Bulford Medical Centre

Bengal Road, Bulford, Wiltshire, SP4 9AD

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?	**Good**	
Are services well-led?	**Good**	

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Summary

About this inspection

We carried out this announced comprehensive inspection on 22 October 2025.

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? – good

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 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 staff suggestions 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.
- The practice was well-led. Despite the recent challenges associated with depleted staffing levels, staff indicated strong leadership, good communication and a willingness to adapt meant that the team worked in tangent 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. All significant events and incidents were subject to a thorough root cause analysis. Emerging themes were used as drivers for change.
- The arrangements for managing medicines minimised risks to patient safety.

- Healthcare governance processes were well-developed and routinely used to monitor service performance, including clinical audit.
- 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:

- In conjunction with Wiltshire Council and the local integrated care board, the Senior Medical Officer (SMO) was actively involved in a research-based project led by Healthwatch Wiltshire. The project concerned the health needs and experiences of military families in Wiltshire, with the aim to ensure equity of access for families. The outcome of a survey highlighted loneliness and connectedness as the key issues. As a result, a series of working groups were set up with the aim to improve support in the areas identified. This initiative was recently shortlisted for the Health Service Journal (NHS national awards) national award under the military and civilian collaboration category.
- To ensure patients took the correct care pathway (including NHS pathways), the practice developed a patient access chart. Providing examples for each pathway, it clearly outlined what to do, who to contact and resources to access in the following situations:
    - what to do in an emergency
    - when a care need is urgent but not life threatening
    - injured or feeling poorly in the last 24 hours
    - have symptoms that won't go away or need advice
    - for healthcare administration
    - for advice on common ailments and illnesses.

  We considered this initiative notable practice as it, not only helped to streamline service access, but supported patients with understanding the different and most appropriate access pathways so their needs were met in a timely way.

- Aircrew from RAF Boscombe Down (a military airfield nearby) were previously registered with Bulford Medical Centre. The SMO recognised the practice did not have sufficient suitably qualified and experienced personnel to safely meet the specific healthcare and occupational needs of aircrew. To develop an evidence-base for the care of the aircrew to be transferred to an RAF medical centre, the SMO and SLT carried out a thematic analysis of ASERs over a continuum period (multiple years used), chaired meetings with a range of RHQ personnel, chaired intelligent customer meetings and developed an evidence-based and detailed IRTB (issues, risks, timings, background) staff report. The SLT then used this evidence to develop an informed business case to enable 2 RCDs from cross-regions (Central Wessex and London South) to recommend and approve the RAF aircrew transfer. The RAF doctor at Bulford Medical Centre (previous DSMO at Bulford Medical Centre) also transferred with the patients.

We made no recommendations to the practice.

Professor Bola Owolabi

Chief Inspector of Primary and Community Services

Our inspection team

This inspection was undertaken by a CQC inspector supported by a team of specialist advisors including a GP, pharmacist, nurse and practice manager. Four recently recruited specialist advisors shadowed the inspection as part of their induction.

Background to Bulford Medical Centre

Bulford Medical Centre is 10 miles north of Salisbury and has a patient population of approximately 4,500; 3,300 service personnel and 1,200 families. Routine primary health care is provided for all patients and occupational health for service personnel only. The patient population is diverse and the practice supports a wide range of Army units including 4 main units - 1 Mercian Regiment, Household Calvery Regiment, 5 Rifles and 3 Division Signal Regiment. The practice provides support only to RAF Boscombe Down, an airfield located nearly.

A dispensary is based in the medical centre. There is no Primary Care Rehabilitation Facility (PCRF) as military patients have access to PCRF Tidworth a short distance away. Bulford Medical Centre is a training practice for doctors, nurses and medics. The practice is General Practice Education Committee (referred to as GPEC) accredited.

The practice is open from 08:00 to 16:30 hours Monday, Wednesday and Thursday. On Fridays the opening hours are from 08:00 to 16:00 hours and on Tuesdays from 08:00 to 12:30 hours. The practice is closed for lunch each day from 12:30 to 13:30 hours and Tuesday afternoon for meetings and training. Patients with an urgent care need can be seen during these times. Medical cover until 18:30 hours is provided regionally between Bulford, Tidworth, Larkhill and Warminster medical centres. Outside these hours care is accessed via NHS 111 or 999.

The staff team

Doctors	Senior Medical Officer (SMO) Civilian acting deputy SMO (DSMO) MOD GP x 2.6 full time equivalent (includes the DSMO) Unit Regimental Medical Officers x 4 (3 posts covered by locums) GP trainee General Duties Medical Officer x 2 Foundation year 2 Medical Officer
Nurses	Civilian senior practice nurse Civilian advanced nurse practitioner Military nurse x 2 Civilian nurse x 4 (1 post covered by a locum) Civilian health care assistant x 2 (1 post covered by a locum)

Practice management and administration	Office manager (civilian) Military practice manager Administrators x 4 (2 posts vacant; 1 covered by a locum)
Dispensary	Civilian pharmacy technician x 2
Unit medics	27

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

The Senior Medical Officer (SMO) and acting deputy SMO (DSMO) were the safeguarding leads for the practice. Reviewed in October 2025 and displayed in clinical rooms, the adults and children safeguarding policy referenced and included contact details for the Wiltshire Multi-Agency Safeguarding Hub. All staff were in-date for safeguarding training at a level appropriate to their role.

Vulnerable patients were identified through the patient registration process, through consultations, summarisation of patient records and via the welfare team. A clinical code and alert were applied to individual DMICP (electronic patient record system) records to ensure patients assessed as vulnerable were readily identified. Regular DMICP searches were undertaken by the SMO to ensure all vulnerable patients were captured on the register and alerts/coding was correctly applied to the patient's clinical record.

A range of forums were established to ensure vulnerable patients were identified and effectively supported. The weekly clinician meeting provided the opportunity to respond promptly to any urgent safeguarding concerns. A safeguarding information meeting (SIM) was held every 6 weeks and all available clinicians attended along with the midwife and health visitor. SIM was the main setting to discuss vulnerable adults and children identified on the safeguarding register, and any new patients identified as vulnerable. We were given an example of how a safeguarding concern had been effectively managed with the involvement of the health visitor, midwife and welfare team.

The practice maintained a vulnerable patient register. If clinicians were unsure whether a patient should be added to the register then this was discussed with the SMO or at the SIM meeting.

