Sandhurst Medical Centre

Haig Road, Camberley, Surrey, GU15 4PQ

Defence Medical Services inspection

This report describes our judgement of the quality of care at Royal Military Academy Sandhurst Medical Centre. It is based on a combination of what we found through information provided about the service, patient feedback and through interviews with staff and others connected with the services.

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

Contents

Summary

About this inspection

We carried out this announced comprehensive inspection on 23 July 2025.
As a result of this inspection the medical centre is rated as good in accordance with the Care Quality Commission's (CQC) inspection framework.

The key questions are rated as:

Are services safe? – requires improvement
Are services effective? – good
Are services caring? – good
Are services responsive? – outstanding
Are services well-led? – good

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

This assurance visit is one of a programme of inspections that CQC will complete at the invitation of the DMSR in their role as the military healthcare regulator for the DMS.

At this inspection we found:

- The medical centre demonstrated a person-centred approach to accommodate the needs of individuals and the Chain of Command. Patients were involved in decisions about their treatment and care.
- Our review of records and processes to monitor care showed patients received effective and timely clinical care.
- The medical centre worked collaboratively with the Primary Care Rehabilitation Facility (PCRF) to enhance the safety, welfare and wellbeing of patients.
- Evidence of appropriate recruitment and completion of mandated training was in place for all staff.
- Patient feedback about the service was positive. It demonstrated patients were treated with compassion, dignity and respect.
- The medical centre had only one pharmacy technician to manage day-to-day the dispensary and drive continuous improvement. They worked hard to improve and provide a safe and efficient service for patients. However, some aspects of medicines management required strengthening including the management of controlled drugs and the review of patients prescribed repeat medication.

- Effective safeguarding arrangements were in place. Patients vulnerable due to their mental health and/or social circumstances were well managed and supported.
- Both the medical centre and the PCRF were old buildings and in need of refurbishment. Improvements had been made in most areas identified previously to ensure patient safety. However, this was not sustainable in the long term.
- Staff spoke highly of the culture within the team and described an inclusive and supportive leadership and management style.
- Governance systems underpinning the safe running of the medical centre were up to date.
- ASER, the organisational-wide system for reporting significant events, was effectively used and changes were made as a result of incidents.
- Flexible access and services were offered to patients with a caring responsibility.
- The medical centre had good lines of communication with the units and welfare teams to ensure the wellbeing of patients. Extensive links had been developed both internally and externally to enhance the support provided to patients and staff.

Notable Practice

- The medical centre had undertaken a significant piece of work to mitigate the risk of heat illness. They engaged with the Sandhurst Chain of Command (CoC) and contributed to their training risk assessments. They identified that specialist equipment was available that would optimise the treatment of heat illness. When funding was refused, they engaged with Sandhurst CoC and they contributed to the business case for the procurement of the equipment (3 immersion bags and waterproof rectal thermometers compatible with equipment held). Initial training in the use of the specialist bags was undertaken in March and May 2025 and further training was planned.
- The medical centre practice had ‘grab bags’ available for patients who were being admitted to hospital from the medical centre; these were male/female specific and available in different sizes. The bags contained basic items for a 24 hour stay (wash kit/ shorts/ t/shirt/ flip flops). During the inspection these were seen being given to patients.
- The medical centre had amended their eConsult availability timings to meets the needs of their patients following feedback. For example, they extended the hours eConsult was available in the evening (Monday to Thursday) to enable patients to submit an eConsult after they had finished work. Opening times had been amended to facilitate Sandhurst training activity, for example opening early 06:30-07:30 hours to be available if there was an increased risk of heat illness.
- The medical centre had incorporated research evidence from the Human Performance Centre, located at Sandhurst, to inform pre-joining briefs and advising future cadets re conditioning and vitamin/mineral intake to help minimise injuries once they arrive.
- The PCRF had developed a system that provided real time tracking of injuries and injury trends. This could be used to both refine the services offered by the PCRF to ensure that they were targeted specifically at the RMAS population, and to give staff oversight of injury trends throughout the training schedule.

- The medical centre had engaged with the local Health Board which had contributed to the publication of the Armed Forces Strategy 2025-2030 (Berkshire-Healthcare-NHS).
- Introduction of the combined metabolic disease register – combined gout, diabetes (including pre-diabetes)/hypertension/chronic kidney disease/non-alcoholic fatty liver disease. This included the nurses updating the register and having a prompt sheet to collect all data required for DMICP so that all information was recorded in one consultation.
- Summarising of cadet notes – one of the nurses engaged with recruiting teams ahead of the cadets arriving so that the notes could by fully summarised before arrival and courses started.
- There was a Patient Participation Group in place with the last meeting being in July 2025. Previously it was noted that when the meeting was held at the medical centre, attendance was small, so to boost participation the last meeting was held at a coffee shop on camp. This saw 61 people attend and discussion were had about appointment times and eConsult.

The Chief Inspector recommends to Sandhurst Medical Practice

- The management of controlled drugs requires an update and review in line with the most recent controlled drug policy. Including duty officer sign-off for destruction certificates.
- Ensure monthly quarterly and external duty officer checks are undertaken as per DPHC policy.
- Review all patients on repeat medicines and ensure they are coded correctly.
- Ensure training in learning disability and autism is provided in accordance with the DSMR regulatory instruction issued in April 2024.

The Chief Inspector recommends to Defence Primary Healthcare (DPHC) and the wider organisation:

- Continue to support the PCRF to improve the infrastructure so that suitable facilities are available to patients undergoing rehabilitation.
- Ensure the DPHC-wide clinical waste policy is updated in a timely way so the practice can confirm management of clinical waste that reflects the 2023 revisions made to HTM 07-01: Safe and sustainable disposal of healthcare waste.

The Chief Inspector recommends to Regional Headquarters.

- The emergency risk assessment for all emergency medicines should be signed off by the Regional Clinical Director.

Professor Bola Owolabi

Chief Inspector of Primary and Community Services.

Our inspection team

The inspection team was led by a CQC inspector. The team of specialist advisors included a primary care doctor, a practice manager, a physiotherapist, an exercise rehabilitation instructor and a nurse. A pharmacist inspected the pharmacy remotely on the 23 of July. A newly recruited specialist advisor shadowed the inspection as part of their induction.

Background to Sandhurst Medical Centre

Sandhurst Medical Centre is the British Army Officer Phase 1 training establishment. The medical centre provides primary and occupational healthcare for around 1,480 service personnel and 530 civilian patients including families. There was a formal network arrangement in place between Sandhurst Medical Centre and Pirbright Combined Medical Practice, which optimised patient care through shared resources and strengthened resilience.

The services provided include routine nurse, doctor and Combat Medical Technician (CMT) medic clinics, eConsult nurse triage, duty doctor triage/consultation, adult and child immunisations, well woman clinics, fitness to deploy medical screening, routine occupational medicals and a dispensing pharmacy. The Primary Care Rehabilitation Facility (PCRF) provides routine and urgent physiotherapy to service personnel, along with exercise rehabilitation support to military patients and entitled civilian patients are referred to Frimley Park Hospital.

