CQC's inspection programme of Defence Medical Services: Annual report for 2024/25 (Year 8)

Summary of inspection activity in 2024/25

During 2024/25 – Year 8 of this programme – we carried out 34 comprehensive inspections, comprising:

- 20 medical centres (including primary care rehabilitation facilities with expertise input from DMS physiotherapy and exercise rehabilitation specialist advisors)
- 14 dental centres.

We also carried out 14 follow-up inspections to ensure that services have resolved the concerns we found on initial inspections. We re-inspected:

- 9 medical centres (including primary care rehabilitation facilities with input from DMS physiotherapy and exercise rehabilitation specialist advisors)
- 3 dental centres
- 1 pre-hospital emergency care (PHEC) service

- 1 military department of community mental health.

Most services have been able to deliver some improvements, although there are still barriers to improvement in some areas, specifically:

- insufficient leadership capacity
- lack of a clinical information system to provide a comprehensive set of performance indicators
- poor infrastructure
- gaps in training.

In our inspection reports, we continued to highlight exemplary practice to encourage other services to learn from it and to adapt what is relevant to use in their own improvement journey.

All inspection reports for Defence Medical Services are available on our website.

The impact of the inspection programme 2017 to 2025

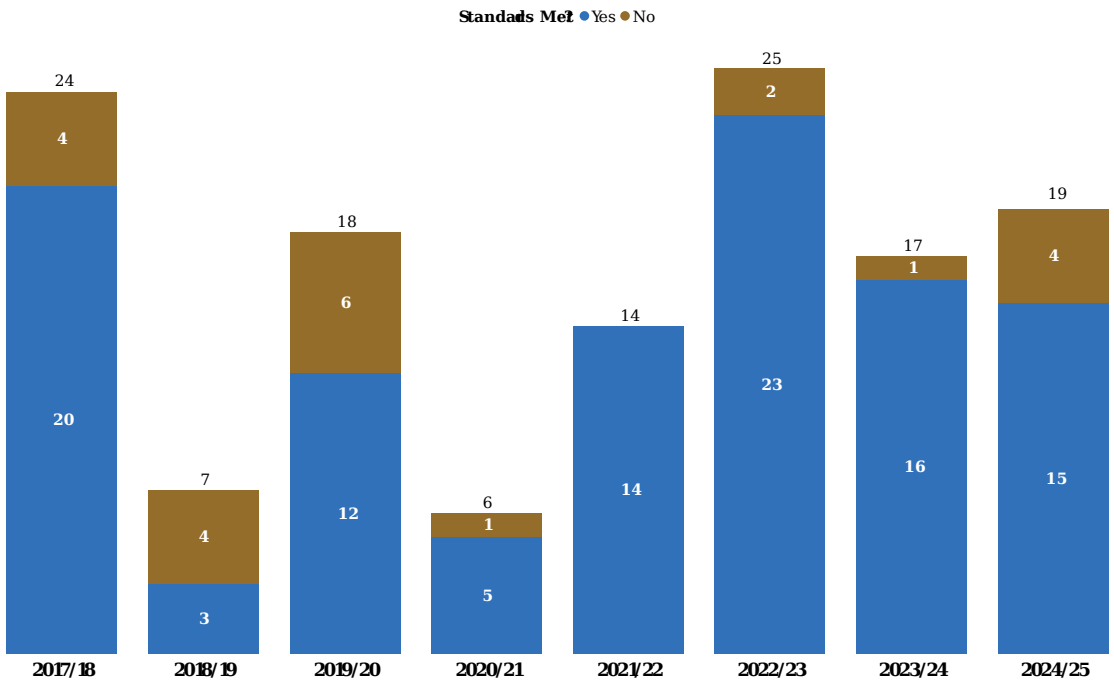
This year, we have looked back at the outcomes of our inspections to identify any trends and improvement.

Improvement in dental centres

Our team of 4 inspectors have carried out 130 first and follow-up inspections since 2017. As with our inspections of CQC-registered dental providers, under the Health and Social Care Act we do not give a rating to these services, instead we assess whether they are meeting standards.

Figure 1 shows the numbers of dental centres that met standards across the 8-year programme.

Figure 1: Outcomes of inspections of dental centres 2017/18 to 2024/25



Source: CQC inspection outcomes
Note: We carried out a limited number of inspections in 2020/2021 because of COVID-19 restrictions.

Improved infrastructure

Across the 8-year programme, we have identified where the infrastructure has not allowed teams to comply with basic standards for infection prevention and control and safe dental decontamination (cleaning and sterilising instruments and equipment to prevent the spread of infection). We have reported concerns and issued recommendations, followed by enforcement action from the Defence Medical Services Regulator as necessary.

This approach has acted as a catalyst to secure improvements in infrastructure at some dental facilities, either through a new building or refurbishing the Central Sterile Supply Department (CSSD).

A flagship example is the new dental and medical facility at Leuchars Station. The new building is designed to be as sustainable as possible, including through thermal efficiency, solar panels, air source heat pumps and providing 4 electric vehicle charging stations. Building materials were selected not only based on suitability but to reduce carbon impact on the environment. The building aims to be an example of sustainability in construction for future MOD medical and dental centres.

