Marham Combined Medical Practice

Marham Medical Centre, Burnthouse Drive, Upper Marham, King's Lynn, Norfolk, PE33 9NP

Honington Medical Centre, Bury St Edmunds, Suffolk, IP31 1EE

Defence Medical Services inspection report

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information given to us by the practice and patient feedback about the service.

Overall rating for this service	**Outstanding**	☆
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?	**Outstanding**	☆

Contents

Summary

About this inspection

We carried out an announced comprehensive inspection of Marham Combined Medical Practice on 26 and 27 March 2025.

As a result of this inspection the practice is rated as outstanding overall in accordance with the Care Quality Commission's (CQC) inspection framework.

Are services safe? – requires improvement

Are services effective? – good

Are services caring – good

Are services responsive to people's needs? – outstanding

Are services well-led? – outstanding

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

This inspection is one of a programme of inspections the CQC will complete at the invitation of the DMSR in its role as the military healthcare regulator for the DMS.

At this inspection we found:

- Feedback showed patients were treated with compassion and respect, had prompt access to the service and were involved in decisions about their treatment and care. The practice pro-actively responded to patient feedback and made improvements to the service as a result.
- Extensive safeguards were in place, including close working with the welfare team and local safeguarding team to support vulnerable patients.
- The practice was well-led and the leadership team demonstrated they had the vision, capability and commitment to take the service through the combining process whilst continuing to provide a patient-focused, caring and responsive service. The leadership approach was collaborative and inclusive.
- There was an open and transparent approach to safety. A well-developed system was in place for managing significant events. All significant events and incidents were

subject to a thorough root cause analysis. Emerging themes were used as drivers for change.

- The practice worked collaboratively with internal units and departments to enhance the safety, welfare and wellbeing of trainees.
- The arrangements for managing medicines minimised risks to patient safety. In particular, high risk medicines were well managed.
- Combined healthcare governance processes were well-developed and routinely used to monitor service performance, including clinical audit.
- Staff consistently sought ways to develop and improve. Quality improvement activity was embedded in practice and was used to drive improvements in patient care.
- The infrastructure at Marham was old and not designed as a healthcare environment. In particular, improvements were needed to the rehabilitation gym to ensure patient safety.

We identified the following notable practice, which had a positive impact on the patient experience:

- The combining of Marham and Honington medical centres had been successfully executed with minimal obstacles. Led by an experienced and pro-active senior leadership team, the approach was heavily underpinned by stakeholder engagement, up-to-date transparent communication regarding each stage of the process and the involvement of staff. The success was evident through high staff morale and departments effectively working together, 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 had been successfully introduced during the transition to the combined model. Throughout the combining process the practice had continued to make improvements to the patient experience.
- In response to patient feedback, a peripatetic clinic had been set up at Robertson Barracks in Swanton Morley to reduce the travel time for patients attending the Primary Care Rehabilitation Facility (PCRF).
- A practice-wide patient focus group was held 6-monthly and included the dental services The welfare team was also represented at the group. Between 45 and 50 patients dialled into the last 2 focus groups. Whilst patients could raise issues and ask questions, each department for the practice provided updates on any developments.
- Through welfare meetings, it was identified that women in the Regiment Training Wing were exposed to sexual contextual language. As a result, an open door policy was put in place offering women the opportunity to chat about any issues that were worrying them.
- A pro-active approach to injury prevention had been developed at Honington involving the tracking of injury presentation for the rehabilitation platoon. Injury patterns were shared with commanders to indicate if a revision in training was required to reduce injury rates. Based on these patterns, tracking supported the PCRF to plan ahead with the aim to improve patient care and outcomes.

- A local working practice policy was established for the management of high risk medicines (HRM). Monthly searches were delegated to all clinicians on a rolling basis with the aim to ensure all clinicians had an awareness of the system and management of these medicines. An HRM register was held on DMICP and searches were cross-checked with DMICP. This robust system was beyond the Defence Primary Healthcare (DPHC) recommended quarterly HRM checks.

The Chief Inspector recommends to DPHC:

Given that the plan for a new build at Marham has shifted to 2045, the infrastructure should be reviewed to ensure it is fit for purpose. In particular, the PCRF and rehabilitation gym should be prioritised to identify and agree a sustainable solution to ensure the safety of patients.

The Chief Inspector recommends to the practice:

Review how patients using the PCRF and rehabilitation gym are monitored so that patients can be viewed at all times to ensure they are safe.

Professor Aidan Fowler

Interim Chief Inspector of Healthcare, covering Secondary and Specialist Care and Primary and Community Care

Our inspection team

The inspection team was led by a CQC inspector and supported by a CQC regulatory officer. The specialist advisors included a primary care doctor, practice nurse, pharmacist, physiotherapist, exercise rehabilitation instructor and practice manager. Two newly recruited specialist advisors shadowed the inspection as part of their induction.

Background to Marham Combined Medical Practice

Marham Medical Centre (referred to as MRM throughout the report) fully combined with Honington Medical Centre (referred to as HON throughout the report) in December 2024 to form Marham Combined Medical Practice (referred to as 'the practice' throughout the report). The medical centres are 32 miles apart.

Based in the DPHC East Region, the practice supports a Tri-Service population with 2,967 patients registered at the time of the inspection. Families are not registered at the practice and are directed to register with local NHS primary healthcare practices.

MRM provides a service for multiple squadrons who often deploy at the same time. There is a dispensary at MRM and the Primary Care Rehabilitation Facility (PCRF) for physiotherapy and rehabilitation is located in 2 buildings close to the medical centre.

The key demographic at HON is the Regiment Training Wing undergoing Phase 2 training. HON is also the hub for RAF Force Protection, incorporating the RAF Regiment and RAF police headquarters. Furthermore, it is the base for the Tactical Police Squadron and 3 regiment field squadrons, so the preparation of personnel for high readiness to deploy and routine deployments is essential. The premises is a new building and accommodates a dispensary and a PCRF.

The opening hours are from 08:00 to 18:30 hours Monday to Friday for MRM and until 17:00 hours for HON. From 17:00 to 18:30 hours patients at HON contact them Main Guardroom who then contact the duty medic who can liaise with the doctor if required. Although Wednesday afternoons are protected for staff training, patients still have access by telephone and so those with an urgent need can be seen. From 18:30 hours, patients are directed to contact NHS 111.

RAF Marham is staffed out-of-hours by a duty medic who is responsible for providing crash cover and medical response to the airfield only.

Practice staff

The practice senior leadership team		(PMO) Warrant Office (WO) Band 7 nurse - due to start July 2025 OC PCRF (lead physiotherapist)
Staff team	**MRM**	**HON**

Doctors	PMO Deputy Senior Medical Officer Unit Medical Officer x 4 - locum cover for 1 post and the **other post temporarily vacant** MOD General Practitioners x 2 - both part time	Senior Medical Officer MOD General Practitioner x 2 - 1 post with locum cover
Practice nurses	Practice Nursing Officer – locum cover applied for Practice nurse manager Senior Non-Commissioned Officer – covered by a locum Junior Non-Commissioned Officer (JNCO) Band 6 – **long term leave** Healthcare assistant Nursing team admin	Band 7 practice nurse - **vacant** Band 6 practice nurse Band 5 practice nurse
PCRF	OC PCRF Second-in-command physiotherapist - **vacant** Band 7 physiotherapist Exercise rehabilitation instructor (ERI) x 3 PCRF team admin	OC PCRF - **vacant** Band 6 physiotherapist Band 7 physiotherapist ERI x 3 - 1 **vacancy**
Practice management and administration	WO Combined Practice – covers both medical centres Practice manager Deputy practice manager Resource manager JNCO x 3 - **1 vacancy** Reception x 2 Admin officer x 2 Admin assistant x 2 - **both posts vacant** * Medics x 11 - **1 vacancy**	Practice manager Deputy practice manager Receptionist Admin officer Admin assistant - **vacant** JNCO medics x 3 Medics x 8
Dispensary	Civilian pharmacy technician	Civilian pharmacy technician

	SNCO pharmacy technician – covered by a locum	
Environmental health	Practitioners x 2	One practitioner

*A medic is a unique role in the forces. Their role is similar to that of a health care assistant in NHS GP practices but with a broader scope of practice.

Are services safe?

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

Safety systems and processes

Both the Principal Medical Officer (PMO) and Senior Medical Officer (SMO) for HON were the leads for safeguarding and nurses from MRM and HON deputised. Developed in February 2025, a practice-wide safeguarding policy for adults and children was in place. It included links and referral pathways for both Norfolk and Suffolk safeguarding teams. Notices were displayed about how to report suspected abuse to the local authority. Although no children were registered, staff considered the family as a whole and addressed child safeguarding concerns, including using the safeguarding app for out-of-area referrals.