The camp has a highly transient population which includes foreign national cadets and personnel. The officer training cadet population has a thrice yearly outflow of approximately 225, in April, August and December. There is a thrice yearly inflow in January, May and September as well as a 3 yearly short course for professionally qualified officers/interns and reserves.

The staff team

Senior Medical Officer (SMO)	One
Deputy Senior Medical Officer (DSMO)	One
Senior Nursing Officer (SNO)	One (deployed)
Deputy Senior Nursing Officer (DSNO)	One
Practice Manager	One
MOD GPs	One
Senior Nursing Officer (acting)	One
Medical officers	One (currently absent)

Nurses	Five
Medics	Five (Academy Unit Aid Post (UAP)
Pharmacy technician	One
Exercise rehabilitation instructors (ERI)	Two
Administrators	Four
PCRF Officer Commanding Physiotherapists	 One Four

Are services safe?

We rated the medical centre as requires improvement for providing safe services.

Following our previous inspection, we rated the medical centre as requires improvement for providing safe services. We found shortfalls with:

The standard operating procedures to support the safe management of medicines required review.

Notes summarising.

The emergency medicines trolley needed to be kept within the correct temperature range.

Alarms were to be made available within the Primary Care Rehabilitation Facility (PCRF) and tested regularly.

At this inspection we found all of the previous recommendations we made had been actioned.

Safety systems and processes

The medical centre worked to the Defence Primary Care Healthcare (DPHC) safeguarding policies. All staff within the medical centre had received up-to-date safeguarding training at a level appropriate to their role. The standard operating procedures (SOPs) for adult and child safeguarding had been reviewed and included contact details for local safeguarding teams. Sandhurst sat on the boundary of 3 counties and based on where patients lived depended on where safeguarding referrals were sent. Staff had a single point of contact into the Child and Family Consultation Service which alleviated any delays.

A primary healthcare team meeting was held monthly where any safeguarding concerns were discussed, this was attended by the camp welfare representatives, representatives from the medical centre, PCRF and NHS community teams.

Vulnerable person registers, including patients under the age of 18 and care leavers, were maintained and a search of DMICP (electronic patient record system) was undertaken monthly.

All doctors had information given to them regarding safeguarding arrangements and this was included in the practice information pack (a document with many useful links within it). Information regarding safeguarding was displayed in every clinical room and on the notice board for patients to read.

The medical centre had a mix of male and female staff who acted as chaperones, there was a SOP in place to support this. An electronic list of trained staff was available for the clinicians to use. There was information about chaperones in the practice leaflet and displayed in the waiting room. All trained chaperones were in date for their Disclosure and Barring Service (DBS) check. Chaperone training was last conducted in April 2025. A chaperone audit was planned to align with best practice.

The full range of recruitment records for permanent staff was held centrally. The practice could demonstrate that relevant safety checks had taken place for the staff at the point of recruitment including a DBS check to ensure staff were suitable to work with vulnerable adults and young people.

Professionally registered clinicians had their personal identification numbers recorded in the staff data base and the record of registration checks were held within the Healthcare Governance (HCG) workbook.

All staff had completed training in infection prevention and control (IPC). A staff member was the dedicated IPC lead for both the medical centre and the PCRF and they had completed the link training. IPC audits were conducted regularly, the last one being in June 2025, any shortfalls were discussed at practice meetings and managed on an action plan. Two of the nurses were monitoring hand washing and the use of clinical wipes. A recent audit showed 100% compliance for the clinical rooms but the use of hand soap did need improving. Since then staff training had been delivered and improvements made.

There were measures in place to minimise the spread of infectious diseases. Staff were kept updated of any trends or new training requirements. Personal protective equipment was available in all clinical areas. Hand gel was available in all areas for staff and patients. There was no bedding down facility at the medical centre but each accommodation block had designated areas to isolate cadets and a mass isolation block could be created in the event of mass outbreaks. There was an active outbreak plan in place and the deputy Senior Nursing Officer (DSNO) was part of the working group.

An environmental cleaning schedule was in place and was monitored by the IPC lead in conjunction with the contract manager. A written cleaning schedule was in place and this was signed off to confirm that cleaning tasks had been completed in line with the agreed frequency. Within the PCRF, daily clinical cleaning was completed by an external contractor. A full deep clean took place every 14 weeks.

The management of healthcare waste was in line with policy. Clinical waste was bagged, secured and marked with the medical centre code before being recorded in a waste log and held in a dry store. Consignment notes were held and were cross-referenced. An action plan was in place from the last annual clinical waste audit (December 2024); the plan included - clinical waste posters to be displayed in some rooms, outdoor clinical waste store required a sign and ensure the outdoor clinical waste store was clean and secured. We saw all actions had been completed.

Following some key changes to the HTM 07-01 in December 2024, Defence Primary Healthcare (DPHC) practices await guidance around the treatment of clinical waste.

Staff within the PCRF provided acupuncture to patients. All staff were aware of the acupuncture SOP and risk assessment, which were reviewed regularly. Verbal consent was obtained and documented using the appropriate read coding and synonym, in line with DPHC policy. A sharps bin was held on trolley in the PCRF, and it was disposed of by the medical centre when it was full or 6 monthly. Acupuncture updates were provided both formally and informally.

Gym equipment in the PCRF treatment area was maintained, serviced and monitored. Checks on equipment were completed daily. All rehabilitation equipment was in good condition and meeting the needs of the patient population.

Risks to patients

There was a good balance of well-trained civilian and military staff which afforded continuity of care. The medical centre had a weekly diary meeting looking at the following 2 weeks' workload. They discussed factors that impacted on care delivery, for example, leave and new courses due to arrive.

The risk register highlighted the risks of having one person in post in the dispensary. The dispensary shut if the pharmacy technician was absent and seeking locums was challenging. This meant that when the pharmacy technician was away, they came back to additional work because patients did not always use the outsourcing pharmacy or the option to receive dispensed medication delivered from Pirbright/Aldershot. The pharmacy technician also carried out additional tasks such as checking the emergency trolley drugs for the medical centre and amending/ managing Patient Group Directives (PGD) stock on DMICP. They worked hard to support their colleagues at all times. They attended the HCG and practice meetings and also had input responding to eConsult's for repeat medication and printing the prescriptions for the doctors to sign.

Communication was identified as a risk due to a faulty telephone line. The request for improvement had been approved by headquarters and was due to be actioned.

The PCRF and medical centre infrastructure was aging and required improvement. Infrastructure risks were held on the medical centre healthcare governance (HCG) workbook and had been escalated; the risk was held by the Regional Headquarters (RHQ).

