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, and information given to us from the provider and patients.

### Ratings

<table>
<thead>
<tr>
<th>Overall rating for this service</th>
<th>Good</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are services safe?</td>
<td>Good</td>
</tr>
<tr>
<td>Are services effective?</td>
<td>Good</td>
</tr>
<tr>
<td>Are services caring?</td>
<td>Good</td>
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<tr>
<td>Are services responsive to people’s needs?</td>
<td>Good</td>
</tr>
<tr>
<td>Are services well-led?</td>
<td>Good</td>
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</tbody>
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Summary of findings

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced inspection at Regional Medical Centre RAF Marham on 27 February 2018. Overall the practice is rated as good. Our key findings across all the areas we inspected were as follows:

- There was an open and transparent approach to safety. An effective system was in place for managing significant events and staff knew how to report and record using this system. There was an innovative approach to managing minor incidents that did not need to be escalated as significant events, but where learning could be promoted and shared.

- Safeguarding arrangements were effective and well managed. The practice knew which of its patients were vulnerable and proactively ensured that a good level of support was available through a strong partnership arrangement with key stakeholders.

- The assessment and management of risks was comprehensive, well embedded and recognised as the responsibility of all staff.

- The arrangements for managing medicines, including obtaining, prescribing, recording, handling, storing, security and disposal in the practice minimised risks to patient safety. There was a robust and consistent approach to the monitoring of patients on high risk drugs.

- Staff were aware of current evidence based guidance. Staff had received training so they were skilled and knowledgeable to deliver effective care and treatment.

- The practice promoted better health outcomes for patients. For example, a recent practice display around prostate cancer had led to swift diagnosis in a patient who saw the display and is now in recovery.

- There was evidence to demonstrate quality improvement was embedded in practice, including a programme of clinical audit and quality initiatives used to drive improvements in patient outcomes.

- Despite significant gaps in current staffing resource, the staff team had pulled together to manage risks on a daily basis and to ensure that no issues of importance were overlooked. As a result, patients received a safe and effective service.

- Results from the Defence Medical Services (DMS) patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.

- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.

- Patients we spoke with said they found it easy to make an appointment with urgent appointments available the same day. Home visits could be requested and we noted examples
where home visits had been made to ensure the safety of vulnerable patients and babies.

- Facilities and equipment at the practice were sufficient to treat patients and meet their needs.
- There was a clear strong leadership structure and staff felt engaged, supported and valued by management. Staff told us they enjoyed working at the practice and, as a result, they went the extra mile to offer good care.
- The practice had robust and comprehensive governance systems in place. They were embedded in practice and all staff understood their role and responsibilities in the governance structure.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.
- The practice was taking action to address the issues they had identified with the building. Paint was flaking off consultation room walls and we noted damp, rust and mould in the patient toilets, which presented an infection control risk.

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

- Paediatric attendance at Accident and Emergency departments was routinely monitored by the Senior Medical Officer to identify any trends, ensuring that children were protected in line with best practice safeguarding guidelines.
- Guidance for staff around home visit management had been developed and implemented in the form of a traffic light Standard Operating Procedure for the duty medical officer and reception staff. This meant that vulnerable patients were offered the most appropriate care in the most timely way. We have not routinely seen this approach at other DMS GP practices.

The Chief Inspector recommends:

- Ensure that training records are up to date for all staff and that POPMAN training (a clinical search facility) is delivered to staff who require it.
- Staffing levels were 54% on the day of this inspection. The Regional Management Team should review the gaps and consider ways to increase staffing levels in order to reduce the burden on staff who were working beyond their normal hours to deliver good care.
- Extend the programme of audit and improvement work to include administrative audits to give reassurance that processes and procedures are working in practice.
- Ensure that effective long term conditions management underpins the best outcomes for patients, specifically smoking cessation and asthmatic reviews.

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice
Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**
The practice is rated as good for providing safe services.

- The practice prioritised safety. An effective and robust system was embedded for reporting and recording significant events. Significant events and also minor incidents were reviewed at team meetings and lessons were shared with the wider staff team.
- The practice had clearly defined systems, processes, and practices in place to keep patients safe and safeguarded from abuse. Staff were appropriately trained, they knew which patients were vulnerable and they worked closely with other military stakeholders to deliver proactive support.
- The SMO routinely monitored all paediatric attendances at A&E to identify trends and protect young patients.
- When things went wrong patients were engaged and received reasonable support, relevant information, and a written apology.
- Risks to patients were assessed and well managed to minimise risks to patient safety.
- Comprehensive protocols and guidelines to cover the dispensing of medicines were in operation.
- Effective recruitment processes were in place. However staffing levels were effectively 54% of establishment at the time of this inspection.
- The practice had adequate arrangements to respond to emergencies and major incidents.

**Are services effective?**
The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were in line with other military practices.
- Practice staff assessed needs and delivered care in line with
current evidence based guidance.

