High Wycombe Medical Centre

RAF High Wycombe, Walters Ash, Buckinghamshire, HP14 4UE

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?	**Requires improvement**	
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 8 January 2026.

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

Are services safe? – requires improvement

Are services effective? – good

Are services caring? – good

Are services responsive to people's needs? – good

Are services well-led? – good

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.
- Safeguards were in place, including close working with the Station Personnel Support Committee and welfare team. Patients vulnerable due to their mental health and/or social circumstances were well managed and supported.
- Despite the challenges associated with depleted staffing levels, staff indicated the leadership was strong and communication was effective. Staffing levels had not been reviewed since the patient population increased.
- Physiotherapy record keeping was not in accordance with expected standards.
- There was an open and transparent approach to safety. A comprehensive process was in place for managing significant events. Emerging themes were used as drivers for change.
- The arrangements for managing medicines minimised risks to patient safety.

- The Primary Care Rehabilitation Facility (PCRF) infrastructure was in a poor state of repair and did not fully meet infection prevention and control (IPC) standards. The building was not accessible for people with mobility needs.
- Healthcare governance processes were well-developed and routinely used to monitor and improve the service. However, integration between the medical centre and PCRF would benefit from improvement.

The Chief Inspector recommends to the Station:

- As a priority, the PCRF infrastructure should be reviewed and a sustainable solution agreed to ensure it is safe for patients, meets IPC standards and is fully accessible in accordance with the Equality Act 2010.
- Ensure contractors provide the practice with evidence of the utility checks, including water temperature checks.

The Chief Inspector recommends to Defence Primary Healthcare:

To ensure the staffing level is sufficient to meet the needs of the increased patient population, consider undertaking an establishment review to check if there has been a change in resource need since the last review in January 2022.

The Chief Inspector recommends to the practice:

- Organise a deep clean for the PCRF.
- Carry out a fire evacuation drill for the PCRF.
- Undertake a physiotherapy record keeping audit to monitor if templates are used correctly and outcome measures are routinely recorded as this will enhance the accuracy of Apollo data. In addition, undertake a clinical record keeping audit for the exercise rehabilitation instructor.
- Review the governance and administrative arrangements between the medical centre and PCRF to enhance integration between the 2 services and reduce unnecessary duplication.
- Revise the business continuity plan (BCP) to include relevant information relevant to the PCRF. In addition, ensure the BCP provides guidance for system outages, including the DPHC referral system.
- When the ‘Operational Pressures Activity Levels’ (referred to as OPAL) rating allows, engage in routine chronic disease recalls and audits to ensure delivery is in accordance with recommended national guidelines. This should include patients with diabetes to ensure they are appropriately recalled for eye screening and patients on the hypertension register to ensure they have been appropriately recalled for a blood pressure check.

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 primary care doctor, pharmacist, primary care nurse, physiotherapist, exercise rehabilitation instructor and practice manager.

Background to High Wycombe Medical Centre

High Wycombe Medical Centre provides primary health care to service personnel working for Headquarters Air and UK Space Command. At the time of inspection, there were 1,900 registered patients. Families of service personnel are not registered at the practice so are signposted to local NHS practices.

In addition to routine primary care, the practice provides a physiotherapy and rehabilitation service from the Primary Care Rehabilitation Facility (PCRF) located a short distance from the medical centre. Occupational health services are provided for patients and for a small number of reservists. Family planning advice is available and patients could also be referred to NHS community services. Maternity and midwifery services are provided by NHS practices and community teams. The practice does not have a dispensary and has an ad-hoc contract with a local pharmacy.

The staff team

Medical team	Senior Medical Officer (SMO) – **position gapped** Deputy SMO – acting as SMO MOD GP x 3 (1 locum)
Nursing team	Civilian practice nurse Military practice nurse - **position gapped** (locum cover) Health care assistant
Practice management	Civilian practice manager Military deputy practice manager (DPM)
PCRF	Civilian Band 6 physiotherapist x 2 Exercise rehabilitation instructor
Administration	Administrators x4 – **1 post gapped**
Medic*	RAF medic

Are services safe?

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

Safety systems and processes

The Senior Medical Officer (SMO) and deputy SMO (DSMO) were the safeguarding leads for the practice. Reviewed in May 2025, the adults and children safeguarding 'quick reference guide' was displayed in all clinical rooms. The staff team were in-date for safeguarding training relevant to their role.

Vulnerable patients were identified through the patient registration process, via consultations, summarisation of patient records and through the welfare team. A clinical code and alert were applied to individual records to ensure patients assessed as vulnerable were readily identified. Rather than maintain a vulnerable patients register, the SMO ran regular DMICP (electronic patient record system) searches to identify patients coded as vulnerable. These patients were then reviewed at the clinical meeting each month. Workload permitting, the SMO attended the station welfare meetings at which vulnerable service personnel were discussed.

Staff provided examples of how vulnerable patients were monitored and supported. One such example demonstrated a multi-agency approach was taken to manage the risk including involvement of the RAF Health Directorate, Chain of Command and the police.

The chaperone standard operating procedure (SOP) was reviewed in September 2025. A list of trained chaperones was available with training expiry dates identified. The practice developed its own bespoke DMICP synonym (short cut to standardise clinical activity) for when a chaperone is offered/utilised to ensure standardisation of record keeping. A chaperone audit was conducted in October 2025 and it highlighted the coding of chaperones as an area for improvement.

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 (DBS) certificates to ensure staff were suitable to work with vulnerable adults and young people. DBS checks were renewed every 3 years. The professional registration for clinical staff was monitored and was up-to-date for all staff. The nursing team monitored the vaccination status for staff and all were in-date. All staff had crown indemnity. A process was in place to ensure locum staff were appropriately recruited.

The practice nurse was the lead for infection prevention and control (IPC) and had completed the link practitioner training for the role. All clinical staff had completed the mandated IPC training. The IPC audit was undertaken annually and was last completed for the medical centre in September 2025.

A separate IPC audit was conducted for the Primary Care Rehabilitation Centre (PCRF). This was completed by the lead physiotherapist. They had not undertaken the link practitioner training and liaised with the IPC lead regarding the audit, although there was

no formal check or sign off of the PCRF IPC audit. The poor state of the PCRF meant maintaining IPC compliance was a challenge. Statements of need had been submitted for replacement flooring in the waiting areas and toilets.

Although not delivered at the time of the inspection, IPC measures were in place for the provision of acupuncture including an acupuncture SOP and sharps SOP.