Doctors engaged with the unit welfare teams through the Regimental Medical Officers (RMO) for each unit. Safeguarding concerns were also discussed at the monthly Unit Healthcare Committee meetings, at which the practice was represented. A unit-led Vulnerability Risk Management process was established to monitor the care of service personnel identified as vulnerable and to monitor trends for each unit.

The practice had developed links with external safeguarding services and teams. Clinicians made referrals to the local Multi-Agency Safeguarding Hub and participated in child protection conferences. The SMO attended the quarterly meetings facilitated by Wiltshire Safeguarding Vulnerable People Partnership. In addition, the SMO organised domestic abuse training for the Army Welfare Service in 2024.

Chaperone training for the staff team was held in July 2025. A list of trained chaperones was displayed in all clinical rooms. Information detailing the use of chaperones was available at the practice and in the practice information leaflet. The recently released Defence Primary Healthcare (DPHC) chaperone policy was discussed at the clinicians'

meeting to ensure all were aware of clinical coding in line with the policy. The SMO planned to undertake an audit in 6 months to review compliance with the policy.

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 Disclosure and Barring Service certificates to ensure staff were suitable to work with vulnerable adults and young people. The professional registration for clinical staff was monitored and was up-to-date for all staff. The nursing team monitored the vaccination status of staff and all were in-date. All staff had crown indemnity. Recruitment packs for locum staff were reviewed on arrival and via the online booking system.

One of the nurses was the lead for infection prevention and control (IPC) and 3 other nurses deputised. The lead nurse had completed the required IPC training and the senior practice nurse was due to complete the training in December 2025. All staff were in-date for IPC training. The IPC audit was undertaken annually and was last completed in May 2025. Issues identified have been captured on the issues register or building fault log so were monitored and followed up until completed.

The spread of infectious diseases was minimised by the practice adhering to the IPC policy. Personal protective equipment was readily available. Hand gel and face masks were available in the waiting area for patients and those who felt vulnerable to infection could ask clinical staff to wear face masks too. The infrastructure was IPC compliant, including the flooring, wipeable surfaces in clinical areas, flushing of water outlets and disposable privacy curtains changed every 6 months. The risk of an outbreak was indicated on the risk register. A communicable diseases outbreak plan and reporting process was in place in the event of an outbreak.

An environmental cleaning schedule was in place and a colour coding system displayed to indicate the frequency of cleaning in each area. A deep clean was last carried out in September 2025 and the carpet in administrative areas had been cleaned periodically throughout the year.

One of the administrators was the lead for managing clinical waste. A clinical waste log and consignment notes were in place and up-to-date. The pre-acceptance audit was completed in February 2025. Sharps boxes were labelled, dated and disposed of appropriately. Clinical waste was securely stored outside the building.

Risks to patients

Based on DPHC ASSESSREP guidance, the practice had been functioning with an ‘Operational Pressures Activity Levels’ (referred to as OPAL) rating of red since October 2024. This was due to significant understaffing. Staffing levels had improved in the months leading up to this inspection with successful recruitment to posts and the appointment of locums to fill vacant positions. All staff we spoke with confirmed staffing levels had improved. Patient feedback and wait times demonstrated patients were seen in a timely way. The exception was for occupational grading reviews which had an approximate wait of 10 working days.

The wait for grading reviews was partly due to locum doctors not having the skill to undertake occupational grading reviews. It was anticipated that the wait time would reduce in November 2025 as an experienced DPHC MOD GP was due to join the practice.

A staff tracker provided oversight of cover across all departments. The clinicians' meeting was used to forward plan for any expected absences such as deployments and exercises. Planned staff absences were managed in advance. For example, the medics worked closely with the administration team and provided cover where needed, such as at reception. Furthermore, the duty doctor provided cover if a nurse was unavailable to undertake duty.

Checks of the medical emergency kit were carried out by the duty nurse each day. A full check of the kit and emergency medicines was undertaken monthly or if the trolley had been opened/used. All the emergency equipment was in-date. Equally, emergency medicines and medical gases were compliant with the DPHC standard operating procedure (SOP). One of the nurses was the first aider for the practice. A notice indicated the first aid box was located by reception.

The advanced Nurse Practitioner (ANP) was the lead for medical emergencies and resuscitation and had completed Intermediate Life Support training. As the ANP was a qualified Basic Life Support (BLS) instructor, they facilitated the BLS training for the staff team. Specific paediatric training was included in the BLS training programme. All staff were in-date for BLS training including use of the automated external defibrillator and anaphylaxis. Emergency trolley familiarisation training was provided for the staff team in January 2025.

Scenario-based or moulage medical emergency training was regularly held. Staff described a recent moulage session based on a patient who collapsed while attending the practice. The medics received trauma training facilitated by an external team, which included moulages. A moulage area was recently established within one of the major units.

Staff completed sepsis training regularly with training sessions facilitated in January and September 2025. Both clinical and non-clinical staff were familiar with the signs and symptoms of sepsis. Sepsis information was displayed in the practice. Relevant staff had completed heat and cold injury training. Musculoskeletal injuries was included in the training programme to ensure staff were aware of red flags and the need for urgent referral.

Information to deliver safe care and treatment

Disruption in the provision of clinical care due to IT and DMICP failure was captured as a longstanding risk on the risk register. In the event of an outage of the DMICP system, the practice followed the business continuity plan. Routine clinics were cancelled and only patients with an emergency need were seen. These consultations were recorded on paper forms which were scanned onto DMICP when connectivity resumed. Resilience packs containing the paper forms were available in the administrative office. Routine appointments were rescheduled once DMICP was available.

Summarisation was nurse-led. Until recently, limited staffing levels meant summarisation had not been a priority and this was captured on the risk register. When staffing levels improved, the nursing team was allocated 2 afternoons a month for the summarisation with an initial focus on civilian records and vulnerable adults/children. Once those records were summarised, the focus shifted to military patients with the nurses working to a plan for summarisation of these records. Medics had received training so they could support with summarising. At the time of the inspection, summarisation was up-to-date for civilian records and 78% of service personnel had been summarised within the last 3 years.

