the electronic notes 100% of the time (not necessarily coded but free texted or the consent form scanned on).
- The procedure was documented in the notes 100% of the time as was the type, batch number and expiry date of the local anaesthetic used.
- Histology samples were sent 100% of the time and all results were documented in the electronic notes (recorded, not necessarily coded).
- Complication rates were low.

Verbal consent was taken for acupuncture in line with DPHC guidelines.

Clinicians understood the Mental Capacity Act (2005) and how it would apply to the patient population. Nurses interviewed had a good understanding of Fraser/Gillick competence, including the nurse at Condor who had no contact with patients below the age of 18.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

As part of the inspection, we received feedback about the service from 31 (15 at Leuchars, 16 at Condor) patients via completed CQC feedback cards and we interviewed 8 patients in person. In addition, we considered the 36 responses from the patient experience questionnaire. The feedback from comment cards and discussion with patients was complimentary and staff were described as friendly, polite and willing to go the extra mile to help them.

Staff provided numerous examples of when the practice had shown kindness, respect and compassion to patients. Some of these examples included:

- A doctor had visited and provided treatment through home visits.
- The practice routinely used a service that provided essential transport supported for the armed forces community (including families of serving personnel) which ensured that veterans and their families could access vital medical care.
- The doctors worked with a patient who needed a cardiac treatment to get back to work to complete their final years of service. The doctor applied to the RAF Benevolent Fund to seek financial support for the patient. After much persistence, the doctor was able secure a grant. This allowed the patient to buy a house that was adapted to their needs post-transplant and live a comfortable life in retirement.

We met with the station Deputy Chief of Staff (DCOS) at Condor who spoke highly of the agile and flexible nature of the team to support the ability of patients to be held at extremely high readiness.

Involvement in decisions about care and treatment

Feedback indicated patients were involved with planning their care and this was confirmed by our review of patient records. The patient questionnaire responses rated the practice as good or excellent for giving clear information, treating you with kindness and compassion and respecting privacy and dignity.

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

The Senior Nursing Officer was the lead for patients with a caring responsibility who were identified through the new patient registration process, at the complex patients' meeting or opportunistically. DMICP searches to look for carers were last run at both sites in August 2025. There were differences in the searches at both sites with Leuchars' carers search only looking at military personnel which risked civilians and child carers being missed. At Condor, the carers search only looked for patients coded as carers in the last 5 years

which risked those who were long-term carers being missed. We compared the practice search results with the DMICP Shared Carers search which looked at all patients coded as carers. This showed 12 patients were carers at Leuchars compared to the practice's own search which showed 9 patients, the 3 missing were all civilian patients. At Condor, the search showed 8 patients compared to only 6 on the practice's own search.

We reviewed the patients identified as carers and the appropriate code was in place for each. Alerts were in place for 7 of the 10 patients. Only 3 had evidence that their care status had been reviewed and their needs considered and with no active recall for the flu vaccine was in place, only 1 had been given the flu vaccine in 2024/25 and opportunities were missed when the patients had attended in person.

Information about support for carers was displayed and outlined in the practice patient information leaflet. The practice was aware of a survey for Unpaid Carers to be shared with patients by Carers Scotland.

Privacy and dignity

Patient consultations took place in clinic rooms with the door closed. Privacy curtains were available in all clinical rooms for intimate examinations. Staff were clear on arrangements at reception for patients to talk to the receptionist discreetly. We discussed how these could be supported by clear signage. The reception area and waiting room at Leuchars were separated by a door and a television in the waiting area at Condor could be used to minimise risk of conversations being overheard.

There was a mix of male and female clinicians practice-wide should patients have a preference to see a clinician of a specific gender. The PCRF had a mix of male and female staff between the 2 sites. Women's health patients at Condor were offered the opportunity to see the female GP at Leuchars.

Are services responsive to people's needs?

We rated the practice as good for providing responsive services.

