Brawdy Medical Centre

Cawdor Barracks, Brawdy, Haverfordwest, Pembrokeshire, SA62 6NN

Defence Medical Services inspection report

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

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

Contents

Summary

About this inspection

We previously carried out an announced comprehensive inspection of Brawdy Medical Centre on 5 September 2024. We rated the service as requires improvement overall with a rating of requires improvement for the safe, effective and well-led key questions. The caring and responsive key questions were rated as good.

A copy of the previous inspection report can be found at:

www.cqc.org.uk/dms

We carried out this announced comprehensive follow up inspection on 9 November 2025. The report covers our findings in relation to the recommendations made and any additional improvements made since our last inspection.

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

Are services safe? – good

Are services effective? – good

Are services caring – good

Are services responsive to people's needs? – outstanding

Are services well-led? – good

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

This inspection is 1 of a programme of inspections 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 timely access to the service and were involved in decisions about their treatment and care. The practice pro-actively responded to patient feedback and made improvements to the service as a result.

- Extensive safeguards were in place, including close working with the units, welfare team, community services and the local safeguarding team to support vulnerable patients.
- Staff indicated strong leadership, good communication and a willingness to improve meant the team worked collaboratively to ensure patients received safe and effective care.
- There was an open and transparent approach to safety. A comprehensive process was in place for managing significant events.
- The arrangements for managing medicines minimised risks to patient safety.
- Healthcare governance processes had been effectively developed in the last 12 months and were routinely used to monitor service performance.
- Staff consistently sought ways to develop and improve. Quality improvement activity was embedded in practice and was used to drive improvements in patient care.

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

- The Senior Medical Officer (SMO) responded to a theme of patients presenting with foot problems and lower limb injury, which was impacting deployability. As there was an indication these issues may relate to ill-fitting boots, the SMO procured a Brannock Foot Measuring Device. This device was available in the waiting room for patients to check their foot size. Since its introduction, the SMO confirmed there had been a marked decrease in patients presenting with foot problems. Furthermore, patients provided positive feedback about the device as it has ensured they order the correct sized boots. This initiative had been raised as a good practice ‘purple’ ASER.
- As the defence system is not linked with Welsh NHS online services, the routine bowel screening test; NHS home test kit (referred to as FIT) has not been available to the practice. The nurses made contact made with the NHS FIT testing team and obtained an electronic referral form and email address to submit bowel screening referrals for actioning. A local working practice policy was developed to support this process. As a result of this initiative, the time it has taken for the patient to receive a test kit has been considerably reduced. This initiative was identified as a quality improvement project (QIP).
- In accordance with recently released guidance regarding cold-water immersion to rapidly cool a patient with heat stroke, the SMO procured an inflatable dingy (in the absence of a fixed bath or immersion kit). The dingy remained inflated and was held in the accessible toilet/shower room. If a patient presented with a heat injury then they could be promptly immersed in cold water. The practice does not have responsibility for pre-hospital care management, but given the remote nature of the unit, including the risk of a delayed 999 response, this temporary solution is both appropriate and innovative to ensure rapid treatment of a patient with a heat injury.

The Chief Inspector recommends to the practice:

Review the duty of candour register to ensure all duty of candour incidents are captured.

Professor Bola Owolabi

Chief Inspector of Primary and Community Services

Our inspection team

The inspection team was led by a CQC inspector supported by a team of specialist advisors including a physiotherapist, practice manager, primary care doctor, nurse and pharmacist.

Background to Brawdy Medical Centre

Rurally located and a short distance from the village of Brawdy, the medical centre provides a routine primary care, occupational health and rehabilitation service to a military service population of approximately 458 who are subject to operational deployment at short notice. The practice also provides occupational health support only to a large number of reservists living in the local area.

A primary care rehabilitation facility (PCRF) is located within the medical centre and provides a physiotherapy service. As there is no dispensary at the practice, prescriptions are dispensed from a local pharmacy.

The medical centre is open from 08:00 to 17:00 hours Monday to Thursday. Medical cover is provided on Friday through the General Practice Remote Support (referred to as GPRS) South Wales Group Network. From 18:30 hours midweek, during the weekends and public holidays patients can access NHS 111.

The staff team

Doctors	Senior Medical Officer
Nurses	Military nurse Civilian nurse
Practice management and administration	Practice manager Practice administrator
PCRF	Physiotherapist
Combat Medical Technicians (medics)*	Two (unit assets)

*In the army, 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 centre.

Are services safe?

We rated the practice as good for providing safe services.

Following our last inspection, we rated the practice as requires improvement for providing safe services as we found shortfalls with:

- pre-employment checks for locum staff
- infection prevention and control (IPC) staff training
- management of Primary Care Rehabilitation Facility (PCRF) referrals
- health and safety processes
- risk management
- equipment care
- reporting of significant events.

At this inspection the recommendations we made had been actioned.

Safety systems and processes

The Senior Medical Officer (SMO) was the safeguarding lead and a practice nurse deputised. Records showed all staff were in-date for safeguarding training at a level relevant to their role. Reviewed in January 2025, the safeguarding policy for adults and children included contact details for the local safeguarding teams. In addition, staff had access to the organisational 'Safeguarding Children, Young People and Vulnerable Adults' standard operating procedure (SOP), which included links, email addresses and contact details for the welfare team based on the camp, and local and regional external safeguarding agencies.

Vulnerable patients (VP) had a recognised clinical code and alert applied to their DMICP record (electronic patient record system). The code was used to run DMICP searches in order to monitor the number of vulnerable patients and to update the practice VP register. The searches ran in October 2025 indicated there were no patients under the age of 18 or care leavers registered at the practice.

As there was a discrepancy between the VP search used by the practice and our search, we checked this with the Regional Quality Assurance lead who originally set up the search. They explained that a 'core' VP search was undertaken each month along with a wider 'potentially vulnerable' search, which looked for anyone with other coding that may have been added incorrectly. The wider search took account of stress at home, anxiety with depression, suicidal ideation, alcohol misuse, sexual abuse and drug dependency. By identifying patients with issues who were not specifically coded as vulnerable went beyond the requirements of policy.

A VP register was held in the restricted clinical area of electronic record system and only clinical staff and the practice manager had access. All VP were reviewed by the clinical team each month at the chronic disease clinic and their clinical record updated at the time of the meeting. The SMO attended the Commanders Monthly Care Review meeting at which the care of VP was discussed. They also attended ad hoc meetings with the Chain of Command and welfare team if there were specific concerns about a VP.

The SMO described excellent support from the unit welfare team who had a dedicated room in the medical centre to see vulnerable patients. To reduce the stigma of access, they could also see patients in Haverfordwest, approximately a 20 minute drive away. We were given an example of how a safeguarding concern had been managed, which involved extensive engagement including with the welfare team and safeguarding team.

The availability of a chaperone was outlined in the practice information leaflet and displayed in the patient waiting area along with a list of staff who were trained chaperones. Staff acting as chaperones had completed the necessary training. A chaperone audit was completed in March 2025.

