Tidworth Combined Medical Practice

Tidworth Medical Centre (QEMHC), St Michaels' Avenue, Tidworth, SP9 7EA

Middle Wallop Medical Centre, Stockbridge, Hampshire, SO20 8DY

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 an announced comprehensive inspection of Tidworth Combined Medical Practice on 14 and 15 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 one of a programme of inspections the CQC will complete at the invitation of the DMSR in its role as the military healthcare regulator for the DMS.

At this inspection we found:

- The tailored mission statement was embedded into working practice and decision making and had been formulated with input from all staff.
- An inclusive whole-team approach was supported by all staff who worked collaboratively to provide a consistent and sustainable patient-centred service.
- The practice had good lines of communication with the regional team, welfare team, the Regional Rehabilitation Unit and the Department of Community Mental Health to ensure the wellbeing of service personnel.
- The arrangements for managing medicines, including the management of medicines given under Patient Group Directives and Patient Specific Directive were good. We highlighted some areas for improvement with the management of high-risk medicines.
- There was good compliance with mandated training for staff, in particular the 10 courses identified by Defence Primary Healthcare (DPHC) as priority.

- A comprehensive programme of quality improvement activity was in place and this was driving improvement in services through innovation and a focus on patient need.
- All staff knew how to raise and report an incident and were fully supported to do so. The systems and management of significant events was effective and utilised as a driver for change.
- Referral management was governed by a robust process which ensured regular monitoring.
- Patients found it easy to make an appointment and urgent appointments were available the same day. The total triage system had been implemented and was working well for patients and staff.
- Governance systems were well established for the combined practice model. All relevant information was captured to monitor service performance.
- Staff were aware of the requirements of the duty of candour, (the duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). There was a duty of candour register on the healthcare governance workbook and patients had been informed when needed.
- There was a strong culture of continual improvement for the benefit of both patients and staff.

We found the following area of notable practice:

- The practice consistently developed links to improve patient experience as well as their wellbeing, treatment and care. Examples included extensive networking with external parties involved in safeguarding, local NHS services to make them available to service personnel and their families.
- A clear strategy to maintain staff wellbeing to support them in proving a high level of service to patients was evident throughout the inspection. Initiatives included reward schemes, close clinical supervision and mentorship, a whole team approach to formulate a 5-year plan and the introduction of a behaviours charter. The success of these was evident in the positive comments made by staff.
- The training environment was supported by a strong culture for learning that had been commended at the last General Practice Education Committee visit. The practice operated as a training hub in number of areas to support the wider DPHC organisation.
- Extensive quality improvement work and innovation projects were positive drivers for change both within the practice and across the wider organisation. Of note, the ‘healthcare for healthcare workers’ project had been initiated having identified the need for more support for those working in the sector.

The Chief Inspector recommends to the wider Defence organisation:

- Review the diabetes template on DMICP so that it can be used effectively for pre-diabetic checks.

The Chief Inspector recommends to the medical centre:

- Continue to strengthen the arrangements for reviews of patients on repeat medication and for those on high-risk medication.
- Ensure to write the day to take medication on the prescriptions for methotrexate.
- Review arrangements for calling for assistance in a medical emergency to ensure all areas are covered.
- Improve the recording of significant events to ensure lessons learnt are clearly documented.
- Ensure that all staff receive training in how to interact appropriately with people with a learning disability and autistic people, at a level appropriate to their role.
- Implement the most recent DPHC template for patient specific directions.
- Provide sepsis awareness training for staff working in the Primary Care Rehabilitation Facility.

Professor Bola Owolabi

Chief Inspector of Primary and Community Services.

Our inspection team.

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

Background to Tidworth Combined Medical Practice

Situated in the Central Wessex Region, Tidworth Combined Medical Practice (TCMP) is made of Tidworth Medical Centre and Middle Wallop Medical Centre. The combined practice declared themselves fully operational in January 2021.

The practice delivers routine primary care services to a patient population of 13,000, including families of service personnel and civilian staff. This comprises reservists and contractors who utilise the practice for their occupational health needs. The Middle Wallop site has phase 2 training for the Army Air Corp and Tidworth garrison is home to 20 Army units, including the Army Headquarters in Andover. The population fluctuates throughout the year when an additional 500+ patients register

on a temporary basis whilst attending training courses or exercise within the Salisbury Plain Training Area.

An occupational health service is provided for military personnel and entitled family members. A dispensary is also located within the Tidworth Medical Centre, at Middle Wallop, patients can collect their prescriptions that are dispensed at Tidworth. Located alongside the medical centre, the Primary Care Rehabilitation Facility (PCRF) is an integral part of the medical centre and provides service personnel with a physiotherapy and rehabilitation service.

Secondary healthcare (SHC) is provided primarily by Salisbury District Hospital. Local minor injuries unts were available at Andover War Memorial Hospital, Salisbury Walk-in Health Centre and Trowbridge Hospital. Maternity services are hosted at Tidworth each week (midwives and health visitors), sexual health services are provided in-house at Tidworth where a walk-in service is provided by an in-house team. The nearest Department of Community Mental Health and Regional Rehabilitation Units are at Bulford, approximately a 10-minute journey by car.

Tidworth and Middle Wallop Medical Centres both open from 08:00 hours to 16:30 hours Monday to Thursday and close at 16:00 on a Friday. An MOD medical advice line is available between 16:30 and 18:30 Monday to Thursday and from 16:00 on a Friday. Calls are connected to a doctor and nurse within the region. There is a regional rota that rotates between Bulford, Tidworth, Larkhill and Warminster medical centres. A daily ‘sick parade’ is used to triage same day access requests; patients are invited to send a text message between 07:50 and 08:30 each weekday (excluding bank holidays). Outside of these hours including weekends and public holidays, patients are signposted to the NHS 111 and 999 services. E-Consult is also available at any time for patients to make requests for an appointment, repeat prescription, administrative support or to provide information on a health concern.

The staff team

Doctors	1 Senior Medical Officer (SMO) 1 Deputy Senior Medical Officer (DSMO) 9 MOD GPs - 6 Full time equivalent (FTE) - 0.8 currently gapped 12 Regimental Medical Officers (RMO) they are unit assets, not part of DPHC - 0.2 FTE per RMO - 5 posts vacant – very variable.

Nursing Team	1 Senior Nursing Officer 1 Deputy Senior Nursing Officer 1 military nurse (Staff Sergeant) 3 military nurses 1 Band 7 civilian nurse 3 Band 6 civilian nurses 1 Band 5 civilian nurse 2 civilian Band 3 healthcare assistants
Medics	67 Combat Medical Technicians (CMT), non-DPHC
Practice management	1 Business Manager 1 Practice Manager 2 Deputy Practice Managers (1 post currently vacant)
PCRF Team	1 Officer in Command (OC) physiotherapist – post gapped 1 2nd in Command military physiotherapist (back full-time from January 2026) 2 FTE B7 civilian physiotherapists – 1 gapped 8.7 FTE B6 physiotherapist – 1 gapped (awaiting onboarding), 1 gapped as in temporary promotion to B7. 2 military exercise rehabilitation instructors (ERI) 5 civilian ERIs 2 PCRF administration support
Dispensary	3 Pharmacy Technicians (civilian)
Administration	1 Administration Office Manager (civilian)

	12 Administrators (civilian)

Are services safe?

We rated the medical centre as good for providing safe services.

Safety systems and processes

The Senior Medical Officer (SMO) was the overall safeguarding lead for the practice and was supported by named leads for adults, children, phase 2 trainees and domestic violence. The overall safeguarding lead was supported with dedicated administration time, the child safeguarding lead received monthly notifications from social services on any child in need or who had a child protection plan. Staff working at the practice had received safeguarding training at a level appropriate to their role and this also formed part of the induction for all staff. There was a practice safeguarding policy (last updated in September 2025) that included children and vulnerable adults. This was available to all staff on SharePoint and a link was provided on the healthcare governance (HcG) workbook. A number of examples highlighted that practice staff were proactive in identifying and reporting safeguarding concerns. Examples of note included when a safety netting pathway was created to mitigate the risk of female genital mutilation and an example from the Primary Care Rehabilitation Facility (PCRF) staff.

The overall safeguarding lead had established direct communication with the local NHS GP practice and had confirmed the name of each lead (some families had service personnel registered at the practice and their families were registered at the local NHS practice). There was a safeguarding group across the Salisbury Plain area to streamline processes across the military practices. Local schools had been sent a letter clarifying lines of communication and how to get in touch if they had any safeguarding concerns and a good working relationship had been forged with the health visitor. Plans had been made with school bursars and members of the Parent Teacher Association for a representative from the practice to work with local schools; for example, at health fairs. Every 2 months, the NHS led safeguarding meeting was attended by the SMO. Case discussions, reviews and teaching (for example, the ICON project to support people who care for babies to cope with crying) were then shared internally in meetings or training sessions.