The PCRF building was co-located with the main gym which had a Wet Bulb Globe temperature machine (used to monitor the environmental heat accounting for air temperature, humidity, radiant heat and air movement). Readings were constantly monitored, and control measures were put in place. Staff had a comprehensive understanding of the necessary actions and work/rest plans

All staff members within the medical centre and the PCRF were up to date with Basic Life Support training (BLS), anaphylaxis and the use of an automated external defibrillator (AED). The DSNO was trained in Immediate Life Support and Paediatric Immediate Life Support (PILS). Four of the nursing team had recently completed Paediatric BLS courses and were currently awaiting assurance from the trainer prior to them delivering training at practice level.

Both clinical and non-clinical staff we spoke with were aware of the signs and symptoms of the deteriorating patient that included symptoms of sepsis. Training records showed sepsis training was undertaken for all staff in May and June 2025. Sepsis recognition and awareness posters were displayed throughout the medical centre.

Regular scenario-based training or ‘moulages’ were evident with the last sessions taking place in May and June July 2025 which discussed and demonstrated the effects of heat illness and sepsis.

The PCRF had an SOP for ‘Actions on Medical Emergency’ including an agreement with the medical centre who had a grab bag to respond to any emergency in the PCRF, but without delaying calling for an ambulance. The PCRF recently ran a moulage with the medical centre and the plan worked well. There was an AED in the PCRF, this was checked daily.

The waiting room was not visible from reception with staff being unable to see if any patient became acutely unwell whilst waiting for their appointment. There was no CCTV in place, so to mitigate this, the medical centre purchased a baby monitor with the screen that was held in reception. All other waiting areas were in line of sight of staff.

All staff undertaking vaccinations received training annually. Information and medicines were in all clinical areas for management of anaphylaxis for adults and paediatrics

Unplanned admissions to hospital were managed well, including effective communication and monitoring between the medical centre and the hospital itself. Upon discharge from hospital the patient was given a follow up appointment with a doctor.

All staff knew where the emergency medicines were located. We found all medicines on the emergency trolley were appropriate and in-date and a risk assessment was in place. There was an AED on the emergency trolley that could be used for paediatrics. Each emergency trolley had laminated paediatric algorithms for BLS, Advanced Life Support and anaphylaxis. Laminated copies for paediatric temperature and blood pressure parameters, the paediatric early screening tool and the sepsis screening tool for 0-5 years and 5-11 years old were also evident.

Oxygen was held and was accessible with appropriate signage in place. All clinical staff has received training in medical gases usage.

Information to deliver safe care and treatment.

Doctors had regular case discussion between themselves and nurses and medics were supported by the duty doctor during morning fresh cases and total triage clinics.

Arrangements were in place for the auditing of consultation records for clinicians. The MOD doctor reviewed the clinical records for doctors (including their own). We discussed the different options available by using different people to peer review giving a wider scope of feedback and opinion. This was well received and they agreed to implement this moving forward.

As the medics were mainly involved in fresh cases, the doctors reviewed their clinical records at the end of each clinic. Physiotherapy and exercise rehabilitation instructors (ERIs) records were audited annually.

DMICP permissions were set correctly for ERIs to enable them to access relevant clinical information. In addition, all initial assessments were completed jointly for complete awareness.

Systems were available for sharing information between the PCRF and medical centre staff these included;

- Signal (secure messaging app) was used for immediate/non-clinical communication
- DMICP messenger was used for any clinically related communication.
- A weekly multidisciplinary team meeting was held for exchange of information between all professional groups.
- Information within the PCRF was shared on a OneNote platform. This held all meeting minutes and agendas.

Peer review for nurses took place quarterly. A local working practice was in place with a clear process and structure. The team were invited to provide consultations and paperwork was completed and held by the DSNO so that staff could refer back to it for revalidation purposes. The process was clear and provided a 360-degree view for the team and gave opportunities for development and training. Alongside this, the nurses had a monthly meeting where they had the opportunity to discuss any issues. Furthermore, they also met every morning to discuss and plan for the day, and twice weekly, had coffee together for informal discussions.

The medical centre experienced issues with accessing connectivity and access to DMICP similar to other Defence-wide medical centres. In the event of an outage, the business continuity plan was followed. Clinic lists were printed the day before in case of an outage so staff were aware of which patients they were expecting that day. The team reverted to seeing only patients with an urgent need when DMICP was unavailable. Paper documentation was used and uploaded to DMICP at a later point.

The medical centre used different ways to share information with patients; these included the use of television screens located in the waiting room and reception which gave patients information about all aspects of the medical centre and their care.

Processes were in place for the summarisation of civilian and permanent staff's records. A clinical code applied to DMICP records confirmed summarisation had been completed. At the time of the inspection, 90% of civilian and permanent staff's records had been summarised. The medical centre had implemented changes with the summarising of cadet's notes as previously the notes would arrive round the start of term which resulted in the medical centre not being able to summarise in preparation of their arrival and delays were inevitable. The DSNO had worked with the recruiting service so that the details for the next intake were sent in advance and summarisation could be completed prior to the cadets arriving. Approximately 80% of cadets came via the University Officer training Corps route and these notes were summarised by the medical centre, the remaining 20% of cadets had their notes summarised by the summarising hub as part of the recruitment process. We saw that 100% of cadet's notes had been summarised.

An effective system was in place for managing both internal and external referrals including urgent 2-week-wait referrals. There were 2 civilian administrators responsible for

referral management included internal and external referrals for hospital appointments, urgent and non-urgent. Staff were able to describe the process in detail. Details were uploaded onto the portfolio spreadsheet tracker and showed when the referral was made and the date of when to review progress, this was checked weekly. The doctors made referrals to Department of Community Mental Health and kept oversight of these. Follow up appointments were booked with the patient whilst attending their initial and ongoing appointments to ensure weekly or 2 weekly reviews were in the diary.

The nursing team oversaw the process for the management of samples. A specimen register was maintained and a 100% check of samples was conducted every week. A doctor worked from home every day and they undertook some occupational medical/work and reviewed test results. Test results were then uploaded onto the patients record; patients were notified by text or telephone call.

Safe and appropriate use of medicines

The SMO was the lead for medicines management and the day-to-day tasks were delegated to the pharmacy technician. This was reflected in the terms of reference (ToRs). The ToRs were signed electronically and were in-date.

Arrangements were established for the management of controlled drugs (CDs), including destruction of unused CDs. Monthly and quarterly checks were in place but were not carried out as per DPHC guidance. A review of the most recent destruction certificate confirmed that accountable and controlled drugs were not being consistently destroyed in accordance with policy. We discussed this with the pharmacy technician and were assured that the policy would be completely adhered to moving forward. A CD audit and the annual declaration had been completed and submitted to headquarters.

Patient Group Directions (PGDs), which authorise practice nurses to administer medicines in line with legislation had been signed off by the doctor and this was monitored by the pharmacy technician. Nurses had completed the required training and a PGD audit was completed annually. Patient Specific Directions were not used.

The medical emergency trolley was kept in a temperature-controlled environment. Medicines were checked daily and monthly or if the trolley had been opened/used. Tags were in place with a list of expiry dates held. A number of items had not been documented on the emergency risk assessment and required sign off from the Regional Clinical Director (RCD). We noted on the heads of department meeting minutes that the risk assessment had been forwarded to the RCD for sign off but this was still outstanding.