Water management

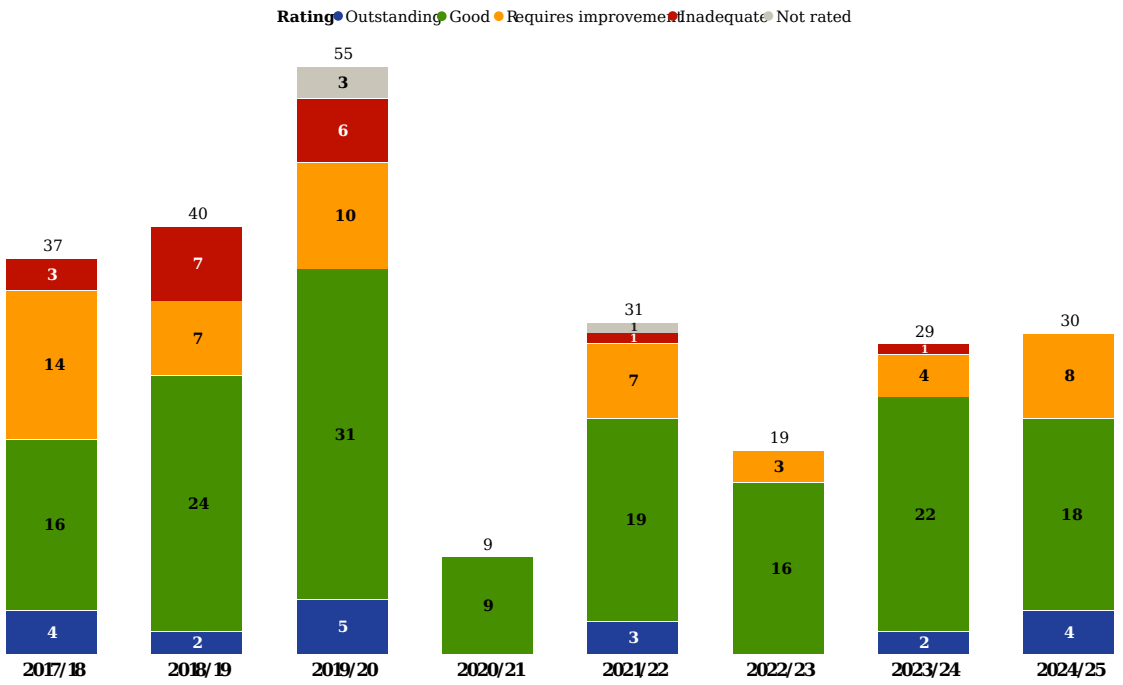
A number of sites have improved how they manage water safety, although more work is needed to ensure consistency across all Defence Primary Healthcare.

We have re-inspected a number of dental centres to ensure that services provide clear information about water safety management to dental teams and that they resolve risks relating to routine water safety checks to minimise the risk of Legionella in the water system.

Improvement in medical centres

Since 2017, a team of 4 CQC inspectors have carried out 231 first and follow-up inspections of Defence medical centres. In the first 3 years, more medical centres were rated overall as inadequate or requires improvement. However, in 2024/25 (Year 8) no medical centres were rated as inadequate overall (figure 2).

Figure 2: Overall ratings for medical centres 2017/18 to 2024/25



Source: CQC inspection outcomes
Note: We carried out a limited number of inspections in 2020/2021 because of COVID-19 restrictions.

Throughout the programme, we have seen how services have made improvements to the quality of care in some of the following key areas.

Safeguarding

Early in the programme, we found services that were not fulfilling their duties to safeguard people who may be more vulnerable, including children. But in recent inspections, we have seen improvement in the way these patients are recorded in the patient record system, and how alerts are applied to their records. Information sharing with key stakeholders such as welfare teams and Multi-Agency Safeguarding Hubs (MASH) has also improved.

Managing high-risk medicines

As the inspection programme has progressed, we have found improved systems to manage patients who are prescribed high-risk medicines and fewer patients without a shared care protocol.

Managing test results

Defence healthcare facilities do not have access to Integrated Clinical Environment (ICE) Order Communications Software (a single system that allows healthcare professionals to electronically request tests and view results, including those from both primary and secondary care). Medical centre teams have therefore adapted manual systems to manage test results.

At the start of the inspection programme, we frequently identified services with no failsafe system to manage test results. More recently, we have found that more medical centres have systems in place. Nevertheless, incidents will still happen due to human error, inadequate deputising arrangements when staff are on leave, or because significant events do not lead to embedded learning.

Accessible services

We have noted more access audits for premises, as defined in the Equality Act 2010.

Complaints management

Complaints management has improved, including a move to record and act on verbal as well as written complaints. Services are also increasingly using analysis of trends from complaints as opportunities to improve care.

Managing long-term conditions

In the early years of the programme, we identified gaps in managing the care of patients who have a long-term condition. This included a failure to recall patients in line with National Institute for Health and Care Excellence (NICE) guidance. In recent inspections, we have noted wider adoption of a standardised chronic disease management tool (CDMT) and standard operation procedure to manage chronic conditions.

