Aldershot Combined Medical Practice

Aldershot Centre for Health, Hospital Hill, Aldershot, GU11 1AY
Minley - Gibraltar Barracks, Camberley, GU17 9LP

Defence Medical Services inspection

This report describes our judgement of the quality of care at Aldershot Combined Medical Practice. It is based on a combination of what we found through information provided about the service, patient feedback and through interviews with staff and others connected with the services.

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

Contents

Summary

About this inspection

We carried out this announced comprehensive inspection on 15 October 2024. We visited both Aldershot and Minley practices. As a result of this inspection the practice is rated as good in accordance with the Care Quality Commission's (CQC) inspection framework.

The key questions are rated as:

Are services safe? – requires improvement
Are services effective? – good
Are services caring? – good
Are services responsive? – good
Are services well-led? – good

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

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

At this inspection we found:

The practice had formalised a practice network with another practice in the region (Odiham). A formal Memorandum of Understanding was in place and this was referenced in the practice's business resilience plan.

Processes were in place to identify patients who were considered vulnerable and coding was applied on the patient record. Staff had completed safeguarding training appropriate to their role.

There were suitable health and safety arrangements in place to ensure a safe service could be delivered.

The practice, across both sites, was well-led and the leadership team had the vision, capability and commitment to provide a patient-focused service. At the time of the inspection, staffing levels were adequate. However, there was a history of inconsistent staffing levels to ensure sustainability of the provision of safe clinical care, maintain governance systems and to safeguard the health and wellbeing of staff.

There was an effective programme in place to manage patients with long-term conditions. Patients received effective care reflected in the timeliness of access to appointments, reviews, and screening/vaccination data.

Staff worked collaboratively with internal and external stakeholders and had good lines of communication with the many units, welfare teams, local NHS, and the Department of Community Mental Health to ensure the wellbeing of service personnel.

Whilst patients received their medicines in a safe way, management of staff access required oversight.

Quality improvement was embedded in practice, including various approaches to monitor outputs and outcomes used to drive improvements in patient care.

An effective system was in place for managing significant events and staff knew how to report and record using this system.

Feedback showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment

Patients found it easy to make an appointment and urgent appointments were available the same day.

We found the following areas of notable practice

For safety and thoroughness, the practice had developed a template containing a checklist of concerns to be considered when discussing vulnerable patients. This template was on DMICP (electronic clinical system) and had been shared for general use across all Defence Primary Healthcare.

The SMO has developed a quality improvement project programme to identify issues which may be a theme. Every person had a quick reference or ‘QR’ code to log any issues no matter how minor. It led them to a Microsoft forms page which asked 3 short questions to describe the issue. This was monitored by the practice manager to see if there were any themes emerging and if necessary to raise as an ASER.

To protect patient’s privacy and dignity a private corridor at the exit of the practice was identified as a key location for patients to engage with more sensitive health promotion materials and obtaining condoms, and most specifically an opportunity to pause and scan QR codes to obtain current health promotion materials. A noticeboard was put up and a defence approved QR code was sought that did not request patient personal information. QR codes for resources were produced and printed onto posters. While patients may not have always actively used these QR codes, the titles highlighting the content would serve to make patients aware of opportunities for health promotion they may not have been aware of (breast and testicular cancer risk calculators) and additional services offered by the medical practice such as the delivery of home sexually transmitted infections test kits to the medical practice for those who struggled to receive post within the garrison.

The practice had conducted a project to enhance access to smoking cessation services for their patients. They arranged for SmokeStop Hampshire to provide specific clinics at the practice to enhance access to alternatives to support smoking cessation. The project was successful and the patient feedback was positive.

The practice enhanced their delivery of asthma reviews to patients by using QR codes as an additional educational tool. This was used in the nurse clinical consultations, and the dispensary when inhalers were dispensed.