The spread of infectious diseases was minimised by the practice adhering to the IPC standards. Personal protective equipment and hand gel was readily available along with handwashing posters. The practice 'Pandemic, Flu and Communicable Disease' plan was reviewed in December 2025. Privacy curtains in clinical rooms were changed every 6 months.

An environmental cleaning contract was in place for both the medical centre and PCRF. The cleaning schedule included a risk assessment of each room/area to determine the IPC risk level. A colour coding system was displayed in each area to indicate the frequency of cleaning. A deep clean was carried out each year and was completed for the medical centre in February 2025. A deep clean was outstanding for the PCRF as this had not been arranged at the same time as the deep clean for the medical centre. Although evidence was not available at the time of inspection, we were advised that cleaning standards were monitored and audited by the cleaning supervisor and contract management team. However, there was evidence of regular and appropriate communication between the practice manager and the cleaning supervisor. The practice manager confirmed they undertook a weekly environmental spot check. The exercise rehabilitation instructor (ERI) cleaned the PCRF equipment each month.

The nursing team oversaw healthcare waste. A clinical waste log and consignment notes were in place and up-to-date. The waste log was cross referenced with the consignment notes. The pre-acceptance audit was completed in March 2025. Sharps boxes were labelled, dated and disposed of appropriately. Clinical waste was securely stored outside the building. At the time of inspection, the practice was still using orange waste bags as the new 'tiger bags' were not yet available to ensure compliance with the changes to the safe and sustainable management of healthcare waste (HTM 07-01). After the inspection, the practice manager provided evidence to confirm they had followed up on the tiger bags with the station.

Risks to patients

Based on Defence Primary Healthcare (DPHC) 'ASSESSREP' guidance, the practice had been functioning with an 'Operational Pressures Activity Levels' (referred to as OPAL) rating of amber. This was due to depleted staffing levels. Three posts were vacant (both administrative and clinical roles) which represented 18% of the staffing establishment. Locum staff were employed to cover clinical roles only. The OPAL rating of amber meant routine care provision, routine force preparation and occupational health activity may be delayed or diverted.

The last establishment review was undertaken in January 2022. Repeating this could inform the practice of a resource need particularly as the patient population increased with

the addition of UK Space Command. Workforce and the potential for it to fall below minimum standard was captured on the risk register.

We noted from the staff survey that morale was impacted by low staffing levels. The SMO and practice manager regularly prioritised the workload in line with OPAL guidance with the aim to minimise burn out. Given the network arrangement, the practice could reach out to the team at Halton Medical Centre for support.

Checks of the medical emergency kit were carried out by the nurses each day. A full check of the kit and emergency medicines was undertaken monthly or if the trolley had been opened/used. Although not recorded, the trolley security tag was checked daily when the temperature was checked. The practice addressed this by adding the security check to the temperature monitoring sheet. A signed and up-to-date risk assessment was in place with the controlled drugs (medicines with a potential for misuse) removed from the list by the SMO and MOD GP. They had been risk assessed as not required on the medical emergency trolley as we were advised there was an 8 minute response time for an ambulance. All clinical staff were aware of where the risk assessment was held. Our check of the trolley showed the emergency equipment was in-date. A 100% check of emergency medicines was undertaken monthly and medical gases were compliant with the DPHC SOP. An automated external defibrillator (AED) was available in the PCRF gym. First aid, eye care and biohazard spill kits were located by reception along with a form confirming the kits were checked each month.

Training records confirmed all staff were in-date for basic life support (BLS) training along with use of the AED and anaphylaxis. Staff confirmed that moulage or scenario-based training was infrequent and formed part of the BLS training held in February and August 2025. Following a patient presenting with acute breathing difficulties, the SMO reviewed the SOP for emergencies. A moulage was facilitated in August 2025 to ensure non-clinical staff were aware of the action to take in the event of a medical emergency. We highlighted that more regular moulage training for the whole team, including PCRF staff, would be beneficial.

Although not DPHC mandated training, staff told us they had not completed sepsis training recently. It was last delivered in July 2022 but there had been a turnover of staff since then. The practice manager confirmed that the General Duties Medical Officer was due to deliver sepsis training for the team in December 2025 but it had to be rescheduled to February 2026. Staff we spoke with were aware of the signs/symptoms and action to take if sepsis was suspected. Furthermore, sepsis awareness posters were displayed in clinical rooms and the waiting area. Training records showed staff had completed heat illness training.

Information to deliver safe care and treatment

During DMICP outages the practice deferred to the business continuity plan (BCP) and only saw patients with an urgent need. Consultations were recorded on paper forms which were later scanned to DMICP when connectivity resumed. Paper packs for this purpose were held in the dry store along with paper copies of the current version of the BCP. Routine clinics were cancelled during an outage with appointments rescheduled once DMICP was available.

At the time of the inspection there was an outage of some digital systems and this had been the case since mid-December 2025. This outage was Defence-wide and affected the organisational-wide system for reporting significant events (referred to as ASER), the Healthcare Assurance Framework, the internal governance review system and the DPHC referral system. Staff were unable to access these systems during the inspection. The practice had been advised that the issue would likely be resolved mid-January 2026. Paper copies of ASER documentation were available should a significant event need to be reported during a system outage.

Due to depleted staffing levels, the practice acknowledged there was a backlog with summarisation and this issue was captured on the risk register. Initially, the plan to address the backlog was to provide the practice nurse with dedicated time each day for summarising but this had been paused due to further staff gaps in the nursing team. The development of a regional clinical hub was also planned to assist with the backlog. However, recruitment to this regional post was halted due to the DPHC-wide civil service recruitment freeze. At the time of the inspection, 63% of patient records had been summarised; 700 records were outstanding for summarisation. This had improved since June 2025 when there were 1,300 outstanding so it was evident the practice was working to address the backlog.

Arrangements were in place for the review and/or auditing of record keeping across all clinical staff groups. The doctors, including the SMO, conducted a regular peer review record keeping audit with the most recent in June 2025. Each doctor was given feedback individually so they could reflect on any areas identified for improvement. Similarly, the nurses audited each other's record keeping in April 2025. The 2 physiotherapists had audited each other's records. The ERI was newly qualified and had been in post for 6 months. Although not formally reviewed, there had been an informal verbal evaluation of the ERI's record keeping. The medics' role with patients was solely occupational health based, including undertaking audiology testing and blood tests.