Although the full range of recruitment records for permanent staff was held centrally, the practice manager demonstrated that relevant safety checks had taken place at the point of recruitment, including a Disclosure and Barring Service (DBS) check to ensure staff were suitable to work with vulnerable adults and young people. The status of DBS checks were regularly monitored by the practice manager and were renewed in accordance with Defence Primary Healthcare (DPHC) policy. The vaccination status for staff members was checked on induction. The professional registration for clinical staff was checked 6 monthly.

The lead and deputy lead for IPC were held by the practice nurses. All staff were in-date for the DPHC mandated annual IPC training. A range of IPC audits had been undertaken throughout 2025. The findings and actions were discussed at the regularly held audit meetings. Actions identified had been added to the Health Assessment Framework management action plan.

Measures were taken to minimise the spread of infectious diseases. The outbreak management plan was reviewed in July 2025. All treatment rooms were equipped with handwashing facilities and appropriate sanitising products to support effective hand hygiene practice. If a patient telephoned for an appointment and was suspected as having an infectious disease, they were triaged by telephone. A separate entrance and ‘hot area’ were used to assess the patient. Sufficient personal protective equipment was available for staff to use. A register was maintained indicating when the disposable privacy curtains in clinical rooms were changed; last changed in June 2025. The next scheduled change was in December 2025.

The practice manager oversaw the environmental cleaning contract. Although the cleaning contract was held by the unit, a meeting could be requested with the contract holder if required. A cleaning register was maintained, which documented the standard of cleaning on a monthly basis to ensure consistent hygiene practices. The most recent deep clean was completed in August 2025.

A lead and deputy were identified to oversee clinical waste. The records we reviewed showed a waste log was maintained and consignment notes were up-to-date. The last pre-acceptance healthcare waste audit was undertaken in August 2025. The practice manager planned to complete an audit to ensure the consignment notes correlated with the waste log. Secure storage for clinical waste was located outside of the building. Sharps boxes were labelled, dated, used and disposed of appropriately.

Risks to patients

Although fully staffed at the time of inspection, there was limited staffing resilience particularly if a member of staff left the service or was absent from the practice. The SMO was the only doctor at the practice. If they were absent from the service, the General Practice Remote Support (referred to as GPRS throughout the report) South Wales Group Network provided cover. The option of employing a locum doctor was limited due to the short period of employment and remoteness of the location. A weekly meeting was held with practices in the group network to ensure they all had sufficient medical cover, particularly Brawdy Medical Centre given its geographic isolation.

The locum physiotherapist had been appointed as a full time member of staff since the last inspection. Although not scaled for an exercise rehabilitation instructor (ERI), the team indicated that the addition of an ERI would be advantageous. The high tempo of physical training meant an increase in injuries and the consequent downgrading of service personnel. Because of a surge in musculoskeletal injuries, the practice borrowed an ERI during the summer. If the physiotherapist was absent from the service then locum cover was sought. Patients could also access the PCRF at either St Athan or Brecon if needed.

One of the practice nurses was military and the post was a non-deployable role. All other staff were DPHC employed aside from the 2 medics who were assets of the 14 Signal Regiment. Their primary role was to provide medic duties and to cover exercises for the regiment. When not required in their primary role, they worked at the practice. The medics maintained a rota of their activity with the regiment, including a forecast of events and their annual leave, which enabled the practice manager to monitor their availability for the practice workforce. Whilst the medics contributed to the operation of the practice, their input at the practice was not guaranteed given their primary commitment to the regiment, meaning they could be recalled by the regiment at any stage.

Since the last inspection, the practice manager was based at the practice full time. They and the administrator managed their annual leave to ensure administrative cover.

The nurse with the lead for resuscitation was trained in Advanced Life Support and carried out the routine checking of the medical emergency kit and emergency medicines. The other nurse deputised. The trolley was secured with a serialised tag and a log was completed when the trolley was accessed. The ambient temperature was checked in accordance with the DPHC SOP for temperature monitoring. Our review of the monitoring records showed checks of the kit, gases and medicines were up-to-date. The oxygen cylinder was full and in-date. A blood glucose monitor was held on the trolley along with in-date control test solutions. The emergency medicines risk assessment had been completed in line with policy.

The staff team was up-to-date with Basic Life Support (BLS) training, anaphylaxis and the use of an automated external defibrillator. BLS training was facilitated in October 2025. Moulage or scenario-based training formed a core part of the in-service training programme. Moulage topics this year included cardiac arrest, tropical disease, sepsis and climatic injuries. The moulage held in October 2025 was a structured training session focused on intravenous procedures. The session utilised a dedicated 'training arm' to allow staff to practice and refine their cannula insertion techniques in a controlled and supportive environment. The team also engaged in a series of moulage scenarios designed to simulate real-life clinical situations. These scenarios aimed to enhance clinical decision-making, teamwork, and response to emergency situations through realistic role-play and visual effects.

A whole-team approach was taken with ensuring awareness and recognition of the deteriorating patient/sepsis. Facilitated by the SMO, a sepsis moulage session was held in January 2025 to ensure staff understood the action to take if a patient presented with symptoms of sepsis. Staff had completed both heat injury training and non-freeze cold injury training.

Whilst undertaking a moulage for sepsis, staff identified there was a delay with preparing antibiotics as they needed to read how to reconstitute the medicine (process of adding liquid to powder/crystals). This resulted in the printing and laminating of the antibiotic reconstitution details for quick reference. A further sepsis moulage in August 2025 confirmed it took less time to administer the antibiotic therefore the likelihood of improving the patient outcome. This initiative had been identified as a quality improvement project.

The administrator was the first aider for the practice and had completed the relevant training for this role. Evidence was in place to confirm the first aid kit was checked each month.

Information to deliver safe care and treatment

Challenges associated with the age of the DMICP system were captured on the risk register, including slow response times, regular system outages and limited compatibility with newer technologies. These issues impacted DPHC services widely and were a risk to clinical efficiency, data integrity and timely patient care. When unplanned outages occurred, the practice deferred to the business continuity plan (BCP). In preparation for loss of connectivity, the clinic list was printed for the next day and clinical staff made paper notes which were added to DMICP when the system was back online. The BCP provided guidance to ensure continuity of care by leaning into the GPRS network for support and implementing a paper-based system temporarily.

When new patients registered at the practice their records were summarised by the nurses. In addition, the SMO took available opportunities, such as when new patients registered and when undertaking occupational medical gradings (standard of fitness), to summarise and tidy the DMICP front page of the patients record. This was evident through our review of clinical records. Summarisation was fully up-to-date in line with DPHC policy.

Arrangements were in place for the annual auditing of clinical record keeping. The 2 nurses audited each other's records with the input of the Regional Nurse Advisor if needed. The nurses also audited the medics' clinical records. The SMO's records were audited by an external doctor, usually a doctor from the South Wales Group Network who did not routinely provide clinical cover at the practice. The Band 7 physiotherapist at St Athan PCRF audited the physiotherapist's records.