Responding to and meeting people's needs

We were given a wide-range of examples of when the practice had responded to both collective and individual needs of patients. Some of these examples included:

- The practice provided evidence of appropriate care and support being given to patients who had gender dysphoria (unease or dissatisfaction). Examples included facilitating treatment at other practices when the patient deployed, changing gender on DMICP as per policy, bridge prescribing (temporary hormone replacement therapy for a patient waiting to be seen at a specialist Gender Identity Clinic) of medication, ensuring the practice understood the issues the patients faced. There were gender neutral toilets in the practice.
- The practice supported a large geographical area in providing specialist aircrew medicals.
- Additional vaccination clinics were facilitated for service personnel deploying at short notice.

Access audits for the buildings used by the practice had been completed; Condor in May 2024 (now out-of-date as should be completed annually) and Leuchars in September 2024. No significant issues were identified. Accessible parking, ramp access with a dropped kerb and accessible toilet facilities were available at both medical centres. Wheelchairs were available should they be needed. The accessible toilet facilities at Leuchars included a baby changing table and nappy bin.

Timely access to care and treatment

Although different approaches were taken, staff reported that the access to appointments was good. Urgent queries were referred to the duty doctor. The e-Consult system was available but doctors had mixed views on it being the best use of their time. Home visits and telephone consultations were both offered as alternatives to attending in person. Home visits were provided although a request for such would be considered in line with the DPHC home visits policy. Out-of-hours arrangements were displayed on the front doors at both sites and in the patient information leaflet.

Requests for an urgent consultation could normally be accommodated by a doctor on the same day. Routine appointments with a doctor or nurse could be facilitated within 1-2 days. An appointment with the healthcare assistant at Leuchars was available within 1-2 days. Aviation and other medicals were facilitated through a routine appointment; 2 Military Aviation Medicine Examiner slots were protected each week at Leuchars.

Total triage (TT) had been implemented but subsequently stopped. We were given mixed reports as to the reasons why. Some staff stated that it was a waste of clinical time, others felt that it did not fit into the doctors' arrangements of working from home unless on duty.

An urgent appointment with a physiotherapist was available within 1 working day at Leuchars and 6 working days at Condor. However, staff at Condor reported that they would fit in any urgent requests and this was evidenced in a patient record we checked. A routine new patient appointment with a physiotherapist was 11 working days at Leuchars and 6 working days at Condor. Follow-up appointments could be accommodated within 11 days (the key performance indicator was 10 days) at Leuchars and 5 days at Condor. New and follow-up appointments with an exercise rehabilitation instructor were available within 7 days and 5 days respectively. There was a rolling programme with immediate availability for a rehabilitation class.

Patients could refer themselves directly to the Primary Care Rehabilitation Facility (PCRF) by speaking to the administration team in the medical centre. There had been no formal assessment to measure uptake and effectiveness but there was an average of 2-4 self-referrals each month at Leuchars. At Condor, the self-referral rates were 6-12 per month. Administration staff temporarily stopped self-referrals when the physiotherapists were on leave and booked a doctor's appointment instead to ensure there was no delay to a patient being seen by a clinician. The PCRF had a 'did not attend' standard operating procedure (SOP) which was in line with the Defence Primary Healthcare (DPHC) SOP, and they made efforts to contact all their patients when they failed to attend, giving them 10 working days to rebook.

Multidisciplinary Injury Assessment Clinic appointment wait times were less than 3 weeks on average so staff did not feel that there was any delay.

Listening and learning from concerns and complaints

The practice manager was the lead for complaints. Complaints about clinical care were referred to the Acting Senior Medical Officer.

Minutes showed that complaints and compliments were a standing agenda item at the practice's healthcare governance (HcG) meetings with links to the more detailed record held on a log sheet. Complaints and compliments were also a standing agenda item at the full practice meetings. The HcG workbook detailed a summary of the 4 compliments that had been received in the last 12 months. There had not been any complaints made during the corresponding time period. However, staff demonstrated the knowledge on how complaints were to be managed in accordance with DPHC policy.

Patients were made aware of the complaints process through the practice information leaflet and information about how to make a complaint was displayed in patient waiting areas. A complaints/compliments/suggestions form together with a post box was positioned close to the main entrance but out of sight from reception to allow feedback to be given confidentially. There was also a prominent DPHC poster with quick response or 'QR' codes to encourage patient feedback. As part of the patient experience survey, 69%

of patients said they knew how to make a complaint or provide feedback about the practices, 31% did not know how to do this.

Are services well-led?