- Clinical audit took place and led to improved patient outcomes. However there was scope to embed a rolling programme of improvement work to deliver ongoing improvement.
- The practice valued and encouraged education for all practice staff giving them the skills, knowledge, and experience to deliver effective care and treatment.
- Patients were actively supported to live healthier lifestyles through a targeted and proactive approach to health promotion and wellbeing.
- Most registered patient records had been summarised.
- There was evidence of appraisals and personal development plans and support for all staff.

**Are services caring?**
The practice is rated as good for providing caring services.

- Patients were treated with compassion, dignity and respect, and were involved in decisions about their care and treatment.
- The patient’s experience survey demonstrated that patients were satisfied with the care and attitude of staff at the practice.
- Information for patients about the service available was accessible.
- Systems were in place to maintain patient and information confidentiality.
- We received four comment cards and interviewed five patients. All of the feedback was positive about the standard of care received.

**Are services responsive?**
The practice is rated as good for providing responsive services.

- The patient’s individual needs were central to the planning and delivery of their individual care.
- The service was flexible to ensure patients’ needs were met in a timely way.
- Patients found it easy to make an appointment and urgent appointments were available the same day. Appointments for children were available outside school hours.
- Telephone consultations were provided as an alternative to visiting the practice.
• Patients could select the gender of clinician they wished to be seen by.

• Eye care and spectacles vouchers were available to service personnel at the medical centre.

• Transport for patients to hospital appointments was available if needed.

**Are services well-led?**

The practice is rated as good for providing well-led services.

• The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.

• There was a strong leadership structure and staff felt engaged, supported and valued by management.

• Clinically and management led governance structures and systems were embedded and took account of current models of best practice.

• There were effective systems and processes in place to identify and monitor risks to patients and staff, and to monitor the quality of services provided. Regular practice and multi-disciplinary team meetings took place, which supported effective communication and shared learning within the team.

• The practice was aware of and complied with the requirements of the duty of candour. A culture of openness and honesty was promoted at the practice.

• The practice proactively sought feedback from staff and patients, which it acted on.

• There was a strong focus on continuous learning and innovation at all levels.
Our inspection team

Our inspection team was led by a CQC inspection manager. The team included a GP specialist adviser, a practice nurse specialist adviser and a practice manager specialist adviser.

Background to Regional Medical Centre RAF Marham

Regional Medical Centre RAF Marham is located in the military station in the small town of Upper Marham near Kings Lynn. The medical centre operates over two floors.

The medical centre offers care to both service personnel and their dependants, including children. At the time of inspection, the patient list was approximately 3060, including 2160 service personnel and 900 dependants (550 of which are children). Patients are predominantly aged 18 to 55 years. Occupational health services are also provided to service personnel and reservists.

In addition to routine GP services, the medical centre offers travel advice, a Well Woman clinic, antenatal clinic (provided weekly by a community midwife), chronic disease management, smoking cessation, over 40’s health screen and family planning advice. Childhood immunisations and vaccinations are also offered at the medical centre.

At the time of our inspection the staffing establishment was 48 staff. However the practice was operating with only 54% of this staff resource in place. This was due to staff having been deployed, vacancies, gapped posts (vacancies which could no longer be recruited to) and staff on maternity leave. On 27 February 2018, the staff team comprised a mix of military and civilian staff, including a Senior Medical Officer (SMO) and three civilian GPs who were employed on a locum basis. Four GP posts had been gapped and so could not be filled. Four practice nurses were in post and there were 11 medics (the work of a military medic has greater scope than that of a health care assistant found in NHS GP practices). The medical centre was led by a practice manager supported by five administrative staff. Located in a nearby building and integral to the practice team, was the primary care rehabilitation team consisting of three physiotherapists and three exercise rehabilitation instructors (ERI). The two permanent pharmacy technicians were not on site on the day of the inspection. One is due to return to Marham in March 2018. Locum provision was provided to cover the Manning. There was a good gender balance in the clinical team so patients had a choice of whether they were seen by a male or female clinician.

The medical centre was open from 08:00 to 18:30 hours Monday to Friday. The practice closes for an hour over lunch and is closed to routine enquiries from 17:00 until 18:30. The practice closes on Wednesday afternoons. However urgent enquiries can be made during these times and a duty doctor is on call. Between 18:30 and 08:00 hours and on bank holidays and weekends, patients are advised to contact NHS 111 who can refer to clinics in both Kings Lynn and Downham Market. The dispensary opening times were displayed at the practice and in the practice leaflet.
Throughout this report the medical centre will be referred to as ‘the practice’.

**Why we carried out this inspection**

The DMS are not registered with the CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014 and are not required to be. Consequently DMS services are not subject to inspection by the CQC and the CQC has no powers of enforcement. This inspection is one of a programme of inspections that the CQC will complete at the invitation of the Surgeon General in his role as the Defence Authority for healthcare and medical operational capability.

**How we carried out this inspection**

Before visiting, we reviewed a range of information about the practice.