Safeguarding information was clearly displayed, this included local contact details in clinical rooms. Coding and alerts were used to highlight vulnerable patients and a register was held on the electronic patient record system. A dedicated, multidisciplinary team meeting was held each month where the nurses and doctors reviewed patients and their families where there was any concern. In addition, a quarterly full day meeting was held to review all vulnerable children and service personnel aged under 18. The nurse at Middle Wallop monitored serving personnel aged under 18 through a monthly search. Discussions were also held in between the dedicated safeguarding meetings; for example, at the doctors' meeting. Staff including from the PCRF had received awareness training in the vulnerable risk management process and suicide prevention.

A review of the records of patients on the vulnerable patient register and the minutes of the meetings where cases were discussed highlighted that improvements could be made in the highlighting of patients on DMICP (the clinical operating system) and notes of discussion. Although we were assured that discussion took place at meetings, there was little evidence of a systematic review for this group of patients and alerts were missing from 2 of the 5 records we checked. Alerts and correct codes were in place for all 5 of the records of care leavers that we checked.

There was a list of trained chaperones which was linked in the HcG workbook. Administrative staff were not used as chaperones. There were both male and female chaperones available and refresher training was last delivered in June and July 2025. Information regarding chaperones was included in the practice leaflet and displayed in clinical rooms (including within the PCRF) and at reception. We reviewed a selection of patient records and found that patients that had been offered or used a chaperone had been recorded. Both the clinician and the chaperone had made a record in the consultation notes.

Staff had been subject to safety checks to ensure they were suitable to work with young people and vulnerable adults. The practice had a system in place for recruitment checks which included a check on the criminal record through the Disclosure and Barring Service (DBS).

Arrangements were in place to monitor the registration status of clinical staff with their regulatory body. Professional registrations were recorded on the HcG workbook for all staff including locums, and this was monitored by the practice management team. Staff had professional indemnity cover and information was in place to confirm staff had received all the relevant vaccinations required for their role. Pre-employment checks for permanent staff were conducted during the onboarding process and locum checks were conducted by the practice managers via an online system. Professional registrations and DBS certificates were monitored via the staff database. All clinical staff were in-date for their professional registrations. There were 4 staff who did not have a DBS certificate, all had a line manager’s risk assessment in place and there was an entry on the risk register with mitigating actions detailed.

There was a lead and deputy responsible for infection prevention and control (IPC) who were appropriately trained for the roles. Other members of the staff team were up-to-date with IPC training. The practice followed the Defence Primary Healthcare (DPHC) mandated monthly IPC audit timetable. This audit was completed as a rolling programme throughout the year and broken down into sections. The standards were being met. Deep cleaning was carried out 6-monthly and privacy curtains were cleaned 6-monthly as a minimum. Spill kits were available at each site. A light box was used to check and refresh staff on their handwashing technique. There was an outbreak of infectious disease plan and the Tidworth site had a designated isolation area with its own entrance at the back of the building.

Environmental cleaning was provided by an external contractor. Cleaning schedules and monitoring arrangements were established and extended to the PCRF. The practice managers at both sites monitored cleaning standards weekly and

documented their findings. In addition, the cleaning contractor carried out their own internal inspections to assure that cleaning standards were being met. Again, checks were documented and these included a record of actions required. The practice managers at both sites spoke positively on the working relationship with the contractor and stated that any concerns or issues were addressed quickly and easily resolved. During the inspection we observed the practice to be visibly clean.

The PCRF was cleaned twice daily and one of the physiotherapists was the lead for the IPC requirements within the department. Supported by the IPC lead for the practice, these included completion of audit forms, attendance at IPC meetings and liaison with the cleaning managers.

Clinical waste was well managed. Waste audits were completed at both sites in June 2025 with no concerns identified. The waste was secured and annotated with the practice code and recorded in the waste log. The consignment notes were maintained and pre-acceptance waste audits were completed separately at both sites in June 2025. The external waste bins at both sites were locked and secured in place.

Acupuncture was provided in the PCRF and arrangements were in place for the safe provision of this treatment, including an acupuncture health screening assessment, a form for obtaining written consent and a patient information sheet which we saw had been completed. This was detailed in a standard operating procedure (SOP) which contained links to DPHC policy. Those clinicians in the PCRF who provided acupuncture had formed a specialist interest group to ensure continued professional development requirements were met.

Risks to patients

Although uncertainty around military staffing levels (due to deployment) was included on the risk register, clinical capacity and leadership across the medical team was sufficient to provide safe and effective care. There were only 2 vacant civilian posts and these had been covered by locum staff. The PCRF was the exception having experienced 3 recent changes in the lead (Officer in Command) post. The practice had identified a number of posts due to become vacant and placed this on the risk register.

Planned staff absences were managed in advance. Rotas were reviewed and adjusted to ensure safe cover for clinical and administrative staff. From our discussions with staff, we were advised that current staffing levels were adequate. There was an effective system to ensure that 3 doctors were always available to cover on the day, a duty doctor, duty support doctor and a clinical supervision doctor. This provided capacity to see patients who needed to be seen urgently. A doctor was always present during total triage sessions.

The practice had a named lead and deputy for resuscitation. The staff team was up-to-date with basic life support training (BLS), anaphylaxis and the use of an automated external defibrillator. Staff were trained in paediatric BLS. All staff who

had completed BLS training since January 2025 were trained in paediatric BLS and there was a dedicated resuscitation kit for children. Emergency response training formed part of training days held termly and a session on acute asthma was planned for November 2025. The local ambulance service had accommodated the medics within their 4 day trauma training and a real time exercise.

There was a sepsis policy in place. Sepsis red flag posters were displayed in clinical rooms and at reception. Sepsis training was last conducted in September 2025 and completed by both clinical and non-clinical staff. In addition, there had been an interactive sepsis workshop. However, PCRF staff had not attended and although displayed in clinical rooms, there was no flow chart for reception staff to follow. Keeping up to date with sepsis management helps protect patients, lower death rates, and improve care quality. Heat illness training had been delivered in May 2025 and cold injury training was planned October 2025. Specific training for burns had been delivered in late 2025 in response to the potential risk as Phase 2 trainees worked with fuels.

Moulage (simulation) training was held and all available staff could attend. The most recently attended in May 2025 was heat injury in response to 2 cases that had occurred. Another session on chest pain was delivered in May 2025. A practical session in treating epilepsy was scheduled for December 2025. The SMO was previously the Army Rugby MO and the Deputy Senior Medical Officer (DSMO) was the Army Boxing SMO. They utilised their experience to ensure head injury management was being conducted correctly. Two physiotherapists had been trained in this area and the management of concussion formed part of the monthly training. Staff had attended head injury training delivered by the regional Defence Medical Rehabilitation Centre in March 2025.

The seal on the medical emergency trolley was checked and recorded daily by the nursing team and 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. A small number of consumable items had passed their expiry date and were removed on the day.

Waiting patients in the main reception areas at both sites could be observed at all times by staff working on the front desk. At Middle Wallop, this was facilitated by the use of a video camera that was used for monitoring, no recording was made. At Tidworth, the layout of the waiting area allowed clear visibility from the reception desk. This allowed staff to monitor any patient that may be in need of urgent treatment.

Information to deliver safe care and treatment.

Patient and clinic information was available at both sites via the electronic patient record system. A selection of records were examined and were of good quality, with clear history, examination findings, management plan and safety netting recorded

when a patient's condition or diagnosis is uncertain to inform what should be done if their condition worsens.

Staff we spoke with told us that any instances of the DMICP system not being available was short in most instances and had minimal impact on patients. A log was maintained of the frequency and we saw the business continuity plan (BCP) was enacted approximately once a month mainly for outages, more so at Tidworth than Middle Wallop. The PCRF had experienced regular issues with WiFi in recent months and this had been escalated to the heads of departments for discussion with region. As a result, an upgrade and extra WiFi boxes had been provided.

Clinics were printed daily for the following day. In the event of an unplanned outage that lasted for more than 1 hour, only urgent appointments would be facilitated, all other non-urgent activity was rescheduled. Urgent patient contacts were recorded on paper forms which were held in a 'BCP' box in the administration office at both sites.

The administrative team managed referrals. We reviewed the process for both internal (within DPHC) and external referrals to contracted services. One of the administrators received a task from the referring clinician, added it to a tracker spreadsheet and liaised with secondary care services. The tracker was comprehensive and well maintained, the status of referrals checked daily included urgent and 2-week-wait referrals. The administrators reported that urgent referrals were addressed promptly with appointments confirmed within 2 weeks. An SOP supported staff in providing guidance on the process.