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

Vision and strategy

A network was formed between Leuchars and Condor medical centres with full operational capability achieved in May 2025. The formal merging of the 2 practices was considered by senior staff to be more of a requirement from Defence Primary Healthcare (DPHC) than a response to a local need. The 2 practices had informal networking arrangements that were longstanding and the formal merge was considered by some to be more of an administrative burden than a positive development. The significant reason for this was that the patient lists could not be merged due to information technology limitations (the 2 practices were on different NHS spines because they were in different NHS Trusts) and therefore could not be viewed by single access. Staff had to log off from 1 practice and log onto the other when switching between patients. We observed staff experiencing delays when switching between systems and often writing down patient details that increased the risk of error and breaches of confidentiality.

The practice had their own mission statement defined as:

> "Our practice teams are central to our communities and aim to deliver the highest levels of safe and effective care to all our patients. We are open, honest and responsive to the needs of our units and families and endeavour to train new generations of clinicians to the highest of standards in this happy environment."

The practice had a different mission statement on their SharePoint page which was:

> "East of Scotland Combined Medical Practice will deliver safe, effective, and compassionate care to our patients, through a collaborative and accountable approach to healthcare governance. We strive to uphold the highest standards of clinical excellence, ethical conduct, and patient satisfaction while fostering a culture of continuous improvement and innovation."

Although we highlighted a significant number of areas that needed improvement, practice staff were patient focussed. However, most staff working at the combined practice did not describe an ethos which was delivering against the principles of their mission statement. They were unable to confirm that they worked in a 'happy environment' and there was limited evidence of 'a collaborative approach to healthcare governance'. We identified a significant requirement to address the concerns associated with high staff turnover, long periods of staff absence and clear divisions across the practice team. We fed back to external stakeholders that this was having a significant impact on staff members and raised a number of concerns about the welfare of certain individuals.

The practice had taken steps to address environmental sustainability. Recycling bins were available throughout both sites and they strived to be paperless practice as much as possible. Lights were switched off when not needed to conserve energy.

Leadership, capacity and capability

The gaps in management and interim measures in place to cover the gaps were having a clear impact on the practice. In particular; a lack of clear leadership, capacity constraints for those staff who were at work, confusion over lead roles, lack of governance and general lack of oversight over the daily running of the practice. Although staff were stepping in to cover the roles, this was not always appropriate and it was evident that some staff were taking on roles that they were not suitably qualified or experienced to carry out. This was most notable in the nursing department. All of the nurses we spoke with commented that they were struggling with the additional workload and responsibilities when covering gapped posts. Concerns had been raised by the Chain of Command due to the lack of military leadership. Of note, the leadership of the nursing team was an enduring problem and the arrangements we encountered led to concerns being raised to external stakeholders.

The absence of any contingency to cover lead roles was placing additional pressure on staff and leaving significant gaps in governance. One of the nursing team informed us that they had been line managed by 6 different managers in the last 16 months. Line management for nursing had been transferred to another Senior Nursing Officer in the region who was fulfilling the role remotely.

We explored the problems with staff retention in recent years and the reasons put forward were the resilience of staff posted into the roles and the lack of experience in a families practice. There was no clear plan to draw conclusions and fix the problem.

Both practice managers had been in post for less than 1 year and both were in their first practice manager roles. They had both undertaken the ‘Joint Practice Managers’ course at Lichfield. However, both were struggling to complete their healthcare governance (HcG) workbooks. Both were conscientious and well supported by the Business Support Manager but there was a lack of practice manager knowledge across both sites, and this was evident throughout the inspection.

The combined model did not appear to have served any purpose as networking between the practices had been a longstanding arrangement to provide resilience and peer support.

The acting leadership team described gaps in the support offered by the regional team and indicated they had a responsibility for many of the practice’s limitations. However, there was also evidence that the intervention of the regional team had been met with resistance. Some staff we spoke with alluded to untimely delays with email correspondence from the Regional Headquarters. The practice managers felt well supported by the Regional Warrant Officer. They spoke positively of the Area Manager who was the project lead for the new build at Leuchars.