Quality improvement work

In earlier inspections we noted a lack of comprehensive quality improvement work that was relevant to and targeted around delivering improved outcomes for patients. More recently, we have found more examples of cyclical improvement programmes designed to identify improvements across both clinical and management areas, and which integrate the needs of patients using the medical centre and the primary care rehabilitation facility.

Key findings from inspections in 2024/25

What we found from our inspections in 2024/25.

- Dental services
- Medical centres
- Combined medical centres

- Pre-Hospital Emergency Care
- Defence Community Mental Health Services

Dental services

For our inspections of DMS dental services, rather than give a rating, we judge whether the service is meeting standards, and we make recommendations in the inspection report.

DMSR asked CQC to carry out first comprehensive inspections at 14 dental centres. Of these, 13 were meeting the regulations for all 5 key questions.

Only one dental centre inspected did not meet safety standards, as the unit had failed to provide clear information and resolve risks relating to routine water safety checks to minimise the risk of Legionella in the water system. We also identified the need to:

- implement temperature monitoring for perishable consumables
- make clinical waste management fully effective
- observe waiting patients at all times.

Dental care provided overseas

We inspected the 3 dental centres on Sovereign bases in British Forces Cyprus. Our recommendations to DPHC Overseas were to:

- ensure that all suspected oral cancer cases are referred without delay, and to manage 2-week referrals consistently across the island

- ensure that staff understand how to access general anaesthetic for children aged under 3 years
- explore the possibilities and benefits of a more co-ordinated approach across the island to maximise standardisation, provide a platform for clinical peer review and share best practice across practices.

Re-inspections

We re-inspected the safe key question at 3 dental centres in 2024/25 to follow up our previous recommendations. Of these re-inspections, Blandford Dental Centre had substantially improved health and safety systems around managing clinical waste, and routine water safety checks were now in place to ensure patient and staff safety.

However, 2 centres did not meet standards for the safe key question. We noted ongoing non-compliance at both Weeton and Mount Pleasant Dental Centres. This was because poorly-designed and maintained buildings were unable to achieve 'basic standards' as detailed in guidelines on decontamination and the control of infections and related guidance. Although both centres had appropriately escalated concerns through the risk system and submitted statements of need for remedial work, funding had not been approved and so improvements had not been delivered.

Medical centres

All military personnel, some dependants, and some civilian staff are entitled to use the services of a military GP practice.

Unlike most NHS patients, military staff do not have the right to register with a GP practice of their choice, but must register at the location where they are assigned.

The overall ratings for each medical centre are determined by aggregating ratings for the 5 key questions. Of the 20 first comprehensive inspections of medical centres in 2024/25:

- 3 were rated overall as outstanding
- 10 were rated overall as good
- 7 were rated overall as requires improvement
- none were rated overall as inadequate

As we have found in every year of the programme, problems are more often related to the centre's approach to safety and how well it is led and managed (relating to the safe and the well-led key questions).

We found that most patients were able to access care that was compassionate, assessed under the caring key question. There were concerns around the effectiveness of care delivered at 4 medical centres (effective key question). All medical centres we visited were delivering responsive care and 5 teams achieved a rating of outstanding for the responsive key question.

Improvement on re-inspection

Where we identify shortfalls in the quality of care, we return to re-inspect to ensure the service has made sufficient improvement. In 2024/25, we re-inspected 9 medical centres. All these services demonstrated positive improvements in the quality of care, with one service rated overall as outstanding.

Total Triage

Defence Primary Healthcare (DPHC) has introduced 'Total Triage' – the triage of patient contacts to enable care to be provided by the right person, at the right time, in a way that meets each patient's needs.

We inspected 2 medical centres that have rolled out 'Total Triage' following guidance from the British Medical Association Care navigation and triage in general practice. We re-inspected Catterick and Barrow Group Practice having previously identified some concerns with the triage system – our follow-up work showed that the renewed approach was safe and effective. We also identified best practice approach at Marham.

Examples of improvement resulting from Total Triage

The following examples are from inspection reports that demonstrate safe implementation of Total Triage

Catterick and Barrow Group Practice

When we inspected the group practice in June 2023, we reported concerns around use of the 'Total Triage' system. This was being piloted with the aim of rolling the system out across all Defence Primary Health Care. We recommended a review of the pilot triage system to ensure staff followed clinically safe working practices, including making sure that non-GP staff work within their competencies and provide appropriate advice and triage. In October 2024, we returned to follow up our previous concerns.

- Following an internal review, the practice had developed a model to provide initial patient contact by suitably trained Combat Medic Technicians and primary healthcare nurses, but with immediate, 'in-room' supervision provided by a nurse prescriber.
- Overarching 'reach back' support was provided by the duty doctor for that day (always a trained GP). If staff needed to raise immediate questions about patients, these were reviewed initially by the supervising nurse practitioner, who could also ask the duty doctor if necessary.

- Updated local working practices for supervision and monitoring triage clinics showed robust processes. Our review of total triage processes, including audits and clinical notes, found that the clinical governance was effective.

