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

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

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of Warminster Primary Healthcare Centre on 8 August 2017. The practice was rated as requires improvement overall, with a rating of requires improvement for the key questions of effective, responsive and well led.

A copy of the report from our last comprehensive inspection can be found at:

http://www.cqc.org.uk/what-we-do/services-we-regulate/defence-medical-services#army

We carried out this announced inspection on 20 March 2018. This report covers our findings in relation to the recommendations made and any additional improvements made since our last inspection.

Our key findings were as follows:

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events.
- The fire risk assessment had been reviewed.
- A formal clinical induction pack was in place for locum GPs.
- Staff were competent in the use of the electronic patient record system. For example, to run clinical searches, create specific patient registers, provide assurance around patient recall systems, easily identify vulnerable patients and produce accurate performance data.
- We saw the performance data related to patients with long term conditions and children requiring vaccinations had improved.
- A policy was in place to help determine what level of patient service was to be provided. For example, home visits for patients too unwell to attend the practice. Information regarding home visits was available within the practice leaflet.
- Governance arrangements had been reviewed and improved 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 practice identified any patients who were also carers and held a carers register.
- The practice was continuing in its efforts to form a patient participation group.
Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice
Our inspection team

The inspection was undertaken by a CQC inspector.

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 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 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 practice is open between 0800 and 1630 hours Monday to Thursday, and from 0800 to 1600 hours on a Friday. Cover is rotated between the military practices in the area between the hours of 1630 and 1830. 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.
How we carried out this inspection

To conduct this inspection, we contacted the practice manager on 13 March 2018 and advised that we would be following up our findings of the inspection of August 2017. We visited the practice on 20 March 2018, we gathered further up to date evidence and considered this in June 2018.

As this was a follow-up inspection, we focused on the three key questions where improvements were required. We did not speak to patients as part of this review or use CQC comment cards to gather patient views of the service.
Are services effective?  
(for example, treatment is effective)

Our findings

Following our previous inspection on 8 August 2017, we rated the practice as requires improvement for providing effective services. At that time we found:

- Staff required further training in the use of the electronic patient record system to enable them to proactively run searches and recalls for patients and set up registers. For example, a carer register.

- Data from the Quality and Outcomes Framework (QOF) showed patients outcomes for many of the QOF indicators were below Defence Primary Healthcare targets.

- 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 have required further review in order to deliver quality improvement.

- 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.

- At the time of inspection there were 50 sets of civilian patient notes waiting to be summarised. There was no priority plan in place to summarise children’s notes first.

When we carried out this follow up inspection we found that all the above recommendations had been acted on. Following our review of the evidence provided, the practice is now rated as good for providing effective services.

Monitoring care and treatment

The practice used information collected for the 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 number of patients with asthma on the register was 42. Twenty nine of these patients had received a review in the past 12 months.
Patients that had not had a review had been sent three letters of reminder but failed to respond. The practice told us that they were working to proactively encourage all asthmatic patients to attend their review.

The number of patients with asthma, on the register, aged 14 to 19 years was three, two of these patients had a record of their smoking history.

There were eight patients with diabetes on the register. Seven of these patients had a blood pressure reading (measured in the preceding 12 months) of 150/90 or less which is an indicator of positive blood pressure management.

Of the eight patients with diabetes on the register, five had a measured total cholesterol (measured within the preceding 12 months) of 5mmol/l or less.

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 eight. This equates to an achievement of 100%.

The latest practice data shows improvement since the last inspection in the management of long term conditions. The practice had a plan in place to continue with active recall and was taking every opportunity when seeing patients to ensure their reviews were undertaken.

All military medical notes and 92% of civilian notes had been summarised.

Management, monitoring and improving outcomes for people

There was evidence of quality improvement including clinical audit:

An ongoing programme of clinical and non-clinical audit was in place and demonstrated a commitment to improving outcomes for patients at the practice. Audits undertaken were relevant to the needs of the patient population, including a rolling programme of audit for long term conditions. There was evidence of two cycles for some audits. Examples of completed clinical audits we looked at included asthma screening, travel health, and hypertension.