At the previous inspection, the medics described well-structured support following the daily triage of patients with minor illnesses, which we highlighted as notable practice. This level of support for the medics had continued. In the absence of a Regimental Medical Officer (usually the facilitator of supervision for the clinical work of medics), the SMO was providing ongoing support. Following the triage clinic, the medics presented each case to the SMO who encouraged them to critically appraise the course of action they took and consider whether alternative approaches could have been taken. The patient records were reviewed by the SMO as part of this process. Medics said the nurses were also available for support. The medics were aware of their clinical limitations and referred to the SMO or nurses if they believed they were triaging a patient outside of their scope of practice.

An SOP was in place for the management of samples and the nurses oversaw the process. A specimen tracker was maintained and used to monitor the status of each sample. Military transport was used to take the samples to the laboratory. The SMO or network duty doctor in their absence checked Path Links each day for results. The SMO also checked the tracker each week to follow up on test results not received. Patients were contacted by their preferred method to inform them of their results.

An effective process was in place for managing referrals including urgent 2-week-wait referrals and internal referrals. The practice used the DPHC centralised process for referral management, which provided a variety of functions to support the monitoring of referrals, including an alert to prompt follow-up on a referral. The administrator oversaw and monitored the progress of referrals. Since the last inspection, referrals made by the physiotherapist were monitored through this process.

On receipt of a task from the SMO, the administrator added the referral to the system. In the absence of a system, such as the English NHS e-referral Service (known as e-RS), additional processes were in place to ensure the referral had been received and was being processed. The SMO highlighted that poor IT interoperability with NHS systems could sometimes mean cross-border referrals to England were a challenge and could result in lengthy waits for secondary care.

Safe and appropriate use of medicines

One of the nurses was the lead for medicines management and the SMO was the deputy lead. Terms of reference were in place for these lead roles and staff were aware of their roles and responsibilities in relation to the management of medicines. As there was no dispensing pharmacy attached to the practice, prescriptions were dispensed from a 'local agreement pharmacy'. Prescriptions were written, signed, scanned and emailed to the pharmacy. The original prescription was then posted to the pharmacy. No dispensed medicines were held at the practice for patient collection.

FMed 296 forms (standard military prescriptions) were recorded in a bound book and stored securely in the locked dispensary room. All boxes of FMed 296s were accounted for in the log. Robust processes were in place for the issuing of prescriptions, which were issued by serial number.

All vaccines were in-date and evidence was in place to confirm they were correctly rotated in the pharmaceutical fridge. There was sufficient space around the vaccine packages for air to circulate. No food or specimens were held in the pharmacy fridges. Evidence was seen of twice daily monitoring of the fridge temperatures and the external thermometers were in date. Stock was accounted for on DMICP.

Patient Group Directions (PGD) were used by the nurses. Evidence was in place to confirm the nurses were in-date for PGD training and they demonstrated how to access to the published Defence Medical Services PGDs. Authorisation to use PGDs was completed in line with policy. A spot check of DMICP consultations confirmed that the PGD template was routinely used. Our spot check of the PGD over-labelled medicines showed all medicines were in-date and correctly accounted for on DMICP. Patient Specific Directions were not used and there were no non-medical prescribers working at the practice. A PGD audit was undertaken in June 2025.

An SOP was in place for access to keys and the cabinet for controlled drugs (medicines with a potential for misuse) and accountable drugs (AD). The controlled drugs (CD) keys were kept separate from the dispensary keys. As a non-dispensing practice, a minimal stock of CD/AD drugs were held. Our spot check of physical stock and documentation in the BMed 12 (register for CDs) showed no errors in the accounting of these medicines. Internal and external checks had been completed in accordance with policy. Destruction certificates were in place and appropriately signed, witnessed and stored. The regional pharmacist completed a CD audit in October 2025.

Through discussion and review of DMICP, we were assured that patients' medicines were reviewed by an appropriate clinician. A spot check of DMICP records confirmed that prescription, treatment and clinical medication reviews were undertaken.

It was evident that the high risk medicines (HRM) register supported the safe and comprehensive management of patients prescribed these medicines. The SMO used the DPHC national searches to confirm the HRMs and also compared this with the local health board in Wales which referenced a slightly different system to the 'red, amber, green' system used in England. Monthly DMICP searches were undertaken for patients prescribed an HRM and the clinical tracker updated. Patients were then discussed at the monthly chronic disease clinic meeting.

We reviewed a range of DMICP records. Relevant HRM and shared care alerts had been added to records. Prescribing was correct including a 'hospital issue only' medicines on the DMICP screen so interactions could be monitored even when the medicine was not prescribed in primary care. The records confirmed that appropriate and timely blood monitoring had been undertaken. The annual HRM audit was completed in April 2025. The SMO had raised with Regional Headquarters (RHQ) that the list of medicines in the mandated audit was not accurate, and the audit was subsequently corrected.

A clear process was in place for requesting and issuing repeat medication. The patient submitted an eConsult. The SMO reviewed the request and issued the repeat medicine or requested a face-to-face consultation with the patient.

We were advised that a notification of changes to a patient's medicine from other services such as out-of-hours, hospital discharge letters and out-patient appointments were scanned onto the patient's clinical records. A clinician was tasked to action or review the patient. If notifications or changes were urgent, the patient was given an appointment to see the doctor for a medical review. The team were confident that this process worked effectively and efficiently, and a local working practice policy was in place to support it.

Regular searches were undertaken for valproate (medicine to treat epilepsy and bipolar disorder) and topiramate (medicine to treat migraine). At the time of the inspection, no patients were prescribed these medicines.

The SMO adhered to the Welsh government prescribing guidelines. They also referred to the National Institute for Health and Care Excellence, 'NB Medical Education' and 'GPnotebook'. An antibiotic prescribing audit was completed in 2025. The outcome was that the next audit should be undertaken by an external assessor for impartiality. This had since taken place as part of the audit cycle and results confirmed appropriate prescribing.

Track record on safety

The practice manager was the lead for health, safety and fire prevention. They had completed the Institute of Occupational Safety and Health course in July 2024. A health and safety inspection was carried out by the practice manager in May 2025 and no remedial actions were identified. Meeting minutes confirmed health and safety was a standing agenda item at the practice meetings. Staff accidents were reported through the 'MySafety' system.

Measures were in place to maintain the safety of the facilities. The 5-yearly fire risk assessment (FRA) was undertaken in October 2021. Weekly fire alarm testing took place and monthly checks of the fire alarm system and firefighting equipment. Staff identified gaps at the top and bottom of several fire doors which could compromise the fire-resistance integrity of the doors. The issue had been added to the risk register and reported to the fire department. An FRA was scheduled the week after the inspection to review the fire doors. The last staff evacuation fire drill was held in July 2025.

The gas was checked in July 2025 and the 5-yearly electrical test in February 2025. The practice manager confirmed Electrical Equipment Testing was carried out the week after the inspection. The legionella risk assessment was reviewed in January 2025. Staff flushed the taps each Monday and the contractor tested the water system each month.

The risk register was concise with sufficient detail to indicate how each risk was being managed. The register was last reviewed and updated at the September 2025 practice meeting. Although the register identified the 'owner' of each risk, it did not reflect the DPHC '4T's process' (transfer, tolerate, treat, terminate) to illustrate at what level of the organisation each risk was being managed. We were advised the new risk register format

no longer includes the ‘4Ts’. A retired risk register along with an issues log and retired issues log were maintained.

