Marham Medical Centre

Kings Lynn, Norfolk, PE33 9NP

Defence Medical Services inspection report

This report describes our judgement of the quality of care at Marham 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 service.

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

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Summary

About this inspection

We carried out an announced comprehensive inspection at Marham Medical Centre on 25 January 2024. The 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 CQC's observations and recommendations.

This inspection 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:

- A person centred culture was embedded to ensure patients received quality and compassionate care to meet their individual needs.
- Patients received effective care reflected in the timeliness of access to appointments, reviews and screening/vaccination data.
- The practice had forged close working relationships within military healthcare, with NHS organisations and with 2 nearby military medical centres in planning how services were provided to ensure that they meet patients' needs.
- Multidisciplinary team meetings were held in the practice on a weekly basis for the doctors and nurses and fortnightly for the rehabilitation staff. Care plans for complex patients were drawn up jointly with other professionals to ensure the best care was provided.
- Processes were in place to identify patients who were considered vulnerable and coding was applied on the patient record. Staff had completed safeguarding training appropriate to their role.
- There was a safe system for the management of specimens and referrals.
- We identified minor deficiencies in the medicines management processes, most were rectified on the day of inspection. However, we raised concerns around the lack of controlled access to the pharmacy.
- The practice had suitable health and safety arrangements in place to ensure a safe service could be delivered.
- Risks to the service were recognised by the leadership team. The main risks outside of the practice's control had been escalated and statements of need submitted. A range of risk assessments were in place for the practice.
- Facilities and equipment at the practice were sufficient to treat patients and meet their needs. However the rehabilitation facilities were not fit for purpose.

- Staff were aware of the requirements of the duty of candour and monitored compliance. Examples we reviewed showed the practice complied with these requirements.

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

- Staff had given up their own time to work on the inside of the building. The 'before and after' photographs evidenced a much improved environment for both patients and staff.
- The practice took steps to protect the environment through recycling and repurposing.

The Chief Inspector recommends to the practice:

- The primary care rehabilitation facility (PCRF) must consider the requirement for emergency equipment for both PCRF locations, especially considering their remote location from the main medical centre building.
- Security arrangements for medicines held in the pharmacy and in clinical rooms throughout the practice should be improved so that there is an effective traceability system in place.

The Chief Inspector recommends to the station:

- Support the practice to improve the infrastructure so that suitable facilities are available to patients undergoing rehabilitation.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Hospitals and Interim Chief Inspector of Primary Medical Services

Our inspection team

The inspection team was led by a CQC inspector. The team comprised specialist advisors including a primary care doctor, a practice manager, a primary care nurse, a pharmacist and a physiotherapist. Two specialist advisors new to the CQC and a colleague from DMSR were also in attendance as observers.

Background to Marham Medical Centre

Located 10 miles from Kings Lynn, Norfolk, Marham Medical Centre provides routine primary care and occupational health care service to a patient population of 2,248 military personnel and their families (although families were no longer able to register and were instead signposted to nearby NHS GP practices). The station is an active operational flying

unit. A Primary Care Rehabilitation Facility (PCRF) situated in a separate building is an integral part of the medical centre and provides personnel with a physiotherapy and rehabilitation service. Entitled personnel based at Swanton Morley were also provided treatment and care at Marham.

The opening hours are from 08:00 to 18:30 hours Monday to Friday. Wednesday afternoons are protected for training, patients can still access services by telephone and urgent patients can be seen. Outside of these hours, patients are signposted to the NHS 111 or 999 service. As a flying station, medical cover is provided 24/7 by a duty medic and Military Aviation Medicine Examiner Medical Officer. Medics triage calls, signpost patients or book appropriate clinical appointments for all persons under care of the medical centre. The duty phone number is detailed in the patient information leaflet and held in the guard room that is manned 24/7. The medical centre also has its own dispensary.

The staff team

Doctors	1 Senior Medical Officer (SMO) 2 Unit Medical Officers (UMO) 2 Civilian Medical Practitioners (CMP) 1 position currently job shared 1 Civilian Medical Practitioner - Locum
Regimental Medical Officer (RMO)	1
Nurses	1 Practice Nursing Officer (PNO) 1 locum nurse (Band 5) 1 Healthcare Assistant (HCA) (Band 3)
RAF medics	13 (DPHC assets, not unit)
PCRF	3 physiotherapists (one officer in command referred to as OC PCRF, one B7 and one military B6) 3 exercise rehabilitation instructor (ERI) (1 is a locum) 1 x Administrator
Practice manager Deputy practice manager	1 1
Pharmacy technicians	2
Administrators	5

*In the armed forces, a medic is a soldier who has received specialist training in field medicine. It is a unique role in the forces and their role is similar to that of a health care assistant in NHS GP medical centres but with a broader scope of medical care.

Are services safe?

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

Safety systems and processes

The practice safeguarding policy was reviewed in January 2024 and included both children and vulnerable adults. The policy was displayed in all clinical rooms and included details for the local Norfolk safeguarding team. Staff interviewed during the inspection were fully aware of the policies and knew how to report a safeguarding concern. Immediate families had previously been able to register at the practice. However, the registration of families had been stopped in July 2023 and they were now signposted to register at an NHS practice.

The status of safeguarding and vulnerable patients was discussed regularly with the welfare team. In addition to informal discussion and the weekly clinical meeting, the needs of vulnerable patients were discussed at the monthly Station Personnel Support Committee meetings attended by the Warrant Officer. We contacted the Welfare Officer for the camp who told us they provided a welfare service to some vulnerable young individuals. They praised the communication with both administrative and clinical staff. We were told that urgent appointment requests had always been accommodated. The practice had also established external links with safeguarding agencies in Norfolk.

The Senior Medical Officer (SMO) was the safeguarding lead with the Practice Nursing Officer (PNO) acting as deputy. Both were trained to safeguarding adults and children level 3. All other staff had completed safeguarding training appropriate for their role (all clinical staff were level 3 trained). Training was delivered through a combination of ‘eLearning for healthcare’ and live online training courses. The SMO regularly attended the local NHS Safeguarding Partnership Board to optimise safeguarding communications with external agencies.

The team made regular contact with all military personnel considered vulnerable. The team had a network of contacts with internal and external services such as the health visitors and Padre. The practice worked closely with the Department of Community Mental Health (DCMH) and the welfare services. We contacted the Padre as part of this inspection to hear that strong links existed with practice staff, communication was excellent and access to urgent appointments were always accommodated.