Read the full follow-up report: Catterick and Barrow Group Practice (October 2024) rated overall as good

Marham Combined Medical Centre

The Total Triage system was initiated and successfully introduced as part of the practice combining process in August 2024.

- To meet the needs of the patient population, the practice Warrant Officer sought the views of other DPHC practices that had introduced Total Triage and trialled different approaches.
- To maximise understanding of the benefits of Total Triage and support for the approach, the practice distributed posters to across the stations and added information to the local news page.
- The practice Warrant Officer engaged with station executives and met with Warrant Officers across both stations. Practice staff were trained in the process.
- We found that Total Triage was working well across the practice. Feedback from patients suggested it provided more timely access to appointments with clinicians, and staff said the process freed up appointments for routine clinics. The Total Triage model at Marham Combined Medical Centre had been raised as a quality improvement project.

Read the full report: **Marham Combined Medical Centre (May 2025)** rated overall as outstanding

Areas for improvement

Although we saw some improvements over the previous 7 years of the programme, there are some common areas that still need to improve across medical centres. We look at specific issues under each key question.

Safe key question

As in previous years, there continues to be a clear link between a lower rating for the quality of leadership (well-led key question) and a lower rating for safety (safe key question). The main areas of concern were:

- **Safe levels of staffing:** Across this programme, we have consistently identified concerns around shortages in the workforce and the resulting challenges in delivering safe and effective care. Services with poorer ratings tend to have more vacancies and posts that have not been covered by locums.
- **Infrastructure:** Medical teams sometimes find themselves working in buildings that are not purpose-built, where maintenance has been poor and where they are therefore unable to meet national infection prevention and control standards or follow health and safety guidance.

  Issues around infrastructure require action from Top Level Budget holders and the Defence Infrastructure Organisation– DPHC alone cannot have a positive influence where responsibility for taking action lies elsewhere in DMS or the wider Ministry of Defence.

- **Information systems:** Defence Primary Health Care (DPHC) has no information system that can provide a comprehensive set of performance indicators across its medical services, as recommended in guidance from the National Institute for Health and Care Excellence (NICE).

  Across this inspection programme, we have highlighted concerns with the completeness and accuracy of patient records at some services. We have found that the accuracy of Read coding is variable, as there is no:

  - agreed listing of the codes that should be used
  - DPHC-wide policy for staff to work to or agreed standards
  - comprehensive audit programme to ensure overall improvements in coding.

Effective key question

In 2024/25, 25 medical centres were providing effective care to their patients (including 9 where we followed up).

Example of outstanding effective care

At **Stonehouse Combined Medical Centre**, we saw specific key areas that contributed to success:

Care for patients with a mental health condition was managed well. All areas of mental health were discussed at clinical meetings, for example depression, self-harm including suicide prevention and Letter of Hope (support for suicidal ideation). An audit of records for any patients diagnosed with depression showed 100% compliance in ensuring these people had received a follow-up appointment within 10 to 56 days. The practice also audited the use of antidepressants in practice, which showed it was following best practice. There was regular liaison with the mental health nurse, who was also invited to attend clinical meetings if appropriate.

Together with UK Commando Forces' mental health nurse, the practice developed a specific Step 1 therapy programme. This service, called TRIGPOINT, was a 6-hour session for Step 1 intervention, which the mental health nurse ran from the welfare hub with support from the practice if needed. Administrative staff booked the appointments for patients to attend this course. Pre and post course improvement scores were measured to monitor effectiveness, and patient feedback has been positive. Those who needed intervention beyond step 1 were referred for an appointment with the Department of Community Mental Health (DCMH).

The practice had engaged with 'Harbour', Plymouth's substance misuse charity. When we inspected, staff were arranging for Harbour to provide a monthly drop-in service at each site to give support to patients and raise awareness. They had also engaged with welfare and the Chain of Command to support this, as it would strengthen how the practice delivers the DPHC policy on gambling.

Annual systematic records searches identified patients with high cholesterol and glucose/HbA1c levels who may not have had any action taken on these results. Affected patients were actively recalled and staff took appropriate action. The team invited patients over the age of 40 to have NHS health screening, which includes measuring their blood sugar levels.

A wide-ranging audit programme covered topics including case finding of conditions (for example, missed diagnoses of diabetes), and a variety of clinical and non-clinical topics. There were 85 completed audits in the previous 12 months. Audits and quality improvement projects were part of the standing agenda for the clinical and healthcare governance meetings.

Read the full report: Stonehouse Combined Medical Centre February 2025 (rated overall as outstanding).

However, we found that 4 facilities had been unable to ensure that the service was effective. Common concerns identified included:

- gaps in the review of patients diagnosed with a long-term condition
- staff being unable to use the DMICP patient records system to facilitate clinical searches, assure recall programmes and monitor performance
- a failure to formalise the training and support requirements for clinical staff who are required to deliver paediatric assessment and treatment and for staff who are required to support autistic patients or patients with a learning disability
- induction programmes that lacked role-specific information and gaps in staff training relevant to specific roles
- failure to monitor patients on repeat medicines
- failure to audit antibiotic prescribing.

