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>
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<th>Overall rating for this service</th>
<th>Requires improvement</th>
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<td>Are services safe?</td>
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<td>Are services effective?</td>
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<tr>
<td>Are services caring?</td>
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<tr>
<td>Are services responsive to people’s needs?</td>
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<td>Are services well-led?</td>
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Letter from the Chief Inspector of General Practice

We carried out an announced inspection at Warminster Primary Healthcare Centre on 10 August 2017. Overall, the practice is rated as requires improvement. Our key findings across all the areas we inspected were as follows:

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events.
- The practice had defined systems to minimise risks to patient safety.
- We saw several areas of governance which required improvement.
- We did not see evidence that the practice used data as a driver to improve performance however audit was being used to provide learning outcomes and some improvements in treatment of patients.
- Staff were aware of current evidence based guidance. Permanent staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment, although one staff member was waiting for training in managing and assessment of risk.
- We found the local induction pack for clinicians required review.
- Results from practice patient survey showed patients were treated with compassion, dignity and respect and were happy with their care and treatment.
- The practice did not offer home visits. There was no protocol in place or risk assessment to support this decision.
- Information about services and how to complain was available. All complaints were handled in accordance with the practice complaints policy. Learning from complaints was shared and improvements made when required.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

Summary of findings
The Chief Inspector recommends:

- A formal clinical induction pack to be developed to include for example, briefings for locum GPs on issues more commonly seen in military practices, such as heat injury.

- A review of staff training in use of the electronic patient record system to assure it is effective. For example, in order that staff can run clinical searches, create specific patient registers, provide assurance around patient recall systems, easily identify vulnerable patients and produce accurate performance data.

- Appropriate further training for staff to enable them to carry out their duties. For example, in relation to health and safety risk assessments.

- Improvement in oversight of performance data to identify and lead on areas for improvement.

- An increased use of risk assessments to help determine levels of patient service to be provided. For example, home visits for patients too unwell to attend the practice.

- Governance arrangements are reviewed to ensure improvement, for example, around checks of all staff professional registrations, job descriptions for clinicians and the handling of MHRA alerts in the absence of the pharmacy technician.

- The accurate identification of any patients who are also carers and maintenance of a carers register.

- The practice should review and consider the formation of a patient participation group.

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice
We always ask the following five questions of services.

**Are services safe?**

The practice is rated as good for providing safe services.

- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients were informed as soon as practicable, received reasonable support, information and an apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had systems, processes and practices to minimise risks to patient safety.
- Some processes and practices required review and updating.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The practice had adequate arrangements to respond to emergencies and major incidents.

**Are services effective?**

The practice is rated as requires improvement for providing effective services.

- Data from the Quality and Outcomes Framework showed patient outcomes for many of the QOF indicators used, were below Defence Primary Health Care targets set.
- There was limited evidence that data was used to drive improvement in performance, however, audit was being used to provide learning outcomes and some improvements in treatment of patients. We saw that some audits may require further review in order to deliver quality improvement.
- Staff were aware of current evidence based guidance.
- Staff had the skills and knowledge to deliver effective care and treatment. We saw that local inductions had been
developed for locum clinicians but a more formal recorded and monitored induction would be more effective. For example, containing briefings for locum GPs on issues more commonly seen in military practices, such as heat injury.

- There was evidence of appraisals and personal development plans for staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients’ needs.
- Clinicians liaised effectively with external services to coordinate patient care beyond the scope of the practice.

**Are services caring?**

The practice is rated as good for providing caring services.

- Data from the practice patient survey showed patients rated the practice highly for several aspects of care.
- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was displayed prominently, accessible and up to date.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

**Are services responsive?**

The practice is rated as requires improvement for providing responsive services.

- The practice understood its population profile but had not fully considered all their needs. For example, in relation to providing home visits.
- We saw that self-referral of patients to physiotherapy services had proved popular and reduced waiting times for patients.
- The practice took account of the needs and preferences of patients and used the Choose and Book system to ensure access to secondary treatment was as convenient as possible.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care.
- When we reviewed appointment availability we saw urgent appointments were available the same day and that waiting times for appointments were no longer than 36 hours.
- The practice had good facilities and was well equipped to treat patients and meet their needs. Where improvements could be made to treatment areas, this had been actioned in a responsive manner by the practice.

- Information about how to complain was available and evidence from two examples reviewed showed the practice responded quickly to issues raised.

- Learning from complaints was shared with staff and other stakeholders.