Vulnerable patients were identified during consultation, DMICP (clinical operating system) searches and on referral from another department such as the welfare team. Coding was applied to clinical records to identify patients considered vulnerable and urgent appointments were offered. A register with restricted access was maintained on DMICP. The register included vulnerable patients and those with safeguarding or welfare concerns. Patients on the register were discussed in the weekly clinical meeting (attended by all clinicians). The Welfare Officer was responsible for updating DMICP with any new information following the meeting.

Chaperone training was captured on induction. Refresher training was provided to maintain knowledge, this had last been delivered in November 2023. Lists of trained chaperones were displayed around the building including at reception. A list was also maintained in the healthcare governance (HcG) workbook. We noted that there was a good mix of male and female chaperones available. The chaperone policy was included in the patient information leaflet.

The full range of recruitment records for permanent staff was held centrally. However, 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. All DBS certificates and professional registrations were checked on a monthly basis and recorded on the HcG workbook. All staff were in-date for DBS and, where required, a professional registration. All staff had Crown indemnity.

Staff were up-to-date with their Hepatitis B vaccination and there was a Hepatitis B register available to view.

A process was in place to manage infection prevention and control (IPC). The current IPC lead was the PNO who linked in with the IPC lead at Woodbridge Medical Centre to support each other's practice. The PNO was yet to complete specific training for the role but was awaiting availability for the 2-day link practitioner course. IPC training was included as part of induction and all staff were currently in-date with training.

Regular IPC audits were carried out including the Defence Primary Healthcare (DPHC) mandated audits that were scheduled into the audit programme. These included the annual audit in October 2023 that identified issues with the infrastructure that were not compliant with best practice. A detailed action plan was raised to address issues identified. The IPC lead had implemented workarounds for each of the issues which met the minimum tolerable requirements for IPC. For example, consultation rooms on the first floor were carpeted so no invasive procedures took place in these rooms and carpet cleaning was being arranged. Areas had been decluttered to allow more effective cleaning and a request had been submitted for soft furnishings to be replaced with wipeable chairs. There were ongoing discussions around a new building but plans had been put back by a minimum of 15 years. The practice had an IPC workbook which included an active issue log and privacy curtain change register. The monthly audits were planned to recommence when the new members of the nursing team had been inducted. The new management team completed a full IPC audit in October 23 and had made numerous improvements since that audit including removal of surplus and non-IPC compliant furniture. The rooms were being painted with IPC compliant paint (on a self-help basis using practice staff). The changes were reviewed in a further full IPC audit carried out in January 2024.

Environmental cleaning was provided by an external contractor. A written cleaning schedule was in place for each room and these were signed off to confirm that cleaning tasks had been completed in line with the required frequency. The building was last deep cleaned in a rolling programme during October and November 2023. Each room was checked by a member of the practice management team and the cleaning manager, these checks were documented. The practice had previously conducted a monthly cleaning audit but this had not been done since June 2023.

Healthcare waste was appropriately managed and disposed of. Clinical waste was monitored daily and when required, orange bags containing waste were secured, labelled and locked in containers awaiting collection. Clinical waste was collected weekly. Waste transfer was recorded by email with paper copies held. Consignment notes were retained by the practice and an annual waste audit carried out in May 2023 showed full compliance. There were two lockable external waste bins located in the airfield ambulance garage. These were locked and secured to the wall. Signed disposal certificates were retained and held on SharePoint.

Three staff members in the Primary Care Rehabilitation Facility (PCRF) were currently providing acupuncture to patients. There was an acupuncture standard operating procedure and risk assessment in place and this had been reviewed regularly and all staff were aware of. Written consent was gained and scanned onto DMICP. Staff we interviewed had appropriate aviation medicine training and were aware of the impact of acupuncture for flying crew (they should not fly for 12 hours after acupuncture).

Gym equipment in the PCRF treatment area was maintained and monitored. Checks on equipment were completed daily. The equipment was new and under warranty so had yet to require servicing .

Risks to patients

The management team believed that the establishment of the practice was adequate for the patient list size. Vacant posts had been filled with temporary healthcare workers whilst recruitment took place. The team told us that staffing levels had been challenging, particularly within the nursing team. With locum support and a loaned nurse from another medical centre in the region, nursing staffing levels were currently at 40%. The recruitment of additional staff had been ongoing and the management team confirmed that they were about to appoint permanent staff to these roles. Most absences were managed using a staff rota. However, nursing was monitored separately to include all nurses in the Valiant Group Practice (an informal networking collaboration between the medical centres at Marham, Honington and Woodbridge).

Despite the staff shortages, we found that access to appointments was good and a system was in place which facilitated same day face to face appointments with a doctor when needed.

Arrangements were in place to check and monitor the stock levels and expiry dates of emergency medicines. We saw evidence to show that an appropriately equipped medical emergency kit and trolley was in place and regularly checked. We identified a number of minor issues that did not present a risk to patients and were rectified on the day. For example, there was a disconnect between which list should be used (hard copy or the list on DMICP). There were a number of items that were showing as out-of-date on DMICP but the physical stocks were all in-date. There was a vehicle that could be used to transport patients from the airfield. The vehicle was clean and stocked with appropriate emergency medicines and equipment. Used daily by a medic and driver to do an airfield run. There was a defibrillator kept in the rehabilitation gymnasium. However, the 2 buildings used by the PCRF did not have direct access to resuscitation equipment within the areas used (of note, there was no defibrillator).

The staff team was suitably trained in emergency procedures, including basic life support (BLS), automated external defibrillator (AED) and anaphylaxis. Annual refresher training in BLS, AED and the use of emergency equipment was mandated for all staff. Annual sepsis training was not mandated by DPHC but an online refresher course had been incorporated into the training programme. All RAF Medics were in-date for 3 yearly Immediate Emergency Care Provider (IECP) which included responding to medical emergencies, the management of thermal injuries and dealing with suspected spinal injuries. Emergency training courses completed by staff online had all been supplemented by face-to-face training delivered by the SMO, by the Warrant Officer (a qualified paramedic) and the PNO (who had a background in Accident and Emergency). Transverse mirrors in the waiting room allowed patients to be observed from the reception desk whilst waiting. The PCRF waiting area could be observed from the reception desk.

Clinical staff had completed their hot/cold injury mandatory training, refreshed in the last 12 months by all staff. Sepsis training had been completed and was also last refreshed in August 2023. The RAF doctors were all trained in aviation medicine and had access to a Flight Medical Officer at Waddington.