Caring key question

As with all our inspections in this programme, the quality of care is again rated higher for the caring key question. We found that all but one medical centre that we either inspected for the first time or re-inspected in 2024/25 provided caring services to their patients.

Medical centre teams proactively identified and supported patients who are carers. For example, providing links with carers' organisations and ensuring that the carer's emotional and healthcare needs are met.

Where we identified a concern, it related to an 'open curtain' policy in the treatment area of a primary care rehabilitation facility, where both cadets and training staff were treated at the same time, sometimes undressed. Although a radio had been provided for background noise, conversations could be clearly overheard. A poster advised about the 'open curtain' policy, but this did not ensure the privacy and dignity of patients.

Example of an outstanding caring service

At **Stonehouse Combined Medical Centre**, we saw specific key areas that contributed to a rating of outstanding for the caring key question.

People were truly respected and valued as individuals and were empowered as partners in their care. Feedback from people who used the service was continually positive about the way staff treated them. People thought staff went the extra mile and the care they received exceeded expectations.

The last patient survey resulted in positive responses, with all those who responded confirming they were satisfied with their healthcare professional and they were treated with dignity and kindness.

The practice manager audited records regularly to make sure that staff accessed records appropriately and legitimately.

Read the full report: Stonehouse Combined Medical Centre February 2025 (rated overall as outstanding)

Responsive key question

In Year 8, all medical centres that we inspected and re-inspected were rated as either good or outstanding for providing responsive care, demonstrating that military patients and their families can access care when they need to. All these medical centres understood the needs of their patient population and designed their service to meet these needs. They had gathered feedback from patients and staff and used this knowledge to ensure that care was convenient and accessible.

Example of outstanding responsiveness

Seria Medical Centre

- The medical team had worked in partnership to identify a group of patients who would benefit from an autism assessment, speech and language, and occupational health support.
- The Oxford University Hospitals NHS Foundation Trust Multidisciplinary Assessment Team had spent a week at Brunei Medical Centre conducting assessments for a cohort of 13 patients, resulting in 12 diagnoses of autism.

- The Defence Children's Service were providing speech and language support, Special Educational Needs Co-ordinator support had been made available in the school on base, and health visitors were being trained to provide play therapy for families. A neurodiversity group 'Brighter Beginnings, Brighter Futures' had been set up to support patients and their families.
- To meet patients' needs and preferences, the Primary Care Rehabilitation Facility provided intensive 2-week rehabilitation courses for patients whose condition needs a period of intensive daily rehabilitation. Patients confirmed that they preferred to received rehabilitation locally, rather than having to leave their families in order to travel to the UK. The approach had been evaluated and patient feedback was 100% 'good' or 'very good'.

Read the full report: Seria Medical Centre June 2024 rated overall as outstanding.

Marham Combined Medical Centre

- The key population at Honington was the Regiment Training Wing undergoing Phase 2 training. Many were very young, and some had left home for the first time. The arduous training meant trainees were a high risk for musculoskeletal injuries and heat illness. The practice made special allowances for these patients to ensure appointments could fit in with their training programme. It also considered that trainees were governed by a separate occupational health policy.
- A peripatetic clinic at Robertson Barracks in Swanton Morley meant that patients did not have to travel to the Primary Care Rehabilitation Facility for rehabilitation.

- A practice-wide 6-monthly patient focus group included the dental services and the welfare team. Between 45 and 50 patients dialled into the last 2 focus groups to raise issues and queries, and each practice department provided updates on any developments.

Read the full report: Marham Combined Medical Practice May 2025 rated overall as outstanding.

Well-led key question

Leadership was strong and effective at most services we inspected in Year 8, and the overall judgement across leadership in military general practice was largely positive.

Examples of outstanding and good leadership

Seria Medical Centre

The staff team at the medical centre in the Brunei Group Medical Practice delivered high-quality care, which provided continuity of service for both patients and staff.

- Staff described a driven and able leadership team, and the Senior Medical Officer at the helm demonstrated an open leadership style designed to deliver results. Consistency in leadership led to ongoing improvement across the service.
- Staff owned detailed terms of reference for their main role and separate terms of reference for any key lead roles. The intimate and aligned working relationships with key stakeholders were beneficial to more vulnerable patients, service personnel, children and families.

- Care was delivered to patients through an integrated multi-disciplinary approach, with patients at the centre of this shared care approach, resulting in positive outcomes.
- Staff enjoyed working together and invested their recreational time in team celebrations, which had led to a strong team ethos. We observed staff going the extra mile to provide a comprehensive service to their patients.

Read the full report: Seria Medical Centre (June 2024) rated overall as outstanding

Eastern Southern Base Area (referred to as ESBA) Combined Medical Practice

- Since the previous inspection (previously called Dhekelia Group Medical Practice), a new Senior Medical Officer and Practice Manager had joined the practice. The refreshed leadership team had delivered change and improvements over 12 months.
- Staff described how the team was more cohesive and engaged with improved capacity in the leadership team. They were inspired by the commitment and hard work of the practice manager and Senior Medical Officer since they joined the practice.
- Staff reported that the refreshed leadership team was providing clear structure and direction for the service. We heard that heads of departments were visible, with staff having prompt access to support and guidance if needed. In terms of capability, staff had confidence in how the leaders were managing the practice.