Clinical and non-clinical risk assessments for the medical centre and PCRF were up-to-date for a review. Data sheets were available for substances hazardous to health (referred to as COSHH products). COSHH risk assessments had been appropriately reviewed.

The practice manager was the equipment lead and a medic was the deputy lead. Clinical equipment was serviced annually by the medical and dental servicing section (a military capability referred to as MDSS). All clinical equipment was in-date for servicing and testing. An equipment inspection (referred to as a LEA) was undertaken in March 2025. The 2 non-conformances identified had been addressed. Pre-user equipment checks (referred to as 373s) were printed at the start of each month and placed in each clinical room. A check of these showed that staff were regularly checking the equipment in the centre clinical rooms and PCRF. The SMO carried out an equipment 373 snap inspection each month. An Equipment Care Directive audit had not yet been completed and the practice manager confirmed that this would be undertaken early in 2026.

Wet globe bulb testing to indicate the potential for heat stress was not required as no PCRF-led outdoor physical activity took place and the gym was temperature controlled.

An integrated alarm system was fitted in clinical areas and accessible toilet so assistance could be summoned in the event of an emergency. The system was tested each month to ensure it was working and a record of these tests was maintained. The practice manager’s office was not included in this system. Instead, they used a handheld alarm. This alarm was not audible throughout this building. Following the inspection, the practice manager moved to the front office, which was central to the practice. Although we were advised lone working rarely happened, an up-to-date risk assessment was in place should staff need to work alone in the building.

Lessons learned and improvements made

Significant events, incidents and near misses were reported and managed through the organisational-wide ASER system. All staff had access to the system.

At the previous inspection we queried the low number events reported and practice staff acknowledged that not all incidents had been reported through ASER. This had improved as the ASER register showed regular and appropriate reporting, including good practice ‘purple’ ASERs. The ASER register was comprehensive and featured a dedicated column linking each ASER to the date it was discussed, allowing for efficient cross-referencing and tracking of governance actions. All submitted ASERs had been appropriately actioned, with only 1 outstanding item pending discussion at the next healthcare governance (HCG) meeting, at which ASER was a standing agenda item.

The regional HCG lead worked with staff in August 2025 to complete an ASER trend analysis. This was shared with the practice, RHQ and the DMSR. Common themes identified were laboratory sampling errors and challenges with supporting the health of reservists.

The practice provided occupational health and medical gradings for a large number of reservists living local to the practice. As reservists were registered with NHS GP practices for primary health care (PHC), the SMO expressed concern about not having access to their PHC records. This placed staff in a potentially vulnerable position making grading decisions without access to full patient records. An example was provided regarding a reservist with a long term condition who received an inappropriate grading which could have resulted in the person being deployed to an unsafe location. The SMO was monitoring this process.

Effective processes were in place for the management and action of Medicines and Healthcare products Regulatory Agency (MHRA) and National Patient Safety alerts. Alerts were received through the Central Alerting system (CAS). An in-date electronic MHRA alert register was used and the practice had a system in place to ensure all alerts relevant to the practice were received, circulated to staff and actioned. Minutes showed CAS alerts were discussed at the practice meetings.

Are services effective?

We rated the practice as good for providing effective services.

Following our last inspection, we rated the practice as requires improvement for providing effective services as we found shortfalls with:

- the assessment process and use of rehabilitation patient-reported outcome measures
- staff induction process
- staff mandated training.

At this inspection the recommendations we made had been actioned.

Effective needs assessment, care and treatment

Processes were in place for clinical staff to keep up-to-date with developments in clinical care, including National Institute for Health and Care Excellence (NICE) guidance, the Scottish Intercollegiate Guidelines Network, Specialist Pharmacy Services, clinical pathways, current legislation and other practice guidance. Staff were kept informed of clinical and medicines updates through the Defence Primary Healthcare (DPHC) newsletter circulated to staff each month. A NICE tracker was maintained and new or updated guidance was discussed at the practice meetings. For example, overweight/obesity management and chronic heart failure in adults were discussed at the meeting in September 2025, and the minutes included a link to the full guidance.

Evidence-based guidance was considered in the treatment and care of patients. In line with updated NICE guidelines, the practice had moved to the prescribing of maintenance/reliever therapy (AIR/MART) with the aim to reduce reliance on short-acting beta agonists inhalers. Our review of patient records confirmed this change in prescribing for patients with a diagnosis of asthma.

Patients with complex or concerning needs were discussed at the monthly chronic disease clinic meeting. The physiotherapist attended the weekly Regional Rehabilitation Unit (RRU) at which patients with musculoskeletal (MSK) injuries and rehabilitation needs were discussed.

Our review of patient records showed an assessment of lifestyle factors, such as mood, sleep and diet was routinely undertaken by the physiotherapist for patients referred to the Primary Care Rehabilitation Facility (PCRF). Since the last inspection, the physiotherapist had access to the Defence Rehabilitation repository and the full range of best practice guidance (BPG).

Standardised outcome measures for patients to report their symptoms and quality of life were routinely used. This included the MSK Health Questionnaire (MSK-HQ) completed at the beginning of treatment and periodically (usually every 6 weeks) during treatment. Patients accessed rehabilitation exercise programmes through Rehab Guru (software for

rehabilitation exercise therapy). Our review of a range of physiotherapy clinical records showed patients were receiving effective person-centred care.

The PCRF was well equipped with sufficient space and equipment to meet the needs of patients. The practice had a 'Game Ready System' (compression with cold therapy) and held 'Game Ready clinics'. All clinicians could use the system which aided recovery from acute injuries without the patient needing to wait for a physiotherapy appointment. The Senior Medical Officer (SMO) indicated this therapy accelerated return to fitness of injured personnel.

Step 1 of the DPHC mental health pathway was delivered at the practice. The SMO used the 'Staying Safe from Suicidal Thoughts' formal risk stratification evidence-based process to develop a 'safety plan' for individual patients. This was then used as a monitoring tool and also to advise the Chain of Command about a patient's risk and to inform the Vulnerable Risk Management system. We identified this as notable practice at the last inspection.

Patients with complex/concerning mental health needs were discussed at the chronic disease clinic. Where appropriate, the safety plan was used to aid referral to the Department of Community Mental Health (DCMH) for patients requiring intervention beyond step 1 of the pathway. Our review of clinical records showed patients with a mental health need were very well managed. Consistent clinical coding was used by the practice with appropriate evidence of doctor-led Step 1 work before considering a referral to the DCMH.

The SMO also used 'Getselfhelp.co.uk' to support learning and professional practice, and to signpost patients to cognitive behaviour therapy resources, including worksheets, information booklets and videos.

Monitoring care and treatment

The nurses oversaw the process for managing patients with a long-term condition (LTC). DMICP searches were undertaken in preparation for the chronic disease clinic. This clinic provided a forum for the nurses and SMO to discuss specific patients and update their treatment plan.