### Are services well-led?

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

- The practice had a vision to deliver quality care and promote good outcomes for patients.

- Staff were clear about the vision and their responsibilities in relation to it.

- There was a clear leadership structure and staff felt supported by management.

- The practice had policies and procedures to govern activity and held regular governance meetings.

- Staff at the practice were unable to show any plans in place to improve performance, for example, in relation to QOF achievement.

- An overarching governance framework was in place. This included arrangements to monitor and improve quality and identify risk. However, we saw some areas of governance required improvement. For example, the update and testing of the fire risk assessment and training for the practice manager in order for them to complete all building risk assessments. This duty has been delegated to the practice manager of the dental centre. We also found there were no current job descriptions for clinicians and that the professional registrations of one of the physiotherapists and the pharmacy technician had not been checked.

- We found a significant event that had not been reported. Although there had been a thorough analysis of what had happened and some changes had been implemented as a result of learning from the event, no formal briefings on heat injury for locum GPs was available in the locum induction pack.

- We were told that the practice did not offer home visits and that any exceptional requests would be subject to telephone triage. The practice provided GP services for 310 children aged 10 years and under, of which 166 children were aged 5 years and under. We were not made aware of any risk
assessment on this approach.

- Administrative staff had received inductions but the local induction for clinicians required improvement and formal monitoring.

- We saw annual performance reviews were in place for all staff and that all staff attended staff meetings and training opportunities.

- The provider was aware of the requirements of the duty of candour. In one example we reviewed we saw evidence the practice complied with these requirements.

- The practice leaders encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff, ensuring appropriate action was taken. However, arrangements for handling alerts were not consistent when the pharmacy technician was absent.

- The practice sought feedback from staff at practice meetings and from patients through the practice survey and a suggestions box. We saw examples where feedback had been acted on. The practice had not formed a patient participation group.

- There was a focus on continuous learning. Staff had access to training opportunities. However the practice manager had not received training to enable them to conduct risk assessments of the premises.

- GPs that were skilled in specialist areas used their expertise to offer additional services to patients, for example, family planning services.
Our inspection team

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

Background to Warminster Primary Healthcare Centre

Warminster Primary Healthcare Centre (referred to in this report as the practice) is located in a modern, purpose built facility situated in the Land Warfare Centre camp at Warminster, Wiltshire. This is a facility which is at the centre of the surrounding accommodation for families of serving military personnel, and as such provides primary medical services to serving military staff and their dependants.

The practice offers a full range of GP services including family planning, childhood immunisations, civilian counselling services, travel advice and smoking cessation. A designated midwife visits the practice weekly to provide maternity care, health visitors visit the practice monthly to attend primary healthcare meetings, and a community mental health nurse visits the practice to see patients as required. There is also a dispensary on site. The practice is a training practice but there were no registrars at the practice at the time of inspection.

The dental care facility is based in the same building but did not form part of this inspection.

The practice has eight consulting rooms, two treatment rooms and a physiotherapy department which has a small gym attached. We do not inspect physiotherapy departments as part of these inspections. At the time of our inspection, the practice had approximately 1,950 patients registered, of which approximately 677 were civilians; of the civilian patients, 407 were aged 18 years and under. More than two thirds of the civilian patient population were female.

The practice also supports military personnel working out of area on training courses. Typically these personnel will spend 10 days on courses in the Warminster and Salisbury area and can access this practice for any care or treatment needed. This can place additional pressure on GP and nurse availability.

The staffing of the practice was made up of a Senior Medical Officer (lead GP), a Regimental Medical Officer (GP), one full time and one part time civilian GP, two practice nurses, one health care assistant, two whole time equivalent (WTE) physiotherapists, one pharmacy technician, one exercise rehabilitation instructor and eight combat medics (the work of a military medic has greater scope than that of a health care assistant found in NHS GP practices), the practice manager who was supported by a lead administrator and two administrative assistants. The practice also had a civilian driver on stand by for use when required.
The practice is open between 08.00am and 16.30pm Monday to Thursday, and from 08.00am to 16.00pm on Friday. Cover is rotated between the military practices in the area between the hours of 16.30pm and 18.30pm. Patients registered with the practice can access services at these neighbouring military practices during these hours. For GP services outside of these hours, patients are diverted to NHS 111.