We carried out an announced visit on 27 February 2018. During our visit we:

- Spoke with a range of staff including, the SMO, two doctors, the practice manager, three practice nurses, a locum pharmacy technician and three administrative staff.
- Spoke with five patients who were attending the practice during the inspection.
- Reviewed four comment cards completed by patients who shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment.
- Looked at information used to monitor the quality and safety of services.

To get to the heart of patients’ experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people’s needs?
- Is it well-led?
Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- There was a dedicated lead to oversee significant events. Staff were familiar with policy and with using the standardised Defence Medical Services (DMS) wide electronic system (ASER) to report, investigate and learn from significant events, incidents and near misses. All staff told us there was a strong culture of reporting and learning from incidents at the practice. Significant events were also a standing agenda item at the monthly practice meetings and also healthcare governance meetings.

- An innovative approach called an ‘issues register’ had been implemented to capture and promote learning resulting from, not only significant, but also minor events, incidents and near misses. Staff escalated and discussed all events and incidents in order to decide whether escalation to the ASER (electronic reporting system) was appropriate. One member of staff was responsible for recording and promoting shared learning from all minor and more significant events across the staff team. Eighteen such events had been identified and managed over the last 12 months. Staff provided a number of examples and described how the incidents were managed. They highlighted any changes made as a result of the investigation. For example, a significant event in relation to a sample not being received from the lab had resulted in weekly searches to chase missing samples. We saw a number of issues raised around patient information being incorrectly placed into other patient’s records. A cause had been identified and mitigating action had been taken, Caldicott principals were referenced and new processes introduced to mitigate future reoccurrence.

- We reviewed safety records and national patient safety alerts, including the minutes of meetings where these were discussed. The pharmacy technician had an overview of the alerts and was the lead for circulating safety alerts for action to the wider staff team. Alerts were discussed at healthcare governance meetings. A register of alerts received at the practice was maintained. When the doctors provided confirmation that an alert had been actioned then the register was updated. For example, the practice had ensured that Ventolin Accuhalers had been recalled in line with the February 2018 MHRA alert.

- When unintended or unexpected safety incidents happened patients received reasonable support, truthful information, a verbal and written apology, and were advised about any action taken to improve processes in order to prevent the same thing happening again. For example, a GP requested a blood test for a patient and the laboratory sent back an unrequested result. The patient was contacted and counselled and the lab team contacted to find out why the test had been undertaken.
Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient’s welfare. The SMO was the lead member of staff for safeguarding. Effective deputising arrangements were in place.

- The staff we spoke with demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. Doctors had received level three training in child safeguarding.

- The practice had effective and well managed systems in place to maintain an accurate and up to date register of patients subject to safeguarding arrangements, and patients assessed to be ‘at risk’. We were provided with a variety of examples of patients currently deemed vulnerable and at risk. Staff described how concerns were logged on the risk register and discussed with other clinicians at the vulnerable patients meeting held every two weeks. From the examples provided, it was evident the practice ‘went the extra mile’ to minimise the risk to the patient by providing and/or sourcing relevant support from external stakeholders.

- An alert facility within the patient record system; Defence Medical Information Capability Programme (DMICP), ensured any risks showed clearly when the medical record was opened. A vulnerable patient meeting was held every two weeks and any concerns were discussed at these meetings. The child safeguarding pathway protocol was located in all treatment rooms. Safeguarding was a standard agenda item at the HCG meetings.

- Paediatric attendance at Accident and Emergency departments was routinely monitored by the Senior Medical Officer to identify any trends, ensuring that children were protected in line with best practice safeguarding guidelines. As a result, GPs had been able to take action to protect vulnerable children.

- Notices in the waiting room and consultation rooms advised patients that chaperones were available if required. Staff who acted as chaperones were trained for the role, and had received a Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

- An infection prevention and control (IPC) policy was in place. The lead nurse for IPC had attended annual infection control training relevant to the role. An IPC audit was undertaken on an annual basis by an external team and the last audit was completed in September 2017. With a score of 93%, the practice achieved partial compliance with the audit. The resulting improvement plan identified 12 actions and 6 of these were in relation to the infrastructure. In particular, the audit highlighted damp in a number of areas of the building. IPC was a standard agenda item at the HCG meetings and we noted from the minutes that the status of the action plan from the last IPC audit had been discussed.

- Appropriate standards of cleanliness and hygiene were in place. Throughout the inspection we noted the premises were clean and tidy. However we noted some areas of damp and mould and rusty radiators in the patient toilets. We also noted exposed plasterwork and holes in some walls in consultation rooms. This presented an infection control risk for staff and patients. The practice manager advised us that remedial work was planned to be completed by the Station in
March 2018.

- All single use items were stored appropriately and were within their expiry date. Specific equipment was cleaned daily and daily logs were completed. Spillage kits were available. Clinical waste and sharps were stored appropriately and securely. Waste was collected from the practice by an external contractor and appropriate documentation was in place to support effective waste collection.