- Succession planning involved liaising with the career managers to minimise the impact of deploying key military management personnel at the same time. Staffing levels had significantly improved since the previous inspection. Leaders said the regional team was supportive and staffing requests were acted on promptly.
- Nurses highlighted team improvements since the last inspection, as doctors were approachable to discuss issues, and patients and nurses also felt supported by the paramedics. New nurses said they were well supported by their colleagues and nurse leaders, and valued the 'Spotting the Sick Child' element of the induction.

Read the full report: ESBA Combined Medical Practice (September 2024) rated overall as good

However, where we identified pockets of poor performance under the well-led key question this affected all areas – particularly the safety and effectiveness of care and treatment.

Areas for continued improvement

Four medical centres were rated as requires improvement for their leadership in Year 8. We will re-inspect these services in Year 9 to ensure that they have delivered improvements. This is in relation to:

- leadership capacity
- culture
- risk management.

Combined medical centres

As part of the Healthcare Improvement Programme, Defence Primary Healthcare is enacting the Combining and Networking Operational Order against a number of medical centres.

Medical teams are asked to achieve initial operating capability by amalgamating information technology systems. Once patient lists and governance structures are combined, the facility undertakes an Internal Assurance Review before DPHC declares 'full operational capability'.

DPHC's aims for combining are:

- improved clinical outcomes for patients
- increased deployability for front line commands
- a better working experience for Defence Medical Service staff
- greater value for money for defence.

DPHC aims to achieve this by sharing resources, data and services to increase healthcare access and delivery options, increased standardisation, enhanced best practice, improved efficiency, adaptability and resilience.

In Year 8 we were asked to inspect 9 combined medical centres:

- 3 were rated as 'requires improvement' overall
- 4 were rated as 'good' overall
- 2 were rated as 'outstanding' overall

Two combined practices lacked the capacity to explore the benefits of combining, and we identified concerns at some combined medical centres.

Combining medical centres with diverse patient populations (and needs) has proven more challenging than where all patients represent a single military service. Patient populations representing the 3 single services have different requirements in terms of occupational health medicals, welfare systems and unit/station/base engagement. The addition of families to this mix requires a broader and more flexible approach to delivering care, which is more challenging and complex than single service military patient populations.

A strong and considered change management approach is needed to deliver optimal benefits from the combining process.

At one combined medical centre, insufficient guidance and support from leadership (at a regional and local level) had led to low morale. Staff told us they were experiencing stress and burnout in the workplace, directly because of the way the combining process had been managed. A number of clinical staff had resigned as they felt disaffected and unable to challenge ways of working.

However, we found how strong change management can lead to success in forming a combined medical centre that delivers the best outcomes for patients, as the following 2 examples show.

Case study: Successful change management

Stonehouse Combined Medical Practice

Stonehouse Combined Medical Practice provides primary care, occupational health, and rehabilitation services to 1,380 military personnel across 2 sites: Stonehouse and Bickleigh. Stonehouse provides a full range of military healthcare services to support serving military personnel, including:

- primary care
- occupational health
- mental health support
- musculoskeletal rehabilitation.

The nature of the population at risk – their unique roles across defence, coupled with the requirement for them to be held at high readiness – creates many challenges. This requires significant unit engagement and we received very positive feedback from the Chain of Command about this. Because both Stonehouse and Bickleigh are Naval bases, benefits from economies of scale are apparent: one culture, one welfare system, and an agreed set of Naval medical requirements.

The dynamic leadership of the practice, primarily led by the Senior Medical Officer and the Officer Commanding of the Primary Care Rehabilitation Facility (PCRF), drove a culture of empowerment, strong communication, and effective teamwork. They had worked on a comprehensive practice development plan, informed by the staff survey, with input from all staff into how it was implemented. Their collaboration ensured seamless co-ordination, which enhanced efficiency and fostered a supportive environment for all.

This united approach ultimately optimised patient care and outcomes.

The practice also plays a key role in pre-deployment preparation and ongoing fitness for duty, offering services such as vaccination programmes, audiometry, acupuncture and physical rehabilitation. Staff work closely with welfare teams, unit command, and regional healthcare services to ensure holistic, timely and effective care, tailored to the specific demands of military life.

In February 2022, the service was formally recognised as a Combined Practice by Defence Primary Healthcare.

While our 2022 inspection had already rated the service as outstanding overall, we found continued progress in 2025 as Stonehouse was operating to a very high standard – particularly in clinical innovation, staff development and improving access to care.

The move to a combined model of care enabled greater collaboration and flexibility across sites, allowing the practice to deliver services more efficiently and responsively.

A culture of proactive quality improvement

Between 2022 and 2025, Stonehouse developed and embedded quality improvement initiatives across all aspects of care. These covered clinical, administrative and operational areas and were developed using regular audit, staff feedback and incident learning.

Some examples included:

- monthly searches to ensure vulnerable people are appropriately coded and reviewed

- streamlined specimen handling and referrals, reducing delays and improving oversight
- digital text alerts for prescriptions, following an audit showing 30% were not collected, with early evidence of improvement.