The PCRF had historically been understaffed. For long periods in 2023 there was only 1 physiotherapist in the department, significantly reducing capacity for clinical and non-clinical output. To manage gaps, the immediate solution was to recruit a locum. If this was unsuccessful, support was going to be sought from PCRFs within the Valiant network either by patients going to PCRF Honington, or a clinician travelling to Marham to support. This had worked previously for ERI cover. If workforce support options were not available, appropriate plans were discussed to manage output and prioritise caseloads to meet operational and clinical urgency.

The PCRF's infrastructure was a significant issue. The rehabilitation gymnasium was on the first floor, with no lift for patients to access. The heating was broken and had not been on all winter, raising risk for staff and patients. Whilst this had raised on the regional issue log and appropriate mitigation taken (heaters, caution relating to wearing the correct clothing) it still impacted on staff and patient experience. It was reported that in the summer, the rehabilitation gymnasium became very hot. To ensure safety, wet bulb globe testing (a measure of heat stress that considers temperature, humidity, wind speed, sun angle and cloud cover) was used to monitor the environmental conditions .

Information to deliver safe care and treatment

The DPHC standard operating procedure (SOP) was followed for the summarisation of patients' notes. The process for summarising and scrutinising notes was incorporated into the arrival process for patients. This process also included the 3 yearly review of patient notes. DMICP searches and audit provided oversight of notes that required summary or review were used by the PNO. A doctor had provided support due to the shortage of nursing staff. A total of 91% of notes were summarised and those awaiting summarisation were not overdue. There was no formal plan for the remaining 9%, staff were aware and planned to fit them in opportunistically.

A peer review programme of doctors' DMICP consultation records was in place. The doctors used an audit tool to review 10 randomly selected sets of notes for another doctor.

A summary of findings was displayed and any learning outcomes fed back accordingly. The peer review of notes for the nurses was carried out at 6 month intervals. The last one the carried out by the PNO in August 2023 had led to a quality improvement project (QIP); 'the introduction of a synonym for the nursing team' (a synonym was used to prompt clinicians to record consent for a procedure or intervention when there was no Read code or template). Medics did not undertake any routine consultations other than recording basic patient information onto templates. This was highlighted to one of the clinicians and the aim was for a doctor to complete the consultation with the medic in attendance

Co-ordinated by the administration team, a comprehensive and effective system was in place for the management of both internal and external referrals. Managed by the staff in patient services, referrals were sent to the team using a shared task list on DMICP. The referrals register was held in a restricted area on SharePoint with DMICP number as the only identifier. The practice monitored both internal and external referrals. PCRF administrative staff monitored rehabilitation referrals. A review of 2 week wait (2WW) referrals highlighted that the entries were being marked as complete even though the appointment date was not always being recorded. This was rectified during the inspection and we were assured that all 2WW referrals patients had been seen appropriately.

An effective process was in place for the management of specimens and this was supported by an SOP. Specimen requests were clearly documented on records and tracked on a register. The duty doctor checked blood results daily for all requestors and then allocated to the requesting doctor or nurse. Sample results were returned via the PathLinks (electronic link between the pathology laboratory and healthcare professionals) inbox. A review of specimen samples conducted as part of the inspection found that all were up-to-date and there were no gaps where sample results had been missed.

DMICP outages and system freezes presented an issue at Marham. The practice reverted to seeing urgent patients only during any system outage. Clinics were printed daily so the practice knew which patients were due to attend. Packs of paper forms were held in readiness to use during outages with any handwritten notes then scanned onto DMICP at the earliest convenience.

Safe and appropriate use of medicines

There were systems in place for the safe handling of medicines. A number of minor issues were raised during the inspection. Most of these were rectified on the day and did not create any risk to patients. There was an issue with access into the dispensary. Medics could access the dispensary throughout the day and night (when on duty) as they shared the room to store their medicines and equipment. This freedom of access compromised the security and traceability of medicines. In the event of items going missing, it would be difficult to establish the responsible individual.

One of the doctors was the named lead for medicines management and the SMO was deputy. This was reflected in their terms of reference (TORs). The day-to-day management was delegated to the pharmacy technicians and this was reflected in their TORs.

Arrangements were in place for the safe management of controlled drugs (CD), including destruction of unused CDs. We saw that monthly checks had been completed; the CD specimen signature list was complete. The CD cabinet was compliant and access controlled. Destruction certificates had been completed and witnessed.

Emergency medicines were easily accessible to staff in a secure area of the medical centre and all staff knew of their location. The storage of oxygen and Entonox (an inhaled gas used for pain relief) cylinders was safe and the area was clear of clutter. Appropriate signage was displayed on the doors of rooms containing medical gases.

Medication requiring refrigeration was monitored twice a day to ensure it was stored within the correct temperature range. Storage arrangements for the vaccinations were secure and all stock was found to be in-date.

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

Bulk prescription pads were stored securely in the dispensary and detailed in a bound book. There was a system to track their issue and usage to the individual prescriber. Records of receipt and issuing to prescribers were complete and accurate. However, the security arrangements for issued prescriptions were not effective. We found 6 locations around the building where unsecured prescriptions were kept; for example in printers, draws and trays.

Patient Group Directions (PGDs) had been signed off to allow appropriately trained staff to administer medicines in line with legislation. The PGDs were current and signed off by the authoriser (SMO). Medicines that had been supplied or administered under PGDs were in-date. Patient Specific Directions were used at the practice by army medics. A check of 5 patient records confirmed that all relevant sections were fully completed. Three medics were qualified to administer vaccinations and were clinically competent and maintained their portfolios.

Requests for repeat prescriptions were managed in person, email or by e-Consult, in line with policy. Most requests were received into a dedicated pharmacy group inbox, printed by pharmacy technicians and signed by a doctor. Pharmacy technicians did not issue medicines if the medication review date had expired, and instead, referred the request to the prescriber. A process was in place to update DMICP if changes to a patient's medication was made by secondary care or an out-of-hours service. The repeat prescription process was detailed in the practice leaflet and in a poster displayed at the dispensary hatch. However, there was no box situated to post the repeat request when the dispensary was closed.