Referrals for PCRF patients were monitored through the treatment plan included in the patient's notes. Annual reviews of referrals to the Regional Rehabilitation Unit were carried out to identify any trends. Information was shared through DMICP tasks (an electronic message that can be sent internally), departmental meetings and the use of administration time to speak with colleagues both within the PCRF and the wider practice team.

There was a safe system in place for requesting, receiving and summarising new civilian patient records into the practice. One of the nursing team led and was supported by the administration team who would action. The practice separated out military and civilian patients notes for summarising so they could prioritise civilian patients with children being given priority.

The practice had a notes summarising SOP. It did not cover checking for alerts on the system, diary records, vulnerable status and chronic diseases. We highlighted this whilst on inspection to help ensure the practice was summarising identified risks and treatment needs. There was a plan to have a regional hub responsible for all summarising.

We found that 562 military notes had never been summarised. On review, it was established that these were mainly reservists and were only seen for occupational medicine and therefore the practice did not have copies of their notes (as their primary care is managed by an NHS GP). However, it was not clear how the practice distinguished these on their own searches to ensure those who needed had been

summarised. Accounting for these reservists, there were only 14 sets of children's notes and 25 sets of adult family notes waiting to be summarised. A number of those had only registered the practice that day.

Nurses and some medics were trained in taking blood samples (medics were required to complete a training package under supervision of the practice nurse to be able to take bloods). There was an effective system in place for doctors to request blood samples. Significant events had been recorded when blood results had been delayed.

The Senior Nursing Officer (SNO) monitored the specimen register daily. The duty doctor actioned results daily. If results were normal, the healthcare assistant sent a text to the patient notifying them of the result. Abnormal results were either dealt with by the requesting doctor, supported if absent by the duty doctor.

There was a clear peer review system in place that was completed annually to ensure consistency in approach to the recording of patient information. We saw where improvements were needed actions had been put in place. For example, new staff and temporary healthcare workers had their notes audited after 1 month, this was included as part of the induction programme. A recent example was the improved use of physical training chits and SMART goals (SMART goals are a framework for setting objectives that are specific, measurable, achievable, relevant and time-bound).

Patient Group Directive (PGD) and notes audits carried out in June 2025 showed good compliance.

The practice manager and deputy practice manager audited the record keeping for medics. Support was provided by a practice nurse when required. Every medic contact was reviewed and checked by the clinical medic lead on the day. This was also done by the clinical supervisor in accordance with the SOP.

Safe and appropriate use of medicines

One of the 3 pharmacy technicians (PTs) had lead responsibility for the day-to-day management of medicines and was aware that the management and working practices was delegated to them. However, this was not reflected in their terms of reference (TORs). One of the doctors was the appointed lead on medicines management and point of contact for the PTs and prescribing clinicians. TORs for the lead doctor were signed during the inspection. A dedicated medicines management meeting held every 2 months was attended by the lead doctor and the PTs. Standing agenda items included shortages, audits, supply chain issues and alerts (about medicines including product recalls). The PTs felt included and integrated within the medical centre.

The PTs had access to the electronic organisational-wide system (referred to as ASER) and demonstrated that they could log in and record an ASER. ASERs were

discussed and the learning shared with the wider team together with any quality improvement plans (QIPs) from the dispensary.

A near-miss log was in place and trend analysis was carried out. Stickers were used following near misses to highlight potential dispensing errors and reduce the risk of repetition.

Searches were run on DMICP to identify any patients prescribed sodium valproate. Staff were aware of the recent changes that sodium valproate must be dispensed as a full pack and was able to locate the patient information leaflets as part of the pregnancy prevention programme.

There were 2 non-medical prescribers (NMP) in the practice. The NMPs were listed on the Nurse and Midwifery Council register as independent prescribers. Evidence was seen that the DPHC Headquarters authorisation to prescribe was in place and training was current. The NMPs attended annual update days and competencies recorded on the online system matched the areas of practice described.

Repeat prescriptions were requested by email, eConsult or by patients dropping off their repeat slips. A lead time of 7 days was advised but workload permitting, requests were normally completed sooner. All requests were Read coded appropriately on DMICP. Through discussion, it was confirmed that no repeat requests were completed by telephone. A spot check of the dispensed repeat prescriptions found that all had been dispensed within 8 weeks. This showed that staff effectively informed patients that their prescriptions were ready for collection and were efficiently returning uncollected medicines to stock if they were not collected within that period.

Medication reviews for patients with long-term conditions could be strengthened with a more systematic review process to ensure the removal of old medicines (no longer prescribed) and consistency of Read coding. Searches highlighted that 2,509 patients were on a repeat medication, 537 (21%) were in-date for a medication review and 1,972 (79%) had not had a medication review in the last 12 months. Medication reviews are important to ensure the medicines prescribed are still the best, safest and most effective treatment.

Staff knew that they should only re-issue repeat prescriptions if the patient's review date was in-date and there were available repeat counts on the patients prescribing record. The process for handing out prescriptions to patients was in-line with the DPHC SOPs. The PTs printed any request that was in-date for the doctor to sign. Any requests that were past their review date were given to the duty doctor.

A process was established for the management of and monitoring of patients prescribed high-risk medicines (HRM). The register of HRMs used at the medical centre was held on the HCG workbook and long-term conditions register, all doctors and relevant clinicians had access to this. We looked at a sample of patient records and saw that all had been coded or had shared care agreements in place. The practice had developed their own searches which were nurse led including the patient recall for blood monitoring. Although the register did not include the

frequency of monitoring, searches ran quarterly were used as a check for each individual patient (including if they were in-date with monitoring). The recall system was found to be effective in the records we checked but could be strengthened to ensure alerts were added for every patient, monitoring was completed in its entirety, old medications removed and Read coding used consistently. In addition, and when reviewing patients on methotrexate (a medicine used to treat certain cancers and a variety of autoimmune and inflammatory conditions), there was no evidence that the practice were writing the day to take medication on the prescription. This was not in line with national guidance.

Patients were informed of side effects to ensure they take their medicines safely. The dispensary held appropriate warning cards. Evidence was seen of comprehensive medication counselling when prescriptions were collected.

Arrangements were established for the safe management of CDs including their destruction. Monthly checks were carried out by one of the PTs and NMPs to support the quarterly checks carried out. A CD audit had been completed annually. There was a local working practice (LWP) in place that named the keyholders and advised on access into the dispensary and the CD cupboard if required out of hours. The keys were kept in a sealed dispensary bag inside a locked safe located within the dispensary. There was a ‘safe log’ that documented access to the dispensary and CD keys. Arrangements were in place for essential access outside working hours. CD destruction certificates were checked against the documentation (BMed12) and all were in place. We highlighted that adding the serial number of the certificate to the BMed12 would help facilitate cross reference. Details (including identification when required) of the person collecting the CD prescription were included on the BMed12.

Emergency medicines were kept on the emergency trolley within easy access for staff and secured during non-working hours. Gases were at least half full and in-date. The medical gas store was clean and the empty cylinders were segregated from full in date cylinders. Correct HazChem signage was in place for the medical gas stores and on the front door of the treatment bay where the oxygen and Entonox (a gas used to control pain or anxiety) were kept. The Entonox was out-of-date but had been retained due to supply issues. This had been added to the risk register. Although medicines on the emergency trolley were in-date, we discussed inclusion on DMICP so they would appear on the stock expiry reports. A risk assessment for additional items (additional to the DPHC list) to be held on the emergency trolley was in draft form. This required completion as some of the items were already held on the trolley.

Well defined processes were in place for the ordering and receiving of vaccines. All vaccines were in-date and vaccines were stored correctly allowing for air circulation. The fridges were cleaned regularly in accordance with the DPHC SOP. Pharmaceutical thermometers were used and the temperatures monitored daily. Transferring vaccines between Tidworth and Middle Wallop (as well as within region) was carried out using insulated boxes.

An LWP was in place for the presentation of non-MOD prescriptions. DMICP was updated if changes to a patient's medication were made by secondary care or an out-of-hours service. There was also an SOP for shared care agreements.

Prescription pads were stored securely. There was a system to track their issue and usage so all prescription numbers could be traced to the prescriber. Regular checks were carried out to identify any discrepancies.

Practice nurses used PGDs for immunisations and primary care treatments. Nurses had been authorised to use the PGDs using the correct (Annex E) form. A review of 5 DMICP consultations found that the PGD template was being used and the batch number and expiry of the medicine supplied was being recorded in the template. Audits were completed annually, the most recent in October 2025, by the SNO (the SNO's PGDs were audited by the Deputy SNO).