- Effective arrangements for managing medicines, including emergency medicines and vaccinations, were established to keep patients safe. The SMO was the medicines management lead for the practice and the pharmacy technician had the delegated responsibility for ensuring effective medicines management in accordance with policy and procedure. This included arrangements for obtaining, prescribing, recording, handling, storing and the security of medicines. Controlled drugs were subject to regular checks and we found no discrepancies or gaps in the checking system.

- The cold storage units for medicines were monitored regularly to ensure temperatures were within the correct parameters. A statement of purpose for the management of out of range medicines was in place and contained detailed procedures to follow. We noted that there had been an issue with fridge temperatures going outside of range in July 2017 and saw that remedial action had been taken.

- Prescription pads were securely stored and there were systems in place to monitor their use. Patient Group Directions (PGD) had been adopted by the practice to allow nurses to administer medicines in line with legislation. The processes in place were comprehensive demonstrating that PGDs were well managed. An effective system was in place to monitor prescriptions/medicines that had not been collected. This involved contacting the patient and if the medicine was no longer required then a note was made on the patient’s record.

- The full range of recruitment records for permanent staff was held centrally at RHQ (Regional Head Quarters). The practice manager also ensured that relevant safety checks had taken place at the point of recruitment, including a Disclosure and Barring Service (DBS) check to ensure that staff were suitable to work with vulnerable adults and young people. However we noted that evidence for one DBS check was missing for a new clinical staff member. The Practice were pursuing this as a matter of priority, and instantly put measures in place whilst waiting for the report to be received from DBS. They also monitored each clinical member of staff’s registration status with their regulatory body. The practice manager confirmed all staff had professional indemnity cover. Information was in place to confirm staff had received all the relevant vaccinations required for their role at the practice.

- Due to staffing resource issues, a meeting was held every day to ensure adequate staff were available to manage the workload for that day.

**Monitoring risks to patients**

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety, including a health and safety policy. A lead was appointed for health and safety and had completed relevant training for the role. Any risks in relation to health and safety were discussed with the wider team at the practice meetings. Risk assessments were in place for fire, Legionella and water safety and had been updated. The checks showed the fire alarm was checked weekly and the practice conducted regular fire drills. The fire equipment was checked by an external contractor on an annual basis. The station was responsible for the electrical safety of the building and a safety certificate was in place. Portable electrical equipment was
checked on a regular basis to ensure the equipment was safe to use. We saw evidence that portable electrical check had been undertaken recently.

- Clinical equipment was checked in line with DMS policy to ensure it was working properly. A process was in place to check equipment each day to ensure it was in working order and appropriately calibrated. A checking sheet for the equipment located in each clinical room was in place and we noted the checks were up-to-date.

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients’ needs. However staffing levels were effectively 54% on the day of this inspection. Some posts were vacant, some were gapped, some staff were on maternity leave and some staff were deployed elsewhere. Whilst we saw no indication that this had impacted the safe and effective delivery of care, we noted that staff were working extra hard (and sometimes long hours) to compensate. Some administrative tasks had been re-prioritised and staff resilience was impacted at times. Given that staffing levels were running at effectively 54% of establishment, the team met on a daily basis to ensure that all essential tasks were covered and that accountability had been assigned. There was a rota system in place for all staffing groups to ensure that enough staff were on duty. A triage system was in place for patients who presented without an appointment and a duty doctor was available throughout the day for patients with urgent health care needs.

- A system was in place to manage high risk patients, such as patients with mental health needs. Providing examples, all three doctors highlighted how patients were identified on the vulnerable patient register and their needs discussed with relevant stakeholders such as the practice team, welfare team, SAFFA and the padre.

**Arrangements to deal with emergencies and major incidents**

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- An alarm system was in place and operational in all consultation and treatment rooms.

- An emergency kit, including a defibrillator, oxygen with adult and children’s masks and emergency medicines were accessible to staff in a secure area of the practice; all staff knew of their location. A first aid kit and accident book was available. Routine checks were in place to ensure the required kit and medicines were available and in-date. Medicines we checked were in date.

- As the practice served an airfield and needed to be poised to attend airfield emergencies, staff underwent training for dealing with airfield emergencies.

- The staff training records provided assurance that all staff received basic life support training on an annual basis.

- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. A copy of this plan was available on the staff intranet and additional copies were kept off the premises.
Are services effective?  
(for example, treatment is effective)  

**Good**

**Our findings**

**Effective needs assessment**

The practice assessed needs and delivered care in accordance with relevant and current evidence based guidance and standards.

- Clinical staff were aware of evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. Staff referred to this information to deliver care and treatment that met patients’ needs. They described how updates on NICE and medicines management were outlined in a newsletter circulated to clinical staff by the Department of Primary Health Care (DPHC) Team each month.

- NICE guidance was discussed at doctors’ meetings. The DPHC newsletter was also discussed at the practice meetings.