Through discussion and review of DMICP records, it was evident that there was a clear audit trail for the request of repeat medication. Upon review of DMICP records, we found 258 patients were eligible for repeat medication but only 98 appeared to have been reviewed or coded appropriately. The patient record system must reliably maintain an accurate and contemporaneous record of patients requiring a medicines review. There appeared to be a pan-Defence Primary Health Care issue with recording repeat medicines reviews and the Care Quality Commission will raise this issue separately to the Defence Medical Services Regulator recommending that Defence Primary Health Care

Headquarters carry out a review of their repeat medicines processes, including policies and procedures with regards to coding and searches.

A process was in place for the management and action of Medicines and Healthcare products Regulatory Agency (MHRA) and National Patient Safety alerts. The electronic MHRA alert register was current and a system was in place to ensure the medical centre received, disseminated, and actioned all alerts and information relevant to them. Current meeting minutes did not show that alerts were discussed or the link shared. Staff were notified of alerts by email.

Medication requiring refrigeration was monitored twice a day to ensure it was stored within the correct temperature range. Fridges were locked in the treatment rooms.

Protocols to access the dispensary were clear. There was an SOP in place that had been updated. We discussed that it would be useful to add staff names to the SOP so it would identify those nominated staff with access.

Prescription pads (Fmed296) were stored securely. There was a system to track their issue and usage so all prescription numbers could be traced to the prescriber. We advised that some minor issues could be improved upon, including the signature of the person the Fmed296 was being supplied to and running totals kept. We were assured that these would be promptly put into place.

The comprehensive high-risk medicines (HRMs) register supported the management of patients prescribed HRMs. An audit had been completed in May 2025 (fourth cycle). Appropriate HRMs and shared care agreement alerts were raised on patient's DMICP records.

Valproate (medicine to treat epilepsy and bipolar disorder) searches were regularly undertaken.

Track record on safety

There was a designated health and safety lead and a board was displayed which was regularly externally audited. Processes were in place and up to date for the checking of electrics and portable electrical appliances.

Evidence was in place to confirm the legionella risk assessment was reviewed in May 2025 (awaiting report) and that water outlets were flushed each week. Electrical safety checks were up to date. A fire risk assessment of the building was undertaken annually. Firefighting equipment tests were current. Staff were up to date with fire safety training and were aware of the evacuation plan.

A system for monitoring and recording the servicing of all clinical/non-clinical equipment was established, this included equipment in the PCRF.

Risk management and health and safety (referred to as SHEF) were well managed. The risk register used the DPHC '4 T's process' (transfer, tolerate, treat, terminate) to illustrate at what level risks were being managed. Risks were addressed during the practice

meeting. Furthermore, risk assessments pertaining to individual products that pose health hazards, known as COSHH, were established.

The medical centre was currently waiting for a new alarm system to be installed (likely in the next month). In the meantime, there were handheld panic alarms in all non-clinical rooms. Safety alarms were installed in clinical rooms, the waiting room and the toilets, these were checked every week. There was an alarm in the PCRF and the gym and these were tested weekly and recorded.

Lessons learned and improvements made

The medical centre worked to the DPHC policy for reporting and managing significant events, incidents and near-misses, which were recorded on the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events and incidents. An ASER register was established and any new incidents/events were discussed at staff meetings. Minutes showed action was taken and changes made if appropriate. All staff interviewed described a recent ASER that was discussed at the meeting.

Are services effective?

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

Following our previous inspection, we found shortfalls with:

The management of the peer review programme for physiotherapists and exercise rehabilitation instructors (ERIs).

At this inspection we found that improvements had been made.

Effective needs assessment, care, and treatment

Processes were in place for clinical staff to keep up to date with developments in clinical care including National Institute for Health and Care Excellence (NICE) guidance, the Scottish Intercollegiate Guidelines Network, clinical pathways, current legislation, standards and other practice guidance. Staff were kept informed of clinical and medicines updates through the Defence Primary Healthcare (DPHC) newsletter circulated to staff each month. Clinical updates were discussed at practice and clinical meetings. A recent example was changes to asthma management and maintenance reliever therapy (MART). The MART regimes led to a discussion and separate training session for all.

The doctors met together every week for case-based discussions. There were a number of trainees and trainers in the building and doctors with enhanced skills, for example minor surgery, contraceptive implants and women's health. This prompted discussion about relevant guidance updates.

Clinicians had access to Red Whale, a UK-based medical education provider specialising in continuing professional development (CPD) for primary care professionals, this supported clinicians in staying up to date with the latest evidence and guidelines.

The Primary Care Rehabilitation Facility (PCRF) accessed other sources for best practice evidence and NHS guidelines, and engaged in a number of clinical meetings for exchange/dissemination of best practice – these included:

- Training Injuries Working Group (TIWG) which took place frequently where trends were identified and changes were subsequently made to training.
- Regular multi-disciplinary team (MDT) meeting were held with the band 8 physiotherapist to discuss patients with external experts.
- Attendance at the Senior Medical Officers (SMOs) case reviews every week.
- Regional in-service training sessions were held regularly by Aldershot regional rehabilitation unit as a useful forum for exchange of best practice.

The range of PCRF clinical records we looked at showed evidence of MDT discussion. The Musculoskeletal Health Questionnaire (MSK-HQ) was the standardised outcome measure for patients to report their symptoms and quality of life. Rehab Guru (software for rehabilitation exercise therapy) was in use to monitor individual patient progress. The use of the MSK-HQ was clinically coded via the DMICP template.

There was a structure for those patients in the rehabilitation platoon (Lucknow Platoon) to progress through weight-bearing stages, to plyometrics (a form of exercise that uses fast powerful movements to improve a person's speed and power) to impact training and then onto load carrying. There were detailed printed programmes for each stage of progression. Lucknow Platoon had its own allocated staff to ensure continuity for the cadets. Each patient was allocated a dedicated physiotherapist and an ERI (if required).

The PCRF measured its performance in terms of patient outcomes by tracking patient outcomes using their patient tracking excel spreadsheet. All patients were entered onto this, which detailed the causation of their injury, and the outcome of their rehabilitation. The spreadsheet could be filtered on numerous variables (time of injury/gender any training exercise the patient was on at the time). The tracker provided a huge amount of detailed injury surveillance data, which could be used to inform training staff about training components which carried a particularly high risk of injury.

Group based therapy sessions were planned and run by the ERI. They were anatomically based and could be either one-to-one sessions or group sessions, were run as a clinic on DMICP and attendance was audited.

The PCRF ensured that it took a holistic view of patients, including mood, sleep and lifestyle. They had delivered presentations to cadets on topics such as sleep, and the effect of the menstrual cycle during training. All patients were provided a physical patient logbook where they could make comment on their exercise programmes. This booklet also contained information on sleep, nutrition and injury prevention. Staff had an excellent awareness of the demands and structure of the courses their patients were on whilst under rehabilitation.