Arrangements were in place for the review and/or auditing of record keeping across all clinical staff groups. This supported with ensuring high quality record keeping and meaningful feedback to inform clinicians' appraisals. The ANP reviewed the records maintained by the medics during the emergency clinic. In addition, the duty nurse reviewed the medics' notes each day to ensure all relevant clinical information had been recorded.

An effective process was in place for managing referrals including urgent 2-week-wait (2WW) referrals. One of the administrators was the lead for managing referrals and, along with the administrative team, managed referrals in accordance with the SOP. The DPHC centralised process for referral management was used, which provided a variety of functions to support with monitoring, including alerts to prompt follow-up. Urgent and 2WW referrals were checked weekly and discussed at the clinicians meetings. The medical centre address was used for service personnel referrals. Families used their home address and the referrals lead telephoned to check if an appointment letter had been received.

The nursing team managed the samples with the healthcare assistant responsible for bagging, labelling and storing the samples. A sample register was maintained and the nurses checked daily for results, following up on results not received. All results were passed to the duty doctor to take action if appropriate and then delegated back to the requesting doctor. The outcome of the results were documented in the patient's record. The duty doctor or requesting doctor contacted the patient with the results. The patient was advised to contact the practice within 7 days if they had not been contacted with their results.

Safe and appropriate use of medicines

The DSMO was the lead for medicines management and the pharmacy technicians were responsible for the day-to-day operation of the dispensary. The dispensary was secured with coded door locks. Additional access doors could be internally locked from the dispensary. Only the 2 pharmacy technicians, SMO and regional pharmacy technician had the code. An emergency access process SOP was in place for prescribers should they need access to medicines when the dispensary was closed.

Controlled drugs (CD) and accountable drugs (medicines with a potential for misuse) were stored securely in a locked cabinet in the dispensary. Monthly and quarterly CD checks were carried out in line with policy. We noted the DPHC update to policy that directs accountable drugs to be countersigned as well as CDs needed to be implemented. Promptly after the inspection, the SMO confirmed all clinicians had been made aware of requirement for second signature for accountable drugs. Additionally, it had been

discussed at both the clinicians and heads of department (HOD) meetings held shortly after the inspection.

An audit of CD prescribing had been conducted. We noted that it included co-codamol (strong pain relief medicine) which was good practice. The main conclusion of the audit was that review dates should not be changed for deployments.

Five pharmaceutical fridges were available for medicines requiring cold storage and arrangements were in place to ensure they were monitored twice a day for temperature control. External probes were available on side of the fridges. Stock was split across fridges to mitigate the loss in the event of a fridge failure. Vaccines were in-date and appropriately stored in the fridge away from the walls and with adequate airflow. The stock we checked was in line with DMICP lists.

Although not in accordance with new guidance, external fridge thermometers continued to be used. We were advised that the practice was awaiting a response from a query submitted to the medical and dental servicing section (a military capability referred to as MDSS) regarding the replacement of internal thermometers.

High risk medicines (HRM) were pro-actively managed by the medicines management lead. Comprehensive searches were undertaken each month with a list held on DMICP for all 3 categories of HRM (primary care prescribing 6P7, shared care agreement [SCA] prescribing 6P8 and secondary care prescribing 6P9). The list contained additional details including monitoring requirements, blood due date and date of SCA. Additional searches were undertaken for brand-name stocked items as the DMICP shared search only accommodated for generic medicines. Alerts were added to clinical records and to the prescribing screen to ensure clinicians were aware the patient was prescribed an HRM. Clinical records we reviewed showed patients prescribed HRMs were well managed. An HRM audit was undertaken in September 2025 and indicated a high compliance with meeting the targets.

Patient Group Directions (PGD) for nurses to administer medicines in line with legislation were used. PGD training was current and PGDs had been signed off by the SMO. The senior practice nurse maintained a comprehensive record of expiry dates of the PGDs as well as the nurses authorised to work under each PGD and the date they were signed off. PGDs were mainly used for vaccines and also for nicotine replacement therapy.

Patient Specific Directions (PSD) were managed by the RMOs as only the unit medics used PSDs. These had been appropriately signed and authorised. Whilst checking records, we noted an injection under a PSD had been given after the paperwork expired. We raised this with the medicines management lead who advised they would provide training for the RMOs as they were new to the role. After the inspection, we were provided with the minutes of the (HODs) meeting confirming the standards and expectations regarding PSDs had been discussed with the RMOs.

SOPs were in place regarding the collection of prescriptions. Notifying the prescriber if antipsychotic, antibiotics and antidepressant medicines were uncollected by the patient within 7 days was not current practice. This was on the practice action plan. Medicines not collected within 8 weeks were returned to stock and a DMICP coded entry made. The dispensary was closed once a year for a full stock check.

An SOP was in place for repeat prescriptions. Except for contraception and CDs, repeat prescriptions were limited to 56 days to reduce wastage. Email requests were the preferred practice option for repeat prescription requests. Although a post box for patients to drop off requests was available, we were informed that this was rarely used. A standardised email response was sent to patients to acknowledge their request. Once confirmed that the request was an authorised repeat, it was printed for the duty doctor to process. If not authorised for a repeat, the patient received an email to book an appointment.

The practice did not transcribe prescriptions indicated by secondary care services. The patient was advised to return to the hospital for the prescription to be completed and to claim back the cost. This approach minimised the risk of transcribing errors.

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 prescribing of antibiotics was routinely audited.

Track record on safety

The practice manager was the health and safety advisor and the office manager deputised. The role included safety, health, the environment and fire (SHEF) oversight for the practice. The practice manager carried out monthly SHEF checks. We looked at the checklist for October 2025 and no concerns were identified.

The 5-yearly fire risk assessment for the premises was completed in February 2022. Weekly fire alarm testing took place and also other weekly and monthly checks of the fire alarm system and firefighting equipment. Fire extinguishers were serviced in September 2025. Staff we spoke with confirmed a fire evacuation drill was held annually.

Processes were in place for the regular monitoring of utilities. The electrical installation safety report was issued in October 2024 and electrical equipment testing was undertaken in October 2025. The gas was checked in May 2025. The legionella risk assessment was reviewed in September 2024. The contractor carried out water safety checks and water tanks were tested for legionella in March 2025.

The SMO and practice manager were the leads for risk management. An active and retired risk register was in place along with an issues log. The risk register reflected the DPHC ‘4 T’s process’ (transfer, tolerate, treat, terminate) to illustrate at what level each risk was being managed. All risks had a review date and risk was a standing agenda item at the practice meetings.