We saw evidence to show that patients' medicines were reviewed regularly and the doctor's notes in DMICP around medication changes were comprehensive. A doctor reviewed patients on repeat medication every 6 months or sooner if the condition or medication required. Not all reviews were conducted face-to-face as telephone consultations are acceptable in many cases. An audit had been conducted on patients who had been prescribed psychotropic medicines (used to treat depression, anxiety and episodes of psychosis) to ensure that appropriate risk assessments and occupational limitations limiting live firearm use had been applied.

Regular reviews of patients prescribed with antibiotics were conducted bi-annually for both individuals and for the practice as a whole. These audits were carried out by one of the doctors who was the appointed lead.

A process was established for the management and monitoring of patients prescribed high risk medicines (HRM). The register of HRMs used at the practice was held on DMCIP and all doctors and relevant clinicians had access to this. We looked at a sample of patient records and saw that all had been coded, monitored within recommended timescales and had shared care agreements in place. Monthly internal audits of HRMs were conducted to ensure close monitoring of patients.

Track record on safety

Measures to ensure the safety of facilities and equipment were in place. Electrical and gas safety checks were in-date. Water safety measures were regularly carried out with a legionella inspection conducted in August 2019 and reviewed in January 2024. Testing was found to have been carried out in line with recommendations. A fire risk assessment of the building was undertaken in February 2021. Firefighting equipment tests were current. Staff were up-to-date with fire safety training and were aware of the evacuation plan. A land equipment audit completed in July 2023 achieved full compliance with three minor observations. Health and safety leads had completed role-specific Institution of Occupational Safety and Health (IOSH) training.

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

Staff had adopted the current risk template as per DPHC guideline and adopted the 4Ts (treat, tolerate, transfer or terminate) to manage risk. Two staff members had completed the necessary courses to conduct risk assessments and all risk assessments were in-date at the time of the inspection. The practice had an active risk register, an issues log and a transferred risk register (although no risks had been transferred at the time of inspection). The risk register included all the main risks identified during the inspection and the risks were reviewed at the monthly healthcare governance meeting. There was a range of both clinical and non-clinical risk assessments in place along with a lone-working assessment. All the required COSHH (control of substances hazardous to health) risk assessments were in place.

A business continuity plan (BCP) was in last updated in January 2024. The BCP was held in the medical centre and was also available remotely. The BCP linked in with the station major incident plan and staff were clear of their role and responsibilities. A station crash exercise involving the medical centre had taken place in June 2023 (tabletop) and in February 2023 (training exercise). The practice had a role within the ‘unit major incident plan’ and this was articulated in the BCP. A tabletop exercise of the unit major incident plan was scheduled for 30 January 2024.

The medical centre had a fixed alarm system that was tested regularly for both serviceability and response.

Lessons learned and improvements made

All staff had access to the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events and incidents. The ASER lead was the Warrant Officer who was deputised by the resource manager, this was reflected in their TORs. The new management team had developed staff understanding of the ASER process and reinforced that it was a non-blame learning process. The root cause analysis was completed by the management team in the HcG meeting. The ASER was then discussed openly with the whole team in the monthly practice meeting. There was a comprehensive ASER log on the HcG workbook which included details of lessons learned, actions taken and correlated with the Duty of Candour log. ASER numbers had increased since the new management team had arrived demonstrating that the new HcG processes were becoming embedded within the team. Minutes of HcG meetings included a link to the ASER register and a link to the annual ASER review (completed in December 2023). There had been 29 ASERs and 1 notable practice recorded during 2023. Trends identified such as administration errors resulted in increased training and mentorship.

From interviews with staff and evidence provided, it was clear there was a culture of reporting incidents for all staff. Both clinical and non-clinical staff gave examples of incidents reported through the ASER system including the improvements made as a result of the outcome of investigations.

A system was in place for managing patient safety alerts and the pharmacist technicians held responsibility for completing any required action. Recent safety notices were checked and evidenced (in the minutes of practice meetings) as correctly being processed during the correct timeframe. There were no patients recorded as taking Valproate (a medicine used to treat epilepsy that can be harmful to the unborn baby if taken when pregnant). Monthly searches were evidenced as completed in January 2024.

Are services effective?

We rated the practice as good for providing effective services.

Effective needs assessment, care and treatment

Arrangements in place to ensure staff had a forum to keep up-to-date with developments in clinical care and guidance included weekly clinical and monthly healthcare governance (HcG) meetings. The Heads of Department (HoDs) weekly meeting incorporated an agenda item to discuss national clinical guidance, including NICE (National Institute for Health and Care Excellence) and the Scottish Intercollegiate Guidelines Network (SIGN). The SMO (SMO) reviewed the updated NICE guidance and ensured communication to all staff.

Our review of clinical records demonstrated that clinicians carried out assessments and provided care and treatment in line with national standards and guidance, supported by clear clinical pathways and protocols.

Staff were kept abreast of clinical and medicines updates through the Defence Primary Healthcare (DPHC) newsletter circulated to individual staff and to the medical centre each month. Participation with regional events and forums also provided an opportunity for clinicians to keep up-to-date.

Monitoring care and treatment

Long-term conditions (LTCs) were managed by the nursing team within which there was an appointed lead and deputy. Defence Primary Healthcare (DPHC) standard operating procedures (SOPs) outlining the management and monitoring arrangements for LTCs reflected current management at practice level. We looked at a sample of patients' notes, they were comprehensive and in good order. The practice provided us with the following data:

- In accordance with best medical practice guidance, foot checks and retinopathy screening should be take place every 12 months, only 7 out of the 14 patients on the diabetes register had been completed at the time of inspection. These patients were now being recalled for monitoring and processes were in place to identify and monitor patients at risk of developing diabetes.
- There were 43 patients on the hypertension register who were regularly monitored in accordance with best medical practice guidance. A total of 40 patients had a record of their blood pressure taken in the past 12 months and 38 had a blood pressure reading of 150/90 or less. The remaining 3 patients were new to the medical centre and had been recalled for testing.
- There were a total of 42 patients with a diagnosis of asthma, 38 had received an asthma review in the preceding 12 months using the asthma review template. Reviews on the remaining 4 patients were planned.

- Audiology statistics showed 77% of patients had received an audiometric assessment within the last two years. The nursing team and medics had an effective recall process in place, completed the appropriate templates and applied the correct Read codes.

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). The practice followed the DPHC guidance and provided step 1 interventions and immediate referral for appropriate diagnoses.

We saw that referrals to the Regional Rehabilitation Units and Minor Injury Assessment Clinics (MIAC) were made promptly with manageable wait times for the patients. However, this was likely to be impacted going forward as the MIACs had ceased in December 2023.