Monitoring care and treatment

The Band 7 nurse and the MOD GP were the leads for long term conditions (LTCs). The Band 7 nurse ran specific clinics weekly on a Monday afternoon. Patients were recalled utilising the GOV.UK Notify text message system, which was proving to be beneficial and engagement with patients had improved. The nursing team all helped with the recall of patients. The Band 7 was currently mentoring the nursing team to support them with chronic disease monitoring clinics independently. There was a chronic disease register in place which was colour coded (invited/ booked appointment in place/awaiting results/completed) so all members of the team could track the recalls. This also included gout, diabetes (including pre-diabetes)/ hypertension/chronic kidney disease/ non-alcoholic fatty liver disease. The nurses updated the register and had a prompt sheet to collect all data required for DMICP and the register so that all information was in competed in 1 consultation.

We conducted searches to identify patients with LTCs on the day of the inspection. Reviews were of good quality and the appropriate templates had been used. Consistent pathways were in place to manage LTCs. These included an SOP and prompt sheets in clinical rooms to ensure all data required for the reviews was captured and all relevant templates on DMICP were populated.

There were 14 adult patients on the diabetic register. For all 14 patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For 13 patients with diabetes, the last blood pressure reading was 150/90 or less which is an indicator of good blood pressure control.

There were 49 patients on the hypertension register and 46 of these had had their blood pressure taken in the past 12 months. Of these, 35 patients had a blood pressure reading of 150/90 or less.

There were 31 patients with a diagnosis of asthma. Of these, 20 had received a review in the past 12 months. Of the 11 that had not had a review, 6 were new patients and/or were newly diagnosed.

On arrival, patients over 40 were offered the over 40s health screening. Searches were run to capture over 40's and a check of their records was completed to ensure they have been offered the service.

Through a review of clinical records and discussions with the doctors, we were assured that the care of patients with a mental illness and/or depressive symptoms was being effectively and safely managed, often in conjunction with the Department of Community Mental Health (DCMH). There had been a recent change and launch of a new Primary Care Mental Health Pathway by Defence Primary Healthcare (DPHC). This initiated step 1 self-directed work for patients via the Defence Gateway and the 'My Healthcare Hub'. Followed by step 2 on the 'Silvercloud' platform (on-line). The medical centre used this to manage their patients. They also used iTalk for local talking therapies service for civilian patients. There were patient information leaflets for cadets, family members and permanent staff. A consistent clinical code was used in patient's notes to avoid duplication or error. The medical centre described a good relationship with DCMH with direct access available for urgent need.

The cadets had good support with their own dedicated welfare officers. They had a protected space called the 'Huddle' where they could go and relax and training staff were not allowed. The training staff had their own separate welfare officers/provision. Family members and the permanent staff could access the welfare team, the Wishstream centre or HIVE the local community centre.

One of the doctors was the lead for audit and there was an audit calendar in place. Clinical audit was used to evaluate the quality of care and improve patient outcomes. The process followed a clear structure, measurement standards, methods, and recommendations. Repeat cycles of clinical audit were evident, including high risk medicines antibiotic audits, and minor surgery. The PCRF undertook their own audits, including recently a traumatic brain injury audit using best practice guidelines. The audit identified some points to be actioned to ensure full compliance with guidelines. These findings were discussed and shared with all staff.

The medical centre had incorporating research evidence from the Human Performance Centre, located at Sandhurst, to inform pre-joining briefs and advise future cadets about conditioning and vitamin/mineral intake to help minimise injuries once they had arrived.

There was active management of children's immunisation status. Staff relied on the Child Health Immunisation Service (CHIS) to send them a list of children who were due or outstanding various childhood immunisation. The medical centre had systems in place that gave assurance that the children registered had been recalled or had an appointment booked at the appropriate time.

We saw that referrals to the Regional Rehabilitation Units (RRU) and Multi-Disciplinary Injury Assessment Clinics (MIAC) were made promptly with wait times of approximately 6 weeks for patients. The PCRF had regular meetings with the MIAC clinicians to discuss potential referrals. All referrals were added to a list held on SharePoint, and this was managed by the clinicians.

The PCRF had carried out a number of quality improvement projects (QIPs) which were recorded on the healthcare governance workbook. These included:

- Capture of real time injury surveillance data to inform the chain of command of injury trends.
- A tracker was instigated to track RRU referrals.
- A synonym was created to identify patients at risk of inflammatory conditions.
- A Lucknow specific patient questionnaire was introduced to better evaluate patient satisfaction with Lucknow Platoon rehabilitation.
- Streaming of targeted patient information onto a rolling screen in the waiting room.

Effective staffing

There was an induction programme in place, with a separate induction for locum staff. DPHC induction and workplace induction were recorded on the staff database.

A member of the administrative team monitored the mandated training and followed up with individuals whose training was due to expire. Staff were given protected time to complete this required training. The training programme was organised around the academy terms and encouraged all members of staff to take training sessions that they may have an interest in.

Issued by the Defence Medical Services Regulator (DMSR) in April 2024, we asked about the Regulatory Instruction, 'Training for staff in learning disability and autism' and how it was being implemented. Training across the staff team had begun and this was ongoing.

Staff had training relevant to the needs of the patient population and the service. In-service training was facilitated on a Wednesday afternoon. Attendance at internal/external training programmes was encouraged. For example, the deputy senior nursing officer was undertaking the nurse prescriber course, one of the administrators was undertaking clinical terminology course at the local NHS hospital, the practice manager was undertaking the Joint Practice Manager course and one of the nursing team recently attended a minor injuries course.

Staff administering vaccines had received specific training which included an assessment of competence. Staff who administered vaccines could demonstrate how they kept up to

date with changes to the immunisation programmes, for example, by access to online resources and discussion at nurses' meetings.

Clinical staff were up to date with their continual personal development (CPD), revalidation and annual appraisal. The nursing team had twice yearly appraisal reviews which enabled them to set objectives. They actively participated in peer review and discussed outcomes from ASERs as a group (if it was nursing specific) identifying learning outcomes and as part of the wider practice governance discussion. They had access to individual training sources through DPHC and also the DPHC CPD fund.

Supervisory and mentorship arrangements were in place for trainees. The Band 7 nurse and the deputy Senior Nursing Officer (DSNO) had both completed mentorship training courses to formally mentor trainees. The Band 6 nurses also had a mix of experience in mentorship and clinical expertise and skills to support learning of any trainees on placement.

Coordinating care and treatment

The medical centre staff met with welfare teams and line managers to discuss vulnerable patients. Staff had forged some good links with other stakeholders, including the local NHS Midwifery and Health Visiting service, multi-agency safeguarding hub, child health community teams, sexual health services (Kingston, Aldershot and Basingstoke) and local safeguarding teams. Engagement with the local health board had aided the implementation and publication of the Armed Forces Strategy 2025-2030 (NHS publication). This document focused on the services already in place and improving how they were used. Focussing on strong communication with NHS services, local government, military organisations and charities enabled the delivery of more joined up care.