Why we carried out this inspection

The Care Quality Commission (CQC) carried out this inspection as one of a programme of inspections at the invitation of the Surgeon General in his role as the Defence Authority for healthcare and medical operational capability. Defence Medical Services (DMS) are not required to register with CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. Consequently DMS services are not subject to inspection by CQC and CQC has no powers of enforcement. However, where CQC finds shortfalls in the quality of services during inspection, we will report them by making a recommendation for action to the Surgeon General’s office.

We carried out a comprehensive inspection of this service. Warminster Primary Healthcare Centre had not been inspected by the CQC previously.

How we carried out this inspection

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

We carried out an announced inspection on 10 August 2017. During the inspection, we:

- Spoke with a range of staff including the Senior Medical Officer, two civilian GPs, a medic, the health care assistant, practice manager, a member of physiotherapy staff, the nursing staff and spoke with patients who used the service.
- Observed how staff interacted with patients in the reception area.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients shared their views and experiences of the service.
- Inspected the clinical facilities in the practice.
- Looked at information the practice used to deliver care and treatment.

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

Clinical treatment for patients was safe. We found some concerns in ‘safe’ which we have attributed to improvements required in governance. We have taken these into account when considering how well led the service is.

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the Senior Medical Officer or practice manager of any incidents. All staff were able to access the electronic recording system for reporting significant events.
- The incident recording form supported the recording of notifiable incidents under 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).
- From the log of 11 documented examples recorded, we reviewed three significant events. We found that when things went wrong with care and treatment, an investigation took place and learning from events was shared. Where necessary, patients were informed as to why things went wrong, were offered an apology and any further support needed.
- We saw that one recent incident had been recorded but not reported, although there was evidence of investigation and corrective actions following the event. This has been identified as a governance issue which will be addressed by the practice.
- We reviewed safety records, patient safety alerts and minutes of meetings where these were discussed. We noted there were no arrangements in place to cover MHRA alerts in relation to medicines when the pharmacy technician was on leave. Also, there was one alert which originated from June 2017 but did not reach the practice until 8 August 2017. Although this may have been a regional governance issue it was not reported by the practice.
- Evidence provided on the day of inspection demonstrated that the practice used the live log of significant events to look for any trends or themes.

Overview of safety systems and processes

The practice had clearly defined systems, processes and practices in place to minimise risks to patient safety.

- 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. There was a lead member of staff for safeguarding. GPs said they attended safeguarding meetings when possible or provided reports
where necessary for other agencies.

- When we checked patient records we saw safeguarding alerts were appropriately used.

- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three. Nurses were trained to safeguarding level two.

- A notice in the reception area and in all consulting rooms advised patients that chaperones were available if required. All staff who acted as chaperones were from the clinical team and had been given training by the previous Senior Medical Officer. We saw these staff 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).

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.

- A practice nurse was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice.

- There was an IPC protocol and staff had received up to date training.

- Annual IPC audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred.

- The practice carried out regular medicines audits, to ensure prescribing was in line with best practice guidelines for safe prescribing.

- Blank prescription forms and pads were securely stored and there were systems to monitor their use.

- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Patient specific prescriptions or directions from a prescriber were produced appropriately.

- The Senior Medical Officer was responsible for the dispensary located within the practice. The dispenser was qualified to NVQ Level III and was registered with the General Pharmaceutical Council. They confirmed they underwent competency assessments. The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had procedures to manage them safely. There were also arrangements for the destruction of controlled drugs.

We reviewed four personnel files. We saw that all required checks had been carried out centrally, for example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS). For locum GPs, the practice manager checks evidence of identity, professional registration and that DBS checks are in
date and valid. However, we noted that no record was kept of the professional registration of the pharmacy technician.

**Monitoring risks to patients**

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The practice had a fire risk assessment but this was out of date. A recent fire drill had highlighted issues which resulted in the fire evacuation plan being re-written. This was awaiting approval. There were designated fire marshals within the practice. Staff we spoke with could describe their role in any required evacuation of the building.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order. We noted that blood pressure cuffs were not listed on the equipment register and brought this to the attention of the practice manager.
- The practice could not produce a copy of the gas and electrical safety certificates for the building on the day of the inspection. These have been submitted to us post inspection. From these we were able to confirm that electrical and gas installations at the practice are safe and fit for purpose.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). The practice manager was the lead for health and safety but had not received any training to support them in this responsibility.
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients’ needs. The practice manager had noted that the patients of the practice tend to take longer periods of block leave. This resulted in ‘quiet’ periods when staff were encouraged to take annual leave.