Overseen by a dedicated administrator, the DPHC centralised system for referral management was used to capture and track referrals, including urgent 2-week-wait (2WW) referrals. At the time of the inspection, the practice had no access to the referrals system due to an outage. Although we were unable to review the status of referrals, we confirmed referrals were completed in accordance with the practice's internal and external referrals SOP.

We were concerned that 2WW and urgent referrals could not be monitored give that the system had been unavailable since mid-December. We discussed this with a regional governance lead who confirmed there was no DPHC-led backup system in place. Promptly after the inspection, the practice explored ways to check the 2WW and urgent referrals. They carried out the following actions to check the status of referrals:

- an audit of tasks completed by the referrals lead
- a search for all referrals sent since the system went offline
- a check of all referrals sent via the NHS e-Referral digital platform. It was confirmed no referrals had been sent via any other means.

An SOP was in place for the management of specimens and pathology results with the healthcare assistant taking the lead and the practice nurse identified as the deputy lead. The specimen tracker was maintained and included when results were received and actioned by a doctor. The nursing team received all results and the duty doctor viewed them each day in the global mailbox to decide if action was needed on the day or if they could wait to be reviewed by the requesting doctor. As an additional failsafe measure, the SMO reviewed the global list each week. A specimen handing audit was undertaken in August 2025.

A large number of laboratory errors had been raised as significant events. Our review of the ASER system identified 57 laboratory errors raised since 2022. To address the matter, the SMO engaged with the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (ICB), the local medical committee and local NHS trust. Meetings were held between the practice nurses and laboratory staff and processes were agreed. The SMO had since attended the ICB meetings so had direct contact to raise any further concerns. The number of laboratory errors had significantly reduced since the new process was put in place. For example, 24 laboratory errors were raised as ASERs in 2024 and just 1 in 2025.

Safe and appropriate use of medicines

The MOD GP was the lead for medicines management and the SMO deputised. This lead role was reflected in the MOD GP's terms of reference. There was no dispensary at the practice. All prescriptions were signed before being scanned and sent to the outsourced pharmacy with physical copies sent on alternate days.

FMed 296 forms (standard military prescriptions) were recorded in a bound numbered log and stored securely in a locked cupboard. The log had a running total and was in line with guidance. Prescriptions were logged in batches of 500 and were signed in and out by the medic and prescriber at the time of issue. A signature log was also in place.

The nurses had completed vaccine training and the vaccine stock was accounted for on DMICP. All vaccines were in-date and evidence was in place to confirm they were rotated correctly in the pharmaceutical fridges. There was sufficient space around the vaccine packages for air to circulate. Evidence was seen of twice daily monitoring of the fridge temperatures and the external thermometers were in-date. The previous 6 temperature logs were available and included the last time the fridge was cleaned. The nurses were aware of the action to take in the event of a temperature breach. They also were aware of how to utilise the data logger and the documentation required for the regional pharmacist to sign off use.

The temperature probe in the larger vaccine fridge was not in a water dropper so the fridge alarm was activated more frequently when the fridge was opened. This was rectified on the day of the inspection. The fridges were located in front of plug sockets so they were not to be accidentally switched off. Destruction of medicines was in line with DPHC policy.

No controlled drugs (CD) were held at the practice. The only (CD) stationery held was for private prescriptions that were logged and stored in a secure cabinet. The practice manager oversaw the re-supply of these via region and signed for them along with a

doctor. The doctor issued these prescriptions with an administrator providing a counter signature.

Patient Group Directions (PGD) were used by the nurses. Evidence was in place to confirm the nurses were in-date for PGD training. Both nurses had been signed off by the SMO for all vaccinations that are required on the small apps system. PGDs were only utilised for the issuing of vaccinations. All 5 PGDs we reviewed were accurate, on the correct protocol template and had been signed off prior to the date they were used. The PGD live link was referenced when PGDs were given. No delegation of PGDs was seen on the day of inspection. A PGD audit had been completed in the last 12 months. Patient Specific Directions were not used and there were no non-medical prescribers working at the practice.

Patients prescribed high-risk medicines (HRM) were well managed as confirmed by our review of a range of clinical records. All showed correct clinical coding with an alert applied to the record. There was evidence of recent scrutiny of the patient's record to check for blood tests, a medication review and whether a shared care agreement (SCA) was in place if applicable. The medicines management lead carried out regular HRM searches which informed the quarterly HRM audits.

Repeat prescriptions were commonly requested through eConsult but also via email and handed in by the patient. If a review was required for HRMs requested, a task was sent to the duty doctor and an appointment made for the patient. The prescription was printed and emailed to the local pharmacy. This was followed by the administrator sending a paper copy of the prescription to the pharmacy.

A process was in place to capture 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.

Regular searches were undertaken for valproate (medicine to treat epilepsy and bipolar disorder) and topiramate (medicine to treat migraine) to identify patients prescribed these medicines to ensure their care was in line with best practice guidance

Track record on safety

The practice manager and deputy practice manager (DPM) were the health and safety leads for the practice. Six-monthly safety, health, the environment and fire (SHEF) inspections were completed with the most recent in August 2025; no actions were identified. Health and safety was a standing agenda item at the practice meetings. The SHEF leads focussed on the medical centre with the physiotherapists and ERI carrying out the SHEF checks for the PCRF. This impacted the clinical capacity of PCRF staff.

The practice manager and DPM were the leads for risk management. The risk register included active and retired risks which could be identified by filter. It also included who was responsible for each risk, including whether risks had been transferred to region. An issues

log was also in use. All risks had a review date and risk was a standing agenda item at the practice meetings.

One of the medics was the lead for fire safety. The 5-yearly fire risk assessment for the medical centre was completed in February 2021 and was next due in July 2026. Evidence was in place to confirm weekly fire alarm testing took place and also other weekly and monthly checks of the fire alarm system. The fire department checked the firefighting equipment in December 2025. Staff we spoke with confirmed a fire evacuation drill was held every 6 months for the medical centre. An evacuation drill had not been held for the PCRF in the last 6 months.

Although processes were in place for the regular monitoring of utilities, contractors did not routinely issue the practice with evidence of these checks. These were provided promptly after the inspection. The electrical installation safety report was issued in April 2025 and the gas and heating system was checked in August 2025. Records demonstrated that the contractor carried out hot and cold water temperature checks each month. Practice staff kept a record of the regular flushing of water outlets.