**Management, monitoring and improving outcomes for people**

The practice used information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. QOF is a system intended to improve the quality of general practice and reward good practice. It is used across many NHS practices. The DMS have a responsibility to deliver the same quality of care as patients expect in the NHS. The QOF provides a useful way of measuring this for DMS. Because the numbers of patients with long term conditions are often significantly lower at DMS practices, we are not using NHS data as a comparator.

The practice provided the following examples of patient outcomes data to us from their computer system on the day of the inspection.

- There were 16 patients on the diabetic register. We reviewed the treatment and care offered to these patients and found that current NICE guidance had been followed. For 14 of these diabetic patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For 14 patients the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.

- There were 50 patients recorded as having high blood pressure. We reviewed the treatment and care offered to these patients and found that current NICE guidance had been followed. All had a record for their blood pressure in the past nine months. Of these patients with hypertension, 34 had a blood pressure reading of 150/90 or less.

- The number of patients who were recorded as current smokers and whose notes contained a
record that smoking cessation advice or referral to a specialist service had been offered within
the previous 24 months, was 178, which was 57% of the smoking patient population. The NHS
target for this indicator is 90%. The practice acknowledged that this was an area that they were
prioritising moving forward in order to deliver improved outcomes for patients.

• There were 59 patients with a diagnosis of asthma. We reviewed the treatment and care offered
to these patients and found that current NICE guidance had been followed. Of these, 40 had
had an asthma review in the preceding 12 months which included an assessment of asthma
control using the three Royal College of Physicians questions. The practice acknowledged that
this was an area that they were prioritising moving forward in order to deliver improved
outcomes for patients.

• There were 11 patients with a new diagnosis of depression in the last 12 months. All had been
reviewed within 10 to 35 days of the date of diagnosis.

Information from the Force Protection Dashboard, which uses statistics and data collected from
military primary health care facilities, was also used to gauge performance. Data from the Force
Protection Dashboard showed that instance of audiometric hearing assessment was above
average compared to DMS practices regionally and nationally. Service personnel may encounter
damaging noise sources throughout their career. It is therefore important that service personnel
undertake an audiometric hearing assessment on a regular basis (every two years). Data from
July 2017 showed:

• 99.9% of patients had a record of audiometric assessment, compared to 98.6% regionally within
DMS and 99% for DPHC nationally.

• 91.3% of patients’ audiometric assessments were in date (within the last two years) compared
to 86% regionally within DMS and 86% for DPHC nationally.

There was evidence to demonstrate that quality improvement took place.

• We saw evidence of some clinical audit work and this had been used to monitor quality and to
make improvements. We looked at clinical audits and discussed with staff the impact that they
had had for patients. An asthma audit had concluded that all clinicians should complete the
asthma template, that smoking history including passive smoking health status needed to be
documented and that when repeat prescriptions were authorised, the annual asthma
consultation needed to be reviewed and updated. We also saw a Co-amoxiclav audit which
resulted from a recent significant event and considered the link between prescribing co-
amoxiclav and C Difficile. We also noted an audit of patients with a diagnosis of B12 deficiency,
which focussed on whether effective monitoring was in place to support the best outcomes for
these patients. Examples of completed audit cycles were shown to the CQC team including
ones on “Steroid Cream Directions Audit”, “Diabetes Audit” and “Audit of NICE Guidance Fever
in under Fives”

• An internal quality assurance tool, the DMS Common Assurance Framework (CAF) was used to
monitor safety and performance. The DMS CAF was formally introduced in September 2009
and since that time has been the standard healthcare governance assurance tool utilised by
DMS practices to assure the standards of health care delivery within DMS. The CAF we were
provided with pre-inspection had been undertaken by regional headquarters in December 2017.
When a CAF assessment is undertaken by RHQ it is referred to as a Health Governance
Assurance Visit (HGAv). It showed that five of the eight domains were partially compliant, with
the remaining three domains rated as compliant. When we reviewed the CAF we saw that
improvements had been made and the majority of deficient areas had been actioned effectively.
We also noted that the practice had used this self-assessment tool appropriately, which aided
the effective management of areas that needed attention.
Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had a generic induction programme for all newly appointed staff. This included topics such as safeguarding, infection prevention and control, fire safety, health and safety, information governance and Caldicott accountability. There was also a specific programme and training for new staff depending on their role and a separate induction for locum staff. Staff had access to and made use of e-learning training modules and in-house training. Relevant competency checks were undertaken before staff engaged in practice or a procedure that was new to them.

- The practice manager organised mandatory training. Records confirmed all staff had received mandatory training in subjects such as fire, basic life support and infection control and this training was refreshed in accordance with organisational policy. The infection prevention and control lead had attended a relevant course. However there were some gaps in the mandatory training records for one clinician. We spoke with the staff member concerned and they confirmed that they had undertaken all the mandatory training required of them and that records would be updated accordingly.

- All clinical staff had been trained around the application of Gillick competence. Gillick is a term used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment without the need for parental permission or knowledge. Three GPs told us about scenarios where they had applied Gillick competency in order to offer the most appropriate treatment to older children.