Wait times for referrals were generally good. However, staff reported long wait times for first appointments with the DCMH. Those patents waiting were assessed by DCMH to prioritise when deemed necessary and monitored by the doctors whilst awaiting the appointment. This was reviewed at least monthly by one of the doctors and an audit had been conducted to look at primary care monitoring for patients on waiting lists for DCMH treatment.

An audit calendar was in place and this extended to and integrated with the primary care rehabilitation facility (PCRF). The practice was engaged with the DPHC regional headquarters audit programme and this was tracked in the HcG workbook. Clinical audits were an integral part of quality improvement. We saw good examples on the day that included a multiple cycle asthma audit (repeated to monitor and drive improvement). Further audits included antimicrobial prescribing, infection prevention and control, high risk medicines and the PCRF had plans to introduce audit of service evaluation.

Effective staffing

There was an induction pack for all new staff that included role specific sections. All staff new to DPHC completed the online DPHC induction. Two induction folders were held and included signed sheets by both the inductee and mentor. New staff inductions were completed within 4 weeks of starting at the practice. Staff were also required to complete a separate health and safety induction. All new doctors were assigned a mentor. The support provided by the mentor included reviews of consultation notes and regular check-ins (daily). Clinical meetings were also used as an opportunity for all staff (including new staff) to bring more difficult clinical consultations to discuss with the rest of the clinical team. Role specific inductions were provided to new nurses. This was a comprehensive induction pack used in conjunction with the DPHC process.

On arrival, locum staff completed the DPHC mandated locum induction programme which has been amended accordingly to include cadres specific elements and information relevant to the unit. According to the staff database, all locums had completed their induction programme and evidence of this was shown at the time of the visit.

RAF medics were not currently MIPs (medic issue protocols) trained and any patient seen by them would then see the doctor for further examination and issue of prescription, if required. MIPs training for medics was included within the practice development plan.

Training completion rates were discussed at the monthly heads of department and HcG meetings and monitored by the Junior Non-Commissioned Officer (JNCO) responsible for the medical stores. Currently the practice was at 96% compliance for mandatory training. Once mandated training expired, staff were individually emailed with their requirements and time was given during normal working hours to complete this. A running board in the crew room detailed completion statistics for mandatory training which encouraged healthy competition and morale, whilst also ensuring mandatory training completion rates remained high. Staff send certificates electronically to the JNCO who updated the staff database and the staff member retained a copy for their records.

The meeting schedule supported continued professional development (CPD) and revalidation requirements through clinical updates, guideline reviews, safeguarding updates and RAF/Defence Medical Services (DMS) specific training.

There was role-specific training for relevant staff. The Warrant Officer was a registered paramedic and had started the return to clinical practice, they had also trained as a DMICP administrator. Two staff members had completed the Institution of Occupational Safety and Health course and were trained risk assessors.

Staff administering vaccines had received specific training which included an assessment of competence. Vaccinators could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to online resources and discussion at nurses' meetings.

Coordinating care and treatment

The Warrant Officer, and when available the SMO, attended the Station Personnel Support Committee (SPSC) meetings (held monthly) at which the health and care of vulnerable and downgraded patients was reviewed (consent from the patient was gained in advance). Due to the nature of the SPSC, no minutes were recorded. Representatives from the practice also attended the unit health and wellbeing meetings.

It was clear that the PCRF was an integral part of the practice. The practice communicated well with staff in the PCRF, meetings were inclusive and governance structures integrated. PCRF staff held multidisciplinary team sessions fortnightly, doctors attended these to enable effective clinical pathway discussions. Additionally, the Valiant joint practice initiative provided opportunity for effective, consistent communication between PCRFs and their clinicians. Since December 2023, there has been no doctor at the Regional Rehabilitation Unit (RRU), so the MIACs had ceased. The Band 7 physiotherapist had also recently left, meaning that once the doctor returned, the clinics would not be MIACs. All new patient assessments were now having to be seen at RRU Colchester, approximately 2 hours from RAF Marham.

For patients leaving the military, pre-release and final medicals were offered. During the pre-release phase, the patient received an examination and a medication review. A

summary print-out was provided for the patient to give to the receiving doctor, and a letter if the patient was mid-way through an episode of care. In addition to this, a thorough 'exiting service pack' was available and provided a thorough 'how to' guide. If a patient leaving the military had a complicated medical problem, a doctor at the practice arranged a handover to the receiving NHS surgery or to a DPHC practice closer to the patient's home address. Patients were also given 6 months of repeat medication if required. This allowed them to register with a new NHS practice and gave sufficient time to get an appointment for review.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred or after they were discharged from hospital. Information was shared between services and we saw that a full copy of findings from investigations and any further treatment requirements were sent to the medical centre to update the patient's records. Links were established with NHS GP surgeries where family members of serving personnel were registered. Other services where good links had been forged included the Integrated Contraception and Sexual Health services in Norfolk, the NHS Norfolk and Waveney safeguarding teams and the Norfolk and Norwich Hospital.

Helping patients to live healthier lives

The practice had a named lead and deputy for health promotion. There was a structured programme of health promotion activity with a yearly planner aligned with the DPHC calendar. The health promotion displays were comprehensive, clear and positioned in reception. At the time of inspection, there was a 'Dry January' promotion featured on the noticeboard. Staff has been involved in supporting health fairs and linked in with station health promotion work such as the annual 'health and wellbeing day'. PCRF staff intended to re-start unit-wide health and wellbeing meetings now that there were sufficient staff numbers.

A nurse with specific training (STIF) took the lead on sexual health training and provided sexual health support and advice. Patients were signposted to a local NHS sexual health clinic for procedures not undertaken at the medical centre. Posters to promote the service were displayed in the building and staff were aware so could signpost patients. Patients could obtain a self-test kit online and condoms were available from the practice (discreetly positioned in the toilet).

The number of eligible women whose notes recorded that a cervical smear had been performed in the last 3-5 years was 216 which represented an achievement of 92%. 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. At the time of the inspection there were a small number of patients identified that met the criteria for screening. A recall system was in place that monitored uptake and those eligible were in-date for screening.