The annual equipment inspection (referred to as a LEAT) was completed in September 2025 and 1 minor non-conformance with service policy (not legislative) was identified for 6-monthly snap checks not undertaken by Regional Headquarters (RHQ). The next LEAT was scheduled for February 2026. Equipment was in-date for servicing, including PCRF equipment serviced by the medical and dental servicing section (a military capability referred to as MDSS). Electrical equipment testing was undertaken in September 2025.

The PCRF was in a separate building to the medical centre. From our review of the building, we considered it was in a poor state of repair. The roof was leaking and it was structurally supported by internal scaffolding as staff said it was not safe. Furthermore, a building survey confirmed the roof was unsafe. The changing rooms and toilets were significantly aged and in need of repair. Although air conditioning and heating was available in the gym area, this was not the case for the offices and clinical rooms. The heating was not working in these rooms and we were advised that it could not be fixed. Staff reported that these rooms overheat in the summer so external doors were left open to ventilate the premises. This presented a risk as the PCRF was located outside the station's secure perimeter fence. Since security of the PCRF was breached on at least 2 occasions resulting in damage to the building, improvements were made to the security following a unit crime prevention survey in August 2020.

Some patients who responded to the PCRF feedback survey highlighted their concerns about the environment. Comments included: "DIO [Defence Infrastructure Organisation] should look after the building, no leaks and provide heaters. Staff and patients deserve better facilities", "the PCRF building is clearly beyond it's intended life with multiple issues throughout. However, the clinical team were fantastic and clearly making the best of a bad situation" and "waiting area has a leaky roof".

These infrastructure concerns were captured on both the practice and station risk registers. Although discussions were taking place about relocating the PCRF within the station, no firm plan had been agreed.

Although not held together in an integrated way, a range of risk assessments were in place both for the PCRF and medical centre. In addition, risk assessments and safety data sheets for substances hazardous to health (referred to as COSHH) were in place for COSHH products held at the practice. We noted some COSHH products that had exceeded their expiry date were stored in an unlocked non-compliant cupboard in a disused treatment room. These products were no longer in use.

Evidence was in place from July 2025 that the practice manager had regularly engaged with the station SHEF team to request a compliant COSHH cupboard for both the medical centre and PCRF. Also, removal and disposal of the out-of-date COSHH items had been requested at the same time. These requests had not been actioned. Although the matter was not recorded on the issues log and had not been elevated to RHQ, it was captured on the risk register. Promptly after the inspection, the practice manager provided confirmation that removal of the COSHH products had again been requested. This was confirmed once the cost for removal was agreed. In addition, the practice manager confirmed after the inspection that a compliant COSHH cupboard had been supplied and products were now stored securely.

A fixed alarm system was in place for some areas of the medical centre and, for other areas, portable hand-held alarms were in use. Both systems were tested weekly and a record maintained of the checks. The lone working SOP for the practice was reviewed in September 2025.

Wet globe bulb testing to indicate the potential for heat stress was used in certain circumstances if a need was identified.

With the PCRF outside of the security perimeter fence, lone working was avoided but this was not always possible as the PCRF team was small. Lone working was mitigated by an administrator working from the PCRF. The physiotherapist informed the medical centre if a member of staff was working alone and they telephoned the medical centre to check in at 10:30 hours, 14:30 hours and when they left the building. If it was after 17:00 hours, they checked in with the guard room every hour. The PCRF panic alarm system was linked to the guard room and was checked each week.

Lessons learned and improvements made

The practice worked to the DPHC policy for reporting and managing significant events, incidents and near-misses recorded on the ASER system. At the time of inspection, 95% of staff were in-date for ASER training. All staff, including locums, had an ASER log-in. Part 2A access was held by the SMO and practice manager who engaged with the appropriate staff as part of the root cause analysis.

Although the live ASER system was not accessible at the time of the inspection, we were able to review recently raised significant events on the practice's ASER register. It included details of lessons learnt and outcomes which all staff had access to. All ASERs were discussed as a standing agenda item at the healthcare governance meetings. They were also discussed at the PCRF meeting.

Staff we spoke with provided examples of ASERs, including the action taken, changes made and lessons learnt. We noted there had been a significant decrease in the number of ASERs submitted for 2025 in comparison to previous years. The regional governance lead explained that the this was due to the improvements in laboratory processes resulting in a reduction of errors. The SMO explained that incidents were reviewed and only reported via the ASER system if they reached the threshold. The practice submitted ASERs in order to escalate an issue to RHQ and/or if there was learning that could be shared widely with other medical centres. A recent (paper) ASER was raised due to the systems outage and staff being unable to access the hospital referral tracker.

Medicines and Healthcare products Regulatory Agency alerts were received directly to the practice inbox as well as through the group email box. They were recorded on the alerts register and all entries included details of the action taken in response to the alert. We noted that National Patient Safety Alerts received from the Central Alerting System (CAS) were not included in the register. This was addressed during the inspection.

Are services effective?

We rated the practice as good for providing effective services.

Effective needs assessment, care and treatment

Clinicians advised us that National Institute for Health and Care Excellence (NICE) guidance, updates from the Scottish Intercollegiate Guidelines Network, local integrated care board updates and other best practice guidance (BPG) were discussed at the monthly clinical meetings. Our review of the meeting minutes for November 2025 confirmed detailed discussions took place regarding clinical updates. Furthermore, staff were kept informed of clinical and medicines updates through the Defence Primary Healthcare (DPHC) newsletter circulated each month.

In addition, the Primary Care Rehabilitation Facility (PCRF) staff kept up-to-date regarding wider Defence Rehabilitation matters through the DPHC homepage, Defence Rehabilitation SharePoint, the DPHC standard operating procedure (SOP) handbook, the regional Teams page and from the Band 8 Regional PCRF lead. The PCRF team attended the monthly networking meetings with other PCRFs at which updates to physiotherapy and rehabilitation were discussed.

Patients of interest, such as those with complex health needs, musculoskeletal (MSK) injuries and vulnerable patients were discussed at the clinical meetings and referred to by just their DMICP number in the meeting minutes. PCRF staff attended the remote multi-disciplinary meeting held with the Regional Rehabilitation Unit on a regular basis.

The PCRF team took a holistic approach when assessing patients and considered lifestyle factors, such as mood, sleep and diet. They used the Defence Occupational Fitness (referred to as DOfit) programme to support patients with lifestyle changes.