The leadership team actively supports innovation from all staff groups, and improvement work is closely aligned to practice development plans.

This culture of continuous learning and reflection means that people's safety remains a priority while encouraging staff to develop their practice.

Improved leadership and access to rehabilitation

Rehabilitation services at Stonehouse had been strengthened with better co-ordination across sites and a focus on reducing delays. When long waiting times were identified at the Regional Rehabilitation Unit for electronic shock wave therapy (ESWT), the practice acted quickly, training a physiotherapist to deliver the therapy in-house and establishing a dedicated clinic. This reduced waiting time from 8 weeks to one week.

The physiotherapy team also completed specialist training in vestibular rehabilitation, allowing them to offer more tailored care for people with traumatic brain injury.

Physiotherapists and exercise rehabilitation instructors (ERIs) worked closely together, which helped people receive timely support, even during periods of staff shortages. Joint care planning and shared caseload management have become the norm, contributing to consistently high-quality rehabilitation.

The transition to a combined practice model has supported greater resilience across the workforce and improved continuity of care for people. Shared protocols, more flexible staff deployment, and improved internal communication have all played a role in strengthening the service.

The experience at Stonehouse highlights the value of integrated team structures, proactive leadership, and a clear commitment to individualised care. The team's ability to build on an already outstanding foundation demonstrates how continuous improvement is possible.

Read the full report: Stonehouse Combined Medical Centre (February 2025) rated overall as outstanding

Marham Combined Medical Centre

Marham and Honington Medical Centres became fully combined in December 2024 to become Marham Combined Medical Centre. It supports an RAF patient population, excluding families.

Combining Marham and Honington medical centres was successfully executed with minimal obstacles. Led by an experienced and proactive senior leadership team, the approach was heavily underpinned by stakeholder engagement, up-to-date and transparent communication regarding each stage of the process, and the involvement of staff.

The success was evident through high staff morale and departments working together effectively, notably the nurses, dispensary staff and leads for secondary healthcare. Although the practice only formally combined in December 2024, integrated governance structures were effective. Furthermore, Total Triage was introduced successfully during the transition to the combined model. Throughout the combining process the practice continued to make improvements to the patient experience.

Read the full report: Marham Combined Medical Practice (May 2025) rated overall as outstanding.

Pre-Hospital Emergency Care

We inspected the Pre-Hospital Emergency Care (PHEC) service for British Forces Cyprus for the first time in June 2022.

We returned in October 2023 to follow up the concerns raised at the initial inspection and noted that, although some improvements had been delivered, there were still concerns in some critical areas. In October 2024, we returned to follow up the concerns raised in 2023.

We rated the service as requires improvement.

Several significant improvements had been implemented since October 2023:

- A clinical director had been appointed, who held 'Fellowship in Immediate Medical Care' and had extensive PHEC experience. Together with the Lead Paramedic, they had significantly progressed governance and safety in a short period through tangible, accessible leadership.
- The PHEC service across the island was now a paramedic response service, led by a PHEC specialist clinician.
- The 3 sites (Akrotiri, Episkopi and Dhekelia) were now working together. Where processes were not yet completely specific across the island, Sovereign Base Area Ambulance Service (SBAAS) standard operating procedures had been drafted and were waiting to be ratified.
- Monthly pan-island PHEC clinical governance meetings had been established to which all paramedics, dispatch nurses and BFC representatives were invited. This brought crews together regularly to discuss learning, governance and new policy.
- At the last inspection, staff highlighted the limitations of waiting for strategic decisions to be made. This had affected their confidence and morale – most notably for those who attended the scene of a road traffic accident and were still having to deliver care in an unsafe environment. At this inspection, the feedback was positive in interviews across all 3 sites when discussing scene safety.

We identified several key areas that required improvements:

- There was wide consensus within the PHEC team that 16 paramedics was not enough to staff the ambulances. Although locums were used to fill the gaps, the short-term nature of these contracts was proving unsustainable in practice due to the constant need to offboard, recruit and onboard locums. There is a need to consider alternative and optimal ways to ensure staffing resource for the PHEC service, taking into account abstraction (staff away from work).

- Crews need the right equipment to allow them to manage cardiac events and to meet the requirements of Resuscitation Council UK and National Institute for Health and Care Excellence guidelines on the management of patients requiring ROSC (the resumption of a sustained heart rhythm after cardiac arrest).
- Blurred lines of accountability at a senior leadership level, fragmented lines of accountability and unclear risk escalation pathways continued to pose risks to the safe delivery of the service. Although we saw examples of risks that had been identified, assessed and actions proposed, the ownership of these risks was unclear, which hindered progress and resolution. This included risks with a potentially serious impact. Local PHEC leaders had clearly identified key risks, but escalation to the regional team, DPHC, Single Service and British Forces Cyprus (BFC) had not resolved the issues – instead issues had remained a concern for over 3 years.
- Crews must have adequate personal protective equipment.
- Drivers must undertake blue light training.
- The PHEC service was targeted to attend the scene within 20 minutes of receiving a call. We were told that this had been achieved for over 90% of call-outs, with an average response time of 10 minutes. The timings started from the ambulance being dispatched, not when the call was received (UK standards are measured from when the call is answered) and so the assertion that 90% of calls had been reached within 10 minutes was not accurate. Where ambulance response time targets sit outside UK standards, risks to entitled personnel should be mitigated as far as possible and should be owned by Commander BFC and above. This includes that before arriving on the island, families and visitors should be informed about the ambulance response time target so that they can consider their personal circumstances and make an informed decision.