The staff induction pack covered safeguarding arrangements and the majority of staff were in-date for safeguarding training at a level appropriate to their role. There were mitigating circumstances for the small number out-of-date, such as deployment. Training had been scheduled for May 2025.

Clinical coding and alerts were applied to individual patient records to ensure vulnerable patients were readily identified and to facilitate the routine DMICP (electronic patient record system) searches for vulnerable patients. A vulnerable patients register was held within DMICP. Chaired by the PMO, a weekly clinical meeting was held and patients of concern were added to a DMICP ‘ghost clinic’. These patients were discussed and an entry made on their clinical record.

The practice held 4-weekly meetings to discuss the needs of patients assessed as vulnerable. In addition, practice staff were represented at the Station Personal Support Committee (SPSC) held at both MRM and HON. All patients on the vulnerable persons register were discussed. This was particularly important for HON as the majority of patients under the age of 18 were based there for Phase 2 training, including care leavers. An exercise rehabilitation instructor (ERI), nurse and medical board staff at HON attended the monthly review meetings specifically for trainees.

The Commanding Officer (CO) for RAF Honington attended the SPSC and also described how practice staff were responsive to any concerns. The SPSC and CO had direct access to the HON safeguarding leads for any patients they were concerned about. The practice had links with the East region safeguarding forum and MRM participated with the Norwich safeguarding meeting.

We were given examples of how safeguarding concerns were effectively managed with the involvement of the practice, Chain of Command and welfare team.

A chaperone policy was in place and chaperone leads were identified for both MRM and HON. The availability of a chaperone was displayed throughout the buildings and referenced in the patient information leaflet. Clinical staff had received chaperone training and a list of available chaperones was displayed in all clinical rooms. A clinical code was added to the patients’ record to confirm the offer/use of a chaperone for intimate examinations. All trainees under the age of 18 were provided with a chaperone.

A chaperone/consent recording audit carried out in May 2024 identified that clinical coding was not always applied for the offer/use of a chaperone. Consequently, staff received training about the use of coding. Our review of patient records showed coding was consistently applied.

Although the full range of recruitment records for permanent staff was held centrally, the practice manager demonstrated that relevant safety checks had taken place at the point of recruitment, including a Disclosure and Barring Service (DBS) check to ensure staff were suitable to work with vulnerable adults and young people. DBS checks were renewed in accordance with Defence Primary Healthcare (DPHC) policy. A DBS check for a non-clinical member of staff was out-of-date and a renewal check had been requested. We were advised that the delay was due to a failure of the on-line identification process. This risk was added to the risk register and a self-declaration risk assessment was in place.

Locum recruitment checks were conducted via the online locum booking system. The professional registration of clinical staff was checked each month. The nursing team managed the staff vaccination register, including the occupational health register with new staff providing documented evidence of their vaccination status.

There was an infection prevention and control (IPC) nurse lead and deputy at both MRM and HON. The leads had completed the IPC link practitioner training. Staff were up-to-date with mandated IPC training. IPC was part of the staff induction. A practice-wide IPC workbook was in place and the IPC leads carried out checks of the premises each month. Any cleaning issues were identified and followed up. A log of disposable privacy curtains was in place. IPC audits were up-to-date and minutes confirmed IPC was a standing agenda item at the practice meetings.

Acupuncture was provided by the physiotherapy team at MRM and IPC measures were followed for this procedure, including the safe disposal of needles. A clinical sink was available in the main Primary Care Rehabilitation Facility (PCRF) clinical area at MRM but the OC PCRF's room contained a kitchen sink. We were advised that acupuncture was currently undertaken only in the main clinical area.

Measures were in place to minimise the spread of infectious diseases, including 'bitesize' training for staff. The team at HON had responded appropriately to a potential concern about Mpox (previously known as monkey pox). An isolation room, equipment and personal protective equipment was available. Hand washing technique posters along with first aid measures to manage sharps/body fluid exposure were displayed.

Copies of the cleaning schedules were held at MRM and HON and cleaning staff recorded to confirm that cleaning tasks had been completed. The IPC leads carried out a regular review of cleaning standards against that schedule.

A statement of need (SON) was submitted for a hand washing sink for cleaning staff at HON. As an interim measure to mitigate risk, cleaning staff used paper towels to open doors to the nearest hand washing facility. We observed the staff washing their hands in the Belfast sink used for mop buckets. The absence of a sink was documented on the issues log with evidence of engagement with the contract cleaning management team to seek a resolution. Both MRM and HON had a deep clean in December 2024.

Leads and deputies were identified for the management of clinical waste. Clinical waste logs and the required documentation were in place and up-to-date. A pre-acceptance audit was completed in September 2024 for MRM and in November 2024 for HON. Clinical

waste was stored securely, including pharmaceutical waste. Sharps boxes were labelled, dated and disposed of appropriately.

Risks to patients

Staffing levels was identified as a top risk for the practice and a standing agenda item at the practice meeting. Minutes from the February 2025 meeting showed the status of staff levels was discussed. At the time of the inspection, some positions were vacant and unfilled by locums, mainly for MRM. Despite this, staff we spoke with said there were sufficient staff within the practice to ensure a safe, timely and effective service for patients. They reported that the combined practice model had helped greatly with mitigating reduced staffing levels. Staff from both MRM and HON worked closely including providing support if one of the facilities was short of staff due to staff vacancies, staff absence or an increase in workload due to a deployment. The mix of civilian and military staff in all departments support with continuity.

The OC PCRF position was vacant at HON and a locum worker had started the week of the inspection. The OC PCRF at MRM was due to deploy. Although a locum request had been submitted, we were advised there were limited locum options in the area. Historically HON had provided support but it was unclear if this had been discussed as an option.

The medical emergency trollies were checked in line with DPHC policy, including when a trolley had been opened/used. All medicines and emergency equipment were in-date. Medical gas cylinders were stored correctly and appropriate signage was in place. Gas cylinders were full and in-date. Required risk assessments were in place. Staff were aware of the trolley locations at both MRM and HON.

An automated external defibrillator (AED) was available in the rehabilitation gym at MRM. Although there was no AED in the PCRF and no alarm system linked directly to contact the medical centre, there was prompt access to an AED and medical emergency kit in Marham dental centre based in the same building.

Medical emergencies were covered in the staff induction. A practice lead and 3 deputies were identified as resuscitation coordinators. The staff team was mainly up-to-date with Basic Life Support training, anaphylaxis and the use of an AED. There were mitigating circumstances for the small number of staff out-of-date. Some military staff were trained in Pre-Hospital Emergency Care, Intermediate Life Support and Battlefield Advanced Trauma Life Support.

Practice-wide scenario-based or moulage training was facilitated monthly. Topics included the management of a collapsed patient, sepsis, a road traffic accident and anaphylaxis. Debriefing was held to identify what went well and areas for improvement. We were advised that scenario-based training had not been held specifically for the rehabilitation gym at MRM. This training would be beneficial as the facility was in separate building to the main medical centre and did not have direct access to a medical emergency kit. We were advised that this training had been added to the training schedule.

Staff reported that heat injuries were a regular occurrence in 2024 so staff training was provided. This had supported the evidence for a business case for the installation of air conditioning (AC) in the treatment room at MRM. Heat illness guidance was displayed in clinical rooms. A training session on recognising the deteriorating patient/sepsis was held

at HON in February 2025 and a further session was planned to take place at MRM in June 2025. Both clinical and non-clinical staff were familiar with the signs and symptoms of sepsis. After the inspection, the practice confirmed sepsis information had been placed in reception.

Information to deliver safe care and treatment

Staff reported minimal concerns with IT outages. 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 nursing team coordinated the summarisation of patient records. They reviewed the records of newly registered patients, including a review of recalls, clinical coding and alerts. Anything of concern was tasked to a doctor for review. The medics carried out searches for records due for the 3-yearly summarisation and then tasked follow-up work to the nurses. HON was supporting MRM with a backlog of the 3-yearly summarising. At the time of the inspection, 85% of records had been summarised.

Arrangements were in place for the auditing of consultation records for clinicians. Between them, both the PMO and SMO at HON reviewed the clinical records for doctors. One of the nurses was the lead for the auditing of nurses record keeping and records for all the nurses were audited in September 2024. As the medics were mainly involved in total triage, the doctors reviewed their clinical records at the end of each clinic. Physiotherapy and ERI records were audited in January 2024 for MRM and in April 2024 for HON. A re-audit was due and will be combined for both PCRFs to encourage sharing of best practice. The outcome of record keeping audits was discussed at the practice meeting.