Administration of treatment from a Patient Specific Direction (PSD) had been extended from 7 days to 14 days but it was unclear on who had authorised this. In the 5 records checked, all information requested on the template had been completed. However, an outdated template was being used for PSDs and some information required by DPHC was not included.

All staff who administered vaccines had received the immunisation training as well as the mandatory anaphylaxis training.

There were cupboards holding over-labelled medicines for the supply out-of-hours. A stock check of 5 medicines found the stock levels to be correct and transaction reports showed evidence of good stock accounting and stock management. The cupboard was locked and access was controlled.

Track record on safety

The practice manager and SMO maintained oversight of the risk register on the HcG workbook. Each risk was reviewed quarterly as a minimum and a summary of the review added. A health and safety board was displayed at both sites. The 4T principles (terminate, treat, transfer and tolerate) were applied to all risks and were reviewed regularly. Electrical safety checks were up-to-date at both sites for both hard-wire and electrical equipment testing. Regular water safety checks took place and a full legionella risk assessment was carried out in September 2022 at Middle Wallop and October 2023 at Tidworth. The fire risk assessments of both buildings were in-date (July 2024 at Middle Wallop and March 2022 at Tidworth). Equipment tests including fire extinguishers were current. Staff were up-to-date with fire safety training and were aware of the evacuation plan. The appropriate Control of Substances Hazardous to Health (COSHH) risk assessments were in place and up-to-date.

Within the PCRF, there was ample space for the training equipment which was checked daily. The lead ERI had oversight for the maintenance and servicing and comprehensive records were kept of all equipment including any faults and the dates

when servicing was due. The servicing of all equipment was in-date. Daily wet bulb monitoring took place with an announcement of changes to training daily in accordance with policy. Lone working was avoided where possible. One of the gyms had air conditioning, the other did not but had ample natural ventilation and fans were used when required.

The SMO was the named risk manager and was deputised by the practice manager who had completed the Institution of Occupational Safety and Health training. Risk assessments had been reviewed in August 2025 by a trained risk assessor who had completed building custodian training. The medical centre had current and retired risk registers and an issues log in place. Risks and issues were a standing agenda item at the monthly practice/HcG meetings. There was a range of clinical and non-clinical risks in place and any new risks were sent to the SMO and SNO for review and for the register to be updated.

There was a fixed alarm system in place at Tidworth including in the pharmacy, the PCRF and in each clinical room. The dispensary alarm automatically closed the hatch and sealed the room when triggered. At Middle Wallop, handheld personal alarms were used. However, we found the changing area alarm could not be heard unless someone one was in the immediate vicinity. The testing of alarms at both sites was recorded monthly. We tested the alarm in the PCRF on the day of inspection, staff arrived from the main medical centre (upstairs) but no audible sound was made and PCRF staff were unaware it had been pressed. This was the same for the cubicles in the main department, though with no closed doors, a clinician shouting could raise attention. A rapid response ensures the safety of patients and staff in the event of an emergency.

Lessons learned and improvements made.

All staff in the medical centre and the PCRF had access to the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events and incidents.

Training on the system formed part of required training for each staff member and the compliance rate was 80% at the time of the inspection. There was also a regional significant event analysis tool process on the online system.

All incidents reported were logged through the system and a register was maintained. incidents were discussed at the heads of department and monthly governance meetings. The details on most entries on the system were limited and lessons learned were not always clearly identified. The meeting minutes were not always detailed and the ASER log was not linked to the meeting where it was discussed. This meant it was not always clear what the incident was and what, if anything, changed as a result to mitigate the risk of the incident happening again and putting patients at risk of harm.

From speaking with staff and evidence provided, it was clear there was an open culture of reporting incidents. Both clinical and non-clinical staff could give examples of incidents and learning as a result of investigations.

Root cause analysis of incidents was undertaken which ensured that any underlying cause was identified so appropriate action could be taken. We reviewed a number of incidents and found that the process was effective in identifying lessons learned. For example:

- The scanning desk had been moved to a quiet area, medics were not permitted to scan until they had received training and would only scan occupation health documentation. Letters and results were scanned by civilian administrative staff to ensure continuity in this key area.
- An ASER was raised in the dispensary when a blank CD prescription went missing. An investigation conducted included the regional pharmacist and concluded that it had been accidentally shredded.
- The nursing team provided a recent example of when a vaccination had been given early. Although there was no learning outcome from the investigation, the review reinforced the need for effective communication and for the DMICP template to be used by the medics before administering any vaccine.

The medical centre had a system in place to distribute National Patient Safety Alerts and alerts from the MHRA and what action had been taken. The alerts were also discussed at key meetings. Alerts were managed by the pharmacy technicians.

Are services effective?

We rated the practice as good for providing effective services.

Effective needs assessment, care and treatment

Patient records informed us that clinicians carried out assessments and provided care and treatment in line with national standards and guidance, supported by clear clinical pathways and protocols. Arrangements were established to ensure staff were up-to-date with current legislation, research and guidance, including NICE (National Institute for Health and Care Excellence) and the Scottish Intercollegiate Guidelines Network (SIGN). Updates to NICE guidance, reminders and new indications were summarised in the minutes of the practice/healthcare governance (HcG) meetings. The agenda for the weekly doctor's meetings included discussing complex patients, medication management updates, NICE and SIGN updates.

Staff were also kept informed of clinical and medicines updates through the Defence Primary Health Care (DPHC) newsletter circulated to staff each month. As well as providing advice during consultations, patients were signposted to websites for guidance in self-management for long-term conditions such as diabetes.

Primary Care Rehabilitation (PCRF) staff held separate governance meetings at which evidence-based guidance was shared and discussed. The PCRF staff were familiar with Defence Rehabilitation Best Practice Guidelines (BPG) and staff we spoke with provided examples of treatment delivered based on the guidance and care pathways. Some staff were part of BPG working groups; examples of established groups included ones for Achilles tendon and anterior cruciate ligaments. Our review of PCRF patient records showed use of exercise prescription software that allows medical professionals to send structured exercise programmes and educational information to individuals.

The PCRF ensured that it took a holistic view of patients. As part of the new patient questionnaire, there were prompts to ask about sleep, mood, diet and stress. Patients were referred to the dietician, smoking cessation and the medical centre when needed. The musculoskeletal health questionnaire and other reported outcome measures were utilised by staff during treatment. We saw clear measurable outcome measures for patients. A handheld dynamometer (a device for measuring force) was used for upper limb strength outcome measures to show progress.

Monitoring care and treatment

The nursing team took the lead for all long-term conditions (LTCs), clinical oversight was maintained by the doctors. Registers were held on DMICP as well as on a 'chronic disease spreadsheet' with leads named for each. An effective patient recall

process was in place. The DMICP searches were compared against the spreadsheet and the patient contacted by a combination of telephone and text message.

There was a register of diabetic patients in place and on review we found that their care indicated positive control of both cholesterol control and blood pressure. For 77 patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For 163 patients, the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control. Patients at risk of developing diabetes were identified through the Defence Primary Healthcare (DPHC) protocol which included relevant testing (HbA1c -average blood glucose (sugar) levels), lipids (for QRISK), body mass index, waist circumference, lifestyle factors (diet, alcohol, smoking status). QRISK is a scoring tool that estimates the percentage chance of a person having a heart attack or stroke in the next 10 years.

We reviewed the clinical records for 3 patients on the diabetes register. We found no concerns but identified a coding issue that was systemic, not practice based, and was being reviewed by DPHC. The template did not automatically apply the Read code placing the patient on the diabetes register.

There were 270 patients on the hypertension register. Of the 270, 108 had not had a blood pressure recorded in the past 12 months in line with best practice guidance. The practice had implemented a plan to address this and 104 of the 108 had been contacted in the past 3 months to come in for a review (the remaining 4 had just exceeded their review date and were due to be recalled). Patients out-of-date for 6 months or more had 2 or more recalls to come in for a review. We reviewed 3 patient records from the hypertension register and 1 had no record of any blood pressure reading since February 2022 but had been reviewed by a doctor in December 2024.

We found that most of the patients with a diagnosis of asthma had had a review in the preceding 12 months in line with best practice. The DMICP asthma template was used for reviews to ensure continuity and correct Read codes. A sample review of 3 patients with a diagnosis of asthma showed good quality reviews were being undertaken. The asthma lead had reverted to telephoning patients to reduce the failure to attend rates.