- Staff administering vaccines and taking samples for the cervical screening programme had received specific training including an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes.

- Nurses and doctors told us they maintained their own continual professional development (CPD). Nurses attended a clinical supervision group every three months and they were supported to attend both internal and external training events. The nursing supervisor had received recent training specific to the role. GPs held doctors’ meetings where they discussed complex cases and shared learning. From our discussions with nurses and doctors we determined that they had a detailed knowledge relevant to their specialist roles and shared their knowledge when relevant with the wider practice team. However there had been no formal peer review by nurses or doctors of clinical notes or consultations.

- The learning and support needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. All staff had received an appraisal within the last 12 months.

Coordinating patient care and information sharing

There were well managed systems in place to ensure effective coordination of patient care.

- The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice’s patient record system and their intranet system. The DMICP system was used for managing patient records. Read coding, a system used to support clinical encoding of patient details, including diagnosis was used by all clinical
staff with access to patient records. The sample of anonymised patient notes we looked at was of a high standard. Notes included risk assessments, care plans, consultation records and investigation/test results. There was an appropriate summary screen of patients’ health needs on DMIC and a patient’s diagnosis was easily found. At the time of inspection there was no significant backlog in summarising notes.

- We found the practice shared relevant information with other services in a timely way. Referrals to secondary care were managed in a timely way. Where appointments were not secured within the required time parameters, the practice followed this up. Reports were usually received from the out-of-hours service (OOH) service within 48 hours of a patient having accessed treatment. These reports were scanned on to DMICP and alerts sent to a doctor to ensure they were reviewed and appropriate follow up instigated if necessary. The reviewing doctor coded problems/conditions as necessary on DMICP. If practical, patients seen by the OOH service were required to present to the practice the next day for review.

- There were fail safes in place for tests and samples sent to the laboratory. A protocol was in place for nursing staff to follow. Incoming results were checked on a daily basis by a nurse and any outstanding results were followed up. Results received at the practice were logged, dated, stamped and scanned onto the patient’s record by the administration team. They were then passed to the doctor to review.

Consent to care and treatment

Staff sought patient consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

- Where a patient’s mental capacity to consent to care or treatment was unclear, the doctor or practice nurse assessed the patient’s capacity and recorded the outcome of the assessment. Two doctors we spoke with gave examples of when they had employed the Mental Capacity Act appropriately.

- When providing care and treatment for young people, staff carried out assessments of capacity to consent in line with relevant guidance. We saw that any parental or guardian involvement in patients’ care or treatment was with the consent of the patient.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services.

- All new patients to the practice were asked to complete an assessment form on arrival. The practice nurses followed up any areas of concern such as raised blood pressure.

- A weekly health promotion clinic run by an external advisor was in place and was well attended by patients looking for advice around weight management and smoking cessation. Referrals to fitness programmes were available. Sexual health advice and free condoms were available and referrals to local community clinics could be made where appropriate.

- The practice had a health promotion calendar to promote specific issues relevant to the service population and its requirements. Health promotion sessions were held for military personnel. The practice had recently arranged a display board about recognising the symptoms of prostate cancer. This had led to the diagnosis and effective treatment of a patient who is now in
recovery.

- Patients had access to appropriate health assessments and checks. A six monthly search was undertaken for all patients aged 47 to 64 years who were entitled to breast screening. The practice also engaged with all national screening programmes and had a mechanism to ensure that eligible patients were referred into the bowel cancer or abdominal aortic aneurysm (AAA) screening programs.

- The number of women aged 25 to 49 and 50 to 64 whose notes recorded that a cervical smear had been performed in the last three to five years was 469 out of 485 eligible women. This represented an achievement of 96%. The NHS target was 80%. There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test.

- The immunisation of children was led and delivered by local NHS healthcare teams. The Practice did not have data around childhood immunisation rates. The practice undertook checks of the community immunisation database to pick up children who had not received an immunisation and also ran searches from DMICP to ensure that immunisations had taken place for all children who were registered at the practice.

It is important that military personnel have sufficient immunity against the risk of contracting certain diseases. The World Health Organisation sets a target of 95% for vaccination against diphtheria, tetanus, pertussis and polio and measles, mumps and rubella. The data below from October 2017 provides vaccination data for patients using this practice:

- 98.4% of patients were recorded as being up to date with vaccination against diphtheria compared to 96.7% regionally and 94.9% for DPHC nationally.

- 98.2% of patients were recorded as being up to date with vaccination against polio compared to 96.6% regionally and 94.9% for DPHC nationally.

- 89.8% of patients were recorded as being up to date with vaccination against Hepatitis B compared to 85.2% regionally and 81.5% for DPHC nationally.

- 95.7% of patients were recorded as being up to date with vaccination against Hepatitis A, compared to 94.7% regionally and 92.4% for DPHC nationally.

- 98.3% of patients were recorded as being up to date with vaccination against Tetanus, compared to 96.7% regionally and 94.9% for DPHC nationally.