Risk assessments for substances hazardous to health (COSHH) were reviewed annually or if there was a change to the products used. Cleaning staff were responsible for managing the COSHH products they used and held data sheets and risk assessments for each product. All COSHH products in the building were stored securely.

The practice manager was the lead for equipment care. The annual equipment inspection (referred to as a LEA) was completed in February 2025 and the 3 non-conformances had been addressed. Equipment was in-date for servicing.

A fixed alarm system was in place throughout the building and it was tested each month to ensure it was in working order. The lone working SOP for the practice was reviewed in February 2025.

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. All staff were familiar with the ASER process as the practice manager circulated an email in October 2025 that included detailed information about when and how to use the ASER system.

A comprehensive ASER register was in place and minutes showed they were discussed at the practice meetings. All HODs had part 2A ASER access, which ensured the HOD could undertake the root cause analysis (RCA) for ASERs relating to their department. On occasions the RCA was conducted by a team of people if the ASER required this. The practice had an open culture of ASER reporting. A log book was used to capture any improvements across the practice. ASER trends were discussed at both the HODs and practice/healthcare governance (HCG) meetings. The SMO carried out monthly checks of ASERS and action taken. A ‘near miss’ log was maintained by dispensary staff.

All staff we spoke with provided examples of ASERs, including the action taken, changes made and lessons learnt. An ASER was raised when a blood sample was placed in the sample box after the samples had been collected for the day. A new SOP was implemented and a laminated lid was introduced to place on top of the box to indicate the collection had taken place.

The pharmacy technicians managed medical alerts received via the Central Alerting System (CAS). An SOP was in place to support the management of alerts along with a CAS alert register. Numerous staff received the alerts by email as well as through the MS Teams channel for the region. Meeting minutes showed alerts were a standing agenda item at the practice/HCG meetings. The minutes included a link to the CAS homepage.

Are services effective?

We rated the practice as good for providing effective services.

Effective needs assessment, care and treatment

The practice/healthcare governance (HCG) meetings were the main forum to discuss developments in clinical care including National Institute for Health and Care Excellence guidance (NICE), the Scottish Intercollegiate Guidelines Network, clinical pathways, current legislation, standards and other best practice (BPG) guidance. The outcome of practice-led clinical audits were also discussed at the meeting. The practice/HCG meeting minutes included links to updates for staff to access. In addition, developments in clinical care were issued to the team via the Defence Primary Healthcare (DPHC) updates.

Along with the safeguarding information management meeting, the weekly clinical meetings also provided the opportunity for staff to discuss specific clinical matters including the treatment and care of individual patients with complex needs. In addition, the nurses held a meeting each month.

The practice pro-actively responded to patients with mental health needs. Doctors provided Step 1 of the DPHC mental health pathway. They also referred to 'SilverCloud', a recently introduced digital psychological wellness resource to support with issues like stress, anxiety and depression. Patients who needed intervention beyond step 1 were referred to the Department of Community Mental Health (DCMH). Patients presenting as acutely unwell were discussed with the DCMH on the same day. Staff described how the DCMH was responsive to any concerns raised. Our review of clinical records showed patients with a mental health need were well managed, and appropriate clinical coding was used.

Clinicians had effective relationships with the Chain of Command for each unit, which meant concerns about the mental health of service personnel were identified early. Clinicians were aware of the importance of occupational impact in relation to mental health as this was discussed on induction with clinical staff. They considered the patient's occupational role when assessing the risks for patients with mental health needs. If deemed appropriate for safety reasons, these risks were communicated to the Chain of Command. The duty team had the capacity to assess patients with an urgent need, including acting on concerns raised about a patient by the unit or welfare service. If required, the duty team attended unit-led Vulnerability Risk Management case conferences at short notice.

Monitoring care and treatment

As the practice had an OPAL rating of 'red' it was not required to meet 2 of the 5 healthcare priorities outlined in DPHC guidance, which defined how limited resources should be used to balance capacity against demand. Although routine clinical care,

including chronic disease management, was not identified as a priority, the practice continued to provide this service.

The deputy Senior Medical Officer (DSMO) was the lead for long-term conditions (LTC) and the senior practice nurse deputised. Responsibility for the management of LTCs was shared amongst the nurses with each nurse allocated an LTC to manage.

An LTC register was established and was updated following each monthly search. The register used a traffic light system to alert when recalls were due. Patients were recalled via text or a phone call from the nurse. If the patient did not respond to the first invitation then 2 more were sent. If there was still no response, the clinical lead was informed. Clinicians used the appropriate templates when conducting LTC reviews. LTC meetings were held to discuss the register and compliance with new or updated changes to policy or any risks identified.

Eighty-five patients had a diagnosis of asthma and 60 (71%) had an asthma review in the preceding 12 months. The DMICP asthma template was used by both nurses and doctors for reviews.

Of the 56 patients identified on the register as having high blood pressure, 52 had a record of their blood pressure taken in the past 12 months. Twenty-eight patients had a blood pressure reading of 150/90 or less.

There were 27 patients on the diabetic register. For 16 patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. A gestational diabetes (diabetes first diagnosed during pregnancy) register was maintained and patients were invited for an annual blood tests. A non-diabetic hyperglycaemia (high blood sugar) register was also held to track HbA1c (test to measure blood sugar) monitoring and monitor patients at risk of developing diabetes.

The clinical records we reviewed showed patients with asthma, high blood pressure and diabetes were well managed.

Hearing Conservation Programme searches were undertaken each month and audiometry assessments were in-date for 84% of the patient population. Our review of patient records demonstrated Joint Medical Employment Standards (referred to as JMES) were appropriately managed.

The DSMO was the lead for quality improvement activity (QIA) and QIA was used to monitor standards and make improvements to the service. A comprehensive and well evidenced annual audit programme was in place. It consisted of the mandatory DPHC audits (must) along with good practice audits (should), and clinical audits relevant to the needs of the patient population. Audit was a standing agenda item at the practice/HCG meetings. Audits completed each month were discussed at the meeting, including proposed improvements. A range of medicine and LTC audits had been undertaken, including a comprehensive annual audit of LTCs. The use of clinical coding was audited shortly before this inspection.