It was clear that the PCRF was an integral part of the medical centre. There were good streams of communication with staff in the PCRF, meetings were inclusive, and governance structures integrated.

The physiotherapists had specified times where the RRU clinicians (Band 7 and podiatrist) were available for case discussion. There were 2 fixed sessions in place each week where the SMO was available for clinical discussion.

For patients leaving the military, pre-release and final medicals were offered. During the pre-release phase, all patients received a summary of their healthcare record, including immunisations and medication and information on how to obtain a full copy of their records. They also sent patients a bespoke leaflet, listing charities, services and how to register with an NHS doctor, dentist and access other services.

Service leavers also received a patient information leaflet detailing how to register with an NHS GP, how to find a dentist and information about the Armed Forces Compensation Scheme.

Helping patients to live healthier lives

One of the nurses was the lead for health promotion. The medical centre followed the DPHC health promotion calendar. The health promotion displays at the medical centre were comprehensive, clear and positioned strategically to target the most relevant cohort of patients. However, the medical centre had acknowledged that the notice boards needed to reflect specific activities for the population at risk, so they had implemented protected time for the nurses to update information. Health promotion information throughout the practice was displayed in different ways – posters/ notice boards/ booklets/ scrolling news screens. Although information was primarily in English, information was available for Nepali patients.

The team attend unit health fairs and sought opportunities for health screening with patients where possible. Quick Responses/QR codes were widely used throughout the medical centre for patient education and health promotion – these provided current information to patients via direct links to organisations so information given was up to date.

The MOD GP was the lead for sexual health and, together with 2 of the nurses, were trained in sexual health (known as STIF). Condoms and chlamydia self-testing kits were available in the toilets, and local NHS sexual health screening clinics were advertised.

All eligible female patients are on the national cervical screening database were recalled by the nurse. The latest data confirmed an 86% uptake; the NHS target was 80%. 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.

Numbers of patients identified for screening:

- Bowel 38
- Breast 36
- AAA 0

DMICP searches had been created for all national screening.

Vaccination statistics were identified as follows:

- 86% of patients were in-date for vaccination against diphtheria.
- 86 of patients were in-date for vaccination against polio.
- 87% of patients were in-date for vaccination against hepatitis B.
- 97% of patients were in-date for vaccination against hepatitis A.
- 97% of patients were in-date for vaccination against MMR.

Child Immunisation

The percentage of children aged 1 who 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/Hepatitis B) was 96%.

The percentage of children aged 2 who had received their booster immunisation for Pneumococcal infection (i.e., received Pneumococcal booster) (PCV booster) was 100%.

The percentage of children aged 2 who had received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e., received Hib/MenC booster) was 95%.

The percentage of children aged 2 who had received immunisation for measles, mumps and rubella (one dose of MMR) was 100%.

The percentage of children aged 5 who had received immunisation for measles, mumps and rubella (two doses of MMR) was 91%

Consent to care and treatment

Clinicians understood the Mental Capacity Act (2005) and how it would be applied to the patient group and had completed annual training. Clinicians were aware of both Gillick competence (young people under 16 with capacity to decide) and Fraser guidelines (advice/treatment focused on a young person's sexual health). Clinicians advised us that implied consent was accepted for basic procedures such as the taking of blood pressure. Written consent was taken for more intimate examinations and minor operations. A consent audit for minor operations and implants had been completed July 2025 it showed 100% of cases had been appropriately coded in the patient's notes.

Are services caring?

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

Following our previous inspection, we found shortfalls with:

Patient privacy within the Primary Care Rehabilitation Facility (PCRF).

At this inspection we found improvements had been made and privacy was fully respected.

Kindness, respect, and compassion

As part of the inspection, we received feedback about the service from 38 patients. In addition, we considered the practice's patient survey 2025 (30 respondents). All feedback indicated staff, from all departments, were kind, helpful and supportive. Patients described the staff as respectful and caring.

Patients could access the welfare team and various support networks for assistance and guidance. We spoke to a member of the welfare team and they described the medical centre team as highly responsive and always ready to provide help and support. Information regarding these services was available in the waiting areas and the clinical staff were fully aware of these services to signpost patients if required.

We spoke with 2 international cadets, they told us that the team at the medical centre understood how their culture may differ to others and said consideration was given if needed, for example during Ramadan. They described the care they received as exceptional.

We spoke to 7 cadets they described how comfortable the doctors and nurses made them feel, giving them time to understand and have things explained with no rushing. They told us staff were really kind.

The medical centre practice had 'grab bags' available for patients who were being admitted to hospital from the medical centre – these were male/female specific and available in different sizes. The bags contained basic items for a 24 hour stay (wash kit/ shorts/ t/shirt/ flip flops). During the inspection these were seen being given to patients.

Involvement in decisions about care and treatment

The clinicians and staff at the medical centre recognised that the personnel receiving care and treatment could be making health care decisions 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 evidence-based guidance and clinical facts.

Patients identified with a caring responsibility were captured on DMICP and alerts were made on individual patient's notes to ensure that longer appointments were given if needed. One of the administrative staff was a 'carers champion' and one of the nurses was designated to monitor young people and carers. There was information for carers of the medical centre information boards. The band 7 nurse was the carers lead. Monthly searches were completed for existing patients and new arrivals to the medical centre completed registration paperwork, this was then screened by a member of the administrative team following which the nurse then identified any specific needs and offered the patient a health check. The medical centre had a specific group mailbox email address for carers to access. There were 22 carers were currently on the register, 18 had attended for health checks. The nurse was planning to re-send text messages to the patients ahead of the 2025 flu season to capture any patients who may not have asked previously.

Privacy and dignity

Patient feedback showed patients were confident information kept about them would remain confidential. Consultations took place in clinic rooms with the door closed. The reception area was separate to the waiting room meaning that conversations between patients and reception would not be overheard. If patients wished to discuss sensitive issues or appeared distressed at reception, they were offered a private room to discuss their needs.

Patients could request clinicians of a specific gender or a second opinion. Patients were offered alternative appointments if there is not an appropriate clinician on any given day.

The physiotherapist assessment and treatment area within the Primary Care Rehabilitation Facility had curtained cubicles. To promote privacy the department had in place a multiple speaker system to create better ambient sound through the department. This allowed more private conversation while keeping sound level even for all therapists and patients rather than uncomfortably loud for one and good for the rest- (with one speaker). Clinicians could use the rehabilitation office for confidential conversations

All staff had completed the Defence Information Management Passport training which incorporated the Caldicott principles.

Are services responsive to people's needs?

We rated the practice as outstanding for providing responsive services.

Responding to and meeting people's needs

The Senior Medical Officer (SMO) and the staff team were acutely aware of the battle rhythm (schedule of activities) of the college intakes and their ongoing needs and requirements. As such, they were aware of when to expect issues pre and post exercise, when there will be a surge of individuals seeking routine vaccinations and times when sick parade (walk in on the day clinics) would need to be bolstered. All of this allowed for planning, upsurging of staffing and ultimately provided the patients with an improved journey and enhanced service when needed.