At the time of the inspection, there were 12 patients coded as pre-diabetic. For 8 patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For 12 patients, the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control. Seven patients were coded as pre-diabetes (resolved through lifestyle changes) and they remained on the register for an annual review. Over 40 health checks were provided and included a blood test (referred to as HbA1C) to check for pre-diabetes.

Twenty patients were identified as having hypertension (high blood pressure). Six patients had a record for their blood pressure taken in the past 12 months. The nurses confirmed that all patients within the search had been recalled via text message for blood pressure

check. Thirteen patients had a blood pressure reading of 150/90 or less with 2 under investigation for a raised blood pressure.

Twelve patients had a diagnosis of asthma and all had an asthma review in the preceding 12 months. The asthma template within the chronic disease DMICP menu was consistently used.

We reviewed a range of records for patients with an LTC and those with pre-diabetes. We identified no concerns as records showed appropriate recalls; monitoring and follow-up was up-to-date. Clinical coding was consistently accurate for all records we reviewed.

Audiometry assessments were in date for 90% of the patient population. A review of patient records indicated appropriate Hearing Conservation Programme recalls were in place and patients were being managed in line with DPHC policy.

The nurses were the leads for clinical audit and the administrator led on non-clinical audit. An integrated, comprehensive and well evidenced rolling audit cycle was established, which was used to evaluate the quality of care and improve patient outcomes. It consisted of the mandatory DPHC audits (must) along with good practice audits (should). Audit, along with QIPs and 'purple' ASERs were discussed at the healthcare governance meeting and captured on the audit and ASER trackers.

All 'must' and 'should' audits had been completed on the mandatory audit templates. The range of audits we reviewed were of a high standard. Although additional clinical audits had not been undertaken, a clinical 'assurance check' was conducted each month ahead of the practice meeting. This involved the nurses undertaking searches and presenting the statistics for discussion. The searches were for LTCs; high risk medicines; controlled drugs; screening, including for cancer and over 40s and Force Generation (audiometry, vaccinations and downgrades). In addition, the administrator presented the statistics for waiting times and non-attendance at appointments. Given the limited resources within the small team, we considered this was an efficient way of routinely monitoring clinical outcomes and outputs. The physiotherapist planned to undertake BPG audits in 2026, and the SMO aimed to audit adherence to MART and green inhaler prescribing.

Effective staffing

The practice manager monitored the induction status of all staff through the use of an induction register. Staff new to the practice completed a local induction for the practice and the defence induction pack used across the Wales region. The induction pack included a comprehensive list of mandatory training requirements, along with direct links to relevant training modules. Although the pack did not include a role specific induction, staff confirmed this was in place. For example, the physiotherapist had received a bespoke induction following the last inspection. It included spending time shadowing/observing at Larkhill PCRF. The SMO advised that new doctors were given the national 'MoD GP handbook'; particularly useful for civilian doctors.

The practice manager, supported by a nurse as deputy, was responsible for overseeing that staff training was up-to-date. They used the mandatory training register to monitor the

status of training. A dedicated training meeting was held each month to review mandatory training compliance, Regional Headquarters (RHQ) bitesize training sessions and in-service (trade) training. The meeting was also used to identify any emerging training needs. Records showed a 99% compliance with mandatory training.

Along with regular moulages, a detailed in-service training (IST) programme was in place with training sessions facilitated at least once a month. In addition, staff attended regional training and events, such as conferences. For example, the physiotherapist participated in the regional rehabilitation IST training days. Staff reported that IST supported them with their continuing professional development (CPD) and revalidation. Staff were encouraged to complete CPD courses to improve practice outputs/outcomes and further enhance their skills. Clinicians were suitably skilled and clinically experienced to respond to the needs of the patient population. Patients were referred to an alternative Defence medical centre for diving and aviation medicals.

Both in-service and regional supervision was in place for clinical staff. The nurses had access to formal regional clinical supervision and informal supervision at the practice. We discussed with the nurses the value of formalising practice-based clinical supervision to demonstrate reflection and professional learning/development. The SMO had access to support from other doctors through the South Wales Group Network, including the network doctors monthly meeting. The medics were closely supervised by the SMO through the daily triage debriefs. The physiotherapist was receiving mentorship and peer review from a Band 7 physiotherapist at the PCRF in St Athan. The practice manager was supported by the area manager.

All staff maintained a personal development folder which contained their induction, terms of reference and training records.

Coordinating care and treatment

The practice had effective relationships with the regiment and welfare team, enhanced by regular attendance at the monthly Commanders Monthly Care Review (CMCR) meeting and quarterly Unit Health Committee meeting. The physiotherapist was scheduled to attend the CMCR to present the injury data they had been collecting. In addition the physiotherapist attended the weekly meeting with the RRU to discuss referrals.

The nurses had direct access to the laboratories to discuss any issues or queries regarding samples. Through shared care agreements, they also had well developed relationships with the retinopathy screening service, diabetic nurse and gastroenterology nurse.

For patients moving to another defence medical centre, a handover was provided to the receiving SMO, including a summary of care. If there was a concern about a patient, then the SMO spoke with the receiving SMO directly. Patients were signposted to a range of civilian services. A ‘support for service leavers’ leaflet was available in the waiting area.

When leaving the service, a release medical was completed for the patient to take to their new GP who can then request their clinical records. We discussed the possible impending

handover of a vulnerable patient to the NHS and the SMO was clear they would do so via the multi-disciplinary team or a phone call to the safeguarding service and/or to the new GP. The release medicals we viewed were of good quality and included the action taken for abnormal results, a structured mental health assessment and evidence of a discussion with patients about how to access NHS care. The welfare team advised us that patients were informed about the Armed Forces Covenant, which is a guarantee that those who have served in the armed forces are treated with fairness and respect.

Helping patients to live healthier lives

One of the nurses was the lead for health promotion. A health promotion calendar and log were in place. A dedicated health promotion room was attached to the waiting area and included a range of displays and health promotion leaflets. Quick response or QR codes for both clinicians and patients were available to access health information. For example, a QR code was displayed for patients to access the NHS body mass index calculator. Staff participated in the unit-led health promotion events when they were held.

A television screen was used in the waiting room to share a wide-range of up-to-date health promotion information. This information was electronically displayed around the camp so ensured up-to-date information was accessible to a wider audience. It also meant the health promotion refreshed monthly by the practice was consistent with the information displayed around the camp and promoted key health and well-being priorities. We identified this initiative as notable practice at the last inspection.

To improve communication and engagement, the physiotherapist installed patient information boards in the PCRF. The boards included self-management resources and health promotion information and rehabilitation pathways. This initiative was raised as a quality improvement project.

Although the SMO saw patients with sexual health needs, patients were mainly signposted to the local integrated contraception and sexual health unit (referred to as iCaSH) or to ‘Frisky Wales’ sexual health for advice, contraception and testing/screening. Condoms and chlamydia testing kits were available in the waiting room.

Processes were in place to ensure patients eligible for national screening were recalled. DMICP searches were undertaken each month. At the time of the inspection, no patients were eligible for breast and aortic aneurysm screening, and 8 were eligible for bowel screening.