We reviewed a selection of clinical audits, including for cytology, hypothyroidism (low levels of thyroid hormones) and the firearms license audit. All were easy to follow,

understand and of a high standard. There was evidence of audit leading to improvements. For example, the Equality Access Audit led to the fitting of a hearing loop.

Effective staffing

Staff new to the practice, including permanent and locum staff, completed a structured induction relevant to their role. The main element of the induction form was retained by staff for their reference and the practice manager retained the completed checklist. A member of staff we spoke with during the inspection described how they received a thorough induction over 2 weeks, including shadowing other members of staff.

The office manager oversaw mandatory training. Staff received an email advising them of the training they needed to complete and this included links to the training courses. Protected time was allocated each month for the completion of mandatory and other training.

As the practice had an OPAL rating of red, it was working to the Regional Clinical Director's (RCD) 'top 10' priorities (until recently it was 11 priorities). This meant DPHC mandatory training had been reduced from 49 required to 10. The RCD accepted the risk of deferring all other mandatory training, provided the core 10 were completed. This arrangement was captured on the regional risk register. We confirmed all the RCD's priority training that included safeguarding, basic life support and infection prevention and control (IPC) had been completed.

The MOD GP was the practice training lead and discussed the training programme at the heads of department meetings. The in-service training (IST) programme for 2025 confirmed that a wide range of training relevant to the patient population and operation of the practice had taken place. IST supported staff with continuing professional development (CPD). Staff we spoke with said they were encouraged and supported to undertake CPD relevant to their role. They could apply for course funding through Regional Headquarters.

Individual staff had completed training relevant to their role and the needs of the service, such as IPC, minor surgery, aviation medicine and occupational diving. The practice manager and office manager had both completed the Joint Practice Managers training course. Staff also had opportunities to attend regional/national forums and training.

Peer review and clinical supervision was facilitated in a variety of ways, such as through auditing of clinical records and case discussion at the clinicians' meeting. Although an autonomous practitioner, the Advanced Nurse Practitioner (ANP) was mentored by 1 of the doctors. In addition, medics were supervised by the ANP, including their record keeping. The senior practice nurse and ANP were in the process of developing a plan to introduce formal clinical supervision for the nurses.

Through the Defence Post-graduate Medical Deanery, the practice was accredited by the General Practice Education Committee programme (GPEC) as a training practice for doctors. The aim of GPEC is to ensure training, and the training environment, for military doctors meets specific standards to maintain quality and consistency. The practice had a GPEC visit in October 2025 and received positive feedback. It was GPEC accredited for a further 3 years. Supervision arrangements were in place for trainees. The SMO was a GP

trainer and 3 of the doctors were supervisors for the General Duties Medical Officers and Foundation year 2 Medical Officer.

Coordinating care and treatment

The practice had effective relationships with the units and was represented at Unit Healthcare Committee (UHC) meetings where possible. Vulnerable patients, downgraded patients and occupational health statistics were discussed at the UHC meetings. The practice also had good links with internal defence services including the DCMH, Regional Occupational Health Team and the Primary Care Rehabilitation Facility at Tidworth.

The local midwife worked at the medical centre 1 day a week. The health visitor linked in with the safeguarding information meeting or contacted the practice directly if they had immediate concerns about a child. The Senior Medical Officer (SMO) had sent letters to local schools and NHS primary care practices to develop communication links between services, particularly in relation to safeguarding.

The practice was a Royal College of General Practitioners and NHS England 'Armed Forces veteran friendly accredited GP practice'. This meant it had a dedicated clinician with a specialist knowledge of military related health conditions. Staff had received additional training and advice regarding the healthcare needs of veterans.

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. The practice liaised if a 6 month extension was required for vulnerable adults.

The practice was veteran-friendly accredited. Patients leaving the service were provided with a leavers pack that included a range of information about additional services, such as Op COURAGE, a free NHS service in England that provides mental health support for veterans and their families. OP RESTORE is a further NHS service for service personnel who sustained a physical health injury during their time in service. 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.

Helping patients to live healthier lives

With an OPAL rating of 'red' health promotion was not 1 of the priorities the practice was required to meet. We found the practice had continued to provide this for patients.

The healthcare assistant was the lead for health promotion. The practice followed both the NHS and DPHC health promotion calendars so health topics were refreshed regularly on a rolling programme. Primary health prevention interventions provided at the practice included health education and risk-factor reduction, such as smoking cessation clinics and weight management.

The waiting area monitor screen system provided a range of educational information and videos for patients to watch while they were waiting. The main health promotion topics displayed at the time of the inspection were regarding cold and flu, hearing protection and sexual health. A range of patient-orientated resources were available regarding mental health wellbeing including QR codes and booklets for issues, such as suicide, stress, bereavement, post-traumatic stress disorder, managing depression and coping with suicidal feelings.

Sexual health services were provided from the Tidworth hub, including contraception and screening. The practice had open communication with Tidworth for advice if needed. Referrals were made to the defence sexual health consultant for patients with complex needs and if occupational health advice was required.

Although the OPAL rating of 'red' meant health screening was not a priority for the practice, staff had continued to effectively manage patients eligible for national screening programmes.

The nursing team led on the national screening programme and carried out monthly searches to identify patients eligible for screening. A register was maintained of the details of patients requiring screening. Cervical screening was completed by 2 of the nurses. Non-responsive patients were followed up in accordance with DPHC policy.

At the time of the inspection, a small number of patients were eligible for abdominal aortic aneurysm screening, 69 patients were eligible for bowel screening, 17 for breast screening and 631 for cervical screening.

The number of eligible women whose notes recorded that a cervical smear had been performed in the last 3-5 years was 526, which represented an achievement of 83%. The NHS target was 80%.

Vaccinations for babies and children were tracked and recalled centrally. The status of childhood vaccinations was:

- 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 93%.
- The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e., received Pneumococcal booster) (PCV booster) was 94%.
- 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 94%.
- The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) was 94%.
- The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) was 78%

Unit medics were responsible for the monitoring and recall of occupational vaccinations for service personnel in the larger units. The senior practice nurse over saw the management

of vaccinations for the smaller units. At the time of the inspection, the status of vaccinations was:

- 88% of patients were in-date for vaccination against diphtheria.
- 88% of patients were in-date for vaccination against polio.
- 89% of patients were in-date for vaccination against hepatitis B.
- 94% of patients were in-date for vaccination against hepatitis A.
- 88% of patients were in-date for vaccination against tetanus.
- 99% of patients were in-date for vaccination against measles, mumps and rubella.