The Primary Care Rehabilitation Facility (PCRF) team did not feel supported internally or by the regional team. Staff reported having no support with regards to the current situation of managing the non-DPHC exercise rehabilitation instructors and felt excluded from other discussions that may affect them. The PCRF reported raising their concerns about the recent integration of DMICP systems and felt their concerns were dismissed.

Culture

From patient feedback, we confirmed holistic and person-centred care was key to the principles of the practice. The team often went 'above and beyond' to support individual patients and squadrons/units. For example, at Condor, the medical centre was complimented by the Chain of Command for supporting the high readiness of service personnel.

Staff we spent time with presented mixed views on the culture within the practice. On the day of our inspection, we found a team facing significant issues in the workplace. Due to gaps in leadership skills and capacity, we saw no firm plan in place to secure the improvements that were urgently required. This included the need for cultural change, management of risks to staff, monitoring quality and safety and ensuring that staff had the necessary skills and qualifications, experience and competence to carry out or supervise activities.

A resistance to change culture had developed and seemingly widened with a strong resistance to the wider DPHC organisation. Senior staff appeared to be working in isolation and this was a clear contributing factor to the high turnover of military staff sent in to implement DPHC practice and policies. Examples included total triage, long-term condition management and safeguarding vulnerable patients.

Team morale was found to be mixed throughout the inspection. Some staff that included the 3 doctors reported good morale and that the practice was a lovely place to work but others had been impacted by the lack of continuity and commented on a discord between staff. There were multiple reports of a military-civilian divide. It was evident through discussion that there was a blame culture within the practice and regular references were made to individuals when talking through the problems and challenges. Reporting lines had become blurred due to decisions being questioned and there were multiple mentions of bullying and harassment. Although some staff spoke of a positive team culture, others spoke of a clear divide and told us made it difficult for certain individuals to have patient discussions between different clinicians. Of concern, we were told that some clinicians would go out of their way to discuss cases with individuals who they felt were more receptive.

Not all staff we spoke with were aware of the whistleblowing process nor the Freedom To Speak Up (FTSU) and options for civilians. Some staff were unsure where to find the relevant information. There was a Defence Medical Services poster on a noticeboard that included information for whistleblowing. However, it advised that issues should firstly be raised with the line manager or lead clinician. There was no signposting to speak with someone externally. There was a FTSU poster that included a link for signposting staff to SharePoint.

Processes to ensure compliance with the requirements of the Duty of Candour (DoC), were in place but required strengthening as part of an overall review of governance processes to ensure those affected received reasonable support, information and a verbal and written apology. DoC is a set of specific legal requirements that services must follow when things go wrong with care and treatment. A DoC register was maintained in the HcG workbook.

At Condor, outside picnic benches were funded which allowed for the team to socialise in the good weather and provided time to ‘get away from desks’. Internally, the building was undergoing further improvements; sofas were procured for the breakout room and painting was due to commence shortly.

We did find that efforts had been made to promote a positive working environment and team culture. The practice manager at Condor has personally bought administration staff flowers as a thank you. The business support manager had applied and received awards for the 2 of the administration staff based at Condor. The practice manager at Condor had introduced ‘’Butty Fridays’’ which included DPHC staff and the Pre-Hospital Treatment Team to improve team cohesion within the Condor site.

Governance arrangements

There was a resistance to engage with the wider organisation and therefore to benefit from the organisational wider governance framework. Many of the issues we identified were as a result of a lack of governance and a lack of assurance. It was reported by a number of staff that the doctors within the practice had refused to engage with some elements of the DPHC HcG which made engagement across the practice difficult.

In the absence of an SMO and SNO, the practice lacked a clear reporting structure in which staff were aware of their own roles and responsibilities as well as those of colleagues. Although there were delegated leads and secondary roles in specific topic areas, in practice, there were gaps which were not always being managed. Terms of reference (TORs) for staff were not in-date and senior staff felt that it was the responsibility of RHQ to complete these in the absence of senior leadership. For example, the acting SMO’s (A/SMO) TORs had not been reviewed since they took up the A/SMO position.

Formal and informal communication channels were established and a meeting structure was in place. The meeting schedule was detailed in the HcG Workbook with direction and minutes recorded on SharePoint. There was a combined HcG meeting held each month at Leuchars, usually attended by most staff. Staff at Condor joined online. Minutes were sent out to staff after the meeting. The minutes from March 2025 and August 2025 were brief with no discussions of ASERs, policies and Central Alerting System alerts. The minutes from the June meeting chaired by the SNO were more detailed. There was also a significant gap in HcG minutes held within SharePoint from December 2024 to March 2025 in the absence of an SNO.