- 9.7% of patients were recorded as being up to date with vaccination against Typhoid, compared to 39.9% regionally and 53.5% for DPHC nationally.

The Typhoid vaccine has a lower uptake than other vaccinations. Current guidance state DMS practices should offer the Typhoid vaccination to personnel before deployment and not to routinely vaccinate the whole population.

The practice provided at short notice additional vaccination clinics to ensure all personnel due to be deployed were effectively immunised.
Are services caring?

Our findings

Kindness, dignity, respect and compassion

- During our inspection we observed that members of staff were courteous and helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients’ privacy and dignity during examinations, investigations and treatments.

- Consultation and treatment room doors were closed during consultations; conversations taking place in rooms could not be overheard. Conversations taking place across in the reception and pharmacy areas could be overheard from the waiting room, although staff used a radio to try to mitigate this. Reception staff said that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. There was a notice in the waiting room to signpost patients.

- We had the opportunity to speak with five patients during the inspection. They told us they were satisfied with the care provided by the practice and said they were able to get an appointment when needed.

- Results from the December 2017 DMS Patient Experience Survey showed patients felt they were treated with compassion, dignity and respect. For example:
  - 97% of patients said their privacy and dignity was respected and maintained throughout their visit to the practice.
  - 100% of patients said they were seen by the most suitable practitioner to meet their need.
  - 100% of patients said that the medical centre would keep information about them confidential.
  - 97% of patients said if family, friends and colleagues could use the practice, they would recommend it to them.
  - 97% of patients said the practice always tried to improve services for patients.

- We did not receive any comparator data to set out alongside the above data. However, the views of patients expressed on CQC comment cards and those from patients we spoke with aligned with the views above. We received four completed comment cards prior to the inspection and feedback was complimentary about the practice. Patients said that care choices were explained carefully to them and that staff were kind and listened to their concerns.

- The practice had an information network available to all members of the service community, known as HIVE. This provided a range of information to patients who had relocated to the base and surrounding area. Information included what was available from the local unit and from
Care planning and involvement in decisions about care and treatment

- The feedback provided by patients indicated that clinical staff took the time to explain their condition or injury and treatment plan.
- Data received from the latest DMS patient experience survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment:
  - 97% of patients said they were offered information and choice about the care they received.
  - 94% of patients said they knew they could obtain advice about their health and lifestyle if they required it.
- The data presented by the practice was not benchmarked against regional and national averages for the DMS or against the previous year’s performance.

Patient and carer support to cope emotionally with treatment

- Patient information leaflets and notices were available in the patient waiting area, which advised patients about how to access a number of organisations. We saw that information that was age appropriate and relevant to the patient demographic was prominently displayed and accessible.
- The practice proactively identified patients who were also carers and at the time of inspection two carers were identified on the register. Where patients identified themselves as carers, a code was added to their records in order to make them identifiable so that extra support or healthcare could be offered as required. The practice had implemented a carer identification protocol which supported patients to identify themselves as carers and also guided practice staff and other healthcare professionals to identify patients who were also carers.
- Clinical staff attended vulnerable patient meetings. The wider staff team was made aware of any vulnerable patients at the practice meetings.
Are services responsive to people’s needs? (for example, to feedback)

Our findings

Responding to and meeting people’s needs

The practice understood its population profile and had used this understanding to meet the needs of its population.

- A wide range of services and clinics were available to service personnel and their dependants. For example, a smoking cessation clinic, over-40’s health screening, sexual health, Well Woman, physiotherapy and travel advice. Antenatal clinics were held at the practice every week. The practice provided patients with access to midwives and health visitors.

- Access to a doctor was good for patients; most patients were seen within 48 hours of requesting an appointment. Patients could have 15 minute appointments with the doctor and up to 30 minute appointments with the practice nurse. If needed patients could book a double or triple doctor appointment. Reception staff knew to offer vulnerable patients triple appointments. Appointments were available after school hours. Telephone consultations were available with a doctor.

- Home visits were available although not often required. Guidance for staff around home visit management had been developed and implemented in the form of a traffic light Standard Operating Procedure for the duty medical officer and reception staff.

- The practice provides Aircrew Direct Access to Physiotherapy Services. This removes the initial appointment and referral from a GP, which improves patient care ensuring that Aircrew return back to flying duties as soon as possible. There is also close liaison between the Physiotherapists and the Medical Officers to ensure that there are no concerns regarding flight safety.

- There was an accessible toilet in the building. A room was available for baby changing and/ or breastfeeding.

- Same day appointments were available for those patients who needed to be seen quickly. Children were seen at the practice on the day an appointment was requested.

- Referrals to the physiotherapy service were made by the GPs.

- Eye care and spectacles vouchers were available to service personnel at the medical centre. Transport for patients to hospital appointments was available if needed.