Consent to care and treatment

Implied, verbal and written consent was taken depending on the intervention. Implied consent was obtained for blood samples and vaccinations and verbal consent for examinations requiring undressing, intimate examinations. Written consent was secured for minor operations. Minor surgery had not been carried for the last 6 months whilst the practice was short of clinicians.

Consent was considered as part of the record keeping audits. A specific consent audit was not undertaken due to staffing shortages within the administration team. A plan was in place to carry out this audit following the introduction of a new policy and clarification of clinical coding.

Clinicians understood the Mental Capacity Act (2005) and how it would apply to the patient population. The practice aimed to provide mental capacity refresher training annually with the most recent training held in September 2025. Mental Capacity was considered when clinical case discussions took place at the clinician meetings. We were given an example of a recent concern regarding a patient's capacity to make informed decisions. This was managed by the RMO and DCMH, including discussion with the SMO.

Doctors were aware of the 'Gillick competence' (process to assess whether a child has capacity to consent to medical treatment) and the 'Fraser guidelines' (process to decide if a child can consent to contraceptive or sexual health advice/treatment). Both these topics were discussed at the recent mental capacity training, delivered in-service by 1 of the doctors. Some of the nursing team were absent for this training so the senior practice nurse planned to share the training pack with the nursing team and discuss the topic at the next nurses' meeting.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

As part of the inspection, CQC received feedback about the service from 25 patients. In addition, we considered the results of the Defence Primary Healthcare (DPHC) patient feedback survey for 2025. All feedback indicated staff were friendly, understanding and caring. Furthermore, all patients who responded to the survey said the staff treated them with kindness and compassion.

Staff highlighted various scenarios of when the practice had shown compassion to patients. For example, to avoid a patient attending a secondary care facility for regular treatment for a progressive condition, clinicians provided daily home visits. The pharmacy technician went over and above to source the patient's medicines as they were not held in the dispensary and delivered the medicines to the patient. A member of staff described how they stayed for approximately 6 hours with a patient who was in crisis until a support plan was agreed.

A range of support networks were available to patients, including the welfare service, chaplaincy and HIVE (camp support network). The padre visited the medical service each month.

Involvement in decisions about care and treatment

Feedback indicated patients were involved with planning their care with all of those who responded to the DPHC survey indicating they were given clear information about their treatment and care. Our review patient records confirmed the involvement of patients in decision making about care. Some of feedback CQC received indicated patients were listened to and provided with the information they needed.

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 practice leaflet was available in Nepali. A practice clinician could provide translation for Nepalese patients if the circumstances were appropriate.

One of the doctors was the lead for patients who had a caring responsibility and a standard operating procedure was in place outlining how the practice supported carers. Clinical coding and alerts were applied to DMICP records to facilitate searches and to provide enhanced support, such as an invitation for the annual flu vaccination and annual health check. Information for carers was outlined in the practice information leaflet and there was a display in the waiting area. A Wiltshire Carers Association board had been displayed in the waiting area. It was recently damaged and the practice was awaiting a replacement.

Privacy and dignity

Purple cards were available at reception for patients to indicate they wished to speak with someone in private. Patient consultations took place in clinic rooms with the door closed. If headphone sets were used for telephone consultations then the patient's ID was checked prior to any information being disclosed. Privacy curtains were available in all clinical rooms for intimate examinations.

At the time of the inspection, there was a balanced mix of male and female clinicians so patients had the option to see a clinician of a specific gender.

Are services responsive to people's needs?

We rated the practice as good for providing caring services.

Responding to and meeting people's needs

We found that the practice was highly responsive to the needs of patients and the occupational health requirements for service personnel. Clinics were co-ordinated to meet those needs, such as a baby immunisation clinic, audiology clinic and a cytology clinic. Vaccination clinics could be coordinated at short notice to meet occupational demand. After school appointments were available for children and young people.

Patients could access the service in a variety of ways including via the daily walk-in emergency clinic (referred to as sick parade), Total Triage, eConsult and the use of email for repeat prescriptions. They could also telephone or call in to book a specific appointment such as for a smear, the flu vaccination and occupational health/medical board appointments. The use of alerts on clinical records meant patients who were vulnerable, had complex needs and carers were offered 30 minute appointments if they needed the extra time.

To ensure patients took the correct care pathway (including NHS services), the practice had developed a patient access chart. The use of colour meant it was visually obvious when displayed in the practice and on the front door. Providing examples for each pathway, it clearly outlined what to do, who to contact and resources to access in the following situations:

- what to do in an emergency
- when a care need is urgent but not life threatening
- injured or feeling poorly in the last 24 hours
- have symptoms that won't go away or need advice
- for healthcare administration
- for advice on common ailments and illnesses.

We considered this initiative notable practice as, it not only helped to streamline service access, but it supported patients with understanding the different and most appropriate access pathways so their needs were met in a timely way.

In line with the Equality Act 2010, an access audit for the premises was completed in July 2025 and no actions were identified. The premises could accommodate people with mobility needs as it was spacious with accessible parking spaces, an automatic opening front door, an accessible toilet and a hearing loop. A lift was available to access the upper floor. Signage was clear throughout the building.

For patients transitioning, the Defence Primary Healthcare (DPHC) policy was followed and patients added to screening surveillance lists when required. Gender-neutral toilets and baby changing were available. The doctors had recognised the need for a transgender

clinician lead to be identified and this had been discussed at a recent clinicians' meeting as best practice.

The practice had been awarded 'gold' by the LGBT Foundation for its ongoing commitment to LGBTQ+ inclusive healthcare.

Approximately 70% of staff had completed training in how to interact appropriately with people with a learning disability and/or autism. Although not mandated by DPHC, staff were required to complete it in line with the DMSR's Healthcare Defence Code of Practice. The leadership team were encouraging staff to complete the training to optimise awareness of individuals with different learning and communication styles. Given the practice had an OPAL red status, the training was deprioritised in accordance with the Regional Clinical Director's 'Top 10 Priorities'.

Timely access to care and treatment

The introduction of Total Triage had improved efficiency regarding access to care particularly given there had been limited clinician availability. The triage response team included a doctor, nurse and medic and patients could access this service each day via text or a phone call. Telephone appointments were routinely available and home visits were facilitated if it was clinically indicated.