A safe process was in place for sample management. Requests for tests were made by the clinician through DMICP. Samples were logged on a practice-wide register, which was checked daily. Results returned via Path Links were indicated in green on the register. If a test was rejected, the requestor was tasked to confirm if the patient should be recalled. Results are given to the patient through the dedicated results telephone line that was staffed from 13:00 to14:00 hours. If a result was abnormal, the doctor tasked reception to contact the patient to make an appointment. Results were usually returned within 2-3 days, although some specific tests took longer.

A well-coordinated system was in place for managing referrals, including urgent and 2-week-wait (2WW) referrals. The dedicated referral leads for MRM and HON worked as a team, including the use of the DPHC centralised process for the management of all practice-wide referrals. The leads coordinated their annual leave, ensuring both were not absent at the same time so referrals were always covered. The leads had developed a local working practice (LWP) policy for managing referrals, which some staff could reference on the rare occasion that both leads were absent from the service. The leads spoke to each other daily particularly if patients wished to attend a secondary healthcare (SHC) facility out-of-area.

MRM and HON were based in separate integrated care board (ICB) areas; MRM in Norfolk and Waveney ICB and HON in Suffolk and North East Essex ICB. Because of their close

working relationship, both referral leads had a good understanding of the referral pathways for each ICB. In addition, they both attended the quarterly referrals meeting at The Queen Elizabeth Hospital, Kings Lynn, as this was the main referring facility for MRM.

The DPHC referral management system provided a variety of functions to support the monitoring of referrals, including an alert to prompt follow-up and the ability to transfer details of the referral if the patient moved to another practice. We were shown how the system facilitated each lead isolating their own referrals for monitoring purposes. The NHS e-Referral Service was predominantly used to triage and process referrals. In some instances, patients were contacted directly and an appointment booked. The leads checked 2WW referrals daily, urgent referrals twice a week and routine referrals were checked weekly. There were 414 active SHC referrals at the time of the inspection.

The PCRF team managed its own referrals. A case management review meeting was held every 6 weeks and the status of referrals was reviewed at this meeting.

Safe and appropriate use of medicines

The PMO was the lead for medicines management and the SMO at HON was the deputy lead. The pharmacy technicians (PT) were responsible for the day-to-day operation of the dispensaries. One of the PT positions at MRM was vacant due to deployment and locum cover had been requested. On occasion, appropriately trained medics supported the PT and the practice was actively training other medics in medicines. The PTs at both dispensaries supported each other and reported that the medicines leads were also supportive.

Dispensary and controlled drugs (medicines with a potential for misuse) keys were stored securely and effective measures were established, including the use of logs and tamper proof pouches. Both MRM and HON had an LWP for both dispensary and controlled drugs (CD) and accountable drugs (AD) access. Doctors' bags were held at both the dispensaries.

Military prescriptions (Fmed 296) were appropriately managed and stored securely. Arrangements were particularly advanced at MRM as prescribers were issued a folder so they had ease of access to prescriptions when facilitating 'Total Triage'. These folders were stored securely at the end of the triage clinic. The aim of Total Triage was to remove pressure from reception staff by experienced clinical staff swiftly identifying which care pathway the patient should take.

Even though minimal stock was held, CDs and ADs were very well managed practice-wide, including up-to-date account manager delegated authority forms. An LWP was in place for access to these medicines, which were stored securely in line with legislation. Checks were completed monthly in accordance with the DPHC standard operating procedure (SOP). We highlighted at the time of the inspection that it would be best practice if a second registered healthcare professional at HON undertook the checks with the account holder. The destruction of CDs was witnessed appropriately and destruction certificates were retained. A CD audit was completed in March 2025 and showed 100% compliance with the standards.

The pharmaceutical fridges were clean, tidy and appropriately stocked to allow adequate ventilation. A record of fridge cleaning dates was in place. Data loggers and external

thermometers were calibrated and in-date. Temperatures were monitored as required and records showed all were in range. A record of stock was held on DMICP. At MRM, all fridges were powered from 1 extension cable. We queried whether this was a risk of electrical overload This was rectified after the inspection with single sockets used for each fridge.

Robust measures were in place for the monitoring of doctors' bags. At MRM, medicines were stored in pouches with tamper proof security tags which were recorded in a log. Daily checks were undertaken by the duty doctor.

One of the nurses at HON was a non-medical prescriber and the required authority was in place. Patient Group Directions (PGD) to administer medicines were used in line with legislation. Training was current for clinicians who used PGDs and annual vaccination and immunisation training had been completed. PGD stock was held in the dispensaries and it was in-date and labelled appropriately. We reviewed a range of DMICP consultations and all followed the tri-service immunisation protocol. Annual PGD audits had been completed and no concerns were identified. If a PGD was due to expire then it was raised at the clinical meeting and the duty doctor and PT were informed.

Patient Specific Directions (PSD) were rarely used unless a PGD was not available, such as when the PGD for the Japanese encephalitis vaccination expired. (MIPs) were in use at HON. Doctors completed competency assessments for the medics at HON who worked to Medics Issuing Protocols.

Effective arrangements were in place for repeat prescription requests, including via email or a paper slip at HON. For MRM, eConsult was also used. Repeat prescriptions were processed within 48 hours or sooner if workload permitted. Arrangements were in place to recall the patient if a medication review was required. The nationally recognised 'NO TEARS' tool was used for reviews.

An LWP was established for the management of high risk medicines (HRM). Monthly searches were delegated to all clinicians on a rolling basis with the aim was to ensure all clinicians had an awareness of the system and management of these medicines. An HRM register was held on DMICP and searches were cross-checked with DMICP. This robust system was beyond the DPHC recommended quarterly HRM checks. The March 2025 HRM search and review showed 100% compliance. A practice-wide HRM audit was completed in December 2024. Our review of a selection of patient records showed HRMs were effectively managed, including the use of alerts and completion of medication reviews. Shared care agreements were in place if required and were accurate and up-to-date.

All prescriptions were signed before dispensing and were issued with the patient information leaflet. In addition, the PTs held all the relevant medicine information and warning cards.

Prescriptions awaiting collection were held securely and patients were sent a text message to inform them their prescription was ready. Reminder texts were also sent as patients were given 28 days for collection. This dispensary texting service had been raised as a quality improvement project. Patients who failed to collect their medicine within 3 days, such as antibiotics, were contacted by the PT and the matter highlighted to the SMO. A record was made on DMICP using the 'not collected' clinical code.

Privately obtained prescriptions and SHC medicines were recorded on DMICP appropriately. Both MRM and HON did not accept external prescriptions. Patients were

directed to local pharmacies and provided with guidance about how to reclaim prescription costs. A risk assessment was completed for patients who acquired privately obtained medicines.

Routine DMICP searches for patients prescribed Valproate (medicine to treat epilepsy and bipolar disorder) were undertaken. The PTs was aware of the considerations and action required for patients prescribed this medicine. No patients were prescribed this medicine at the time of the inspection.

Track record on safety

The practice Warrant Officer was the lead for risk and had completed the required health and safety training, as had both of the practice managers. Building custodians and deputies were identified for MRM and HON, along with leads and deputies for fire safety, the environment and health and safety (referred to as SHEF). SHEF was a standing agenda item at both the healthcare governance (HCG) and practice meetings.

The practice risk register included medical centre specific and practice-wide shared risks. It reflected the DPHC ‘4 T’s process’ (transfer, tolerate, treat, terminate) to illustrate at what level each risk was being managed, including a review date. Both a closed risk register and transferred risk register were also in place. A SHEF audit was completed for MRM in March 2024 and for HON in October 2024.

A wide range of regularly reviewed clinical and non-clinical risk assessments were in place. The OC PCRF at MRM had oversight of all practice-wide PCRF risk assessments and updates were led by an ERI at HON with the involvement of a recently appointed ERI at MRM.

Risk assessments for substances hazardous to health (referred to as COSHH) were reviewed annually or if there was a change to the products used. COSHH products were stored securely. Cleaning staff were responsible for monitoring the COSHH products they used.

Processes were in place for the regular monitoring of utilities and equipment at both MRM and HON. Gas and electrical safety checks were up-to-date. Legionella risk assessments had been completed and the safety of water was regularly checked and recorded. Annual equipment checks (referred to as LEA) were up-to-date. All equipment was in-date for servicing, including PCRF equipment. Electrical Equipment Testing (previously PAT testing) was completed for MRM in April 2024 and for HON in September 2024.