Patients with a mental health need were provided with initial mental health support which included sign posting to mental health resources, a padre, third sector support, welfare support and routine prescriptions. Service personnel were referred to the Department of Community Mental Health if more specialist support was required. Civilian patients were now able to access Improving Access to Psychological Therapies (IAPT) through self-referral to local services provided by a mental health charity. Service personnel would soon be able to access the same services. Safeguards had been put in place to refer them back with any occupation health concerns such as weapons handling. Access to Child and Adolescent Mental Health Services, known as CAMHS, was in place and children and parents could self-refer into the service. We reviewed a sample of patients notes and found that note taking was detailed and clinical coding correct.

Hearing Conservation Programme searches were undertaken each month and effective with audiometry assessments in-date for 78% of the patient population. Our review of patient records demonstrated Joint Medical Employment Standards (referred to as JMES) were appropriately managed.

The Senior Nursing Officer (SNO) was the audit lead supported by the Deputy SNO. Audits in place were a mixture of mandatory audits from DPHC and internal audits. There was an audit calendar on the healthcare governance (HcG) workbook, mandated DPHC audits were colour coded in red. All entries on the calendar included links to the last 2 cycles, retired audits were archived in a separate area. We reviewed 2 examples from an extensive set of audits to find that they were of good quality and drivers for change. Examples included an asthma audit and an unopposed oestrogen audit (high levels of oestrogen in the body that can lead to complications if left untreated).

There was a specific audit calendar in place for the PCRF that was driven by the needs of the patient population, for example, a review of the fast-track anterior cruciate ligament contract change. A physiotherapy and exercise rehabilitation instructor (ERI) notes audit was completed annually. The audit programme included plans for repeat cycles and ongoing service evaluation of all rehabilitation classes.

Effective staffing

The practice, including the PCRF, used the DPHC mandated induction which included cadre specific elements (a specific one for the pharmacy technicians was being developed with regional headquarters). Permanent staff had a more in-depth induction to include elements which were specific to their role. There was a well-developed induction pack specific for medics which included a comprehensive list of training specific to their duties. Newly appointed staff spoke positively on the process followed and were provided with shadowing opportunities as part of the induction. Staff new to DPHC were given 2 weeks of non-clinical time (based on previous experience) to learn the processes.

Mandated staff training across the staff group was close to being fully completed at the time of the inspection, in particular for the ‘Commander DPHC top 10 courses.’ Protected time was afforded to staff once a month to complete mandatory training. The practice managers monitored the status of training; heads of department were provided with the completion status within their departments and reminded staff when a course was due. The Unit nurse monitored training for the medics.

The nursing team were well supported to keep up-to-date with training and maintain their professional revalidation. The Senior Medical Officer (SMO) conducted mid and end of year appraisals and this provided an opportunity to discuss courses required for continued professional development. The team had a broad range of experience and this was supported by training specific to the role. Examples of training courses completed within the team included infection prevention and control link practitioner, smoking cessation, non-medical prescriber, sexual health, immunisation and

cytology. Training was provided in-house, online and through study days provided by DPHC. Links developed with local hospitals had also provided opportunities to attend training in diabetes and pre-diabetes. With the practice having children as registered patients, the nurses had completed a paediatric minor injuries and illness course. Patients under the age of 1 would be seen by a doctor. One of the doctors and a paramedic were qualified to deliver paediatric basic life support training.

Training events included inviting external speakers to attend and deliver sessions to staff. A recent example was a training session in cardiology delivered by a military cardiologist from a local District Hospital. Further examples in the last 12 months included asthma training from an asthma lead in Southampton Hospital, a session on compassion fatigue/burnout to support individual clinicians. The Defence lead supporting obesity and lifestyle management with Defence Public Health had also delivered a training session.

There was a formal process in place for the lead ERI to undertakes notes audits, these were completed initially at 3 months for any new staff then every 6 months on a rolling programme. Any issues identified were fed back to the individual staff member in a face-to-face meeting, this was done in a supportive way with the focus on learning and improvement. We saw an example where an initial audit showed 83% compliance and following feedback and support the next audit showed 93% compliance.

Performance appraisals were conducted by line managers for all staff. Doctors were in-date for appraisal and all doctors and nurses had completed timely revalidation.

Coordinating care and treatment

The medical centre team had forged effective links with station commanders, welfare staff, padres, the mental health team and of note, safeguarding points of contact in the local area. We contacted the Chain of Command and welfare team as part of our inspection and they reported strong links and told us the medical centre were very responsive if a patient required urgent access to a doctor.

As military practices were behind civilian practices with NHS digitalisation one of the doctors investigated pathways and found the issue to be military NHS communication and the Integrated Care Board (ICB) having difficulty understanding eligibility to services. Work was underway to make improvements and achieve better understanding between the 2 organisations. Examples included plans for a standalone terminal for receiving results and x-rays, and a new ‘telederm’ service (dermatology using mobile phone technology) ensuring that registered patients were being considered in this new pathway.

Networking in the area included all local hospitals. A point of contact linked in and attended meetings and workshops. These helped improve communication and care pathways for patients. Examples included a network of opticians across Wiltshire that the practice was not known to and therefore referrals were being rejected.

Liaison with the ICB had resulted in these services being opened to Tidworth Combined Medical Practice patients.

The PCRF had good relationships with the Regional Rehabilitation Unit and although representatives did not attend Commander Case Review meetings, they linked in through the doctors when required. A trial was taking place to look at anterior cruciate ligament repair versus reconstruction. Liaison with the musculoskeletal department was underway to exempt service personnel from the trial so the occupation health impact was no longer affected.

Helping patients to live healthier lives.

One of the nursing team was the lead for health promotion across both sites and a medic deputised. The programme followed the DPHC health promotion calendar. The television in the patient waiting area at Tidworth displayed a rolling programme of health promotion. At Middle Wallop, a wide array of health promotion materials were displayed in the patient waiting area to both promote proactive healthcare and provide education on self-care. Leaflet stands were in place at both sites were well stocked.

There was a named lead for coordination of the patients over the age of 40 health checks. Those eligible were invited for a full health check including bloods and identifying risk factors. Lifestyle and health advice, both verbally and written, was provided as appropriate. This check was repeated every 3 to 5 years unless identified as a risk when patients were recalled annually for blood testing.

We saw information leaflets were available in the treatment rooms. There were notice boards located in various places at both sites focussed around the patient waiting areas. Example topics covered included men’s health, mental health, smoking and alcohol. During consultations, patients were given leaflets or items printed from the internet to support them following the appointment.

Unit Health Fairs were undertaken annually and medical centre staff, including representatives from the PCRF, were involved. The next was scheduled for October 2025 and there were posters to promote this displayed in the building. There was a health promotion board in the PCRF, with topics that included women’s health, hydrotherapy (at the local leisure centre), rehabilitation classes (including yoga and Pilates) and nutrition. The PCRF had also used a recent health fair to provide ergonomic advice to patients based at Army headquarters due to the sedentary nature of their job roles.

Practice staff had engaged with Tidworth garrison regarding sexual harassment. External campaigns run by the garrison had been attended by the domestic violence lead. In addition to domestic violence, subjects covered included sexual harassment.

The Deputy Senior Medical Officer (DSMO) led on sexual health and some nurses had the appropriate sexual health training (STIF) and provided sexual health support and advice. The DSMO was qualified to fit coils and implants and to provide training

to others. A sexual health drop-in clinic was held on Wednesday afternoons allowing patients to attend easily. They completed a questionnaire for asymptomatic screening and could book appointments for coils, implants and cervical smear tests. A walk in service improved attendance and had resulted in improved uptake of cervical screening. If symptomatic, patients were referred to a local sexual health clinic. Teenage patients would be seen and contraception for Gillick competence (children aged under 16 having sufficient understanding to consent to their own treatment without parental advice) would offer for children if needed.

Prior to the inspection, the statistics submitted by the practice indicated that the percentage of eligible women whose records indicated that a cervical smear had been performed in the last 3-5 years was 81%. This was in line with the NHS target of 80%. We reviewed the records of 3 patients who were not in-date and found there was evidence of recall letters having been sent for each.

Regular searches were undertaken to identify patients who required screening for bowel, breast, and abdominal aortic aneurysm in line with national programmes. Alerts were added to their DMICP record which allowed for opportunistic discussion with a health professional. Data provided by the practice showed that patient recall was well managed and a sample review of patients not screened highlighted no concerns. Patients from Army Headquarters were more difficult to engage for routine screening due to the travel required so the practice used any opportunity to complete over 40s medicals or dementia screening. An example was when a nurse opportunistically completed an over 50s medical. This picked up a significant diagnosis that may otherwise have been missed.