Urgent appointments with a doctor, healthcare assistant and nurse could be facilitated on the same day and a routine appointment within 3 working days. Medics could see a patient on the same day. Occupational health medicals could be facilitated within 10 days. Home visits were supported if clinically indicated.

Medical cover until 18:30 hours was provided regionally between Bulford, Tidworth, Larkhill and Warminster medical centres. Outside of these hours, care was accessed via NHS 111 or 999.

Listening and learning from concerns and complaints

The practice manager was the lead for complaints and the Senior Medical Officer deputised. Complaints were managed in accordance with the DPHC complaints policy. The DPHC complaints process was used to record and manage complaints. Just 1 complaint had been received in 2025 and it had been appropriately managed. Minutes showed complaints was a standing agenda item at the practice/healthcare governance meetings.

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 caring services.

Vision and strategy

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

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

In addition, the practice had developed a local mission statement defined as:

> "At Bulford Medical Centre, we aim to provide high-quality, holistic care in a compassionate, inclusive, and respectful environment. We are committed to being responsive, honest, and supportive—enabling patients to take an active role in their health and wellbeing. Through a dynamic and disciplined approach, we foster a culture of trust, fairness, and loyalty within our multi-disciplinary team."

From our interviews with staff and review of patient feedback, it was clear the practice was working to the principles captured in its local mission statement.

Due to depleted staffing levels, the practice had moved from an OPAL rating of 'amber' to a 'red' rating in October 2024. At that time, there were vacancies across all staff groups, including within the senior leadership team (SLT), and 7 requests had been submitted for locum staff. Within this context, the 'red' rating meant the practice was only required to meet 2 of the 5 healthcare priorities outlined in DPHC guidance. This guidance defined how limited resources should be used to balance capacity against demand with meeting DPHC outputs. Our findings demonstrated the practice was fully meeting the 2 priorities, which included 'provision of safe and emergency care' and 'readiness and support for operations' (force health preparation, occupational health and statutory medical examinations required to deliver operations).

Despite the low staffing levels, the practice consistently aimed to meet the remaining 3 priorities where possible. The clinical elements of these priorities that were being met included routine provision for long-term conditions, health screening, health promotion and single service prioritisation. Our findings indicated the practice had continued to ensure a safe and effective service for patients across all 5 priorities. We discussed with staff how this had been achieved with limited staffing levels. All highlighted it was due to strong leadership, good communication and a willingness to adapt, with the team working in tangent to find solutions as challenges emerged.

At the time of this inspection staffing levels had improved. The Senior Medical Officer (SMO) had successfully campaigned for an office manager position and recruitment to this post had happened shortly before the inspection. Underpinned by an ASER trend, a business case resulted in the recruitment of a civilian MOD GP. They were due to take up

post in November 2025. A further business case had been submitted to DPHC Headquarters to uplift the position of the MOD GP to DSMO to strengthen resilience of the SLT and stability of the workforce. The MOD GP was currently acting in the role. As staffing levels had improved, the OPAL status was due to be revised to 'amber' in November 2025.

Aircrew from RAF Boscombe Down (a military airfield nearby) were previously registered with Bulford Medical Centre. The SMO recognised the practice did not have sufficient suitably qualified and experienced personnel to safely meet the specific healthcare and occupational needs of aircrew. To develop an evidence-base for the care of the aircrew to be transferred to an RAF medical centre, the SMO and SLT carried out a thematic analysis of ASERs over a continuum period (multiple years used), chaired meetings with a range of RHQ personnel, chaired intelligent customer meetings and developed an evidence-based and detailed IRTB (issues, risks, timings, background) staff report. The SLT then used this evidence to develop an informed business case to enable 2 RCDs from cross-regions (Central Wessex and London South) to recommend and approve the RAF aircrew transfer. The RAF doctor at Bulford Medical Centre (previous DSMO at Bulford Medical Centre) also transferred with the patients.

Given the practice supported families of service personnel, the SMO had developed strong and effective relationships with local health and social care services, including participation with the Wiltshire quarterly safeguarding integrated care board (ICB) meetings.

In conjunction with Wiltshire Council and the ICB, the SMO was actively involved in a research-based project led by Healthwatch Wiltshire. The project concerned the health needs and experiences of families in Wiltshire, with the aim to ensure health equity for military families. The outcome of a survey highlighted key issues of loneliness and connectedness as the main issues for military families. The data resulted in the setting up of a series of working groups with the aim to improve support in the areas identified. The SMO advised that this initiative was recently shortlisted for the Health Service Journal (NHS national awards) national award under the military and civilian collaboration category.

The SLT aimed to communicate change to the patients in a timely way using as many ways as possible. Communication channels included the practice's social media platform, Part 1 orders and displays within the medical centre. The welfare team shared the practice's social media items to broaden the distribution.

To support with environmental sustainability, recycling was encouraged and the use of QR codes and electronic information rather than printed information. A process for waste segregation was in place including printer toner, cartridge and battery recycling schemes. place.

Leadership, capacity and capability

The core members of the SLT were highly experienced. They included the SMO, acting DSMO and practice manager. There had been a change of practice manager in the last 6 weeks and this involved a comprehensive handover with the outgoing practice manager, who was available to support with this inspection.

We interviewed a wide range of staff throughout the inspection and all said the SLT 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 the SLT treated all staff equally regardless of rank or whether they were military or civilian. In terms of capability, staff indicated they had every confidence in how the SLT managed the practice. In particular, staff made reference to how well the service was structured, integrated and how leaders invested in a whole-team approach.

We found that the SLT team worked exceptionally well together, were solution-focussed and had the skills with forward planning to provide a sustainable service for the patient population. This was evident in how the had team organised itself during the OPAL red period. The SLT took a pro-active approach to succession planning to ensure gaps in staffing were minimised and that staff had adequate training, including staff new to the practice. The coherent and collaborative leadership approach meant the smooth running of the practice was not dependent on any one individual.

Staff spoke well of DPHC Headquarters and highlighted that the practice was very well supported by the regional team.

Culture

It was clear from patient feedback, interviews with staff and the welfare team there was a patient-centred culture at the practice. This was also evident from basic observations, such as how patients were greeted at the reception. The team continually explored ways to improve the service for patients. This was reflected in developments and improvements made based on patient feedback, and clarity regarding access pathways.