Defence Community Mental Health Services

Defence Healthcare Recovery Group (DHRG) provides occupational mental health assessment, advice and treatment through a network of departments of community mental health (DCMHs), mental health teams and additional staff at deployed locations.

During 2024/25, we followed up a previous inspection of one regional Network – the Department of Community Mental Health Bulford and Central and Wessex Region.

Since 2021, the Bulford service had also been responsible for delivering care to people across the whole Central and Wessex region, including those based in the catchment areas of DCMH Brize Norton and the Mental Health Team at MOD St Athan.

Before this, the service at Bulford had been rated as good, but when we returned in February 2023, following the merger of the services, although rated as good overall, we rated the service as requires improvement for the responsive key question. This related to significant gaps in the team that affected waiting times and risk response, and a lack of accommodation for the team in the north of the patch. The inspection in 2024 looked at any improvement against previous recommendations.

Safe key question: Rated as good

- Although vacancies remained, overall staffing levels had improved, which led to improved response to referrals and reduced waiting lists.

- The availability of psychiatrists had improved significantly and resulted in greatly reduced waiting times for psychiatric assessment.
- Each patient had an individual risk assessment, the team shared concerns about patients who were in crisis or whose risks had increased, and crisis plans meant that where a known patient in crisis contacted the team, the team responded swiftly. We saw good evidence of the team following up on any known risks.

Responsive key question: Rated as good

- Despite an increase in caseload, the team had met the response target for urgent and routine referrals and waiting lists for treatment had reduced significantly.
- Previously, long waiting times for psychiatric assessment had affected patient's medical boards (impacting the time taken to assess whether people could safely return to work). This had been addressed through quicker access to psychiatric assessment.
- The team operated from the main base at Bulford, with departments at Brize Norton and St Athan, which offered both virtual and in-person appointments. Patients told us that they welcomed virtual appointments as this had reduced travel time to appointments and allowed greater flexibility.

Well-led key question: Rated as good

- Leadership across the service was clear and accountable, and leaders had worked well together to find effective solutions to address all areas of concern that we highlighted following our previous inspections to ensure safe and effective care. Staff were positive and told us that the team worked well together, and that leaders were approachable and supportive of their work.
- Staff had undertaken appropriate supervision and training, and were positive about their role in delivering the service.

- An overarching governance framework considered performance and ensured continuous learning. Effective systems and processes captured governance and performance information. Any potential risks that we found had been captured within the risk logs and the common assurance framework. All risks identified included detailed mitigation and action plans.

Read the full report here: DCMH Bulford and Central Wessex November 2024.

Conclusion

Along with the Defence Medical Services Regulator (DMSR), CQC is committed to ensuring that armed forces personnel and their families can access the same high-quality care as the rest of society.

Clinical teams deliver complex services that span the care requirements of the individual patient as well as the occupational health care requirements of Defence. Military personnel and entitled dependants continue to receive prompt access to almost all services, and most have a very short wait to see a healthcare professional. Defence Medical Services benefits from a cohort of high calibre staff who are often willing to go the extra mile to ensure that patients receive personalised and compassionate care.

Throughout our 8-year inspection programme in partnership with DMSR, we have highlighted multiple internal factors that contribute to high-quality care, as well as factors that may inhibit it. Through sharing learning, Defence Medical Services have demonstrated improvement. Many issues and concerns that we used to find more frequently on early inspections have mostly been addressed. Across Defence Primary Healthcare and the wider organisation, we have seen first-hand how sharing learning, best practice, innovation and resource across some services has improved the quality of care for military patients and their families, as well as delivering significant benefits for staff.

From our re-inspections to follow up recommendations from previous inspections, although some key areas still need to improve, most healthcare services demonstrated sufficient organisational learning and positive improvement to confirm they had improved the quality of care.

Nevertheless, while acknowledging the environmental, resource and capacity constraints, there is still further work to do to ensure that pre-hospital emergency care overseas is safe and effective.

Eight years into our programme we still have the same concerns around:

- The lack of a clinical information system in Defence that can provide a comprehensive set of performance indicators across its medical services.
- shortages in the workforce and the resulting challenges in delivering safe and effective care
- the right level of training and equipment for medical staff who are required to deliver care to children to deliver this confidently and safely.

Some issues are beyond the immediate control of a specific service. For example:

- old infrastructure, where funding for building maintenance had not been approved and so staff were not able to deliver improvements

- the challenges of designing and resourcing services overseas where medical teams are required to deliver out-of-hours cover and bespoke additional care – sometimes for patients who are not registered with them.

Overall, we continue to commend military and civilian personnel across Defence Medical Services for their continued hard work and commitment to delivering high-quality, safe and effective care.