The standardised MSK Health Questionnaire (MSK-HQ) outcome measure for patients to report their symptoms and quality of life was routinely completed at the first assessment. Ideally, this should be completed periodically (usually every 6 weeks) during treatment and at the end of treatment to monitor the effectiveness of care. PCRF staff were not aware of the Apollo Dashboard (for key performance indicator or outcome data) and were also not using templates correctly which was affecting the accuracy of Apollo data. Patients accessed rehabilitation exercise programmes through Rehab Guru (software for rehabilitation exercise therapy). Exercise plans were coded and copied/pasted to the patient's record.

Our review of a range of physiotherapy clinical records was not consistent with the findings of the clinical records audit carried out by the physiotherapists. We found that the assessment of the patient's condition based on history, clinical signs and examination was limited or incomplete, particularly the objective assessment. In addition, the physiotherapist's clinical impression was not always recorded.

The practice pro-actively responded to patients with mental health needs. Doctors provided interventions in accordance with 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 additional intervention were referred to the Department of Community Mental Health (DCMH). Whilst awaiting the DCMH appointment, the RAF Benevolent fund was used to source counselling for patients. Furthermore, referrals could also be made to the Padre and welfare team to provide patients with additional support.

If appropriate, doctors put risk assessments and safety plans in place for individual patients to ensure the occupational elements were captured. For example, if weapon handling was removed from a patient then the doctor informed the armoury. Our review of clinical records showed patients with a mental health need were well managed, and appropriate clinical coding was used.

Monitoring care and treatment

A doctor was the lead for long-term conditions (LTC) and the senior practice nurse deputised. Along with an LTC SOP, a register was maintained to monitor and track patients. Clinical coding supported the searches to identify new patients who were then added to the register. Patients were recalled quarterly via the GOV.UK Notify texting system. Email or a telephone call were used if an alert was present requesting no text. The patient received a telephone call if they did not respond after 3 recalls. If there was no response after 6 attempts then the SMO sent the patient a letter.

The diabetes register identified 26 patients. Our review of a selection of records demonstrated these patients were well managed with good use of templates and a clear flow from the nurses to the doctor for a review. For patients with a HbA1c (blood glucose test) above 59, records showed this was being addressed through an escalation of treatment. Twenty-three patients had not had retinopathy (an eye condition caused by diabetes) screening in last 12 months. Review of a selection of notes indicated some were subject to a 2 yearly recall or had an appointment scheduled. We considered that clinical coding may need a review and/or the search modifying to include 2 yearly recalls.

Our search identified 115 patients with high blood pressure. Of the 115, 38 had a blood pressure of 140/90 or above. Not all patients had their blood pressure checked in the last 12 months.

The 25 patients with a diagnosis of asthma had been reviewed in the last 12 months. A small number of patients were not on Maintenance and Reliever Therapy (MART). Updated NICE guidelines has aimed to reduce reliance on short-acting beta agonists (referred to as SABA) inhalers by promoting MART and sustainable dry powder inhalers. There was an opportunity for the doctors to discuss the switch to MART at the patients’ next review.

Overall, the clinical records we reviewed showed patients with asthma, high blood pressure and diabetes were well managed. There was scope to improve through the consistent use of chronic disease templates.

Hearing Conservation Programme searches were undertaken and audiometry assessments were in-date for 61% of the patient population. There were mitigating

circumstances for the 703 patients who were out-of-date for audiology, notably depleted staffing levels meaning LTC recalls took priority. This matter was captured on the risk register. Our review of patient records demonstrated Joint Medical Employment Standards (referred to as JMES) were appropriately managed and the correct template was used.

The SMO was the lead for clinical audit and an MOD GP deputised. The nursing team led on quality improvement. All DPHC mandated audits (MUST) had been completed and those we reviewed were of a good standard, including the cytology and infection prevention and control (IPC) audits. An antimicrobial prescribing audit was carried out in September 2025. Involving the scrutiny of 9 prescriptions from a specific day in July 2025, it showed 100% compliance against prescribing guidelines. The most recent high risk medicines audit was undertaken in January 2026 and showed 88% were in-date for monitoring with 94% having a shared care agreement in place. Reminders were sent to patients based on the outcome of the audit. The results of audits were discussed with staff as a standing agenda item at the health care governance meetings, including the improvement actions.

Due to depleted staffing levels, DPHC recommended (SHOULD) and BPG audits had not been undertaken, including those for LTCs and rehabilitation. This was captured on the risk register and was in line with the priorities of the current OPAL amber rating.

Effective staffing

Permanent staff new to the practice completed a structured generic induction programme, which included all DPHC mandatory training, including an induction to the PCRF. A specific PCRF induction was also in place and included details about the medical centre. The PCRF induction included risk assessments, SOPs and the expected standards for physiotherapists.

The induction programme was supplemented with a role specific induction, including an IPC induction for all staff and a specific induction pack for locum staff. Completed induction packs were retained by the practice manager. Staff we spoke with during the inspection described how they received a thorough induction, including shadowing other members of staff and access to supervision once the induction was completed.

Overseen by the deputy practice manager, a monthly check of the staff training database was undertaken. This was discussed at practice meetings with any staff who were due refresher training or who were out-of-date, and they were directed to complete the training. Our review of the database showed the majority of staff were in-date for training. There were valid reasons for training gaps including long-term sickness, extended leave or deployment. The in-service training programme for 2025 indicated that training mostly focussed on mandatory requirements.

Staff had completed training relevant to their role and clinical activity. For example, nursing staff were trained in wound care, cervical screening and diabetes. The MOD GPs had completed the Military Aviation Medical Examiners (referred to as MAME) course and the SMO had completed the Diploma in Aviation Medicine. PCRF staff attended a hip course at Halton last year and they also participated in ‘BPG roadshows’. The practice manager had completed the practice management course and had completed the Institute of

Occupational Safety and Health certificate. The SMO had completed healthcare governance training.

Training and development needs were identified through appraisal. Staff we spoke with said they were encouraged and supported to undertake continuing professional development (CPD). CPD opportunities were regularly circulated to all staff, such as access to conferences and application routes for courses. The nurses advised that they had access to funding for CPD. The General Duties Medical Officer (GDMO) reported receiving effective support with their education and had opportunities available to meet the requirements of their professional portfolio. They recently completed the mental health masterclass and provided cascade training for the rest of the team.