Patients due a vaccination were identified when summarising patient notes. The units were responsible for ensuring their individuals booked in for their own vaccines. Force protection performance was high with vaccination statistics identified as follows:

- 94% of patients were in-date for vaccination against polio.
- 94% of patients were in-date for vaccination against hepatitis B.
- 96% of patients were in-date for vaccination against hepatitis A.
- 94% of patients were in-date for vaccination against tetanus.
- 99% of patients were in-date for vaccination against MMR.
- 99% of patients were in-date for vaccination against meningitis.
- 94% of patients were in-date with vaccination against diphtheria.

  * there was no requirement for the medical centre to undertake a pro-active catch up programme for permanent staff. However, they did a periodic vaccine recall and push in line with NHS guidance.

The recall process for routine vaccinations was on hold at the instruction of the regional clinical director. Once nursing capacity increased, the plan was to reintroduce this. However, recalls continued for those on high readiness or deploying.

Child Immunisation

The practice had a system in place to contact the parents or guardians of children who were due to have childhood immunisations. The practice has exceeded the WHO based national target of 95% (the recommended standard for achieving herd immunity) for 1 childhood immunisation uptake indicator. For the 4 indicators where the national target was unmet, the practice could explain that this was down to awaiting essential information about a newly registered child's vaccination history. Results are below:

Child Immunisation	**Practice %**	**Comparison to WHO target of 95%**
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB)	100%	WHO target met.

The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster)	90%	WHO target of 95% not met. There was 1 of the 10 patients who was under specialist advice and had to pause vaccinations).
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster)	90%	As above.
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR)	90%	As above
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR)	94%	Met 95% WHO target of 95% not met. There was 1 of the 10 patients who was delayed with their vaccination programme from being out of area.

Consent to care and treatment

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. There was a consent policy in place for the combined Valiant network group. A review of patient notes evidenced that verbal consent was recorded and coded appropriately on DMICP. Written consent forms were to be used for minor operations and acupuncture. Consent recording formed part of peer review and audits were carried out. The chaperone training module included a section on obtaining and recording consent.

Clinicians had a good understanding of the Mental Capacity Act (MCA) (2005) and how it would apply to the population group. Posters were displayed in every clinical room to inform on the basic principles of the MCA. Although not mandatory, MCA training for all staff was planned in for March 2024. The clinicians stated that they had not had any recent examples of seeing a patient who lacked capacity but mental capacity was assessed for all patients when consulting to ensure they had the capacity to make their own decisions and participate in discussion around their treatment and care.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

In advance of the inspection, patients were invited to give feedback using comments cards. A total of 24 patients responded and feedback was positive. We also observed staff being courteous and respectful to patients in person and on the telephone. The overriding theme was that staff were friendly and helpful.

Patients could access the welfare team and various support networks for assistance and guidance. 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.

The GPAQ (governance, performance, assurance and quality) patient experience survey (15 responses) showed 100% of patients fed back ‘excellent’ or ‘good’ when asked if they had been treated with kindness and compassion.

Involvement in decisions about care and treatment

Patients with caring responsibilities and cared for patients were identified through the new patient registration form and at new patient medicals. New patients identified as carers were offered an initial appointment with the nurse (the carers lead would make contact to discuss their specific requirements). Patients identified as having a caring responsibility had an alert on their notes and were captured on a DMICP register. Priority appointments were given to patients with caring responsibilities when required.

There was a carer’s champion for the practice. Staff had access to a carers’ policy which included their entitlements to care and any other relevant information for both within the RAF and external support services in the local area. The carers’ register was held within the vulnerable adult and child register. The carer’s champion carried out monthly reviews of all patients identified as cared for or as having caring responsibilities

Staff could access ‘The Big Word’ translation service if they needed it and there was a sign to inform patients of the translation service. Staff told us that there had been no requirement to use the service in recent years.

The GPAQ patient experience survey showed 100% of patients fed back ‘excellent’ or ‘good’ when asked if they were given clear information.

Privacy and dignity

Screening was provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. Clinic room doors were closed during consultations.

The primary care rehabilitation facility (PCRF) occupied a separate building to the main medical centre building (used by the exercise rehabilitation instructors) with clinical rooms that provided privacy for patients.

The reception area was separate to the waiting area meaning that conversations between patients and reception would unlikely be overheard. If patients wished to discuss sensitive issues or appeared distressed at reception, they were offered a private room to discuss their needs. This was supported by clear signage at the reception hatch. Telephone consultations were undertaken in private to maximise patient confidentiality. There was a television in the waiting area that provided background noise to promote privacy. There was a sign that requested patients to stand back from the hatch at reception and patients were offered a private area for confidential conversations.

The GPAQ patient experience survey showed 100% of patients fed back 'excellent' or 'good' when asked how well their privacy and dignity was respected.

The staff team were still in-date with their data management awareness courses to ensure awareness when handling personal information.

The mix of male and female staff allowed the medical centre to facilitate patients who wished to see a clinician of a specific gender. This included patients booking into the PCRF. There was no female physiotherapists or exercise rehabilitation instructor but requests could be accommodated by signposting patients to an alternative military medical centre in the region. There was a confidentiality concern in the rehabilitation gymnasium where one of the exercise rehabilitation instructors was working out of a makeshift area within the gym. Although mitigation was in place, awareness and capture of the issue could be improved.

Are services responsive to people's needs?

We rated the practice as good for providing responsive services.

Responding to and meeting people's needs

The practice used an appointment system where patients could be seen in person or by phone. Home visits were provided in rare circumstances when a patient was house bound through ill health but was not in need of emergency treatment. The details around home visiting were detailed in the patient information leaflet. Requests for a home visit would be assessed by a doctor on a case-to-case basis. The eConsult service was used to provide more convenient access to information and advice whilst prioritised patients in need of urgent care could be seen in person.

An access audit as defined in the Equality Act 2010 had been completed for the premises in December 2023. No issues were identified. The building and surrounding area including the car park supported access for those with reduced mobility. There were disabled parking spaces close to the entrance, a dropped kerb and automatic opening front doors. Inside the building, there was an accessible toilet and baby changing and breastfeeding facilities. However, the Primary Care Rehabilitation Facility was having to use an area that could only be accessed using stairs.

A hearing induction loop was available at reception although staff reported that there had been no need to make use of it. A wheelchair were available for any patient that may need support due to limited mobility.

Dependant on the patient's clinical need, the option of a telephone or face-to-face appointment or e-mail reply could be offered. The practice found this system to be highly effective for patients to gain access to appointments so had continued once COVID-19 restrictions relaxed. Telephone consultations had become commonplace, a doctor's routine daily clinic was a mix of face to face and telephone conversations. Aircrew specific medicals were provided. Occupational health clinics were available to aircrew and after school appointments were accommodated for children. Patients from Swanton Morley had a walk-in service available on weekdays.