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.

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

Twenty one children under the age of 12 months were registered with the practice. 100% of children had received the vaccinations required.

Seventeen children aged 24 months and under were registered with the practice. Ninety five percent of children in this age group had received the vaccinations required, one child had not.

There were 62 children aged three and half to five years at the practice. Ninety three percent of children in this age group had received the vaccinations required. Two families were from
overseas, one of whom has had their children vaccinated overseas. Another family has no record of vaccinations. Childhood immunisations were controlled by an outside provider who sends the practice letters to distribute to patients informing them of vaccination requirements. The practice monitors this and maintains oversight for all children registered with the practice. In July 2017 in response to incomplete immunisation records for children, the practice nurse began to request parents provide their “Red Book” in order that the practice could ensure the accuracy of their records.

**Effective staffing**

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

- The practice had an induction programme for all newly appointed staff including locum staff. This included topics such as safeguarding, infection prevention and control, fire safety, health and safety, information governance and Caldicott accountability.

- 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. Job descriptions were in place for each member of staff. Professional registrations of all required staff had been undertaken.

- Staff were trained in use of the electronic patient record system. They were able to run clinical searches, create specific patient registers, provide assurance around patient recall systems, easily identify vulnerable patients and produce accurate performance data.
Are services responsive to people’s needs?  
(for example, to feedback)

Our findings

Following our previous inspection on 9 August 2017, we rated the practice as requires improvement for providing responsive services. At that time we found the practice understood its population profile but had not fully considered all their needs. For example, in relation to providing home visits.

When we carried out this desk based follow up we found that all of the above recommendations had been acted on. Following our review of the evidence provided, the practice is now rated as good for providing effective services.

Responding to and meeting people’s needs

- A policy was in place to help determine what level of patient service was to be provided. For example, home visits for patients too unwell to attend the practice. Information regarding home visits was available within the practice leaflet.

- Patients requesting home visits were triaged by the practice nurse who had dedicated telephone triage slots every morning and urgent slots throughout the day. Patients were therefore assessed more rapidly than if they had waited for a routine lunch time/end of working day home visit. This process facilitated rapid assessment of the need for emergency treatment. If it was assessed that a home visit may be required (or that the patient is particularly unwell but does not require 999) then this was passed to the duty doctor who also had protected slots to further assess the requirements and if required conduct a home visit.

- Requests for home visits were an infrequent occurrence (three in the past 12 months) as the practice had very few elderly and significantly unwell patients. Most of the civilian patients lived very close to the practice and transport (either private or welfare) was available.
Are services well-led?
(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings
Following our previous inspection on 9 August 2017, we rated the practice as requires improvement for providing effective services. At that time we found:

We saw that some areas of governance required improvement. For example, the update and testing of the fire risk assessment. We also found there were no current job descriptions for clinicians and that the professional registration for 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.

- 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 five 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.

- The practice had systems to maintain awareness 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.

When we carried out this desk based follow up we found that all of the above recommendations had been acted on. Following our review of the evidence provided, the practice is now rated as good for providing well led services.

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:

- Staff had received inductions, annual performance reviews and attended staff meetings and
training opportunities.

- 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. Job descriptions were in place for each member of staff. Evidence of professional registrations for all required staff had been obtained.

- Policies from the national framework were implemented and were available to all staff. These were updated and reviewed regularly, including the home visits policy.

- Safe processes were in place for the monitoring of national patient safety alerts.

- Significant events were managed well and actions learnt were shared with the larger staff group.

**Seeking and acting on feedback from patients, and staff**

- The practice had worked hard to set up a Patient Participation Group and had held a meeting inviting patients to come along and be involved, but no patients had attended. Another meeting was scheduled to try again.