Access to the service

- The practice was open Monday to Friday from 08:00 to 18:30. Routine doctor clinics were held from 08:15 to 12:00 Monday to Friday. On Monday, Tuesday and Thursday doctors held an additional clinic in the afternoon from 13:15 to 16:30. Outside of these hours and including
public holidays patients were diverted to the NHS 111 service. The practice leaflet gave clear directions to patients on what to do if they required attention when the practice was closed.

- Results from the Defence Medical Services Patient Experience Survey showed that overall patient satisfaction levels with access to care and treatment were high (score of 75% or more). For example:
  - 91% of patients said the opening hours were convenient for them and their family.
  - 81% of patients said they could normally get an appointment to see a doctor for non-urgent problems within two days.
  - 93% of patients said they could usually see the doctor of their choice within a week.

- Patients told us on the day of the inspection that they were able to get appointments when they needed them.

**Listening and learning from concerns and complaints**

The practice had a system for handling complaints and concerns.

- The practice manager was the designated responsible person who handled all complaints in the practice. They and the staff team adhered to the Defence Primary Health Care’s established policy on the management of complaints. A register on the Healthcare Governance Workbook was used to report handwritten, email and verbal complaints and prompted staff to raise significant events as necessary. There had been five complaints raised since January 2017. No theme or trend had been identified. We saw that there were processes in place to share learning from complaints. This was through the health care governance and practice meetings.

- We noted that information was available in the waiting area to support patients to understand the complaints system. How to make a complaint was summarised in the practice leaflet. We spoke with five patients who told us that they would feel comfortable with making a complaint and knew how to complain if the need arose. They confirmed that military rank would not be a barrier to them raising issues with the practice.

- Complaints were audited through the Common Assessment Framework (CAF). This was used to focus on improvements to the service and to ensure that designated standards were being met on the handling of complaints.
Are services well-led?
(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

Vision and strategy

- The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice had identified four core values to focus their daily work:
  - R – Responsive
  - I – Innovative
  - S – Safe
  - E – Effective
- All staff we spoke with told us that they enjoyed working at the practice and that their opinions, observations and views were valued.
- Staff we spoke with throughout the day made reference to their aim to deliver personalised care which protected the vulnerable patient and supported patient autonomy wherever possible. Staff knew and understood the values and behaviours required to deliver this type of care.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured that:
- There was a clear staffing structure and staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas. Due to identified gaps in staffing resource, staff worked to mitigate risks to patients through daily planning meetings. Each day the clinical and administrative teams met to ensure that all essential roles and tasks could be delivered. Our findings confirmed that leadership and commitment to providing good care meant that patients continued to experience good outcomes, even though effective staffing levels were at 54%.
- Policies from the national framework were implemented and were available to all staff. These were updated and reviewed regularly.
- An understanding of the performance of the practice was maintained. The practice used the Common Assessment Framework (CAF) as an effective governance tool. Practice meetings were held regularly to discuss required improvements. Learning needs were discussed and appropriate training was delivered on Wednesday afternoons.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. This included plans developed and maintained regularly that took account of staffing levels at the practice due to deployment of some staff and gapped posts.
Leadership and culture

- On the day of inspection the leaders in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised responsive, innovative, effective and safe care. Everything we saw on the inspection day, and communications with the practice following the inspection, supported this. Staff spoke about a ‘positive team atmosphere’ and all staff we spoke with told us that leaders were visible and accountable.

- There was a clear leadership structure and staff felt supported by management. Staff told us the practice leaders were approachable and always took the time to listen to all members of staff. All staff were involved in discussions about how to run and develop the practice. We particularly noted the support for innovation in the practice, which was promoted by leaders. A locum doctor described how they had ‘got their enthusiasm back’, working at RAF Marham Medical Centre. They described how they had been able to engage in useful work, supporting the practice to better understand QOF and how to code information correctly. Staff told us the practice held regular meetings and that there was an open culture where staff felt empowered to raise issues and concerns. Minutes were comprehensive and were available for practice staff to view. All staff we spoke with told us that RAF Marham Medical Centre was a happy place to work.

- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour (the duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included training for all staff on communicating with patients about notifiable safety incidents. The GPs and practice manager encouraged a culture of openness and honesty. We found that the practice had systems to ensure that when things went wrong with care and treatment, the practice gave affected people reasonable support, information and a verbal and written apology.

Seeking and acting on feedback from patients, and staff

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- Patients through the Defence Medical Services surveys and from any individual patient feedback received.

- Staff fed back issues through supervision and practice meetings. We saw examples of staff being supported to implement new and innovative ways to deliver safe and effective care. For example the ‘issues register’ and the home visit management plan.

- Completed CQC comment cards from patients supported our findings, that there was an open door policy when it came to patient input and feedback.

Continuous improvement

- There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and from minutes of meetings we reviewed we saw that the leaders of the practice focussed on improving the quality of delivery of care for all patients. For example, the practice had developed sound systems to ensure that all vulnerable patients were known to them and that their holistic and clinical needs were met through a strong partnership approach with SAFFA, the welfare team and padre.