The medical centre demonstrated a clear commitment to addressing the medical needs of its patient population. A significant development included the restructured management of the sick parade, which now employed a multidisciplinary approach delivered collaboratively leading to total triage by doctors, nurses, medics, and physiotherapists. This model ensured timely access to care; thereby minimising patient wait times and reducing disruption to scheduled training activities.

The medical centre had amended their opening times to facilitate Sandhurst training activity, for example opening early 06:30-07:30 hours to be available if there was an increased risk of heat illness.

Patient access to the medical centre was primarily facilitated via 2 routes: attendance at sick parade/total triage and use of the eConsult system. This dual-access framework enabled prompt triage and ensured that patients were directed to the most appropriately qualified healthcare professional. On the day of inspection, this process was observed to be operating efficiently, with patient feedback indicating a high level of satisfaction.

A whiteboard in the nurses' office clearly displayed intakes of cadets and a member of the nursing team was allocated to a 'link nurse' role for each intake which helped maintain communication between the training teams and medical centre. The medical centre delivered presentations at the patient participation meetings. Royal Military Academy Sandhurst had an active social media site which the medical centre shared information through.

In response to patient feedback, the medical centre modified the hours during which eConsult submissions could be made. This change facilitated access for individuals unable to complete online consultations during standard working hours, improving the flexibility and inclusivity of the service.

The medical centre provided specialist medical assessments such as boxing medicals and course medicals. It also maintained dedicated appointment slots for Joint Medical Employment Standards (referred to as JMES) reviews. These were typically conducted via telephone and were reported to be well received by patients, due to the minimal disruption

caused to their attendance at courses or training commitments at the Royal Military Academy Sandhurst.

The medical centre is a listed building and any improvements required had to be requested through Historic England. Improvements were not always sanctioned and because of the age of the building were always costly. The medical centre had done all it could to mitigate identified risks.

An Equality Access Audit as defined in the Equality Act 2010 was completed annually. Any points identified were discussed and put onto the issues register. The audit completed for the Primary Care Rehabilitation Facility (PCRF) identified several issues which were ongoing from the previous year they included;

- Chairs for patients did not have arms should these be required to push up to from a seated to a standing position. A request was made for chairs with arm rests but was rejected due to funding issues. This has now been placed on the risk and issue register.
- There were ramps in the department (which were very steep for anyone, particularly those on crutches) and a handrail that was shorter than the ramp. The potential to change this had been investigated but the infrastructure changes that would be required could not be made (it would have involved moving a doorway to allow for the extension of the handrail). This was on the risk and issue register.

Previously a fire exit was being used as the main entrance to the department – this meant that the fire exit was constantly open. The other entrance to the department was not suitable for use as had steps to access only. The department had engaged with Historic England and had to get permission to change the doors to an electronic access door, this had been actioned and doors have now been changed to an electric door, the electronic opening/closing mechanism was still being installed, this final piece of work should be completed imminently.

Timely access to care and treatment

The medical centre had a flexible approach to the management of appointments to meet patients' needs. The primary point of contact for patients was through eConsult. A recent survey (30 respondents) showed that 100% of patients found it easy to access healthcare.

Longer appointments were available to meet individual patient needs. This included the allocation of extended consultations for vulnerable individuals or those with complex health requirements necessitating additional clinical time.

An urgent appointment with a doctor, nurse or medic could be accommodated on the same day. Routine appointments with these clinicians could be facilitated within 1 day. If a child required an appointment this was sent to the duty doctor and they were seen on the same day.

Nurses could book double appointments or longer if required. Specifics clinics were offered included:

- Weight management – DOFit (Exercise Rehabilitation Officer)
- Smoking cessation
- Over 40s Health
- Well woman / man
- Baby immunisations
- Long term conditions
- Sexual health
- Travel health

Direct Access Physiotherapy (DAP), a DPHC requirement to support patient choice, was available to permanent staff, all referrals for cadets had to go through a doctor first.

Urgent physiotherapy appointments were available on the same day, a routine new patient physiotherapy appointment and follow up appointment was available within 5 days. Cadets could be seen sooner if required.

Waiting times for a new patient appointment to see the exercise rehabilitation instructor was within one week and a follow up appointment was available within a few days. There was no wait for rehabilitation classes.

Listening and learning from concerns and complaints

The practice manager was the lead for the medical centre who handled complaints and the band 7 physiotherapist was the lead within the PCRF. Complaints were managed in accordance with the DPHC complaints policy and procedure. Information was available to help patients understand the complaints system, including in the patient information leaflet and in the waiting room.

Are services well-led?

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

Vision and strategy

Staff we spoke with were clear that their remit was to support patients to achieve the best possible healthcare outcomes which, in turn, supported operational capability.

The medical centre worked to the Defence Primary Healthcare (DPHC) mission statement which was:

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

Sandhurst Medical Centre also worked to its own mission statement which was;

> '*Sandhurst Medical Centre will provide a psychologically safe environment with the welfare and development of staff at its core, and in so doing safeguard the delivery of high-quality care to entitled patients and support to RMAS training outputs'.*

There was a formal network arrangement in place between Sandhurst Medical Centre and Pirbright Combined Medical Practice, which optimised patient care through shared resources and strengthened resilience.

Care was delivered to patients through an integrated multi-disciplinary approach. There was clear engagement and support from the medical centre to support the Primary Care Rehabilitation Facility (PCRF) priorities. There was a practice development plan and management action plan (MAP) in place. The PCRF had their own MAP in place with tasks assigned to individuals to action.

The medical centre was working hard to improve the protection of the environment and they actively promoted the need to recycle and there were many recycling bins around the building. They were also trying to reduce paper wastage within the medical centre where possible by using electronic records and laminating templates. Within the PCRF, they washed their own towels on site, they did not use 'blue roll' and turned off all electrical items.

Leadership, capacity, and capability

The leadership team was robust, with the Senior Medical Officer effectively supported by the Deputy Senior Medical Officer, the practice manager, and a skilled nursing team. Regimental Aid Post medics were an integral part of the medical centre and felt fully included as members of the permanent staff. Continuity of care was enhanced by a knowledgeable, caring and experienced civilian staff team. The PCRF was both well-staffed and effectively managed. The administrators were experienced and demonstrated

flexibility in keeping pace with the demands of the medical centre. They also took a proactive role in leading some governance processes.

The practice manager reported feeling well supported by the Regional Headquarters (RHQ) team and expressed confidence in being able to rely on them when needed. They spoke positively about the guidance and support provided by the regional healthcare governance lead.

Staff within the PCRF reported strong relationships among all stakeholders. Leadership was delivered collaboratively by the Officer Commanding and the Band 7 clinical lead, with effective links between the PCRF and the wider medical centre leadership team. A strong working relationship existed between PCRF managers and RHQ again with the regional healthcare governance lead offering valuable advice and support on governance matters.