The concerns with the old infrastructure at MRM were well known and had been risk assessed. The issues included limited clinical space (medical centre), accessibility (rehabilitation gym), water safety (lead in the water supply to the PCRF) and risk of not meeting IPC standards. The PCRF building had been assessed for asbestos. We noted tape around taps in the PCRF and staff reported gaps in the roof. Despite the risk with IPC compliance, we found the mitigations employed by the practice minimised the risks associated with IPC. This meant the practice was meeting basic IPC standards.

All the infrastructure issues were captured in detail on the risk register including the ongoing action being taken by the practice. It was clear the practice was regularly reporting the issues along with numerous SONs for improvements to be made, particularly

for the gym. The practice had found workarounds to mitigate some risks but these were not a long term sustainable solution. The risks with the infrastructure were last reviewed at the January 2025 HCG meeting. A new build had been planned for 2024 but in January 2021 this was re-scheduled to take place in 2045.

Up-to-date fire risk assessments for all premises used by the practice were in place. The risk assessment for HON highlighted the door risers as a fire risk. All doors were identified as needing to be replaced. As it incurred a large financial cost, the matter had been escalated to the station and was being kept under review. Weekly and monthly checks of the fire alarm system and firefighting equipment were up-to-date. A fire service check was carried out annually. Fire evacuation drills were held annually.

A specific evacuation plan was in place for the MRM rehabilitation gym as it was located on the first floor. A carry chair was available in the ambulance, which was situated outside the medical centre. Since the inspection, the testing of the gym evacuation plan had been added to the training plan and was to be undertaken every 6 months.

The premises at HON was a new building so there was AC throughout. In addition, wet globe bulb testing (WGBT) was carried out in the PCRF to indicate the potential for heat stress. The PCRF and rehabilitation gym at MRM were both in separate buildings and neither were co-located with the medical centre. In the absence of AC, there was limited assurance on the day of the inspection that PCRF staff were adequately assessing the risk of a patient becoming unwell due to increasing temperatures, particularly in the rehabilitation gym.

As there was no WGBT available at MRM, a Met Office forecast of heat stress index for the Marham area was being used. This was not representative of conditions within the gym. There had been discussion about procuring industrial style fans but we understood this had not been actioned. Promptly after the inspection, a WGBT was borrowed whilst a business case for a WGBT was being processed. In addition, the environmental health protection lead was undertaking a thermal risk assessment of the gym. Although the PCRF team was aware of heat illness prevention, management and the use of dynamic risk assessments, staff training in the use of a WGBT had been arranged.

A lone working risk assessment for HON was in place. The configuration of the service at MRM was different as the service was dispersed between 3 buildings. A lone working risk assessment was in place for the PCRF but the risk assessment could not be located for the rehabilitation gym. This was important as sometimes the ERIs worked in the gym on their own. It was subsequently found and updated during the inspection, along with the development of an LWP. Furthermore, gym staff were reminded that 2 clinicians should be available in the rehabilitation gym at all times where possible.

Even though all patients could be observed from reception at HON, reception staff asked patients they were concerned about to sit in chairs immediately in front of reception desk. Convex mirrors were used at MRM to facilitate observation of patients in the waiting area of the medical centre. The rehabilitation gym at MRM comprised multiple rooms which limited the visibility staff had of patients. Similarly, the PCRF at MRM had a separate reception area and staff in the clinical area were unable to observe patients. The PCRF receptionist worked from the medical centre.

A mix of hand-held and fixed alarm systems were used to summon support in the event of an emergency. A fixed alarm system was in place at HON. The handheld alarms were not

being used by PCRF staff at MRM and this was addressed during the inspection and the practice Warrant Officer confirmed all staff had been issued with personal alarms.

Although there was a process to record the checks of the alarms, it was evident during the inspection that some checks were either not being completed or not recorded, particularly for the PCRF and rehabilitation gym at MRM. Management processes were updated during the inspection to ensure these checks were completed in the future. The practice Warrant Officer planned to assume responsibility for PCRF governance processes during the upcoming deployment of OC PCRF.

Lessons learned and improvements made

The practice worked to the DPHC policy for reporting and managing significant events, incidents and near-misses, which were recorded on the ASER system (organisational-wide process for reporting significant events). There was a well-embedded positive, transparent and no-blame culture regarding the reporting of incidents and significant events.

The practice undertook an audit to review ASER training for staff and access to the system. All staff were up-to-date with training and had access the ASER system to report an incident.

A comprehensive practice-wide ASER log was in place that included the details of the team who undertook the root cause analysis (RCA) for each incident reported, lessons learned, details of the meeting where the ASER was discussed and a closure date. Staff in all departments had Part 2A access. ASERs were discussed at both the HCG and practice meetings. Even though an ASER audit was completed for 2024, trends were discussed at the monthly HCG meetings, including improvements needed.

Staff we spoke with during the inspection provided numerous examples of ASERs and changes made as a result. One such example involved an abnormal blood result from the hospital which was tasked the duty doctor who was not in work. This created a delay in follow-up. Although no harm came to the patient, the duty medic orders were updated and training provided. A further example involved the delayed identification of a raised creatine kinase (can indicate muscle damage or heart-related issue). Following an RCA, the SOP was updated to minimise the risk of a reoccurrence.

A safe process was in place for managing notices from the Medicines and Healthcare products Regulatory Agency (MHRA). Alerts were logged on a register and actioned in a timely way. Minutes showed that MHRA notices and alerts received through the Central Alerting System were a standing agenda item for discussion at practice meetings.

Are services effective?

We rated the practice as good for providing effective services.

Effective needs assessment, care and treatment

The weekly clinical meetings were the main forum to discuss developments in clinical care including National Institute for Health and Care Excellence guidance (NICE), the Scottish Intercollegiate Guidelines Network, clinical pathways, current legislation, standards and other best practice (BCP) practice guidance. In addition, developments in clinical care were issued to the team via the Defence Primary Healthcare (DPHC) updates. The practice meeting minutes included links to updates for staff to access.

Relevant departmental clinical updates were also shared and/or discussed at the Primary Care Rehabilitation Facility (PCRF) meetings and nurses‘ meetings. Furthermore, clinical staff advised that continuing professional development (CPD) provided the opportunity to consider developments in primary healthcare. Clinicians provided feedback to the rest of the team following attendance at CPD events.

PCRF staff had access to the rehabilitation BCP guidance through the Defence Learning Environment. The exercise rehabilitation instructor (ERI) ‘toolbox’ was also used. Staff accessed additional websites sites to source and review rehabilitation BPG.

Our review of patient records confirmed physiotherapists used the Musculoskeletal Health Questionnaire (MSK-HQ) and Functional Activity Assessment (FAA). Both the MSK-HQ and FAA are standardised outcome measure for patients to report their symptoms and quality of life. The MSK-HQ was used at the initial appointment. Because many patients were administratively discharged, it was a challenge to regularly complete the MSK-HQ on discharge; this was a common theme across Defence PCRFs. The use of the MSK-HQ was clinically coded via the DMICP template.

It was evident from the clinical records we reviewed that Rehab Guru (software for rehabilitation exercise therapy) was predominantly used for rehabilitation exercise programmes. Instead of Rehab Guru, flight trainees were given a booklet which they used throughout their time on a flight. We were advised that ERIs at HON were actively trying to improve their use of outcome measures. A project led by the by the ERI was driving this improvement. The ERIs at MRM carried out late stage rehabilitation so were working with patients right up to the service fitness tests.

The PCRF at HON was a new building so had been planned to ensure adequate space and equipment. Aside from the specific infrastructure issues at MRM, there was sufficient space and equipment to meet patients’ needs.

Step 1 of the DPHC mental health pathway was delivered at the practice and patients with a mental health need were added to the vulnerable patients register if appropriate. With reference to the Department of Community Mental Health (DCMH) ‘Digby’s referral checklist’, patients were referred who needed intervention beyond step 1. Staff described effective relationships with the DCMH team and said it provided a good service. The DCMH delivered outreach clinics 2 days a week at MRM. A practice-wide mental health information resource had been developed for patients. The tri-service links to Headspace

were available for patients to access evidence-based meditation, mindfulness tools and sleep resources. Our review of clinical records showed patients with a mental health need were well managed and appropriate clinical coding was used.

Monitoring care and treatment

A practice-wide robust integrated approach to the management of long term conditions (LTC) was well established. LTCs were nurse-led with the Practice Nursing Officer (PNO) identified as the lead and a nurse from both MRM and HON deputised. Even though a lead and deputy were identified for specific LTCs, all nurses were experienced with managing each condition.