The practice managers and BSM agreed that the healthcare assurance framework (HAF, an internal system, used by the practice as a development tool and to monitor performance) could be improved but there was resistance to the HcG within the practice. The data stored on SharePoint was reported as being confusing for some staff who said that it hindered their ability to demonstrate and find information. The management team had indicated that the HAF was being well managed by the SNO until their absence.

There was evidence of quality improvement activity and audit but there was scope for further development of a structured programme. The practice managers and BSM explained that this would be discussed at HcG Meetings. Although on the agenda, there was no record of discussion in the minutes of the meeting in August 2025. The minutes

from June 2025 did include discussion from the SNO around audit and quality improvement projects (QIPs).

Managing risks, issues and performance

Risks identified for the practice were logged on the combined risk register and kept under scrutiny through review at practice meetings. However, the practice managers and BSM openly admitted that they required training and guidance within this area. On scrutiny of the risk register and issues log within the HcG workbook, it was found that risks were not always being identified or effectively managed.

We noted that the issues log had no mention of workforce shortages and gapped posts caused by high sickness absence rates. A number of staff we spoke with viewed lack of leadership and experience as the biggest risk. Workforce was mentioned as a risk by the acting SMO but this was specifically around the potential to lose funding for an administrative post at Condor.

Processes to monitor national and local safety alerts and incidents required strengthening. Risk management was included as part of the induction but the Induction package highlighted Defence Unified Reporting and Lessons System (DURALS) which was replaced by MySafety in June 2024.

The main concern identified in the PCRF was the performance of one of the non-DPHC ERIs and issues had been identified across a number of areas, the Regional Trade Specialist Advisor from the RRU was contacted and visited the practice but there was no evidence of any action plan or feedback.

Medics were responsible for the signing of all medical equipment checks (FMED 373s) within the practice. FMED 373 checks should be undertaken by the user as per the DPHC Equipment Care Directive but when asked, we were told that some doctors had refused.

The business continuity plans (BCPs) required updating and merging into a combined document. Both facilities had BCPs. However, they were both out-of-date for review. Leuchars was last updated in November 2022 with a review date of November 2024, Condor had no review date but had last been amended in September 2020 and references to 2012 were found within the document. Not all staff were familiar with the documents, for example, the SNO was not aware of any BCP. The Leuchars BCP did not mention the PCRF which was in a separate building.

It was evident that processes for managing staff performance were resulting in issues and a divide in the workforce. We fed back evidence to external stakeholders and raised concerns around the potential impact on individuals. Staff spoke of their concern that when people were performance managed they would take sick leave and leave gaps in the practice.

Appropriate and accurate information

Accessible to all staff, the practice used the HcG workbook to manage and monitor governance activity. The HcG workbook contained tabs to cover the primary areas such as significant events, audit, risk, SOPs, Caldicott and duty of candour. However, most SOPs were work in progress, the risk register was not being managed in accordance with Defence policy. Staff spoke of their 'struggles' trying to manage the HcG workbook and highlighted the significant gaps of not having an SMO or SNO as the main reason. It was reported by a number of staff that the SNO had made good progress but had subsequently encountered barriers.

The combined practice Internal Assurance Review (IAR) was undertaken in November 2024 and there was a delay in the report being produced (not issued until May 2025). The practice was rated as 'limited assurance'. The main actions were regarding progress towards combining SOPs and achieving full operational capability which we were told had now been achieved. The combined practice was still developing and was now in the SUSTAIN phase (part of the DPHC Combining SOP) which was due for completion by November 2025. However, findings during this inspection did not support the view that this was a truly combined practice. We also noted that key recommendations around supervision, support, integration of the nursing teams and leadership were outstanding.

Arrangements at the practice were in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. However, there was a potential breach of medical confidentiality with the annual leave of a high ranking individual reportedly being added to DMICP.