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

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- Alarms were fitted in clinical areas which sounded in the relevant corridor and admin areas.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children’s masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a business continuity plan for major incidents such as power failure or building damage. This was due for review in September 2017. The plan included emergency contact numbers for staff.
Are services effective?  
(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients’ needs.
- The practice monitored that these guidelines were followed through audits and random sample checks of patient records. New guidelines were discussed at practice meetings and referred to in the Defence Primary Health Care (DPHC) newsletter. Staff also had access to DPHC update courses.

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. The system is used to measure some aspects of performance in NHS practices. The Defence Medical Services (DMS) have a responsibility to deliver the same quality of care as patients expect in the NHS. The QOF provided a useful way of measuring this for DMS).

We reviewed QOF performance of the practice. The performance data can be affected by the constant turnover of patients at the practice, due to incoming battalions and those leaving on tour of duty. On the inspection day, all data was checked with the practice. Following review of the draft report, the practice sent in further data, showing the QOF performance as of end of August 2017. It was noted that the practice disputed the data originally submitted by themselves, ahead of the planned inspection. A recommendation has been made that all staff are trained in the use of the electronic patient record system at the practice, so that accurate data can be used to monitor and improve performance.

The practice achievement is expressed in numbers and percentages and represents achievement as of end of August 2017. QOF performance to the end of August 2017, which is benchmarked against NHS targets for the year 2011/12, showed:

- The number of patients with asthma on the register, who had received a review in the past 12 months was 30. This equates to an achievement of 75%, compared to the Defence Primary Health Care (DPHC) target of 70%.
- The number of patients with asthma, on the register, aged 14-19 years, with a record of their
smoking history was one. This equates to an achievement of 33%, compared to the DPHC target of 80%.

- The number of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) was 150/90 or less was eight. This equates to an achievement of 89%, compared to the DPHC target of 93%.

- The number of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) was 140/80 or less was two. This equates to an achievement of 22%, compared to the DPHC target of 73%.

- The number of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) was 5mmol/l or less, was six. This equates to an achievement of 67% compared to the DPHC target of 75%.

- The number of patients with diabetes, on the register, in whom the last IFCC-HbA1c was 59 mmol/mol or less, within the preceding 12 months was four. This equates to an achievement of 50% compared to the DPHC target of 75%.

- The number of patients with diabetes, on the register, in whom the last IFCC-HbA1c was 64mmol/mol or less, within the preceding 12 months was 4. This equates to an achievement of 50% compared to the DPHC target of 83%.

- The number of patients with diabetes, on the register, in whom the last IFCC-HbA1c was 75 or less, within the preceding 12 months was six. This equates to an achievement of 75%, compared to the DPHC target of 92%.

- The number of patients with diabetes, on the register, who received an influenza immunisation in the preceding 1 August to 31 March was four. This equates to an achievement of 66%. The DPHC target is 95%.

There was no current or legacy plan in place to address lower QOF scores. We did not see evidence on the day of inspection, that data available to the practice was used as driver to improve performance.

There was evidence of quality improvement through clinical audit:

We reviewed nine clinical audits commenced in the last 12 months; four of these were completed audits where the improvements made were implemented and monitored.

Findings were used by the practice to improve services. For example, the practice introduced a system of self-referral to physiotherapy for patients. Patients completed a triage form available in the medical centre. Audit showed that patients accessed physiotherapy more quickly, due to not having to be referred via a GP, which saved the equivalent of 78 GP appointments over a twelve week period. Analysis of self-referral showed that only two patients were unsuitable for physiotherapy treatment and were referred back to a GP.

We reviewed the findings of an audit in relation to smoking cessation treatments. This was informative but lacked evidence of quality improvement, in respect of the treatment available to patients and the impact for the organisation around treatment of these patients. We particularly noted that the practice was below target for smoking cessation interventions, which at 82%, was lower than the target set of 90%.

**Effective staffing**

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

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. However, the induction pack for locum GPs required review, to include briefings on issues more commonly seen in military practices, such as heat injury.

- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions, and for medics dispensing medicines.

- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to online resources and discussion at practice meetings.

- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Other than the practice manager in relation to health and safety risk assessment training, all other staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months.

- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

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.

- This included care and risk assessments, care plans, medical records and investigation and test results.

- From the sample of documented examples we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.

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 secondary care and appointments. Information was shared between services with patients’ consent. Meetings took place with other health care professionals on a monthly basis when any shared care could be reviewed.

Consent to care and treatment

Staff sought patients’ 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.

- When providing care and treatment for children and young people, staff carried out
assessments of capacity to consent in line with relevant guidance.