Clinicians followed both the NICE guidance pathways and Defence policy for the management of LTCs. The nurses were encouraged to participate with the LTC webinars for their CPD. They could access specialist advice, such as from the regional diabetic nurse or specialist clinicians in other DPHC services. A local working policy chronic condition management tool kit was in place and was issued to new staff.

A comprehensive tracker for LTCs was maintained and DMICP searches were undertaken each month. The unreliability of Population Management (referred to as POPMAN) searches had been identified so the nurses developed their own searches and cross-referenced them with POPMAN. Patient recalls were split between the nursing team. The DMICP chronic disease management tool was consistently used. Our review of clinical records for LTCs showed patients were well managed and appropriate templates and clinical coding was used.

Baseline tests were undertaken by the nurses and the healthcare assistant for patients recalled. Once tests were completed including blood tests, the tracker was updated and the patient advised to book a doctor's appointment in a week. The Chain of Command was informed if patients failed to respond after 3 recall requests. These patients were discussed at the clinical meeting and pharmacy staff advised not to issue repeat medicines until the patient was reviewed.

Of the 24 patients on the diabetic register, the last measured total cholesterol was 5mmol/l or less for 21 patients; an indicator of positive cholesterol control. The last blood pressure (BP) reading for 22 patients was 150/90 or less; an indicator of positive BP control. Through annual baseline health monitoring, patients at risk of developing diabetes were identified. They were offered lifestyle intervention, such as weight management strategies.

Seventy-one patients were diagnosed with high BP and 67 patients had their BP checked in the past 12 months. Fifty-six had a BP reading of 150/90 or less. All 26 patients with a diagnosis of asthma had an asthma review in the last 12 months. The chronic disease asthma template was used for all annual reviews,

Audiometry assessments were in-date for 75% of the patient population. Additional Hearing Conservation Programme clinics were being held to improve this figure and in preparation for Operation Highmast (deterrence and readiness). Our review of patient records demonstrated Joint Medical Employment Standards (referred to as JMES) were appropriately managed.

Practice-wide audit activity was coordinated by the nursing team with the PNO identified as the audit lead and a nurse from both MRM and HON deputising. Audits were planned per quarter annually and the 2024 audit register showed a broad range of data searches and clinical audits had been completed, including the DPHC 'must' and 'should' audits. The outcome of clinical audits was discussed at clinical meetings and non-clinical audits were discussed at the practice meetings.

We specifically focussed on clinical audit activity to evaluate the quality of care and improve patient outcomes. Clinical audit topics were selected based on population need, new/updated clinical guidance and operational demands. We reviewed a range of audits completed since the combined practice model was introduced (quarters 3/ 4 for 2024; quarter 1 for 2025). These included diabetes, gout, Patient Group Directions, asthma, hypertension and antibiotic prescribing.

All audits were evidence-based, including appropriate criteria and standards setting. We determined they were of a high standard and included a summary and any actions required. For example, the antibiotic audit was completed for the month of January 2025 because this month was reflective of practice prescribing patterns as it was a peak time for antibiotic prescribing for respiratory tract infections and other conditions. Thirty-one antibiotics were prescribed and all were for relevant conditions with appropriate durations and prescribing practices. Audits undertaken by PCRF staff were focused on process rather than clinical care and measurement against BPGs.

Effective staffing

Staff new to the practice completed the DPHC mandated induction programme alongside a local role specific induction. They were also offered a mentor. Medics who joined the practice within the last 12 months described a comprehensive induction. They told us they received a welcome package, a tour of the station and week-by-week training in the various practice departments. For a member of the reception team, induction involved 2 full days supernumerary and 1 day shadowing another receptionist. Another member of staff stated they shadowed their predecessor for 3 weeks.

Completed inductions were recorded on the staff training database and monitored at the heads of department (HoD) meetings. As part of the induction, the Principal Medical Officer (PMO) and Senior Medical Officer (SMO) ensured all clinical staff had the appropriate skills for their role. Minutes from the practice meeting from February 2025 indicated the practice planned to develop further the practice-wide induction programme.

A medic at both MRM and HON monitored the status of mandatory training. They sent each member of staff an email every month with a training status update, including links to the training courses that were due to be completed. The medics tracked individual staff who were below the training target of 95%, which was also raised at the HoD meeting. Mandatory training was a standing agenda item at the practice meetings. At the time of the inspection, training overall was at 97% for MRM and 98% for HON. All staff had completed the training in how to interact appropriately with people who have a learning disability and/or autism.

A programme of in-service training (IST) was in place and staff advised that they could put forward topics for training sessions. Minutes showed mandated and IST training was a standing agenda item at practice meetings.

A robust clinical development programme was in place for ERIs. At the time of the inspection, a recently graduated ERI was receiving an extensive programme of education under the mentorship of a Band 7 physiotherapist. Similarly, a comprehensive programme of clinical education and development was in place for medics.

Clinicians were supported to stay current with specialist roles. For example, doctors who were Military Aviation Medical Examiners (referred to as MAME) could participate in the aviation medical dial-in held each month for updates to practice. Staff with additional clinical roles were given time to maintain their clinical currency, such as the Helicopter Emergency Medical Service (referred to as HEMS) doctor and the practice Warrant Officer who was a paramedic. Staff with lead roles had received training to effectively fulfil those duties, such as the link practitioner training for the infection prevention and control lead and the Institution of Occupational Safety and Health (referred to as IOSH) course for the risk manager.

Supervision arrangements were in place for all clinicians. Clinical staff had protected time for CPD and all were up-to-date with their CPD and revalidation. CPD formed part of the weekly clinical meetings, including the sharing of updates and relevant clinical information. CPD funding was available and staff were actively encouraged to apply for funding to enhance their CPD. The nurses attended a regional day every 3 months facilitated by the regional nurse advisor.

Physiotherapists providing acupuncture had completed appropriate training and followed the DPHC acupuncture policy. They were aware of limitations for flying staff following acupuncture. The physiotherapist at HON was leading on developing CPD for acupuncture and was in the process of organising a local course.

Coordinating care and treatment

A range of structures were in place to ensure the effective coordination of patients care. Patients with complex healthcare needs were discussed at the multi-disciplinary team (MDT) clinical meetings. In addition, an MDT between the doctors, physiotherapists and ERIs was held weekly at HON and 2 weekly at MRM.

The practice had effective relationships with the station Commanding Officers and squadron/unit commanders so concerns about the health and wellbeing of patients was promptly addressed. The Station Personnel Support Committees provided the main forum for discussing patients, at which the practice was represented. The military nurse attended the Commanders Monthly Case Review meeting for the army unit. The practice also had good links with internal Defence services including the DCMH, Regional Occupational Health Team and Regional Rehabilitation Unit.

The practice had developed strong links with local healthcare services, including sexual health and midwifery services. With the aim of ensuring a seamless referral process, meetings have been held with the 2 NHS hospitals the practice referred to. In addition, links were established with the Integrated Care Board safeguarding leads, including practice representation at the monthly safeguarding conference calls.

To ensure continuity of care for patients undergoing rehabilitation, follow-up was routinely undertaken with the same clinician. Handover from the physiotherapist to the ERI was carried out jointly or face-to-face with the patient present.

For vulnerable patients moving to another area, a DMICP task was sent to the receiving practice. If required, the PMO/SMO discussed the patient's needs with a clinician at the new practice.

DPHC guidance was followed for patients leaving the military including, pre-release and final medicals. During the pre-release phase, patients received a summary of their healthcare record and given information about registering with NHS primary care. They also were provided with information about additional services, such as Op COURAGE, a free NHS service in England that provided mental health support for veterans and their families. Furthermore, patients were advised about the Armed Forces Covenant, which is a guarantee that those who have served in the armed forces are treated with fairness and respect. An overview of the process for leaving the service was displayed with a QR code for patients to access more detailed information.

Helping patients to live healthier lives

A nurse from MRM and HON were the leads for health promotion and medics deputised. The practice followed the NHS health promotion programme so health topics were refreshed monthly. For example, information was displayed about kidney conditions for world kidney day (13 March) and for ovarian cancer awareness month. The waiting area monitor screen system provided a range of educational information for patients while they were waiting.

There were various other health promotion displays and leaflets available, including information about the prevention of musculoskeletal injuries. Resources for mental health wellbeing were displayed including a range of QR codes for issues, such as suicide, stress and bereavement. The practice participated in fundraising events, including raising awareness of breast cancer.

Some of the PCRF team were trained as Defence health and wellbeing advisors. A presentation to the Gunners rehabilitation programme involved sleep, nutrition, stress and stress management. A recent CPD topic for PCRF staff covered having difficult conversations with patients from the Defence Medical Rehabilitation Centre based around holistic care. Lifestyle advise was evident in the patients' records we reviewed.