The number of women that had a cervical smear in the last 3-5 years was 23, which represented 70% of the eligible female population. The NHS target was 80%. One of these patients had not been screened as they were away on operations. There was another patient who was posted and 1 patient had not responded to invitations for screening. A further 7 patients were outstanding for screening. We were advised there was a recent issue with local sexual health service not providing smears. This has since been resolved so the practice anticipated the percentage of 70% should improve. All eligible patients had been recalled.

A system was in place to recall service personnel due vaccinations. The vaccination statistics were identified as follows:

- 92% of patients were in-date for vaccination against diphtheria
- 92% of patients were in-date for vaccination against polio
- 92% of patients were in-date for vaccination against tetanus
- 95% of patients were in-date for vaccination against hepatitis B
- 95% of patients were in-date for vaccination against hepatitis A
- 98% of patients were in-date for vaccination against measles, mumps and rubella
- 92% of patients were in-date for vaccination against meningitis.

Consent to care and treatment

Our review of patient records showed that implied and verbal consent was mainly obtained from the patient depending on the procedure. A consent audit was undertaken in March 2025. It noted that consent was not always recorded. An action plan was in place and this had been discussed with the staff team. A re-audit was due in 2026.

Mental capacity was part of the SMO's standard medical education and they had a good understanding of the Mental Capacity Act (2005) and how it applied to the patient population. Training records showed the staff team received mental capacity and consent training in November 2024. The SMO provided examples of incidents when patients may not have had the ability to provide informed consent and a mental capacity assessment had been undertaken. We reviewed a patient's record and the mental capacity assessment was appropriately and clearly documented. Furthermore, the SMO had subsequently been involved in the sectioning under the Mental Health Act (1983) of some of these patients.

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 from 40 patients who shared their views of the practice. We also looked at the feedback submitted for September 2025 via the Defence Primary Healthcare (DPHC) patient experience survey, which generated 11 patient responses. Collectively, feedback highlighted that staff were kind, understanding and caring. Comments from patients suggested staff were attentive to patients' needs and non-judgemental.

Staff provided various of examples of when the practice had 'gone the extra mile' to ensure sufficient support and appropriate care was in place for patients, particularly for patients with mental health needs.

Involvement in decisions about care and treatment

Feedback consistently highlighted that patients were involved with planning their care; confirmed by our review of patient records and the use of informed consent. A translation service was available but had not been used.

The nurses were the leads for ensuring patients with a caring responsibility were effectively supported in line with the local carers policy, which was updated in June 2025. Information regarding carers was displayed in the waiting area and within the practice leaflet.

Patients could self-identify as a carer at any time. They were also identified through the patient registration process, through the welfare team, the Chain of Command or opportunistically. Coding and alerts were applied to carers' clinical records. A monthly DMICP search was undertaken to check that all carers were identified. Each carer was provided with a resource pack, offered an annual flu vaccine, an annual health check and flexible appointments. Information was displayed in the waiting room and outlined in the patient information leaflet about support for carers. Seven carers were identified at the time of the inspection.

Privacy and dignity

The reception area and waiting area were separate so CCTV was used to monitor the waiting room. If patients wished to discuss a sensitive issue or appeared distressed at reception, they were offered access to the dedicated welfare room as this provided a quiet and private space if needed.

Patient consultations took place in clinic rooms with the door closed. Privacy curtains were available in all clinical rooms for intimate examinations. Only 1 patient at a time was seen by the physiotherapist in the Primary Care Rehabilitation Facility (PCRF) gym.

Given the low number of clinical staff, accommodating a patient's choice to see a clinician of a specific gender could not always be met. The practice could offer the patient a chaperone or the patient could travel to one of the other practices within the South Wales network. The physiotherapist had an arrangement at the PCRF in St Athan if a patient expressed a wish to be seen by a female physiotherapist.

Are services responsive to people's needs?

We rated the practice as outstanding for providing responsive services.

Responding to and meeting people's needs

We found that the practice was responsive to the needs of patients and occupational requirements of the regiment with clinics co-ordinated to meet those needs. Patients deemed to be vulnerable were offered same day longer appointments. The introduction of eConsult and telephone consultations had improved accessibility for patients. Specific clinics with extended appointments were available for occupational gradings each week.

With a waiting list of up to 18 months for referrals to ophthalmology, the administrator made contact with a local optician service to see if they could offer support. A process was agreed whereby patients referred to ophthalmology were triaged to determine if their needs could be met by the optician. Patients accepted were contacted directly by the optician and offered an appointment. Verbal feedback from patients was positive as they said ophthalmology appointments were more readily available and in a timelier way. We highlighted this initiative as notable practice at the last inspection. Since then, it had been identified as a quality improvement project (QIP) and added to the QIP register.

There was evidence that the practice responded to the specific clinical needs of individual patients. For example, the Senior Medical Officer (SMO) was overseeing the care of a patient who was registered with another Defence Primary Healthcare (DPHC) medical centre and 'sick at home' in the Brawdy area. The SMO liaised with the patient's unit to ensure the patient's occupational health requirements were managed correctly. Furthermore, we observed during the inspection, a medic arranging to take a patient to the hospital emergency department as they presented at the practice unwell.

A patient who was on a waiting list for secondary care was deployed for 8 months. Rather than miss their appointment, the administrator liaised with the hospital and, under the 'Armed Forces Covenant', it was agreed that the patient retained their position on the waiting list even if they missed their initial appointment.

The practice was highly responsive to the needs of the units. Staff were on high alert for deployment and if a unit needed to deploy at short notice, clinic times were adapted to ensure the occupational needs of service personnel were met pre-deployment. This could include clinicians working on Friday, a day when the practice is usually closed.

The SMO responded to a theme of patients presenting with foot problems and lower limb injury, which was impacting deployability. As there was an indication these issues may relate to ill-fitting boots, the SMO procured a Brannock Foot Measuring Device. This device, which takes 3 foot measurements – foot length, arch length and width, along with clear instructions, was available in the waiting room for patients to check their foot size. Since its introduction in July 2025, the SMO confirmed there had been a reduction in the number of patients seeking clinical support for foot problems related to non-standard footwear. Furthermore, patients provided positive feedback about the device as it has

ensured they order the correct sized boots. This initiative had been raised as a good practice 'purple' ASER.

As the defence system was not linked with Welsh NHS online services, the routine bowel screening test; NHS home test kit (referred to as FIT) had not been available to the practice. The nurses made contact with the NHS FIT testing team and obtained an electronic referral form and email address to submit bowel screening referrals for actioning. A local working practice policy was developed to support this process. As a result of this FIT requesting system, the SMO said they were assured that the process of requesting this test was timely and effective, particularly given the increasing incidence of bowel related cancer in younger people. This initiative was identified as a QIP.