Unit staff were responsible for the monitoring and recall of service personnel occupational vaccinations. The SNO maintained a spreadsheet for oversight. At the time of the inspection, the status of vaccinations was:

- 88% of patients were recorded as being up to date with vaccination against diphtheria
- 88% of patients were recorded as being up to date with vaccination against tetanus
- 88% of patients were recorded as being up to date with vaccination against polio
- 89% of patients were recorded as being up to date with vaccination against hepatitis B
- 90% of patients were recorded as being up to date with vaccination against hepatitis A
- 98% of patients were recorded as being up to date with vaccination against MMR
- 93% of patients were recorded as being up to date with vaccination against meningitis.

Childhood Immunisations: The World Health Organisation targets a 95% vaccination rate for routine childhood immunisations. An effective recall process was utilised, some families had confirmed that they did not wish for their child to be vaccinated, others who had been joined from overseas (different vaccination schedules) were on a catch up programme. The practice provided the following data:

- 93% of children aged 1 had 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/HepB)
- 86% of children aged 2 had received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster)
- 87% of children aged 2 had received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster)
- 87% of children aged 2 had received immunisation for measles, mumps and rubella (one dose of MMR)
- 79% children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR).

Consent to care and treatment

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. Documented evidence was in place for the practice to share information with the Chain of Command. Consent forms were scanned onto the system and those we reviewed for coil insertions, immunisations and smears gave clear detail on the information being provided and the patient providing verbal consent. There was one exception where we highlighted a clinician who was not recording consent, the practice assured us that this would be addressed. Written consent was appropriately recorded in the clinical records we looked at for acupuncture and for ear syringing. The recording of consent was checked as part of the peer review process (through notes audits).

Staff had a good understanding of the Mental Capacity Act (2005) and how it would apply to the patient population. All staff completed annual mental capacity training online and posters displayed in clinical rooms listed the key principles. Staff we spoke with were aware of Gillick competence and would ask children over 13 years whether they wanted to be seen alone or with a guardian. We saw examples of this recorded in patient notes. Clinicians fully understood the principles of Fraser Competence (a child's ability to consent to contraceptive or sexual health advice and treatment).

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

The practice staff had a comprehensive understanding and focus on the specific needs of the patient population and services were tailored to meet these. We were given examples of where practice staff had gone the extra mile to provide care and support. These examples included where care had been provided to partners and children as well as to serving personnel. Of note, we heard a detailed account of a patient with mental health concerns and a recent example of family members where a high level of support had been provided. One of the doctors worked closely with the units to support those soldiers with no family.

An information network known as HIVE was available to people living on the camp across both sites. Situated nearby, the HIVE provided information about facilities available to families along with Army welfare services, Unite welfare staff, Padres and Salvation Army.

To ensure patient's views contributed to the inspection, we offered patients various opportunities to provide feedback on the service. Views were shared through CQC feedback cards completed by patients prior to the inspection and through conversations with patients on the day of the inspection. We received 42 patient comment cards, these were very positive about their experience.

Two-hundred and fifty-two registered patients responded to the patient satisfaction survey (surveyed across both sites and inclusive of the Primary Care Rehabilitation Facilities or PCRFs) between January 2024 and September 2025. A total of 237 (94%) described their overall experience as 'good'. During this period of time, the medical centre also received compliments in the free text section of the survey that praised the staff for being kind, helpful and professional.

When asked if they felt that they were treated with kindness and compassion, 95% of patients in the patient satisfaction survey responded with good or excellent.

Staff in the Primary Care Rehabilitation Facility (PCRF) used injury recover/maintenance physical training chits alongside light duties chits and linked in with Units and physical training instructors. The PCRF had their own separate patient questionnaire, a review of consultation notes highlighted that patients were involved with decisions about their care and identified goals were patient led.

Involvement in decisions about care and treatment

The clinicians and staff at the medical centre recognised that the personnel they provided care and treatment for could be making decisions about treatment that

could have a major impact on their military career. Staff demonstrated how they gauged the level of understanding of patients, gave clear explanations of diagnoses and treatment, and encouraged and empowered patients to make decisions based on sound guidance and clinical facts. The practice was proactive in seeking out feedback from the patients and communicated action taken as a result of feedback.

The patient satisfaction survey showed that 95% of patients described how they were given clear information as good or excellent.

The practice had a named carers lead who was supported by a deputy. There was information for carers on a dedicated stand at Middle Wallop and at Tidworth, where that was a larger patient waiting area, a dedicated area provided a wealth of information. Information was also included in the practice leaflet. A search ran as part of the inspection reported 79 patients on the carers register. Of the 5 notes we checked, all patients with caring responsibilities had an appropriate alert against their record on DMICP and were recalled annually for a flu vaccination. A reinvigoration of the identification was underway as the DSMO felt the register was small and efforts were being made to identify if there were more carers; for example, through the eRegistration process.

Practice staff had access to a translation service which could be utilised for either verbal translation or written translation. Staff were aware of how to access the service, supported by prominently displayed posters that included step-by-step guidance. The Tidworth camp housed many Fijian patients and as well as translation posters, links had been developed with spiritual leaders and a ‘Prince’ in camp. Conversations about welfare support were attended or supported by practice staff and links had also been developed with a spiritual leader in Fiji. The practice leaflet had been translated into Nepalese and Fijian as well as key support information to detect domestic violence.

Privacy and dignity

All consultations were conducted in clinic rooms with the door closed. Clinical rooms had a separate screened area for intimate examinations.

Arrangements were in place to maintain patient privacy when arriving at the medical centre. Rooms close to the reception area were available at both sites should patients request a confidential conversation away from the desk.

Curtains were utilised in the main clinical area of the PCRF. Side rooms were also available to provide a private clinical area for assessment and treatment or to have a private conversation. There was a radio in the gym used to provide background noise and minimise the chance of conversations being overheard.

The patient satisfaction survey showed that 98% of patients described how their privacy and dignity was respected as good or excellent.

All departments within the practice had clinicians of both genders so patients could choose if they wanted to see a specific clinician. This included the PCRF which had male and female physiotherapists and exercise rehabilitation instructors.

Are services responsive to people's needs?

We rated the practice as good for providing responsive services.

Responding to and meeting people's needs

Equality Access Audits as defined in the Equality Act 2010 had been completed in 2025 at both sites, no concerns were identified at either site. There were accessible parking spaces available close to the main entrances and dropped kerbs were in place to facilitate wheelchair access. Lifts were not required as all consultation rooms and desks for staff were located on the ground floor at both sites. Although the doors at the main entrance to the Middle Wallop building were not automated, they were in direct sight of the reception desk. Patients would be assisted through these doors if required. The reception desk at Tidworth was split level so was suitable for wheelchair users.

Although not mandated by Defence Primary Healthcare, all staff were required to complete learning disability and autism training. At the time of the inspection 60% of staff across both sites had completed the course at the time of inspection.

The medical centre staff understood the needs of its patient population and tailored services in response to those needs. A number of specific clinics included bloods, sexual health, weight management and asthma. A 'drop in' sexual health and cytology clinic where no appointment was required was also provided and had proved to be successful. Telephone appointments were routinely offered and Total Triage was available each day. Longer appointments were provided to complex and vulnerable patients including carers, patients with autism and with attention deficit hyperactivity disorder.

Training afternoons were held on a Tuesday so patients could access care during sports afternoons held on Wednesdays. Training catch up days were held for staff members who did not work on a Tuesday. After school clinics had been held but ceased due to not being utilised.

At the Tidworth site where families were often seen, facilities included a private room for breast feeding and baby changing facilities. The Tidworth site had gender neutral toilets, the Senior Medical Officer (SMO) was the named transgender lead doctor and the approach and work completed had been recognised with a 'Pride in Practice' gold award in 2024.

The e-Consult service was used to support patient choice as appropriate. This service also provided information on self-care and with it being an online system, could be accessed at any time by patients.

The medical staff team were aware of the need to quickly identify and treat patients with mental health needs to ensure the best possible outcome. The welfare service could refer patients for a same day appointment.

Timely access to care and treatment

Patients had good access to treatment and care with a number of options available to them.

Details of how patients could access services when the medical centre was closed were clearly displayed at the front entrance at both sites so could be easily seen when the practice was closed. In addition, the information was relayed in a comprehensive patient information leaflet. Outside of routine clinic hours, patients were encouraged to use e-Consult or NHS111 to access out-of-hours (OOH) care.

Urgent doctor and nurse appointments were available on the day. Routine doctor appointments were available within 3 days. Routine appointments to see a nurse were available the next day. A text messaging service was used to remind patients of their appointments as well as to communicate patient information and advice of results being received. Wait times for appointments were reviewed monthly at the practice meeting. Data was produced for both urgent and routine appointments for the Primary Care Rehabilitation Facility (PCRF), nurses, doctors and grading reviews (routine only). Data showed there was good access to appointments.