Health briefing sessions were provided for deploying squadrons. A physiotherapist at MRM was working with the nursing team to develop a holistic lifestyle approach to health improvement. Nurses could refer patients to the PCRF-led weight management workshop each month. Practice staff participated in the station-led health and wellbeing events.

Led by an ERI with the data used by the wider PCRF team, a pro-active approach to injury prevention had been developed. This involved tracking injury presentations through the training cycle for the rehabilitation platoon at HON. Injury patterns were shared with commanders to indicate if a revision in training was required to reduce injury rates. With the aim to improve patient care and outcomes, tracking supported the PCRF to plan ahead aware of a likely increase in patients with a similar type of injury due to training. We highlighted the benefits of raising this work as a quality improvement project.

The practice took a pro-active approach to smoking cessation, often identified and initiated at the over-40 health checks. Some of the nursing team were qualified smoking cessation practitioners and provided advice, motivational support and a variety of smoking cessation products. We were provided with examples of how patients had successfully stopped smoking, including a shift to vaping. Patients could also be referred to local services for smoking and alcohol advice.

Processes were in place to ensure effective maternity care. Once pregnancy was confirmed at MRM, patients were referred to local community midwifery services. At HON, patients completed a pregnancy self-referral at 7 weeks or they could contact West Suffolk Hospital directly. The practice provided post-natal appointments 6 weeks post-delivery.

One of the nurses was the lead for sexual health and had undertaken the appropriate training (referred to as STIF). Although sexual health advice and screening for some sexual transmitted infections was provided, patients were encouraged to use local sexual health services. We were advised local services provided a timely and good quality service. The MOD GP at HON was qualified to fit intrauterine devices.

In line with the local working policy, nurses carried out monthly searches to identify patients eligible for the national screening programmes. Nurses were qualified to carry out cervical screening and patients could attend the clinics at either HON or MRM. The details of patients requiring screening were recorded on the cytology register and also forwarded to the NHS screening provider. Non-responsive patients were followed up. If results were normal then the patient received an email and patients with an abnormal result were contacted by telephone.

The number of women who had a cervical smear in the last 3-5 years was 208 which represented 95% of the eligible population. The NHS target was 80%. There were very low numbers of patients eligible for bowel screening and no patients met the criteria for abdominal aortic aneurysm screening.

Although the Chain of Command and individual service personnel (SP) were responsible for keeping up-to-date with their occupational required vaccinations, the practice monitored the vaccination status and recalled SP through monthly or 2 monthly searches depending on capacity. With so many squadrons deploying at the time of the inspection, vaccinations were captured as part of the pre-deployment process. If SP due to deploy failed to attend for their vaccinations, the military nurse and practice Warrant Officer were informed.

At the time of the inspection, the vaccination statistics for eligible service personnel at the was identified as:

- 92% of patients were in-date for vaccination against diphtheria.
- 92% of patients were in-date for vaccination against polio.
- 92% of patients were in-date for vaccination against hepatitis B.
- 94% of patients were in-date for vaccination against hepatitis A.
- 92% of patients were in-date for vaccination against tetanus.
- 99% of patients were in-date for vaccination against measles, mumps and rubella.
- 97% of patients were in-date for vaccination against meningitis.

Consent to care and treatment

Implied and verbal consent was mostly taken depending on the intervention. Written consent was obtained from patients receiving acupuncture and patient consent was sought for referrals to the welfare team. Consent was reviewed as part of the consultation and consent audit last completed in quarter 2 of 2024. The patient records we reviewed indicated consent had been appropriately taken and recorded.

Clinicians understood the Mental Capacity Act (2005) and how it would apply to the patient population. Staff completed annual training and mental capacity was also discussed at clinical meetings. The principles underpinning the mental health act were displayed in clinical rooms.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

As part of the inspection, we received feedback about the service from 70 patients via completed CQC feedback cards and interviews with patients. In addition, we considered the 39 responses from the Patient Experience Questionnaire. All feedback was exceptionally positive about the caring nature of staff, indicating they were friendly, empathetic and compassionate.

Staff provided numerous examples of when the practice had shown kindness, respect and compassion to patients. Some of these examples included:

- Providing end-to-end care for a patient who experienced a medical emergency, including a member of staff travelling in the ambulance with the patient and staying with them in the hospital.
- Patients identified as having 'additional needs' were provided with enhanced support, especially when they were referred to external healthcare services.
- Staff at MRM redecorated the medical centre in their own free time to improve the facility for patients and working environment for staff.
- There were 420 Royal Navy personnel based at MRM. A display board provided an explanation of naval language and slang (referred to as Jack Speak). This meant RAF and British Army service personnel were informed about specific terminology used by navy personnel.
- The practice arranged military transport (MT) for patients who did not have a car to attend external healthcare appointments, including booking MT out-of-hours.

The Commanding Officer (CO) at HON regularly engaged with practice staff, including informal visits to the medical centre. The CO took a holistic approach to the wellbeing of service personnel (SP) on the premise that if families were happy and content then this meant SP were happy. Families residing at the station were generally very young, often away from home for the first time so the CO described how they actively monitored the wellbeing and social support for families. They frequently chatted with families at the community café to gain an understanding of their needs and concerns. The rural location meant families were isolated so the CO arranged military transport once a week for families to visit the local town. In addition, they had explored the option of driving lessons for those who did not drive. Based on a station-led community needs analysis, a Community Development Officer (CDO) had been sourced to support families, including accessing 'life lessons' at a local college. The CDO also had links with SSAFA (Armed Forces charity) and the army welfare service.

Both stations had a HIVE network that provided a range of information for service personnel and their families. Breastfeeding facilities were available at both MRM and HON.

Involvement in decisions about care and treatment

Feedback indicated patients were involved with planning their care and this was confirmed by our review of patient records. Many patients highlighted that they felt understood as clinicians listened to them and things were explained in a way that they understood.

A translation service was available for patients who did not have English as a first language and information was displayed for patients about how to access the service.

One of the nurses was the lead for patients with a caring responsibility who were identified through the new patient registration process or opportunistically. Monthly DMICP searches were undertaken and the 13 carers identified had a clinical code and alert applied to their record. Appointments were flexible and carers were offered an annual health review along with vaccinations if appropriate. Staff also considered the impact of work stress and deployment for carers. The needs of carers were discussed at the station health and wellbeing station meetings. Information about support for carers was displayed and outlined in the practice patient information leaflet. The practice had a plan to develop a carers newsletter

Privacy and dignity

Patient consultations took place in clinic rooms with the door closed. If headphone sets were used for telephone consultations then the patient's ID was checked prior to any information being disclosed. Privacy curtains were available in all clinical rooms for intimate examinations. Measures were in place at reception for patients to talk to the receptionist discreetly. Radios and/or televisions were used in waiting areas Primary Care Rehabilitation Facility (PCRF) clinical rooms to minimise risk of conversations being overheard.

There was a well balanced mix of male and female clinicians practice-wide should patients have a preference to see a clinician of a specific gender. The exception was the PCRF as all staff were male. This was documented on the risk register and there was an arrangement in place to access a female physiotherapist at another PCRF.

Are services responsive to people's needs?

We rated the practice as outstanding for providing responsive services.

Responding to and meeting people's needs

We were given wide-range of examples of when the practice had responded to both collective and individual needs of patients. Some of these examples included:

- The key population at HON was the Regiment Training Wing undergoing Phase 2 training. Many were very young and some had left home for the first time. The training was arduous, which meant trainees were a high risk for musculoskeletal injuries and heat illness. The practice made special allowances for these patients as their training programme impacted their availability for appointments. In addition, the practice took into account that trainees were governed by a separate occupational health policy.
- Because of operational need, aircrew staff were prioritised for medicals. In addition, routine appointments were flexible for aircrew to accommodate their flying programme, including appointments out-of-hours.
- For a patient with a painful condition, the appointment times with a range of clinicians were co-ordinated on the same day to minimise the amount of travel time for the patient.
- A medicine was sourced from HON stock and transported to MRM resulting in no delay to the patient's treatment.
- An appointment was organised at the medical centre local to a patient's home so they did not have to return early from leave for a vaccination.
- A pilot's hearing assessment was graded as H4 (poor hearing). The practice responded promptly and then went over and above to secure additional investigations and treatment.
- The healthcare assistant spent time reassuring and calming a patient who usually required sedation due to a needle phobia. On their next appointment, the patient did not need sedation to have blood tests.
- Prompt contact was made with the Defence Consultant Advisor and secondary care liaison to ensure a patient could deploy with a clinical condition.
- It was noted at MRM that patients regularly enquired about how to get vouchers for the optician, so this information was laminated and added to a notice board near reception.
- A local working practice policy was in place to access a female physiotherapist at Colchester Medical Centre.
- 'Practice' fitness tests led by an exercise rehabilitation instructor (ERI) had been introduced for patients nearing the end of their rehabilitation journey.
- A rehabilitation satellite clinic for the Queen's Dragoon Guards was due to start based on patient feedback regarding the lengthy travel time.