Whilst recognising the risk of heat injuries during military activities, during a South Wales Group Network doctors' meeting, a doctor provided an overview of how patients who presented at their medical centre with acute heat stroke had been managed. A key learning point was the benefit of cold-water immersion to rapidly cool a patient presenting with heat stroke. This was in accordance with recently released guidance about the best approach to treat heat injuries. In the absence of a fixed bath or immersion kit (used in Royal Marine units), the SMO found a workaround in the form of an inflatable dingy. The dingy remained inflated and was held in the accessible toilet/shower room. If a patient presented with a heat injury then they could be promptly immersed in cold water in the dingy. The practice does not have responsibility for pre-hospital care management, but given the remote nature of the unit, including the risk of a delayed 999 response, this temporary solution was both appropriate and innovative.

The physiotherapist identified that the layout of the PCRF gym was outdated and lacked the functionality required to provide diverse rehabilitation programmes. As a result, the gym was refurbished this year, including the procurement of new equipment. Patients reported greater satisfaction with the gym environment, citing better equipment and a more motivating atmosphere. This initiative was raised as a QIP.

In response to a patient providing feedback that the DPHC patient survey was too long and repetitive, a simplified feedback system was introduced in July 2025. The new system included:

- voting cards (pink – requires improvement; amber – satisfactory; green – outstanding), each with a quick-response or QR code linking to the full survey.
- a comments/compliments book at reception.
- continued access to the DPHC Patient Experience Survey.

The administrator tracked and analysed patient feedback between July and October 2025 and identified an increased level of engagement with the new system and more consistent use of the compliments book. Although, usage reduced in October possible due to patients completing the CQC inspection feedback cards instead. The practice concluded that this simplified feedback approach had improved patient participation. It offered a more accessible alternative to the full survey while maintaining data quality and supporting continuous improvement. This initiative was identified as a 'purple' ASER.

In line with the Equality Act 2010, an access audit for the building had been completed in October 2025. To support the needs of people with a disability, an accessible parking space, automatic opening front door, accessible toilet and hearing loop was available. Due to the location of existing drains, the accessible toilet could only be accessed from the left hand side and this had been added to the risk register. A statement of need had been submitted to install all doors with automatic opening.

There was a link in the practice SharePoint to the DPHC transgender standard operating procedure should clinicians need to access this. Male, female and gender neutral toilets were available in the building.

In accordance with the DMSR Healthcare Defence Code of Practice, all staff had completed training in how to interact appropriately with people with a learning disability and/or autism.

Timely access to care and treatment

An urgent appointment with a doctor, nurse, physiotherapist or medic could be accommodated on the same day. A routine appointment with the doctor or nurse could be facilitated within a week. In addition, eConsult was available and this process was mainly used for repeat prescriptions.

There was a wait of up to 12 working days for a routine physiotherapist appointment. The Direct Access to Physiotherapy (DAP) referral pathway was available for patients. DAP usage was monitored and recorded. The physiotherapist confirmed referrals via DAP were appropriate and the demand could be managed. Meeting key performance indicators was a challenge at times for the Primary Care Rehabilitation Facility particularly if the sole physiotherapist was unavailable due to leave.

Due to the availability of just one doctor, home visits were not routinely provided.

The patient information leaflet, and patient information board provided details about opening times and access to medical care out-of-hours (OOH). A duty medic was on call and offered advice and could refer the patient to the on call doctor, local hospital or suggest a routine appointment during clinic hours.

A board in reception outlined who was providing OOH and which practice was providing GPRS for the South Wales group network.

Listening and learning from concerns and complaints

The practice manager and SMO were the leads for complaints and the administrator deputised. Complaints were managed in accordance with the DPHC complaints policy. Both verbal and written complaints were recorded on the complaints register. Only 1 complaint had been received since the last inspection and it had been effectively actioned and closed. The complaint concerned a patient waiting longer than usual to be seen. As a

result, a notice was placed in the waiting area to inform all patients that clinics can run a bit late at times.

Complaints and compliments were discussed with the staff team at both the healthcare governance and the practice meetings. Patients had submitted a large number of compliments about the service.

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

Are services well-led?

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

Following our last inspection, we rated the practice as requires improvement for providing well-led services as we found shortfalls with:

- leadership presence at the practice
- healthcare governance (HCG) systems and processes including the Health Assessment Frame (HAF) and Management Action Plan (MAP)

At this inspection the recommendations we made had been actioned.

Vision and strategy

The practice worked to the Defence Primary Healthcare (DPHC) mission statement outlined as:

> "Provide and commission safe and effective healthcare which meets the needs of the patient and chain of command in order to contribute to Fighting Power."

In addition, the Senior Medical Officer (SMO) developed a vision statement as a way to quickly highlight the aspiration for staff to feel part of a team and have purpose in their work. The vision was outlined as 'CORE' – Commitment, Ownership, Responsibility, Excellence. This ethos was apparent in our conversations with staff throughout the inspection.

The challenges associated with clinical delivery at Brawdy Medical Centre have been longstanding. The main challenge being the rural and isolated location, which has impacted staff recruitment. Given the small size of the practice, there was limited resilience to cover staff absence. The loss of just one member of staff has in the past impacted the delivery of safe and effective patient care.

To maximise resilience, the GPRS South Wales Group Network was established in December 2020. Objectives of the GPRS included strengthening service resilience during times of staff shortage, sharing best practice and the use of collaboration to promote collective development. This initiative has been recognised as a regional quality improvement project (QIP). A weekly network telephone call was held to share information, policy updates, discuss support practices need and confirm out-of-hours/shoulder cover. The GPRS provided emergency medical cover on Fridays when Brawdy Medical Centre was closed. Without the network, the SMO highlighted that Brawdy Medical Centre would not be adequately staffed.

Succession planning was considered as part of the practice development plan (PDP). Since the last inspection, the administrator had become familiar with the healthcare governance (HCG) workbook (process to manage and monitor HCG activity). In addition, a 'routine tasks and checks' list had been introduced, which covered all HCG matters, including the lead for each task and frequency of the check. Staff found this particularly useful as the system provided prompts for tasks, including the tasks to complete if a member of staff was absent from the service. The SMO was developing a specific 'weekly tasks' list in the event other doctors from the group network needed to provide cover for an extended period.

The PDP included both future business strategies and staff development initiatives. It also outlined plans to enhance patient involvement through a patient participation group and expand health promotion activities. When necessary, the PDP was actively used and referred to during practice meetings to remind the team of the strategic goals and development priorities.

Major operations and other events impacting the workload at the practice were communicated via the unit-owned medic who participated in unit planning meetings. The medic had access to the planning forecast and informed the SMO of the need for Force Generation preparation. In addition, the SMO attended the Commanders Monthly Care Review (CMCR) meeting, which was the key forum for gathering and sharing information with the units to ensure operational and clinical updates were effectively communicated.

To address environmental sustainability, the practice aimed to reduce the use of paper by communicating via email and the use of links and QR codes. Recycle bins were available and lights were switched off when not needed. The SMO was running a greener prescribing project to move away from older environmentally damaging inhalers containing CFC. Patients prescribed these inhalers were identified at the chronic disease clinic then invited for a review when greener prescribing was discussed with them. The SMO was considering raising this work as a QIP.