- Where a patient’s mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient’s capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient record audits.

**Supporting patients to live healthier lives**

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

- Those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.
- A diabetic clinic was also available at the practice.

Childhood immunisations were carried out in line with the national childhood vaccination programme. From figures supplied by the practice we saw:

- 26 children under the age of 12 months were registered with the practice.
- 81% of children had received the vaccinations required.
- 4% of children had not received the complete set of vaccinations required.
- 15% of children were still awaiting confirmation of vaccination status by the practice as records had not yet been received or were awaiting summarising.
- 83 children aged 24 months and under were registered with the practice.
- 84% of children in this age group had received the vaccinations required.
- 14% of children were still awaiting confirmation of vaccination status by the practice as records had not yet been received or were awaiting summarising.
- 2% of children in this group had not been vaccinated.

For children five years and under:

- The were 82 children aged five years and under at the practice
- 62% of children in this age group had received the vaccinations required.
- 19% of children were still awaiting confirmation of vaccination status by the practice as records had not yet been received or were awaiting summarising.
- 19% of children had not been vaccinated.

We were aware at the time of inspection that there were 50 sets of civilian patient notes waiting to be summarised. This represents 7% of the current civilian population. There was no priority plan in place to summarise children’s notes first. Given that only 62% of children under five had received vaccinations required, this could represent risk in terms of outbreaks of infectious illness.

The practice’s uptake for the cervical screening programme was 97%, which was above the DPHC target set of 80%.

There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and
they ensured a female sample taker was available.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.
Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very 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 these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same gender.

All of the 11 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with three patients. They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the last practice patient survey, carried out in quarter three of 2016 showed patients felt they were treated with compassion, dignity and respect. 20 patients were asked about their experiences with nurses. Results showed:

- 100% of patients said the nurse was good or very good at listening to them.
- 100% said the nurse was good or very good at making them feel at ease.
- 100% of patients said they were confident about their nurse’s ability to provide their care.
- 80% of patients said their nurse was good or very good at explaining their condition and treatment.

When questioned about their experiences with GPs the survey of 20 patients showed:

- 87% of patients said their GP was good or very good at listening to them.
- 96% of patients said their GP was good or very good at making them feel at ease.
- 87% of patients said their GP was good or very good at explaining their condition and treatment
97% of patients said they were confident in their GP’s ability to provide their care and treatment. In relation to patients interaction with reception staff, the survey of 216 patients showed:

- 88% of patients said staff were good or very good at being polite.
- 95% of patients said staff were good or very good at making them feel at ease.
- 95% of patients said staff were good or very good at listening to them.

**Care planning and involvement in decisions about care and treatment**

Responses on CQC comment cards completed by patients, indicated that patients felt involved in decision making about the care and treatment they received. They also informed us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Feedback from patients we spoke with was also positive and aligned with these views.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in easy read format.
- The Choose and Book service was used with patients as appropriate (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).
- Patients who were dependants of serving military personnel also had access to other support through the HIVE facility, details of which were displayed around the medical centre.

**Patient and carer support to cope emotionally with treatment**

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Support for isolated patients included signposting to relevant support and volunteer services.

The practice staff were aware that patients could be marked on the system, as a carer of a dependant with significant health conditions. However, at the time of our inspection the practice did not have any patients who were marked as carers. We were made aware that patients with caring responsibilities could access further support through the HIVE facility.
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 but had not fully considered the needs of all patients, especially young children.

- The practice offered cover alongside other military practices in the Salisbury Plain locality until 18.30pm for patients who could not attend during normal opening hours.
- There were longer appointments available for patients whose needs required this.
- We were told that home visits were available for those patients who had clinical needs which resulted in difficulty attending the practice. However, we noted in the practice information leaflet issued to patients, there was no information on home visits. When we asked about this we were told home visits no longer take place. We were told that any exceptional request would be subject to telephone triage. There was no risk assessment by the practice to support this decision, taking account of the patient population groups served by the practice, for example, younger children.
- Evidence of home visits to two patients in the past 12 months was submitted by the practice, post inspection. However, the policy on home visits is still unclear. The practice have not supplied any updated patient information leaflets confirming that home visits are available.
- The practice took account of the needs and preferences of patients, for example, those who wished to see a male or female clinician.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Military patients were able to receive travel vaccines available on the NHS as well as those only available privately. However, dependants of military personnel who were patients, would have to visit a travel clinic locally. Where a dependant was accompanying their partner or parent on a posting which required additional immunisations, these would be delivered by to the patient by the practice.
- There were accessible facilities and interpretation services available. There was no electronic door facility at the practice and we saw a patient struggled with access to the practice through the manual doors. We brought this to the attention of the practice on the day of our inspection.