- A peripatetic clinic had been set up at Robertson Barracks in Swanton Morley so patients did not have to travel to the Primary Care Rehabilitation Facility (PCRF) for rehabilitation.
- At MRM, a display board was in the place providing clear explanations of medical board terminology and downgrades.
- Additional vaccination clinics were facilitated at lunch time and/or in the evenings for service personnel deploying at short notice.
- Through welfare meetings, it was identified that women in the Regiment Training Wing were exposed to sexual contextual language. As a result, an open door policy was put in place offering women the opportunity to chat about any issues that were worrying them.

A practice-wide patient focus group was held 6-monthly and included the dental services The welfare team was also represented at the group. Between 45 and 50 patients dialled into the last 2 focus groups. In addition to patients raising issues and queries, each practice department provided updates on any developments.

In line with the legislation, access audits for the building used by the practice had been completed; MRM in November 2024 and HON in October 2024. A hearing loop, accessible parking and accessible toilet facilities were available at both medical centres. Wheelchairs were available at the front doors should they be needed.

The rehabilitation gym had no banister or lift to support patients who needed it. This issue was identified on the risk register. To mitigate the risk, the main station gym could be used as it was on the ground floor. In addition, the exercise rehabilitation instructor could assess patients in the ground floor PCRF. A statement of need had been submitted for a banister to be fitted. The PCRF main door was a push/pull type door and up a step which could impede access. This was risk was held by the station. Alternative access could be agreed through the dental centre.

Clinicians were aware of the MOD policy in relation to the management of transgender personnel in the military. Some clinicians had attended a webinar for trans-gender and non-binary people regarding access to breast screening. Staff reported that they asked patients their preferred pronouns.

Timely access to care and treatment

As part of the practice combining process and initially for MRM, the Defence Primary Healthcare's (DPHC) Total Triage (TT) process was initiated and successfully introduced in August 2024. To ensure the model adopted was streamlined to patient population need, the practice Warrant Officer (PWO) sought the views of other DPHC practices that had introduced TT. Furthermore, different approaches were trialled. To maximise understanding and support for TT, posters to display were circulated across the stations and information added to the local news page. The PWO engaged with station executives and held meetings with Warrant Officers across both stations to ensure a collective understanding of TT and its benefits. Practice staff had received training in the TT process.

Although different approaches were taken for MRM and HON, TT was working well practice-wide. Patient feedback suggested TT provided more timely access to

appointments with clinicians. Staff reported that the process freed up appointments for routine clinics. The TT model at MRM had been raised as a quality improvement project.

At MRM, access to both urgent and routine care was triaged via TT. A designated team of 4 administrators/clinicians staffed TT each day and decided which care pathway the patient should take, such as referral to the duty doctor, doctor, nurse or medic. Any queries were referred to the duty doctor. Folders with guidance were available for the TT team who also used a DMICP template to record the telephone conversation with patients and task the relevant clinician. The clinician then telephoned the patient. Patients with an urgent or concerning need were offered a face-to-face appointment. A tracker was maintained of all patient contacts.

As trainees at HON were not permitted to use their mobile phones during working hours, an urgent care clinic was held each morning. The remainder of the patient population accessed urgent care via TT. We were advised that this will extend to routine care as the TT service at HON develops.

The specific needs of individual were identified as part of TT through the use of DMICP alerts, such as those for vulnerable patients and carers. This meant these patients were promptly identified and prioritised for an appointment. Extended appointment times could also be facilitated. Requests submitted via eConsult were dealt with before TT started in the morning.

All requests for an urgent consultation could be accommodated by a doctor, nurse and medic on the same day. Routine appointments with a doctor could be facilitated within 1 day at HON and within 5 days at MRM. A routine appointment with a nurse was available within 8 days and with the health care assistant on the same day. For medics, a same day routine appointment was available at HON and within 3 days at MRM. Aviation and other medicals were facilitated through a routine appointment.

An urgent appointment with a physiotherapist was available within 1 day and a routine appointment for MRM was 5-10 days and for HON it was 2 days. Follow-up appointments could be accommodated within 4 days at MRM and 3 days at HON. New and follow-up appointments with an ERI were available within 3 days. There was immediate availability for a rehabilitation class.

With the exception of trainees, the Direct Access Physiotherapy (DAP) pathway was available for patients. Although DAP was linked to the TT process, PCRF input to TT had been reduced due to the staff limitations. A DAP audit had been completed to measure uptake and effectiveness.

Multidisciplinary Injury Assessment Clinic (MIAC) appointment times varied based on the availability of MIAC consultant, which had led to delays. Alternatively, the Regional Rehabilitation Unit was available for patients to attend courses within an earlier timeframe.

Home visits were not routinely offered although a request for such would be considered in line with the DPHC home visits policy. Out-of-hours arrangements were displayed on the front doors and in the patient information leaflet.

Listening and learning from concerns and complaints

The practice Warrant Officer was the lead for complaints, which were managed in accordance with the DPHC complaints policy. Both written and verbal complaints were recorded on the DPHC register. Complaints about clinical care were referred to the Principal Medical Officer.

Minutes showed that complaints and compliments were a standing agenda item at practice meetings. Staff provided examples about complaints received and how they were managed. All complaints had been appropriately managed to the satisfaction of the complainant. A complaints audit was undertaken during the inspection and no themes or significant concerns were identified.

Patients were made aware of the complaints process through the practice information leaflet and information about how to make a complaint was displayed in patient waiting areas. Complaints packs were available at reception/patient waiting area.

Are services well-led?

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

Vision and strategy

In 2023, a network was formed between Marham, Honington and Woodbridge medical centres. For geographical and operational reasons, Woodbridge Medical Centre was networked with Colchester Medical Centre in April 2024. An organisational safety assessment in May 2024 confirmed no significant risk with the formation of a combined practice between Marham and Honington medical centres.

The Initial phase of the Marham Combined Medical Practice (MCMP) commenced in June 2024. An internal assurance review (IAR) was undertaken in November 2024 and confirmed essential areas of combining had been completed including a single DMICP patient population, single leadership structure, an integrated Health Assessment Framework (HAF) and a consolidated SharePoint. Full Operating Capability (FOC) of MCMP was confirmed in December 2024. The senior leadership team (SLT) had a positive approach to the combining model and considered FOC as just another milestone and not the end point.

From our conversations with patients, the Commanding Officer (HON), the welfare Warrant Officer and a broad range of practice staff, we determined that a considered and structured approach had been taken to combining the 2 medical centres. An anonymous survey regarding the combining identified some low level concerns. To ensure early 'buy-in' from staff, stakeholder engagement heavily underpinned the change process. The SLT engaged with staff and the wider station communities through regular meetings and 1-to-1 sessions to ensure all staff had the opportunity to voice their concerns and any fears allayed. Staff were encouraged to focus on the benefits and potential of working in a combined practice.

The regional team provided a forecast of planned actions with dates to help staff prepare for the new way of working. Each department was tasked with identifying risks with the combining process and also with integrating the local working practice policies. We heard on numerous occasions that the nursing team 'paved the way' as they were the first department to fully integrate with ease. The nurses perceived the combined model as positive in terms of sharing resources, knowledge and skills. The only negative raised by staff was the loss of identity for HON as the practice name just refers to MRM.

It is noteworthy that the Station Personnel Support Committee (SPSC) mirrored the combined approach by restructuring so there was an integrated leadership team overseeing the SPSC for both MRM and HON.

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

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

Given the different operational demands between the 2 stations, the mission statement for MRM was defined as:

> “To deliver battle winning Air Power to current and future operations”.

For HON, the mission statement was:

> "Delivering Air Force Protection Capability for the RAF and Defence”.

Our findings throughout the inspection clearly demonstrated that the practice was successfully meeting the principles of the mission statements.

To address environmental sustainability, recycling was encouraged and the use of quick response (QR) codes and electronic information rather than printed information. Recycle bins were available and lights were switched off if not needed. Paper cups were used for the water dispenser.