Leadership, capacity and capability

The SMO and practice manager were the overall key leaders for the practice and had a clear direction in terms of service development, which was effectively communicated to the wider team. With the practice manager now based at the practice full time, along with the restructuring of clinics and HCG activities, staff reported that limited resources were more efficiently utilised. In terms of clinical leadership, the SMO was the designated clinical lead and the military practice nurse was the nominated deputy. All the team were highly experienced in the delivery of primary health care.

Staff we interviewed during the inspection described how the leadership team had an open-door policy with staff having prompt access to support and guidance when needed. They provided various examples to demonstrate this support. We heard that staff were treated equally regardless of rank or whether they were military or civilian. In terms of capability, staff indicated they had every confidence in how the leaders managed the practice. In particular, staff highlighted that the SMO invested in a whole-team approach.

Practice staff described a good relationship with Regional Headquarters (RHQ), indicating that the Area Manager and Regional Governance Lead were particularly supportive, providing consistent guidance and encouragement. The Area Manager visited the practice each month and maintained regular daily contact, which contributed to operational continuity and positive staff morale.

Culture

From patient feedback, interviews with staff and a review of clinical records, we were assured patients were central to the ethos of the practice. Even with limited resilience in staffing levels, the practice team were diligent with ensuring the needs of patients were met.

We were advised that staff morale dipped following the outcome of the previous CQC inspection. In addition, the SMO was mindful of potential staff burnout especially given the high number of CQC inspections in recent years. The SMO introduced regular 'white space' group activities and staff indicated these sessions had supported with team cohesion and improved morale. It was clear from spending time at the practice there was a strong team spirit, with staff consistently working collaboratively to support each other. The administrative team expressed how they were valued and confident with approaching any member of the team. Written feedback from a doctor who recently provided cover at the practice complimented the SMO on a positive and enjoyable working environment.

The integration with the dental team with social activities further strengthened cohesion, ensuring all departments were aligned and engaged. Additionally, inviting the cleaning staff to participate in team events has been a thoughtful gesture, reflecting the team's appreciation and commitment across all roles.

An open-door policy was in place to encourage transparent communication and approachability across all levels. Staff reported that they felt respected, valued and empowered. Any issues raised by staff were addressed constructively during practice meetings, ensuring concerns were heard and resolved in a timely and supportive way. Staff were familiar with both the whistleblowing policy and Freedom to Speak Up (FTSU) policies and were aware of how to access FTSU representatives.

Processes were established to ensure compliance with the requirements of the duty of candour (DoC) including giving those affected reasonable support, information and a verbal and written apology. DoC is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. Staff had a good understanding of the DoC principles. They provided examples of DoC events and confirmed these were discussed in the practice meetings. We noted 1 example on the ASER register from 2024, which was discussed at an HCG meeting. However, the last entry on the DoC log was in 2020.

Governance arrangements

Staff identified at the last CQC inspection that, although evidence was in place, it was not available in a usable format to demonstrate some of the HCG activities. This led to the Area Manager spending time with individual staff to determine if there was sufficient time for HCG activities, especially in the context of a limited number of staff. As a result of this work, DMICP clinics were re-structured releasing time for staff to focus on governance. From our discussions with staff, it was clear that the new clinic arrangements and focus on HCG has had a positive impact ensuring a smarter use of time. The QIP has been shared within the group network, particularly for the small practices, so they can structure the working week more effectively instead of completing HCG activities on an ad hoc basis.

As part of the improvement plan, the SMO introduced a regular ‘governance week’. This meant for a set time period clinics were reduced providing staff with the opportunity for collective teamwork to develop and embed sustainable HCG structures.

All the shortfalls with HCG structures we found at the last inspection had been rectified. These included recruitment processes, staff training, equipment care, access to and use of the ASER system and underdeveloped improvement plans to monitor the progress of actions resulting from audits and other practice monitoring processes. The HCG workbook included a wide-range of information that was accessible to all staff, such as practice administrative and clinical protocols to support staff in their roles.

There was a clear staffing structure in place and staff were familiar with their roles and responsibilities, including delegated lead roles in specific topic areas. Terms of reference were in place to support job roles, including staff who had lead roles for specific areas. Resilience was provided by appointed leads having named deputies.

Formal and informal communication channels were established including monthly practice, HCG, audit and chronic disease meetings. Minutes showed these meetings were well attended by staff.

Managing risks, issues and performance

Risks identified for the service were logged on the risk register and kept under scrutiny through review at meetings. All risk assessments were up-to-date, including for the Primary Care Rehabilitation Facility.

The business continuity plan (BCP) was available electronically with 3 physical copies held in the building to ensure accessibility in the event of an IT system failure. The BCP has been signed by relevant staff members, confirming their awareness of the procedures outlined.

A tabletop exercise was conducted in July 2025 to test the pandemic outbreak plan. As a record of the actions/outcomes was not made, we highlighted the value of keeping such a record to support continuous improvement and accountability.

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

The leadership team was familiar with the policy and processes for managing staff performance, including underperformance and the options to support the process in a positive way. Staff appraisals were up-to-date.

Appropriate and accurate information

The DPHC electronic Healthcare Assurance Framework (referred to as HAF) was used to monitor performance. The HAF is an internal quality assurance governance tool to assure standards of health care delivery within Defence healthcare. At the previous inspection, the HAF had not been updated since January 2023. At the time, staff reported that navigating and maintaining the HAF was both time consuming and burdensome. To rationalise the process, the Area Manager developed an easy mechanism to quickly identify HAF updates. This change also provided the leadership team with a quick snapshot of how the HAF was progressing. This initiative was identified as a QIP. HAF progress and updates were discussed at HCG meetings.

The last Internal Assurance Review (IAR) was undertaken in April 2023. Further IARs had been temporarily paused due to the frequency of CQC inspections.

Processes were in place to ensure compliance with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. Emails sent from the practice are graded according to the sensitivity of the data they contained. Staff records on DMICP include alerts, and the practice manager conducted monthly Caldicott searches to monitor for any potential data breaches.

Engagement with patients, the public, staff and external partners

Options were available to prompt patients to provide feedback on the service. Patients could contribute to the DPHC patient experience survey via a QR code that was displayed by reception. Alternatively, they could use the recently introduced simplified feedback system. Feedback from patients was displayed and the practice indicated how it had responded to the feedback. Following patient feedback regarding delays in scheduled appointments, a sign was placed in the waiting area to inform patients that clinics may occasionally run late due to unforeseen events throughout the day. This proactive measure aimed to manage expectations and improve communication, helping patients understand the reasons behind occasional delays and reinforcing transparency in service delivery.

Staff were encouraged to provide feedback at the scheduled monthly meetings and via the open-door policy.

The practice worked closely with the Chain of Command and welfare support services to ensure a collective approach to ensuring the health needs of the regiment and with supporting vulnerable patients. The CMCR was held in the medical centre and included participation from the Chain of Command and the Welfare Team.

Continuous improvement and innovation

Despite low morale following the last inspection, along with the work required to improve governance processes, staff continued to demonstrate a commitment to continually improving the service for the benefit of patients. This was evident through the number and range of QIPs and ‘purple’ ASERs presented to us and referenced throughout the report.