Access to the service

The practice is open between 08.00am and 16.30pm Monday to Thursday, and from 08.00am to 16.00pm on Friday. Outside of these hours, additional cover is rotated between the military practices in the area between the hours of 16.30pm and 18.30pm. For GP services outside of
these hours, patients are diverted to NHS 111.

In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for patients that needed them. Results from the practice patient survey carried out in quarter three of 2016, showed that patient satisfaction with their access to care and treatment was good. From a sample of 146 patients:

- 97% of patients said they were able to book an appointment at a convenient time.
- 91% of patients said they were seen within 15 minutes of arrival for an appointment.
- 98% of patients said they were satisfied with access to routine appointments.
- 97% of patients said they were satisfied with access to emergency appointments.

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

The practice no longer provided home visits. If this was requested it was treated as an exception and was subject to telephone triage first by a GP. There was no guidance included in the practice information leaflet, on whether a patient or the parent or guardian of a patient should dial 999 rather than seek a home visit from a practice GP.

**Listening and learning from concerns and complaints**

The practice had a system for handling complaints and concerns.

- The practice complaints policy was in line with recognised guidance for NHS GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. These were displayed close to reception and on patient information boards in the waiting areas.

We looked at two complaints received in the last 24 months and found these had been handled in line with the complaints policy. Individual concerns and complaints were investigated and action was taken to as a result to improve the quality of care where possible.
Are services well-led?
(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Requires improvement

Our findings

Vision and strategy
The practice had a clear vision to deliver quality care and promote good outcomes for patients.

- The practice had a mission statement which staff understood and could refer to.
- The practice had supporting business plans which reflected the vision and these were regularly monitored.

Governance arrangements
The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. We saw that some areas of governance required improvement.

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. However there were no current job descriptions for clinical staff which gave defined lead areas.
- Practice specific policies were implemented and were available to all staff. However, we saw that the fire risk assessment was out of date. The fire evacuation plan had recently been re-written but this was awaiting sign off, which had been delayed by operational duties.
- The practice was unable to provide evidence of fire and electrical safety certificates for the building.
- The practice manager had not received training in assessing risk, for the purposes of managing risks to patients and staff that used the building.
- Checks on the professional registration of the pharmacy technician were not in place.
- The handling of MHRA alerts in the absence of the pharmacy technician was not consistent.
- We saw that the practice was pro-active in clinical audit. However, we did not see evidence that the practice used data relating to current performance, as a driver for improvement. We reviewed minutes of meetings which were held monthly and saw that audit was discussed at these meetings. However, performance figures were not routinely reviewed.
- The practice did not offer home visits. There was no information within the patient information leaflet on whether they should request a visit as an exception to this rule or to dial 999. We did not see any risk assessment to support this approach.
- There were arrangements for identifying, recording and managing risks and issues and a comprehensive risk register was in place.
- We saw evidence from minutes, of a meetings structure that allowed for lessons to be learned
and shared following significant events and complaints. However, in one significant event that was investigated but not recorded, action had not been taken to include a briefing for locum GPs on heat injury, to be contained in locum induction packs.

Leadership and culture

On the day of inspection the Senior Medical Officer at the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the Senior Medical Officer (SMO) was approachable and took the time to listen to all members of staff. We also noted the practice manager and permanently employed civilian GPs were highly supportive of all staff and contributed to a positive, open and transparent leadership culture.

Practice leaders were 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). The practice leaders encouraged a culture of openness and honesty. From the sample of documented examples we reviewed 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 when required.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure and staff felt supported by management.

- The practice held and minuted a range of multi-disciplinary meetings including meetings with health visitors, welfare teams and social workers to monitor any vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and discuss any safeguarding concerns.
- Staff told us the practice held regular practice meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. Minutes were comprehensive and were available for practice staff to view.
- Staff said they felt respected, valued and supported, particularly by the practice manager and clinicians in the practice. All staff were involved in discussions about how to run and develop the practice, and from our observation on the day, we saw staff were encouraged to identify opportunities to improve the service delivered by the practice.

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 surveys, compliments, comments and any complaints received.
- Staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.
Continuous improvement

There was a focus on continuous learning and improvement at the practice. Staff were encouraged to learn and attend courses wherever possible, to extend their skills.