The use of prescribed inhalers was being reviewed to move towards the use of ‘greener’ products. At MRM, a notice was displayed reminding patients to return used inhalers to the pharmacy drop-off recycling service. When MRM deregistered families in 2024, the paediatric medicine stock was sent to Cranwell Medical Centre to minimise wastage.

Leadership, capacity and capability

The SLT team was highly skilled, experienced and worked well together. It was clear they had advanced change management skills, demonstrated by the efficient integration of 2 staff teams and governance systems in a short period of time. Throughout the inspection the SLT exuded positivity and were driven to make service improvements for the benefits of the patients and staff. The SLT adopted a ‘bottom-up’ approach by encouraging the team to contribute ideas to develop the service. They valued the staff, spending time with them to understand their collective and individual needs.

The combined model meant leadership capacity and continuity was maximised. Equally, the model had supported greatly with mitigating periods of reduced staffing levels and/or a surge in workload. Succession planning was considered and planned for, particularly for the SLT in the event any of the leaders deploying.

Both the SLT and wider staff team said the practice was very well supported by the Regional Clinical Director (RCD) and wider regional team.

Culture

From patient feedback, interviews with staff, a review of patient records and outcomes/outputs for patients, we confirmed holistic and person-centred care was key to the principles of the practice. Staff understood the specific needs of the patient population and organised the service to meet those needs. The team often went ‘above and beyond’ to support individual patients and squadrons/units.

All staff we spent time with spoke highly of the SLT, including the inclusive nature of the team. They said morale was good with the doctors indicating team morale was the best it had ever been. Some of the junior staff were apprehensive initially about the combined

model as they found the concept difficult to understand and worried about the impact, such as a potential job change and increased workload. They said multiple SLT-led meetings and informal chats alleviated any fears with everyone kept up-to-date as the combining of MRM and HON progressed.

We heard that this integrated way of working was now the ‘new norm’. Some of the benefits staff mentioned included a better balanced workload, cover for staff absence, access to additional resources and more exposure to different experiences, such as training at Marham airfield for HON staff. A staff survey in February 2025 showed feedback from MRM staff was the best it had ever been. Responses from HON were low in numbers but overall staff were content.

The SLT led by example and the positive team morale was evident throughout the inspection. Staff reported that the practice was a lovely place to work and the whole team worked well together. They told us they were valued and respected by the SLT. There was an open-door policy with everyone having an equal voice, regardless of rank or grade. Some staff had been successful with their request to stay on at the practice after they had been promoted.

The SLT ensured hard work was rewarded with staff In-Year Rewards, Thank You awards, RCD Coins, Commendations and Whitespace activity. A staff ‘stand up’ meeting was held to discuss and arrange social events.

Whistleblowing leads and deputies were in place at both Hon and MRM. All staff we spoke with understood the whistleblowing process and said they would have no hesitation using the policy if they had concerns.

Processes were established to ensure compliance with the requirements of the duty of candour (DoC), including giving those affected reasonable support, information and a verbal and written apology. Displayed for staff to access, DoC is a set of specific legal requirements that services must follow when things go wrong with care and treatment. A DoC register was maintained and a DoC tab was included in the ASER log.

Governance arrangements

The practice Warrant Officer was the lead for healthcare governance (HCG) and the Senior Medical Officer at HON and Practice Nursing Officer deputised. Both clinical and non-clinical governance systems had been successfully integrated and were effectively used to support the smooth operational management of the practice. In relation to MRM, we noted throughout the inspection that there was a reliance on the medical centre by PCRF staff for much of the ongoing governance activity. We raised this during the inspection and the practice Warrant Officer said they would be overseeing the PCRF when the OC physiotherapist deployed shortly. This arrangement will provide the opportunity to identify and address gaps in PCRF governance, including gaps in staff knowledge and skill regarding governance activity.

A clear reporting structure was established and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. Secondary roles were configured to ensure there was a lead and deputy representing both HON and MRM for each secondary duty. Terms of reference for staff were up-to-date.

A wide-range of formal and informal communication channels were established. A comprehensive meeting structure was in place, including singular and integrated meetings. All meetings were combined. There was an integrated approach to coordinating meetings. For example, MRM and HON alternately chaired the practice meetings. Some of the weekly meetings included a multidisciplinary team (MDT) clinical meeting, nurses meeting, HCG team meeting, heads of department meetings. Monthly meetings included the PCRF MDT and practice meeting. HCG and practice meeting minutes were comprehensive and the latter followed the DPHC standardised approach. All meetings were recorded and the minutes added to Sharepoint for staff to access.

Staff said they were given sufficient protected time for administrative and secondary duties. For example, the nurses and the health care assistant had time each week to carry out audits, reviews and to update standard operating procedures.

A programme of quality improvement activity was established to monitor the outcomes and outputs of clinical and administrative practice. The audit calendar for each year along with an audit spreadsheet outlining the status of each audit were in place. Audits were presented and discussed with staff at the HCG and/or practice meeting.

Failure to attend appointments (DNA) was monitored and clearly displayed in reception for patients to see. Appointments not attended resulting in hours wasted was displayed at MRM for each month in 2024. At HON, this information was displayed for the current month. DNA rates were shared with the Chain of Command.

Managing risks, issues and performance

Risks identified for the practice were logged on the combined risk register and kept under scrutiny through review at practice meetings. As staffing levels aligned with high numbers of deployable service personnel (surge in need for occupational health) was a key risk, any forecasted gaps in the workforce were discussed. The combined model had mitigated some of this risk. The infrastructure at MRM was a known risk due to the age and configuration of the buildings, particularly for the PCRF rehabilitation gym. This risk was captured on the risk register along with the action taken by the SLT.

Risk assessments were in-date practice-wide. Significant events and incidents were discussed at practice meetings, including any improvements identified. Processes were in place to monitor national and local safety alerts, incidents, and complaints. This information was used to improve performance.

A combined practice business continuity plan was developed in February 2025 and had been implemented during power outages. Major incident plans (MIP) were in place for each station. The MRM MIP included a role for the medical centre, which had been tested via table top and crash exercises.

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. Staff appraisals were up-to-date.

Appropriate and accurate information

Accessible to all staff, the practice used the HCG workbook to manage and monitor governance activity. In addition, the Health Assessment Framework (HAF), an internal system, was used by the practice as a development tool and to monitor performance. HAF showed good engagement at the self-assessment review and at the IAR. A combined practice management action plan (MAP) was in place to monitor and update action points. The HAF, MAP and practice development plan were discussed and updated at the HCG meeting.

The IAR undertaken in November 2024 resulted in a rating of substantial assurance. Recommendations identified from the IAR had since been actioned.

Arrangements at the practice were in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. The Caldicott Principles, guidelines for the management of patient identifiable information, were displayed. Staff conducted a 10% weekly Caldicott check and raised any concerns to the SLT. The SLT also carried out a weekly Caldicott check. The staff team had completed Defence Information Management Passport training which incorporated the Caldicott principles.

Engagement with patients, the public, staff and external partners

Various options were available to prompt patients to provide feedback on the service, including the DPHC Patient Experience Questionnaire. Complaints and compliment forms were available for patients to complete and submit. A suggestion box was in the waiting rooms. Patient satisfaction surveys were used by the PCRF through QR codes available on clinician desks. A practice-wide patient focus group including the dental centre was held 6-monthly.

Action taken by the practice to address patient feedback was displayed. We were given numerous examples of changes made based on patient feedback. For example, systems had been improved for patients to make contact with the practice, such as through eConsult, email and by telephone. In addition, GOV.UK Notify had been introduced to remind patients about appointments.

The practice worked closely with the Chain of Command, welfare support services and other defence services to ensure a collective approach with meeting the needs of the service personnel population. The PMO attended the local safeguarding meetings.

Staff could provide feedback through the practice meetings and regular staff surveys. Examples of changes made based on staff feedback included a change to the layout the administrative office so it flowed better for Total Triage. It was identified at the HON junior ranks meeting that the duty rota was exhausting so the rota was amended.

Continuous improvement and innovation

The practice team was committed to continually improving the service and this was evident through quality improvement activity. Even though the practice has had additional work with the move to a combined practice model, making improvements to enhance the patient experience had continued, which has been acknowledged throughout the report.

Although there was evidence of innovative practice raised as quality improvement projects (QIP), we identified additional good practice initiatives which had the potential to be raised as a QIP. These included the tracking of injury rates at HON and the approach used to introduce the combined model. Raising ‘purple’ (good practice) ASERs and QIPs and uploading them to the DPHC Healthcare Governance webpage showcases positive performance and also enables the sharing of good practice with other DPHC facilities.