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. The nurses participated in clinical supervision with the nursing team at Halton Medical Centre. The GDMO had an allocated supervisor. Mentorship and supervision was in place for the exercise rehabilitation instructor (ERI). Although not recorded, the ERI had a supervision session on Friday mornings. The Band 6 nurse provided supervision for the healthcare assistant.

Coordinating care and treatment

The practice had effective relationships with the units and was represented at the Station Personnel Support Committee if appropriate. The team also had good links with internal Defence services including the DCMH and Regional Occupational Health Team. The physiotherapist attended the monthly Regional Rehabilitation Unit meetings.

The SMO had developed strong and effective links with the local Integrated Care Board and Local Medical Committee. Either the GDMO or SMO attended the monthly meetings, which had resulted in improvements with secondary care referrals and supported with resolving previous issues with pathology management.

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 were given information about registering with NHS primary care. Guidance about leaving the service was displayed in the medical centre for patients.

Helping patients to live healthier lives

The nursing team took the lead with health promotion, which followed both the NHS and DPHC health promotion calendars so health topics were refreshed on a rolling programme. At the time of the inspection, the range of health promotion displays in the medical centre included information related to cold/flu, sexual health, sepsis, stress/anxiety and climate injuries. Leaflets and booklets providing information on matters such as cholesterol, alcohol use, sugar and prostate cancer were available in the waiting room. There was a nutrition display board in PCRF. Doctors referred patients to the NHS weight management clinics and PCRF staff could refer patients to the DOFit programme.

Staff capacity permitting, a quarterly health promotion newsletter was circulated to the station with the aim to provide updates on upcoming events and relevant health information. The last newsletter was sent in December 2025 and provided information about the flu. Practice staff participated in the station-led health fairs.

The doctors saw patients with sexual health needs and referred them to the nursing team if samples were required. Patients could also be referred to local sexual health services. Referrals were made to the Defence sexual health consultant for patients with complex needs.

The nursing team led on the cervical screening programme and had a process in place to recall patients for a smear. Non-responsive patients were followed up in accordance with DPHC policy. The NHS oversaw bowel and breast screening. However, the nurses monitored all patients eligible for the national screening programme and contacted those that had not been identified for screening.

At the time of the inspection, no patients were eligible for abdominal aortic aneurysm screening, 348 patients were eligible for bowel screening and 26 for breast screening. The number of eligible women whose notes recorded that a cervical smear had been performed in the last 3-5 years was 367 which represented an achievement of 95%. The NHS Target was 80%.

Although it was the responsibility of service personnel to monitor the status of their vaccinations, the nurses carried out searches every 6 months. At the time of the inspection, the status of vaccinations was:

- 89% of patients were in-date for vaccination against diphtheria.
- 89% of patients were in-date for vaccination against polio.
- 92% of patients were in-date for vaccination against hepatitis B.
- 95% of patients were in-date for vaccination against hepatitis A.
- 89% 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. Written consent was taken and scanned to the patient's record. Consent was considered as part of the record keeping audits. The records we reviewed showed that consent was appropriately taken and recorded on the correct template.

Clinicians understood the Mental Capacity Act (2005) and how it would apply to the patient population. There had been no occasions when a mental capacity assessment was required.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

Along with feedback CQC received from the patients prior to the inspection, we considered the results of the Defence Primary Healthcare (DPHC) patient feedback survey for both the medical centre and Primary Care Rehabilitation Facility (PCRF). 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 when the practice had shown care and compassion to individual patients. For example, collecting dispensed medicines from the outsourced pharmacy and delivering them to a patient who was unable to leave their accommodation. On many occasions, clinical staff used their administrative time to accommodate appointments for patients with a pressing need and/or to meet the occupational need of units.

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

HIVE delivered information on a wide range of topics affecting service personnel, including health and wellbeing, accommodation, education and finance. The practice manager regularly communicated with the HIVE Officer to share information relevant to the patient population, including prompts to encourage attendance at the annual station health fair.

Involvement in decisions about care and treatment

Feedback indicated patients were involved with planning their care with the majority of those who responded to the DPHC survey indicating they were given clear information about their treatment and care. Over 80% of patients who completed the PCRF feedback survey strongly agreed that they were listened to, had the opportunity to ask questions, had a better understanding of their condition and felt involved in the decision making regarding their care. PCRF staff had a discussion with patients at their initial appointment to ensure they understood goals and expectations. Our review of patient records confirmed the involvement of patients in decision making about treatment and care.

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 translation standard operating procedure (SOP) was reviewed in July 2025. One of the clinical staff was fluent in Nepalese so could facilitate translation if needed.

The Senior Medical Officer was the lead for patients with a caring responsibility and the MOD GP deputised. An SOP 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. Thirty-eight carers were identified at the time of the inspection. We reviewed a selection of patient records and all had appropriate alerts assigned to identify the patient as a carer.

Privacy and dignity

Signage was observed in the waiting area and reception advising patients they could request to speak with reception staff in a confidential quiet room, a room which could also be used for breastfeeding. Patient consultations took place in clinic rooms with the door closed. Privacy curtains were available in all clinical rooms for intimate examinations.

With the exception of the PCRF, there was a balanced mix of male and female clinicians so patients had the option to see a clinician of a specific gender. If patients wished to see a male physiotherapist or exercise rehabilitation instructor, they were offered the option of attending the PCRF at Halton.

The DPHC mandatory training package included the Records Management Awareness course (95% of staff in-date), Information Knowledge and Awareness course (90% of staff in-date) and Protecting Personal Data course (77% of staff in-date).

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, including at short notice. The practice could be flexible with appointments depending on the needs of individual patients.

Patients could access the service in a variety of ways including via the daily walk-in emergency clinic (referred to as sick parade), eConsult and by using the group mailbox. Many patients worked remotely so telephone consultations were used to aid engagement. Patients 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 Senior Medical Officer advised that these arrangements suited the predominantly senior patient population. The use of alerts on clinical records meant patients who were vulnerable, had complex needs and carers were offered longer appointments if they needed the extra time.

The Defence Primary Healthcare (DPHC) Total Triage system was not in use at the practice so e-consult was highly promoted. The patient population included a significant proportion of aircrew in ground-based roles. Specific clinics were created to ensure all occupational requirements were met, such as for aircrew periodical medical examinations. Specific clinics were in place for chronic disease management and medical boards. These clinics offered extended appointments, longer in duration than routine appointments.