The designated diversity and inclusion (D&I) lead was based at regional headquarters and the deputy came with the role of junior non-commissioned officer for medical stores. The contact details were displayed on a poster in the patient waiting area. There was a transgender policy reviewed and evidenced in May 2023. All staff (military & civilian) were in-date for their D&I mandated training.

The practice had taken a number of measures to have a positive impact on the environment. Waste was segregated to improve recycling, signs instructed staff to turn off lights when rooms were not in use. The use of paper was reduced by using electronic communications such as emails and the use of the shared healthcare governance workbook as a source of information. It was planned to move patients (where possible) to inhalers that were less harmful to the environment.

Timely access to care and treatment

The practice opened Monday to Friday 08:00-18:30. Due to it being a flying station, medical cover was provided 24/7 by a duty medic. Medics would triage any call and signpost patients or book them in for an appointment at the practice. The duty phone number was also held in the guard room that was staffed 24/7. The dispensary opened each weekday morning from 08:30 to 10:00 and 10:30 to 12:00. Afternoon opening hours varied and the dispensary closed on a Wednesday afternoon.

Details of how patients could access the doctor when the practice was closed were available through the patient information leaflet, on the main entrance to the building and on the recorded message relayed when the practice was closed. Details of the NHS 111 out-of-hours service was in the patient information leaflet and instructions were displayed on the doors at the main entrance so could be seen when the practice was closed.

There was good availability of appointments for all clinicians. For example, urgent slots with a doctor were available on the day and routine appointments within 3 working days. To accommodate urgent requests, a good number of same day appointments were available. An appointment with the nurse could be secured the same day and a routine appointment within 3 days. Staff we interviewed spoke of recent challenges with nursing appointment availability. The leadership team had effectively managed this challenging period by prioritising treatment and care with a focus on high readiness and deployable personnel. The wider patient group had been managed concurrently being supported by the other medical facilities in the region.

New patient appointments were available within 5 days to see a physiotherapist. Urgent physiotherapy appointments were available within 1-2 days. The wait times to see an exercise rehabilitation instructor (ERI) were the same. Rehabilitation classes were provided and there was sufficient access for patients who wished to book. Despite the significant workforce challenges, the PCRF had dedicated their output to support their patients, maintaining excellent access to physiotherapy and ERI services. This provided patients with rapid access (consistently performing better than the key performance indicator targets) and enabled the PCRF team to effectively support the high operational demand of this main operating station. This drive was an underlying theme during the inspection. The practice planned to reintroduce the 'direct access to physio'' service.

The GPAQ (governance, performance, assurance and quality) patient experience survey (15 responses) showed 100% of patients fed back 'excellent' when asked how easily they were able to access services.

Listening and learning from concerns and complaints

There was a named lead (Warrant Officer) and deputies for the management of complaints. The process followed was in accordance with the DPHC complaints policy and procedure. Written and verbal complaints were recorded and discussed at the monthly practice meetings together with any compliments that had been received. There had been an insufficient number of complaints recorded historically to trigger an audit but the lead was aware of the threshold and an audit was planned for September 2024.

We reviewed a sample of the 6 complaints received by the practice since September 2023 (no complaints had been recorded by the previous management team between February 2022 and September 2023) and looked at 1 complaint in detail. Appropriate actions were taken within the timescales set out in the complaints policy.

Information on the complaints process was displayed on posters around the medical centre and further information was included in the patient information leaflet. In addition, there were complaints packs positioned in the patient waiting area.

Are services well-led?

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

Vision and strategy

The practice 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’.

Marham Medical Centre had written their own mission statement which was specific to their role on station. This was ‘to provide a high standard of holistic primary care to our entitled patients by working together as a cohesive multidisciplinary team.’

Throughout the day it was clear that this mission statement was relevant, meaningful to staff and central to decision making.

There was a formal practice development plan included in the healthcare governance (HcG) workbook. There was a strong focus on patient care and staff wellbeing and development. There was a plan to introduce ‘total triage’ in 2024. Total triage is a system designed to improve efficiency by taking information from the patient by telephone to assess the need for treatment before offering a face-to-face appointment.

Leadership, capacity and capability

The practice had been through a time when a number of positions in the established team were not filled. This had impacted service delivery in the preceding 12 months. However, we found a team who had gained resilience and had focussed on providing the core services to keep patients safe whilst providing support to other medical centres within the region. The new management team were experienced and knew each other well through having previously worked together. They had brought the team together quickly and effectively. There was a strong team ethos which was evident throughout the inspection. Staffing levels were improving which will provide additional capacity and resilience. The ‘Valiant Group Practice’ was informal (with a plan to formalise by the end of 2024) and provided backfill for deployments of key personnel to ensure consistent leadership. For example, the Senior Medical Officer (SMO) and Warrant Officer at Marham would be supporting Honington Medical Centre when their SMO and practice manager deployed. To support the practice, the Practice Nursing Officer (PNO) had been protected from deployment temporarily until nursing staff returned to the established levels.

There was a comprehensive meeting structure that underpinned the governance structure and promoted an inclusive leadership approach. Staff we spoke with consistently praised the leadership and this was echoed in the feedback from affiliated staff and patients. It was apparent from walking round the medical centre and discussions with staff that there was a high level of respect and support across all levels/ roles and professions within the team.

Staff felt well supported by the regional team and stated that support was provided when required.

Culture

Staff were consistent in their view that the practice was patient-centred in its focus.

We heard from staff that the culture was inclusive with an open-door policy and everyone having an equal voice, regardless of rank or grade. All were familiar with the whistleblowing policy and said they would feel comfortable raising any concerns. The new management team had conducted a staff safety climate survey in November 2023 which evidenced that 20 out of 27 respondents agreed or strongly agreed that they could approach their manager with any concerns that they had. The survey also contained positive comments from staff surrounding improvements in management.

The monthly meetings were inclusive with all staff encouraged to attend. Staff felt involved in decisions made and were comfortable in raising any concerns or issues within their department. Group team building exercises were held regularly. Staff welfare was seen as a priority. Every Thursday morning, all practice staff gathered for ‘tea and toast’, an established teamwork event that was positively referenced throughout the inspection.

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. We were provided with examples of when duty of candour had been applied.