Policy stated that home visits were not provided as standard due to workforce constraints and aim of enabling patients to be seen within the practice building where equipment and clinical support was available. However, there was a standard operating procedure on the healthcare governance workbook in the event of a home visit being offered which was reviewed on a case-by-case basis.

The PCRF offered direct access appointments. This had been streamlined using the eConsult service which allowed both serving personnel and entitled civilians to request direct access. A routine new patient physiotherapy appointment was available within 19 working days. A routine follow-up physiotherapy appointment was available within 2 weeks. There was capacity to see patients urgently on the same day. Appointments to see the exercise rehabilitation instructor (ERI) or a new or routine appointment were available within 1-2 weeks (each regiment had their own ERI assigned for continuity). There was no waiting list for rehabilitation classes.

There was no PCRF at Bulford garrison so patients travelled to Tidworth to be seen. Combined with the 2 gapped posts in the department, this had resulted in the key performance indicator (KPI) for seeing a new referral (10 days) not being achievable (there was 1 exception in August 2025 when the KPI was met) and the risk had been transferred to region.

Waiting times for the Multidisciplinary Injury Assessment Clinic was 4 weeks as the Bulford Regional Rehabilitation Unit (RRU) covered multiple sites. This variation did

not have a negative impact as the RRU had protected appointments for urgent referrals.

Units could contact the SMO or Regimental Medical Officers out of hours to arrange vaccinations for high readiness deployments. Specialist medical wait times were not excessive, 8 days for an aviation medical or occupational diving medicals and 10 days for sport diving.

Listening and learning from concerns and complaints

There was a clear complaints process in place that facilitated learning. The Deputy SMO was the lead for complaints. The administrative tasks involved were managed by the Business Manager who populated the complaints log. There was information regarding the complaints process in the practice leaflet (which included the complaint reporting form) and complaints board in the waiting rooms which detailed the complaints' policy and QR codes to access the online patient survey. When making a complaint in person, patients were encouraged to use a templated form that included a request for consent to access their records. All complaints were monitored on a database that detailed key dates throughout the process and provided a record that was audited annually. Staff were trained on how to deal with complaints and had named points of contact which were detailed on the complaints noticeboard.

All complaints were recorded, verbal or written, had been discussed in practice meetings and had led to changes being made. For example, an external referral had been rejected but not communicated to the patient. This was discussed at the doctors' meeting, used as a learning point on the referrer's appraisal and resulted in any rejected referral being challenged when needed. Further examples of complaints that we reviewed demonstrated that significant events were raised when appropriate, the timeframe of responses met with policy and duty of candour was followed when applicable.

Are services well-led?

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

Leadership, capacity and capability

The practice was close to being fully staffed and the balance of civilian and military clinical input provided resilience and continuity. The leadership team had a clear strategy and vision that was formulated into a 5 year plan. The team spoke of inclusive leadership and felt valued and well supported.

Forward planning helped manage temporary gaps created by deployments. The workload was adjusted to manage reduced capacity; for example, the uploading of equipment onto the Joint Asset Management and Engineering Solutions (known as JAMES) system was stopped in the absence of the practice manager and deputy practice manager to reduce the administrative burden. Planning sessions were held prior to any planned absence.

The practice action plan included succession and cover during transitional periods. We discussed developing this to include a staggering of duties as the leadership in the PCRF were due to return. Practice management support had been provided to Warminster Medical Centre during a 3-month transition period. The combined model was reported by staff as a success and the schedule for senior clinical staff saw regular clinics held at both sites.

The Primary Care Rehabilitation Facility (PCRF) was managed well and demonstrated resilience with multiple changes in leadership over the preceding 12 months. The PCRF felt well embedded into the practice and being such a large department, managed many of the governance functions internally whilst integrating into the main practice governance structure at senior level.

There were well-established links with the regional team and staff confirmed that input and support was provided whenever possible. Support was provided regularly through regional days, visits in person and regular discussion. The regional team were located at Tidworth and the management team at both sites felt they could contact Regional Headquarters (RHQ) staff for support when required. A Band 8 physiotherapist at RHQ was in post to provide specialist support to the PCRF.

The team were committed to delivering the best care through a culture of constant learning and improvement. It was an approved training practice and had a well-established training ethos. The practice had their last General Practice Educational Committee visit in January 2025 and had been complimented for having a strong culture of learning and a high-quality educational experience provided to trainees.

The practice was used as a ‘mentor’ centre for pharmacy technicians in the region who needed additional support. Tidworth was also the regional hub for the training of

long-acting reversible contraceptives and other more challenging women's health issues. The Middle Wallop site had gained approval to be a hub for dive medicals.

Vision and strategy

The practice had a clear vision and strategy to deliver high quality, sustainable care. They worked to the Defence Primary Healthcare (DPHC) mission and vision statement but had developed their own 5 year practice development plan. The management team had also adopted a behaviour charter to enhance the working environment for the team. The mission statement had been updated by the current Senior Medical Officer (SMO), all staff had been given the opportunity to contribute. As well as working to the DPHC overarching mission statement, they had also developed their own which was:

> *"Our practice is committed to providing a high quality, comprehensive, cost effective and continuing service to patients, including the use of effective and economic prescribing methods, diagnostic tests and referrals to secondary care.*
>
> *To achieve this aim we must undertake self-assessments that encourage the whole primary care team to reflect on performance and to encourage a positive learning culture".*

A discussion was held with all staff followed by a thinking period for everyone to contribute on their aspirations for the working practice and environment. A brainstorming session was consolidated into as single document using the subheadings 'people, process and technology'. Short, medium and long-term plans were in place up to 2030. Examples of plans being worked on included social prescribing opportunities planned for 2026. Other examples included bringing the domestic violence working group back into the garrison, prioritising transgender and carers support. Activities were detailed into a planning tool and projects that required wider DPHC involvement had been escalated; for example, an automated cancelling system built into the new clinical operating system.

Environmental sustainability was upheld wherever possible. Waste was separated for recycling at both sites. Prescribers were moving away from aerosol inhalers as part of the environmental special interest group work and in accordance with nationally recognised guidelines. The Tidworth site also had energy saving lighting. Car sharing was encouraged when attending meetings and most of the fleet were electric vehicles and many meetings were moved to being online to minimise travel requirements.

Culture

Staff we spoke with described a strong team ethic across the medical centre whereby the patient's requirements were held central to all decision making. The

leadership team operated an open and honest meeting culture where all staff were encouraged to attend and offer suggestions or raise concerns. Leaders operated an open-door policy for staff to use. Staff were aware of the whistleblowing policy and were also aware of the Freedom to Speak Up process.

Staff said morale was good and the team ethos strong. The management operated an open-door policy and there was a use of first name (including on the badges with staff encouraged to introduce themselves by first name) basis within the practice. They had an inclusive meeting structure and had open staff forums to raise concerns and offer suggestions. The practice used 180 degree feedback, a process of appraisal where feedback is provided from 2 sources, the line manager and the self-assessment. In addition, all staff were recently invited to complete an anonymous feedback survey and a staff suggestion box allowed for ongoing feedback to be provided with anonymity.

The practice team participated in team building activities and charity events. Recent examples included a ‘wear it pink’ day to raise breast cancer awareness, authorisation had been gained from the Chain of Command to wear pink as part of the uniform. There were opportunities for staff to meet informally to provide support.

Staff were recognised with thank you awards and these extended to civilian staff. Recent recognitions included for safeguarding work, liaison with NHS services and for the pharmacy technicians for maintaining the dispensary whilst being a member of staff short. Additional awards included the ‘general good egg of the quarter,’ innovator of the quarter,’ medic of the month’ and ‘patient advocate of the quarter.’ These were decided by staff vote and a free text section was available for comments to be made for the staff member to see. Recent social events included a barbecue, escape room, team sports and a visit to the Aviation Museum at Middle Wallop.

The practice had introduced a ‘behaviours charter’, developed following a conversation with the regional team about culture and behaviours and high performing teams. The charter addressed how staff communicated, respected one another and challenged each other. Staff told us that it was common for everyone to have lunch together and this promoted teamwork and made them feel valued and respected.

There was a positive trend throughout the inspection of staff speaking about the working environment being supportive, inclusive and open. Of note, new doctors and medics were highly complementary of the support and training.

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. There was a duty of candour register on the healthcare governance (HcG) workbook and it was cross referenced to the ASER and complaints registers. A review of the register at this inspection evidenced that entries were comprehensive. One example was when patient information had accidentally been given following a subject access request. A review of the actions showed a detailed investigation had taken place and appropriate communication with those impacted.