In line with the Equality Act 2010, an access audit for both the medical centre and PCRF buildings was completed in June 2025. The medical centre could accommodate people with mobility needs as there was an accessible parking space, ramp to the front door, a gender-neutral accessible toilet and a hearing loop. Signage was clear throughout the building. This was not the case for the Primary Care Rehabilitation Facility (PCRF). Issues highlighted on the audit included a step at the entrance to the PCRF, no hearing loop, stairs to access the toilets and no accessible toilet. Six appropriate higher chairs with arm rests had been requested but not yet received. The mitigation was that patients with accessibility needs could be seen in the medical centre.

For patients transitioning, the DPHC policy was followed. In October 2023, the practice was awarded 'gold' by the Ministry of Defence and LGBT Foundation for its ongoing commitment to LGBTQ+ inclusive healthcare. With consent, alerts were used on clinical records to indicate patients' preferred pronouns. In November 2025, all staff completed the training in how to interact appropriately with people with a learning disability and/or autism.

Timely access to care and treatment

At previous inspections, we noted patients regularly raised concern about access to the practice by telephone. Although improvements were made to the telephone system in 2021/22, this issue was ongoing for patients, notably that the telephone was ringing but not being answered. When patients telephoned they were presented with options, including a number to press for reception. The telephone continued to ring even if the line was busy giving the impression that the telephone was not being answered when it was actually engaged. As the practice was not in a position to modify the telephone system, the practice manager was actively engaging with the Station Defence Manager Voice Services (SDMVS) to resolve the issue with the proposed addition of an auto attendant for the main reception telephone. SDMVS was exploring options to fix the issue. Updates had been communicated to patients through Station Routine Orders (SRO) and announcements. Patients were actively encouraged to use eConsult as an alternative route to contact the practice.

The administrators and medics used a specific question set to triage patients requesting a consultation. The duty doctor was available to respond to any queries emerging from the triage process.

Urgent appointments with clinicians could be facilitated on the same day and, for the physiotherapist, it was 2 days. A routine appointment with a doctor or nurse could be accommodated within 14 days and within 5 days for a medic. There was a wait of 9 days for a routine consultation with the physiotherapist and 2 days for a follow-up appointment. The next available routine appointment with the exercise rehabilitation instructor was 12 days and 3 days for a follow-up appointment. At the time of the inspection, there was immediate availability at the weekly rehabilitation class. Occupational health medicals could be facilitated within 4 weeks. There was a waiting time of 20 working days for referral to the Multidisciplinary Injury Assessment Clinic.

Due to low staffing levels, the Direct Access Physiotherapy (DAP) service ceased in June 2023 and was re-initiated in October 2025. To access DAP, patients submitted an eConsult request which was triaged by the administrative team. It was then reviewed by a physiotherapist with the patient receiving a response within 24 hours.

The home visit standard operating procedure (SOP) was last reviewed in September 2025. Although routine home visits were not usually offered, telephone consultations were available. The practice manager advised that requests would be considered on an individual needs basis and would be facilitated if clinically indicated.

Shoulder cover (out-of-hours) was provided by Halton Medical Centre 17:00 -18:30 hours. From 18:30 hours each day, including weekends and public holidays, patients had access to NHS 111 service. These arrangements were outlined in the practice information leaflet (PIL) and on a notice board outside the front door.

Listening and learning from concerns and complaints

The practice manager was the lead for complaints and the deputy practice manager deputised. The complaints SOP was last reviewed in August 2025. How to make a complaint was communicated to patients via the PIL, a display in the practice and through SRO.

Just 1 complaint had been received in 2025 and it had been appropriately managed. At the time of inspection, verbal complaints were not recorded. Patients with verbal complaints were strongly encouraged to make a written complaint. When patients declined to make a written complaint, we noted the issue was discussed at the practice meeting. Written complaints were recorded on the DPHC centralised complaints register. This register included serial numbers and a tracking process to monitor the status of the complaint. It also enabled trend analysis.

Minutes showed complaints was a standing agenda item at the healthcare governance meetings. If relevant, complaints were also discussed at the monthly practice meeting.

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 outlined as:

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

The practice also worked to the following local mission statement:

> "The aim of the Defence Primary Health Care Facility Royal Air Force High Wycombe is to provide a high standard of safe and effective primary and occupational care to our entitled patients by working together as a cohesive multi-disciplinary team".

The practice development plan was reviewed in September 2023.

Since the last CQC inspection in August 2022, there had been a change of staff, including in the senior leadership team (SLT). At the time of this inspection, 3 posts were vacant. The Senior Medical Officer (SMO) post was gapped and the deputy SMO (DSMO) was acting into the position. Although the DSMO position was vacant, a locum doctor had been appointed for the clinical work. The SMO reported good support from the SMO at Halton Medical Centre along with the Regional Clinical Director. Measures were in place to minimise the SMO being deployed in order to maintain continuity at the practice. From our discussions with staff, it was apparent they had a clear sense of purpose regarding individual, team and practice priorities. They were aware of the staffing pressures and the need to be flexible in their approach.

We found the practice had continued to deliver clinical care effectively despite the staffing gaps. However, it did mean aspects of clinical work and healthcare governance had to be deprioritised. An OPAL rating of amber meant the practice was only required to meet 3 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. The practice was meeting the required 3 priorities for an amber rating. We identified some deficits with priority 4 (routine provision) which were justified in accordance with the practice's current rating.

The addition of UK Space Command to RAF High Wycombe had led to an increase in the service personnel population of approximately 400. An establishment review had not taken place since January 2022 to check if there were sufficient staffing resources to accommodate this increase.

The SLT had considered ways to make best use of clinical resources given the inconsistent staffing levels along with the increase in the patient population. The SMO

identified that Periodic Medical Examinations (PME) were unnecessary or the frequency of the PME could be reduced for aircrew not currently in flying or air traffic control roles. Following a stakeholder engagement, a policy was agreed in June 2025 - ‘ Periodicity of Aircrew and Air Traffic Controller Medicals’. This reduced the frequency of RAF personnel in non-flying/controller roles requiring a PME, which had increased clinical capacity at the practice. This initiative had been raised as a quality improvement project (QIP).

The needs of the patient population was considered as part of strategic planning and service development. The population was older in age in comparison to other Defence primary care practices. Therefore, the focus was on chronic disease management and staff tailored their development and training towards these health needs.