Staff described how the SLT promoted an empowering culture which inspired confidence. We heard from staff that the team worked well together, with staff checking in on each other and offering support when needed. The whole team showed mutual respect for each other throughout the inspection.

We were given various examples of this cohesive and supportive approach. For example, the medics had a strong relationship with the administrative team and provided administrative cover when the team was short staffed. They were not obligated to do so given they were unit rather than DPHC medics. Furthermore, the medics adjusted their rota to support any gaps in the service. The administrative team spoke highly of the medics indicating there were times the team would have struggled with the workload without the additional support.

The SMO had instigated the duty sergeant attending the heads of department (HOD) meetings so unit medics were represented. The medics told us this initiative was inclusive, empowering and meant they felt part of the wider multi-disciplinary team.

In addition to team building events, the SMO introduced the ‘Active Practice’ initiative to promote both health and wellbeing across the team. Sessions provided included mindfulness and yoga session. In order to make this a monthly occurrence, the practice/healthcare governance (HCG) meeting were restructured to prioritise staff health and wellbeing alongside patient safety meetings. Another initiative introduced was staff

taking it in turn to provide a presentation about their role to the rest of the team. The aim of this was to improve awareness of each other's work, including the challenges encountered by individuals through their role.

All staff we spoke with highlighted they had complete confidence and trust in the SLT and would have no hesitation in raising concerns about professional standards issues. They said the practice was a safe space where errors can be acknowledged without blame, and the learning culture ensured lessons were learned.

All staff we spoke with were familiar with the whistleblowing policy. We were provided with an example of concerns that staff escalated to the area manager for resolution. They highlighted that taking that action had supported with developing the positive team culture.

Processes were established to ensure compliance with the requirements of the duty of candour, including giving those affected reasonable support, information and a verbal and written apology. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. A duty of candour log was maintained.

Governance arrangements

The DSMO and advanced nurse practitioner were the leads for HCG. Formal and informal communication channels were established including a monthly combined practice and HCG meeting. Minutes showed these meetings were well attended by staff. A HOD meeting and clinicians' meeting was held each week. Other regularly held meetings included a safeguarding meeting, nurses meeting and administrators meeting.

There was a clear staff reporting structure in place and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. Up-to-date terms of reference were in place for all staff and referenced any secondary roles undertaken. Staff with lead roles had protected time to carry out their additional duties.

The HCG workbook was the overarching system used to bring together a range of governance activities including the risk register, medical alerts, ASER, health and safety and quality improvement. It was comprehensive, easy to navigate and contained all the relevant information to illustrate how the practice was governed. All staff had access and contributed to updating the workbook.

A programme of quality improvement activity was established to monitor the outcomes and outputs of clinical and administrative practice. The DSMO was the lead for audit. Audits were presented and discussed with staff at the practice meetings. All of the DPHC 'MUST' audits and some of the 'SHOULD' audits had been completed. The audit calendar was reviewed at the practice/HCG meetings.

Managing risks, issues and performance

An effective process to identify, understand, monitor and address current and future risks including risks to patient safety was in place. Risks to the service were well recognised, logged on the risk register, kept under scrutiny by the practice manager and discussed at the practice/HCG meetings. Processes were in place to monitor national and local safety alerts, incidents and complaints.

The business continuity plan (BCP) took account of all the likely generic system failures. It was last activated in October 2025 when there was an unplanned DMICP outage. BCP incidents were analysed through a post-activation review.

The SLT was familiar with the policy for managing staff performance and had experience of implementing the policy, including through supervision, appraisal and the use of individual development plan. Underperformance was managed in line with DPHC policy.

Appropriate and accurate information

The Healthcare Assurance Framework (HAF), an internal governance review system, was used by the practice as to monitor performance and as a development tool. The HAF was reviewed with staff at practice/HCG meetings to reinforce good practice, highlight areas requiring improvements and encourage team-based problem solving. A practice development plan was in place and was populated through risks identified, analysis of ASERs and quality improvement activity.

The management of information was in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. The practice manager, SMO and office manager were the leads for Caldicott, a set of principles regarding the use of confidential information. Applying a risk-based approach, the office manager completed the weekly Caldicott report checks. The practice manager also reviewed that the checks had been completed with a particular focus on staff records that had been accessed. All staff had received training in information governance and the General Data Protection Regulation.

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 in the waiting area. They could also use the paper comment forms and they could register to join the patient participation group. Feedback from patients was displayed, in particular ideas for improvement, and the practice indicated how it had responded to the feedback. For example, patients asked for children’s toys in the waiting area. Toys had been purchased and were available on request.

Practice staff had well developed and effective relationships with the Chain of Command, units and welfare teams. The close location of the Department of Mental Health, Regional

Rehabilitation Unit and Regional Occupational Health Team facilitated regular engagement and provided a learning opportunity for trainee doctors.

Staff feedback was sought in face-to-face sessions. The sessions involved staff working in team with colour coded cards used to express how they feel. They were also offered the opportunity to expand on their feedback within the smaller groups to feedback to the management team.

Continuous improvement and innovation

Despite depleted staffing levels in recent months, the practice team was committed to continually improving the service and this was evident through quality improvement activity, including a comprehensive programme of audit and responsiveness to patient feedback. Some of the quality improvement initiatives included:

- The practice achieved ‘Gambling Harms GP Accreditation’ through the Royal College of General Practitioners accreditation scheme. The SMO completed the Gambling Harms eLearning course and delivered the training to clinicians in February 2025. Clinicians also had access to a resource pack. The aim of the training and awareness was to ensure effective screening for behaviours potentially associated with gambling, to provide support and referral to other services if needed.
- Development of a BCP display board in the practice manager’s office so there was easy access to the BCP in the event of an IT or power outage. The display board also included flow charts for the main scenarios and contact numbers.
- Combining all secondary care prescribed medications, shared care agreements and high risk medicines into 1 list with the aim to improve safety and efficiency with monitoring.
- In order to streamline the audiology process, for 1 month the doctors reviewed all audiograms rather than referring the patient for a repeat audiogram. The trial resulted in avoiding 54 repeat audiology appointments; a saving of 18hrs of medic/health care assistant time. This initiative was nominated for the Colt prize.