Governance arrangements

The leadership team had defined responsibilities, roles and systems of accountability to support governance and management. The practice had built in more resilience with leads and deputies in all areas and covering both sites. The HcG workbook was the overarching system used to bring together a range of governance activities, including the risk register, ASER tracker, training register, quality improvement projects and complaints. The workbook was populated with information to provide internal assurance that systems were effective.

A meeting schedule was established, and this included clinical meetings, heads of department meetings, vulnerable patient meetings and monthly healthcare governance and practice meetings for all staff. Discussion at each was recorded and made available to those unable to attend. The nurses also held regular informal huddles and extended the invite to the nurse at Middle Wallop who could dial in. A nurse forum was held monthly as a formal minuted meeting including of actions and timeframes when needed.

The clinical oversight of the medics was highlighted as good practice by the clinical specialist advisors with contact being reviewed by the named lead medic on the day. In addition, each day on a rota, a doctor designated as lead clinical supervisor would review and annotate on all consultations for non-GP trained doctors and medics.

A ‘governance tree’ was used as part of the training as a way of engaging staff with the governance process. This was a pictorial representation to outline activities the practice undertook to ensure an effective and safe service was provided.

Managing risks, issues and performance

The SMO and practice managers maintained oversight of the risk register on the HcG workbook. There were also issues, retired risk and retires issues registers. Risk was discussed at the weekly heads of department meeting and monthly practice HcG meetings as a standing agenda item. There was a range of risk assessments in place covering both clinical and non-clinical risks.

The leadership team was mindful of risks to the service and were proactive in anticipating potential upcoming issues and adding them to the risk register. The top risks identified were workforce (due to being or potential to be deployed), IT and infrastructure. In particular, the aging building at Middle Wallop. The high turnover of staff meant that the medic numbers was regularly below the established number of 72. On some days it was reported to be as low as 10 which put pressure on the workload for those remaining medics as well as the permanent staff. As medics are non-DPHC personnel, a Memorandum of Understanding had been developed between the medical centre and the local units to maintain medic availability to support the Garrison Medical centre. This has now been accepted by the RHQ and passed to HQ DPHC for implementation at HQ level.

A system was in place to monitor performance target indicators. The system took account of medicals, vaccinations, cytology, summarising and non-attendance. Risks to the service were recognised and logged on the risk register. All risks on the register were signed as reviewed by the SMO.

There were business continuity and resilience plans (BCPs) for both sites that were in-date for their annual reviews. Both plans followed the same format and included a key contact list of regional staff, contractors, heads of department and nearby military medical centres. The plans also included actions required by key personnel for department recovery. The BCP has been utilised 5 times in 2025 due to loss of IT, telephone lines and power. All outages were recorded on the HcG workbook. The major incident plan at Middle Wallop relating to the airfield required a response from the emergency medical technicians only and they were Unit assets, not DPHC staff, so the practice did not play a role.

Major incident training took place at Middle Wallop with it being an airfield. The local NHS Ambulance Service combined with practice staff and other emergency services had taken place.

The leadership team was familiar with the policy and processes for managing staff performance. Initial concerns would be addressed by identifying if there were any welfare issues that required support. Training and mentorship would also be offered alongside the appraisal process. Formal performance management would be considered if appropriate or of other processes were not successful.

Appropriate and accurate information

The Healthcare Assurance Framework (HAF) commonly used in Defence Primary Healthcare to monitor performance is an internal quality assurance governance assurance tool to assure standards of health care delivery within defence healthcare. The HAF was overseen by the practice managers and Senior Nursing Officer and formed an effective ‘to do’ list across the combined practice. All staff had access and used it as a management and information resource.

An Internal Assurance Review was undertaken in November 2023. This graded the practice with “substantial assurance”. The HAF had been fully populated which had driven the development of the Management Action Plan. The team had completed 137 actions identified during this process to improve the service.

There was a well maintained audit register located in the HcG workbook. Findings from audits were fed back to the wider team together with any resultant changes in working practice. The programme included repeat audit cycles in some circumstances where further potential improvements had been identified. We reviewed a number of examples that included audits for asthma, chronic kidney disease, and rheumatoid arthritis and found that they provided assurance of consistent and appropriate treatment being provided.

Systems were in place that reflected data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. All staff had received training in the management of confidential information which included Caldicott principles. Caldicott reports on DMICP were reviewed by the practice manager weekly and completion recorded on the HcG workbook.

Engagement with patients, the public, staff and external partners

Patients had the opportunity to make suggestions about the care delivered. The DPHC patient experience survey was displayed throughout the buildings which showed 94% described the service as good, patients were encouraged to scan the QR code to give feedback. It was evident throughout the inspection that the views of patients were sought and considered when making decisions. Examples included the close monitoring of wait times in response to comments from patients around better access. A lot of publicity work had been carried out to educate patients on the eConsult and total triage services. This included prominent displays in the cookhouse as it was established that many patients did not pick up on the messages sent out as part of the service personnel's weekly orders.

The practice was responsive to patient needs changing the service to resolve issues as they emerged. For example, there was often a long queue at Tidworth each morning with patients attending sick parade. The practice implemented a Gov.UK Notify text template to allow patients to request a sick parade review remotely. This reduced the number of patient contacts as patients were signposted to the most appropriate clinician and prevented long delays waiting to be reviewed in person. This service was further developed into Total Triage to improve the supervision during the triage element of the process. The number of personnel attending in person had reduced to a small number who were often unaware of the Total Triage service. The practice had also responded to a patient suggestion for neurodiverse signposting for civilian patients.

The PCRF had a 'you said, we did' board to communicate change made as a direct result of patient feedback. Recent examples included an increase in administration staff and extended hours. A PCRF staff feedback questionnaire had recently been carried out. The supervision and mentoring process resulted from the last one together with increased clinical administration time.

Staff had opportunities to provide feedback to leaders. An anonymous staff survey conducted in late 2024 identified no significant concerns. Changes in working practice were made as a result of staff feedback; for example, medics were unhappy losing their lunch break to cover reception so the management team took the decision to close the facility over lunch time. However, there was a doorbell for patients to gain access if urgent.

One of the doctors spent a day each week engaging with local NHS and community services to identify and enhance care pathways for practice patients. Meetings with NHS colleagues were hosted at Tidworth Medical Centre to further enhance communication. Links had also been developed with the diabetes centre at the local hospital. Nurses had an advice link and were supported with newly diagnosed and pre-diabetes education.

Multidisciplinary team meetings were held monthly with each of the units and sub-units. This included small elements like the band through to representation at the divisional meetings.

Continuous Improvement and Innovation

There was evidence of innovative practice raised as quality improvement projects (referred to as QIPs), of note, the leadership continued the strong training ethos to be innovative to support staff and improve the patient experience. Examples of QIPs included:

- A 'family planning emergency box' had been implemented to be used specifically when responding to an emergency with the insertion of coils and implants.
- With authorisation from DPHC, members of the nursing and PCRF teams had been upskilled in occupational medicine so that they could populate an initial template. The Deputy SMO had developed a training package and presentation to facilitate this which had been adopted and rolled out across the region. This increased capacity for occupational health appointments allowing patients more access.
- The PCRF had submitted a QIP following the introduction of mentorship and supervision for all staff within the department. A peer buddy system was in place for the first 6 months of staff new to the department.
- PCRF staff utilised health fairs for injury prevention work specific to the patient population and ran mobility classes away from the practice buildings as an injury prevention process.
- 'Health care for health care workers' was being developed by the practice in conjunction with DPHC headquarters with the SMO leading on the clinical delivery. Alternative pathways had been developed for those not wishing to be seen at their local DPHC practice. Research work had been carried out on why healthcare workers may be struggling with their work and how best to reach out to provide support.
- Following a recent spike in patents with Rhabdomyolysis (a rare muscle injury where tissue breaks down rapidly leading to potential life-threating symptoms) identified in the PCRF, to be able to learn more and support staff in effective care delivery, the lead ERI had arranged a visit to the Institute of Naval Medicine to enable upskilling of staff and to gain a better understanding of the condition.

- The pharmacy technicians had put in place a new retrieval system which had reduced the patient waiting times and the risks of medication handout errors.
- Medics and healthcare assistants had been trained to be able to complete a full review for patients with hypertension. Staff reported that this proactive approach had commenced in October 2025 to reduce the list of patients due a review.
- To improve uptake and reassure the patients, the nurse at Middle Wallop attended a morning parade and spent time reassuring the service personnel about the vaccines and the protection they provided. This resulted in increased engagement from the Chain of Command and a significant improvement in the numbers vaccinated. There was an 80% increase in uptake in the numbers vaccinated.