The practice was in the process of developing a network with Halton Medical Centre and staff perceived this partnership would provide additional resilience within the service and support with succession planning. It was anticipated that the Initial Operating Capability (IOC) for this formal network would be in February 2026. The practice manager had already established an effective working relationship with their counterpart at Halton Medical Centre. At the time of the inspection, patients had access to clinical services at Halton Medical Centre, such as cervical screening. Despite the IOC not yet fully established, High Wycombe Medical centre was being supported by Halton at times when they needed staff.

The practice had been subject to a sustainability audit in November 2025 resulting in a positive outcome. Colour coded recycling bins were in use, including a specific bin for batteries. Some of the unit mechanical transport (MT) fleet cars were electric vehicles. There had been a shift to the use of quick response or QR codes and electronic information to minimise printing information.

Leadership, capacity and capability

The practice manager, SMO and lead physiotherapist formed the SLT. The practice manager had many years of experience in this role. The SMO had joined the practice as the DMSO 18 months ago and gained considerable leadership experience during this time. The SMO had a clear vision about how they planned to lead the team. Staff spoke highly of the leadership at the practice in terms of visibility and availability.

The SMO conducted a leadership survey with all staff reporting the SLT kept them up-to-date, were approachable and listened and acted on concerns.

The SLT spoke highly of the regional team indicating that they received timely and effective support when they needed it. They valued this support particularly during periods of low or inconsistent staffing levels. The practice manager was keen to utilise the ‘regional clinical support hub’ once it was operational as it could support with tasks, such as managing the backlog of notes summarising. The regional team had provided support to the practice to prepare for the next Land Equipment Assurance visit in February 2026 and also with the implementation of JAMES (a new DPHC-wide system for the management of equipment servicing and calibration).

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, such as changes to the telephone system.

Staff described how the SLT promoted an empowering culture which inspired confidence. They reported a positive working environment and said they enjoyed coming to work. The SMO led by example ensuring they were accessible to staff and taking the time to listen and support individuals.

The SLT acknowledged the work and commitment of staff through the use of Defence 'Thank You' rewards and 'In-year Bonus' schemes. The practice manager obtained a welfare pack for staff from the regional team, which included a coffee machine.

A small number of staff rated morale as 'fair' on a staff survey in December 2025. The practice manager followed this up through interviews with individual staff members. The dip in morale related to the drop in staffing levels resulting in an increased workload. The SLT ensured all staff were taking a half a day per month 'whitespace' for individual or team reflection outside of the practice (in accordance with the DPHC Whitespace Policy). The practice manager had plans to utilise the 'Individual Stress Management Tool' if staff required support to manage their stress. This included redirecting workflows where required.

All staff we spoke with highlighted that they had 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 and the DPHC Freedom to Speak Up process.

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 with entries linked to the relevant ASER number and patients DMICP electronic record number.

Governance arrangements

One of the doctors and the practice manager were the leads for healthcare governance (HCG). The Band 6 physiotherapist led on HCG for the PCRF. Formal and informal communication channels were established including monthly practice, HCG, clinical and management meetings. Minutes showed these meetings were well attended by staff.

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.

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. Audits were presented and discussed with staff at the HCG and or practice meetings. All of the DPHC 'MUST' audits had been completed.

PCRF staff were keen to highlight that relationships were positive with medical centre staff and the meetings were fully integrated. However, we identified that more could be done to include and support the PCRF with operational/governance tasks. For example, the infection prevention and control (IPC) lead could undertake the IPC audit for the PCRF. Including the PCRF when arranging specific activities would avoid unnecessary duplication, such as arranging a deep clean or ordering from stores. Posters printed recently for the medical centre did not include the PCRF so the task had to repeated by the physiotherapists and the exercise rehabilitation instructor. Enhancing governance integration would streamline the service and free the PCRF team up to focus on patient-related activity.

Ways to access the PCRF, such as through direct access physiotherapy, was not included in the practice information leaflet.

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.

Last reviewed in August 2025, the business continuity plan (BCP) took account of all the likely generic system failures. We noted that the BCP did not make reference to the PCRF, which was integral part of the service. DMICP remained fragile and outages were a frequent trigger for BCP activation.

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 plans. All staff were in-date for an appraisal. 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. Both the HCG

workbook and HAF were reviewed at the HCG meetings. The SMO reported that the practice's Management Action Plan (MAP) was a useful tool to help keep track of progress. The HAF and MAP were not accessible at the time of inspection due to an outage. An Internal Assurance Review was undertaken in April 2023. The practice was graded as having substantial assurance overall

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. Although not recorded, the practice manager confirmed they undertook monthly DMICP Caldicott (a set of principles related to the use of confidential information) checks.

Engagement with patients, the public, staff and external partners

Patient feedback from the DPHC survey was notably low (it was also low for the CQC pre-inspection survey). The PCRF received a good response to the survey, which demonstrated a high satisfaction with the service. Patients could contribute to the DPHC patient experience survey via a QR code that was displayed in the waiting area. A 'you said, we did' board was displayed in the waiting room to inform patients of how their feedback had been addressed.

Engagement with Station key stakeholders was mainly through the RAF High Wycombe Station Personnel Support Committee which was held monthly. These meetings were attended by the Station Executives, Padre, HIVE staff, Welfare staff, and the SMO/practice manager. The SMO also attended the monthly Station Executives meeting and the deputy practice manager attended the quarterly road safety meeting. The SMO had developed effective links with the Local Medical Committee and integrated care board.

Staff could provide feedback about the service at meetings, by approaching 1 of the SLT, via the annual staff survey and through the appraisal process. Junior military and administrative staff held their own meeting once a week so any concerns arising were fed back to the practice manager if appropriate.

Continuous improvement and innovation

Despite depleted staffing levels, the practice team was committed to continually improving the service and this was evident through quality improvement (QI) activity. Four QIPs were completed in 2025 and were logged on the DPHC QI register. These included the streamlining of the deployment medicals process and the change in policy for aircrew medicals. The PCRF team were due to write up 2 QIPs.

The SMO introduced a policy whereby any staff member could add an alert if they had any specific safeguarding or concern about a patient. The SMO then included these patients for discussion at the monthly clinical meeting. They anticipated this would improve as staffing posts are filled.

Other improvements made included:

- Developing a printer work around to enable staff to print more easily which has saved clinical time.
- The development of a collaborative digital notebook application that contained a large amount of information on referral pathways, clinical updates and policy. Staff could add to the application and share information through it.
- One of the doctors set up a Gov.UK.Notify text message which was sent to patients once they had been referred to secondary care. This kept the patient informed and detailed the timescales involved.