Engagement with patients, the public, staff and external partners

Various options were available to prompt patients to provide feedback on the service, including the DPHC patient experience questionnaire. Complaints and compliment forms were available for patients to complete and submit. Suggestion boxes were prominent in the waiting rooms.

Condor and Leuchars undertook different methodologies for gaining patient feedback for the IAR. Condor utilised a paper questionnaire as they said their patients did not like QR codes. Comments made were complimentary about the front of house experience.

Leuchars had positive feedback and even though there was an NHS practice in the Leuchars village, staff told us that families registered with Leuchars deliberately as the access was faster than in the NHS.

We reviewed the DPHC wide patient survey. In 2025, 32 patients had completed the survey (31 Leuchars, 1 Condor); 94% of patients were satisfied with their healthcare (compared to 93% for the whole of DPHC) and 94% of patients were able to access healthcare easily (compared to 95% for the whole of DPHC). Whilst there were lots of positive comments, some patients were unhappy with some aspects of the service in

contrast to what was reported by the practice on the day of inspection. Comments included:

- A desire for the dispensary to be open from 08:30 hours to allow the patients who have an early appointment to get their prescription.
- Practice was not offering triage

No specific recent examples of changes made as a result of patient feedback were given as no adverse comments were reported as having been made. A 'you said, we did' board was displayed but this appeared outdated with response mentioning a new build planned to start in June 2023.

The practice worked closely with the Chain of Command, welfare support services and other defence services to ensure a collective approach with meeting the needs of the service personnel population.

Staff could provide feedback through the practice meetings and regular staff surveys. However, a number of staff told us that they did not feel comfortable in speaking up and that responses from some staff members were more dictatorial than supportive. A recent staff survey had been arranged by RHQ. Staff spoke of a clear disconnect within elements of the practice although not all felt impacted. Some staff felt listened to, others felt dismissed when they had tried to raise concerns and did not feel they had support from within the practice or the region.

The BSM and administration teams at both sites were experienced and aware of the healthcare needs of their respective patients, alongside the limitations or issues that could arise when communicating with two separate NHS Boards (Fife and Tayside). The teams mitigated issues wherever possible and had good communication and networking with healthcare providers (NHS Fife/Tayside HSCP) to help ensure that patients were seen within the relevant timeframes.

Continuous improvement and innovation

There was evidence of innovative practice raised as QIPs, we identified additional good practice initiatives which had the potential to be raised in addition to the examples that included:

- The introduction of a recovery troop at Leuchars which mimicked the Harden troop structure at Condor (Harden troop is a Royal Marines-wide construct that allows patients who need rehabilitation to be moved out of their usual company into a specific troop that has a divisional officer and which is dedicated to rehabilitation).
- A review of the emergency kit for attending emergencies outside the medical centre.
    - The previous practice manager took the view that they were only to provide care in the medical centre and cut back on the kit the medical centre held (in line with DPHC policy states that there is no requirement for DPHC facilities to maintain duty staff solely for the purposes of responding to emergencies outside the medical centre).

  - Subsequently a contractor fell off a kerb hurting his back. The General Duties Medical Officer responded to this event and did not know that kit was available in the treatment room as it was not in a mobile bag for taking to emergencies.
  - This led to a review of the equipment the practice held for emergencies and also made sure that there was resuscitation room kit and also a grabbable bag for trauma kit and a doctor's drug bag (although these should be risk assessed and signed off by the Regional Clinical Director).
- The nurse at Condor had submitted 5 QIPS on improvements made with infrastructure, IPC standards, cold chain management, display screen equipment and the resuscitation trolley.
- The physiotherapist at Leuchars was undertaking a project to improve the efficacy of the patient injury management clinics (discussion clinics between doctors and physiotherapists) by auditing the notes taken from these discussions and the subsequent clinical action plan and its implementation. This project was in its implementation stage of the recommendations with a plan to reaudit in the next couple of months. The audit identified that there were some delays to care when an action plan was not followed up in a timely fashion, so a recommendation was made to assign named clinicians to follow-up the plan and timeframes for review.
- The physiotherapist at Condor was collecting injury data from a Commando exercise to look at trends and had discussed the potential for injury reduction with the unit. Although at an early stage, this had the potential to be a significant project.

Discussion of QIPs formed part of the standing agenda for the HcG meeting.