The nursing team described the wider practice team as ‘family’ and were very respectful and supportive of each other. They had regular ‘check ins’ with team, such as the daily nurses’ huddle, weekly meetings and open-door philosophy throughout the whole team. They had a termly meeting programme which included all members of the team. The nursing team feel well supported by the Regional Nurse

During the integration of networking with Pirbright Combined Medical Practice and Sandhurst, all staff stated they were fully involved in the process. The team demonstrated a strong commitment to delivering high-quality care, underpinned by a culture of continuous learning and improvement. The medical centre was an approved training practice, with a well-established training ethos tailored to the needs of its patient population. Protected time was allocated for practice meetings and training, and staff expressed a positive and proactive approach to ongoing learning.

Culture

Feedback from patients, staff interviews, and quality improvement activities clearly demonstrated that patient needs were central to the ethos of the medical centre. Staff felt their contributions to service development were recognised and valued. All team members attended practice meetings, where they were encouraged to share suggestions or raise concerns.

An open-door policy was in place, fostering an inclusive environment where everyone had an equal voice, regardless of rank or grade. Staff were familiar with the whistleblowing policy and knew how to access Freedom to Speak Up Champions.

The team was cohesive and worked collaboratively, united by a shared commitment to delivering high-quality patient care. Social events, such as a recent barbecue, helped to strengthen team morale and camaraderie.

The DPHC staff reward system was widely used along with submissions for ‘commanders coins’ and thank you awards. The medical centre ran a staff questionnaire in spring 2025, this was completed on MS forms, anonymised and not linked to any specific staff group. The results were positive (20 responses). The practice manager collated the feedback and presented this via training sessions so the team could explore some of the feedback

further. The team planned to run this either termly or every 6 months (or in the event there had been a significant change of staff). Staff reported feeling empowered and actively involved in the development of ideas to improve the medical centre. They felt comfortable raising concerns with any colleague, whether face-to-face or during team meetings.

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

Governance arrangements

There was a clear staffing structure in place and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. Terms of reference were in place to support job roles, including staff who had lead roles for specific areas. Resilience was provided by appointed leads having named deputies who were sufficiently trained to deputise. All staff had access to the healthcare governance (HCG) workbook which included various registers and links such the ASER tracker, duty of candour log, IT faults and cleaning issues log.

An audit programme was in place and we saw examples of clinical audits where repeat cycles were carried out to monitor standards and quality.

A range of meetings with defined topics for discussion were held to ensure a communication flow within the team. The medical centre had a designated meeting matrix in place.

The medical centre was networked with Pirbright Combined Medical Practice, this had been of benefit to both especially with their deployment of the business continuity plan.

Within the PCRF there was a dedicated lead for clinical governance. There was an integrated governance approach for the medical centre and PCRF, this was achieved by an integrated audit programme, joint meetings/forums for the whole practice and good communication. Previous actions that had been identified after the most recent governance/assurance/advisory visit and had been addressed including;

- Confidentiality has been improved via closed curtain policy.
- Panic alarms have been installed.
- A Regional Rehabilitation Unit tracker has been instigated.
- The peer review process has been formalised with a standard operating procedure.
- Door replacement has been carried out to improve ease of access.

Managing risks, issues and performance

There was a current and retired risk register on the HCG workbook along with a record of current and retired issues. Whilst the register articulated some main risks identified by the team, some required review. The issues register also required review.

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

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

A business resilience plan was in place and this had been tested in April 2025 when there was no power to the medical centre for a whole day. It clearly detailed the action to be taken in the event of loss of any services.

Appropriate and accurate information

The HAF (health assurance framework) commonly used in DPHC services to monitor performance is an internal quality assurance governance assurance tool to assure standards of health care delivery within defence healthcare. The senior leadership team of the medical centre and the PCRF were predominantly the main authors of the HAF, responsible for the documentation of what was happening within the department. All staff attended the monthly practice meetings which informed the compliance with the HAF command requirements. Staff members we talked with during the inspection recognised their responsibilities in managing the governance and assurance framework.

There were arrangements at the medical centre in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

Various options were available to prompt patients to provide feedback on the service for example, the DPHC online survey, QR codes situated throughout both departments and a comments box. There was a ‘You said we did’ board that illustrated changes made as a result of patient feedback. PCRF changes made included:

- New leg press funded.
- Gym flooring changed.
- General gym improvements.
- Waiting area improved.

A patients' survey had been adapted specifically for cadets in Lucknow Platoon to capture their specific experience of receiving fulltime rehabilitation and collect any specific trends from this population.

There was a Patient Participation Group in place with the last meeting being in July 2025. Previously it was noted that when the meeting was held at the medical centre attendance was small, so to boost participation the last meeting was held at a coffee shop on camp. This saw 61 people attend and discussion were had about appointment times and eConsult.

Continuous improvement and innovation

There was much evidence of continuous improvement across the medical centre and PCRF.

Heat illness

The medical centre had undertaken a significant piece of work to mitigate the risk of heat illness. They engaged with the Sandhurst Chain of Command (CoC) and contributed to their training risk assessments. They identified that specialist equipment was available that would optimise the treatment of heat illness. When funding was refused, they engaged with Sandhurst CoC and they contributed to the business case for the procurement of the equipment (3 immersion bags and waterproof rectal thermometers compatible with equipment held). Initial training in the use of the specialist bags was undertaken March and May 2025 and further training was planned. Alongside this there were established alternative methods of treating heat illness at Sandhurst for those not trained in the use of the immersion bags.

The medical centre had amended their eConsult availability timings to meets the needs of their patients following feedback. For example, they extended the hours eConsult was available in the evening (Monday to Thursday) to enable patients to submit an eConsult after they had finished work.

Sick parade was changed with the introduction of total triage for the cadets. This had resulted in cadets spending less time waiting to be seen and being able to return to their lessons missing more promptly.

Opening times had been amended to facilitate Sandhurst training activity, for example opening early 06:30-07:30 hours to be available if there was an increased risk of heat illness.

The medical centre had incorporating research evidence from the Human Performance Centre, located at Sandhurst, to inform pre-joining briefs and advising future cadets re conditioning and vitamin/mineral intake to help minimise injuries once arrived.

The PCRF had developed a system that provided real time tracking of injuries and injury trends. This could be used to both refine the services offered by the PCRF to ensure that they were targeted specifically at the RMAS population, and to give staff oversight of injury trends throughout the training schedule.

The medical centre had engaged with the Health Board which had contributed to the publication of the Armed Forces Strategy2025-2030 (Berkshire-Healthcare-NHS).

Introduction of the combined metabolic disease register – combined gout, diabetes (including pre-diabetes)/ hypertension/chronic kidney disease/Non-alcoholic fatty liver disease. This included the nurses updating the register and having a prompt sheet to collect all data required for DMICP and the register so that all information was in 1 consultation.

Summarising of cadet notes – engagement with recruiting teams ahead of the cadets arriving so that the notes can by fully summarised before arrival and courses starting.