Governance arrangements

A comprehensive understanding of the performance of the practice was maintained. The system took account of medicals, vaccinations, cytology, summarising and non-attendance. A Healthcare Governance Assurance Inspection had not taken place since 2020. The management team had engaged with regional headquarters healthcare governance colleagues and had agreed that a complete re-write of the eHAF (electronic health assurance framework) was required and would commence after this inspection. The eHAF was used to document and evidence governance activity and had been extensively populated by the management team and other key staff members.

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 (ToRs) 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 HcG workbook which included various registers and links such as the risk register, ASER tracker, duty of candour log, IT faults and cleaning issues log. A range of information was accessible though quick links from the HcG workbook. These included clinical guidelines, ASERs, risk assessments and the standard operating procedure index. The workbook was continually being developed and was managed by the Warrant Officer.

An audit programme was in place and the primary care rehabilitation facility's (PCRF's) planned audits for 2024 were integrated with this.

A range of meetings with defined topics for discussion were held to ensure a communication flow within the team. The practice had a designated meeting matrix in place which included the following:

- Station Executives meeting held weekly.
- Heads of Departments (HoD's) meeting held weekly.
- Full practice meetings held monthly.
- Fortnightly MDT (multidisciplinary) team meetings.
- Weekly clinical meetings.
- Healthcare governance (HcG) meetings held monthly with HcG Working Group meetings held weekly in between.
- PCRF meetings were integrated (included representation at HoDs meeting, HcG Working Group, practice and clinical meetings) and doctors attended the multidisciplinary team meetings held in the department.
- Nursing clinical meetings.
- In-house training held (protected time allocated).

Staff told us that these formal meetings were supplemented by a twice monthly 'stand up meeting'. These were a short 15 minute meet-up to discuss and share urgent information.

Managing risks, issues and performance

Processes were in place to monitor national and local safety alerts and incidents. We checked recent safety notices and found evidence that they had been correctly processed in a timely manner. Practice meeting minutes made reference to recent alerts and these were available online to all staff.

An effective process to identify, understand, monitor and address current and future risks including risks to patient safety was in place. Risks to the service were well recognised, logged on the risk register and kept under scrutiny through review at the practice meetings. There was a range of both clinical and non-clinical risk assessments as well as a lone working assessment. All the required COSHH risk assessments were in place. The Practice had not applied the 4Ts (tolerate, treat, transfer and terminate) to their risks but this was rectified during the inspection.

Risks were actively monitored and managed in line with DPHC policy and through the ongoing review and revision of a risk register. Risks were escalated as appropriate to DPHC and beyond. Where relevant/applicable, risks were raised by the SMO with the Station Commander/executives and if needed, were added to the station's risk register. The risk register was discussed at the monthly HcG meeting. There were a number of issues in the PCRF that were not captured within the 'risks and issues logs, these included inappropriate access to and confidentiality issues in the rehabilitation gymnasium and lone working.

Appraisal was in-date for all staff. Although there had not been a need to use, the leadership team was familiar with the policy and processes for managing under-performance. Welfare support, training and mentorship would be offered initially. If all other processes had been exhausted, disciplinary action would be considered if appropriate.

A business continuity and major incident plan was in place and reviewed annually as a minimum, the last review took place in January 2024. The plan was available for remote access and to all staff through inclusion on the HcG workbook. The plan was tested annually, this alternated between a tabletop exercise and a simulation event.

Appropriate and accurate information

Quality and operational information was used to ensure and improve performance. The DPHC electronic health assurance framework (referred to as eHAF) was used to monitor performance. The eHAF is an internal quality assurance governance tool to assure standards of health care delivery within defence healthcare.

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

Patients had a number of options to give feedback. These included an ongoing patient survey and a comments book in the waiting area (there had been no entries). The establishment of a patient participation group was planned for 2024.

The practice used the Governance, Performance, Assurance and Quality (GPAQ) questionnaire to obtain and correlate patient feedback. The patient feedback was positive but there had been very few respondents (17 in total for the last 6 months). The management team aimed to encourage more responses by initiating text message links to the survey that would be sent to all patients who attended for an appointment.

The PCRF conducted their own patient survey. Last compiled in 2023, we saw that the feedback was predominantly positive and there was a high level of satisfaction in addressing healthcare needs. For example, 100% of respondents said that they would recommend the PCRF.

Staff were surveyed in November 2023 and it was planned for this survey to repeated quarterly.

Good and effective links were established with internal and external organisations including the Welfare Officer, Regional Rehabilitation Unit, Department of Community Mental Health (Digby). Medical staff attended the Station executive's meetings and the monthly Station Personnel Support Committee meetings. The Padre attended the Thursday 'tea and toast sessions' and the Station Commander provided positive feedback to us on the engagement from the practice staff. Safeguarding links were in place with local teams and local NHS GP practices.

Continuous improvement and innovation

The new management team were working to improve understanding of quality improvement projects (QIPs) and relevant audit. There was an active QIP register in place with input from across the team including the PCRF. The Practice operated a whole team approach to improvement through open team discussions and meetings. We identified that the medical centre had a comprehensive plan that was integral in driving improvement. Quality improvement projects (QIPs) had been recorded on the HcG Workbook. Of note:

- The infrastructure of the building had been addressed by long-term aspirations that statements of need had been submitted for (removal of carpets in clinical rooms, air conditioning units for all clinical rooms, new cabinetry for the pharmacy and the complete refurbishment of 3 rooms). In the interim, the practice team had made a concerted effort to do the best with what they had. Staff had worked in their spare time to declutter the building of significant amounts of surplus furniture (5 van loads) and decorate to improve the environment for both staff and patients.
- Improvement of access to restricted areas of the station in case of a medical emergency. Pass forms had been submitted to gain access to a restricted area after delays were experienced as staff had to wait for an escort before being allowed in to deliver treatment.
- An online form was planned to include all details required for deployment. This would enable a more efficient process when ensuring personnel are fit to deploy.
- A review of staff bonus/award schemes. Two of the civilian staff members had been put forward for the Regional Clinical Director 'coin award'.
- The PCRF were working on the introduction of 'First Contact Practitioner' physiotherapist utility. This would see 2 physiotherapists expanding their role to reduce the reliance on doctors for external referrals and investigation access. The implementation of this service would be part of a Defence-wide trial and see Marham at the cutting edge of musculoskeletal delivery. The intent was to commence the trial in April 2024 when the practice rolled out their total triage initiative.