There were approximately 100 females over the age of 40 at the practice and it was felt that addressing the specific needs of this demographic could be improved. A specific women's health clinic was established to include this demographic. Two doctors with special interest in women's health and post reproductive health ran a weekly clinic. The clinic was in high demand and patient feedback was good. The clinic was also utilised by patients from other practices who could not access this area of care at their own practice. The practice had supported several 'Menopause at Work' events within the garrison which were well attended by both male and female patients and their line managers. The practice supported this cohort of patients to establish a self-run support group within the garrison.

The Chief Inspector recommends to Aldershot Combined Medical Practice

A review of the staff training programme needs to be undertaken to ensure staff have the up-to-date skills and knowledge to deliver safe care and treatment. This should include infection prevention and control and basic life support.

The management of controlled drugs requires update and review in line with the most recent controlled drug policy.

Review the throughput of staff within the dispensary with the aim to reduce staff access so risks associated with access to medicines is minimised.

Continue to review the HAF to ensure it is up-to-date.

Ensure training in learning disability and autism is provided in accordance with DMSR regulatory instruction issued in April 2024.

Ensure portable appliance testing (PAT) is completed at the Aldershot site.

Chris Dzikiti

Interim Chief Inspector of Healthcare

Our inspection team

The inspection team was led by a CQC inspector. The team included specialist advisors including a primary care doctor, practice manager, pharmacist, and a nurse. We visited both Aldershot and Minley practices. We were unable to inspect the Primary Rehabilitation Facility (PCRF) in either location due to the lack of a professional advisor to accompany the inspection team. Two new specialist advisors also attended in a shadow capacity.

Background to Aldershot Combined Medical Practice

Aldershot Combined Medical Practice (ACMP) is a dispensing practice serving a patient list of approximately 5000. At the time of the inspection 20% of the population were over the age of 40, 50% were over the age of 50 and 10% were female. The practice is split across two sites, located at Minley (Gibraltar Barracks) and Aldershot Garrison. The practice offers primary healthcare and occupational healthcare to military personnel. Additionally, the practice has a large number of temporary registrations from reservists and personnel attending career courses in the area.

The Aldershot Garrison site provides primary and occupational healthcare to approximately 40 units and is located in the Aldershot Centre for Health (ACfH). The ACfH offers multiple services including NHS X-ray, sexual health clinic and outpatient clinics in addition to Defence Community Mental Health and the regional occupational health team. The Minley site at Gibraltar Barracks is home to around 8 units including phase 2 trainees. The Aldershot site is an accredited GP training practice.

The facility, including the dispensary is open from Monday to Thursday each week, between 08:00 and 16:30 hours and between 08:00 and 13:00 hours on a Friday. The Practice provides a reduced, urgent only service from the Aldershot site on Wednesday afternoons and is closed on Friday afternoons. Between 16:30-18:30 hours (13:00-18:30 hours on Fridays), shoulder cover is provided by Pirbright. After 18:30 hours patients are diverted to out of hour's services provided by Frimley Park hospital emergency department and the NHS 111 service.

The staff team

Senior Medical Officer (SMO)	1
Civilian Medical Practitioner	6 (2 vacant, 1 on maternity leave, 1 sickness absence, 1 is loaned to headquarters 3 days per week, long term)
Practice manager	1
Deputy practice manager	1
Military nurses	2
Civilian nurses	6
Health Care Assistant	1
Exercise Rehabilitation Instructors (ERI)	4
Physiotherapists	6

Officer Command Primary Care Rehabilitation Facility (PCRF)	1
Office manager	1
Administrators	7 (3 vacant)
Combat Medical Technicians* (CMTs)	2 based at Minley but they are not DPHC assets

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

Are services safe?

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

Safety systems and processes

The practice worked to the Defence Primary Care Healthcare (DPHC) Tri-Service safeguarding policies. All staff within the practice had received up-to-date safeguarding training at a level appropriate to their role. The practice standard operating procedures (SOPs) for safeguarding had been reviewed and included contact details for local safeguarding teams. The Senior Medical Officer (SMO) was the safeguarding lead and there was regular contact with the local safeguarding teams on a case by case basis. Safeguarding concerns were discussed at monthly meetings.

Regular searches were undertaken on DMICP (electronic patient record system) for patients under the age of 18, care leavers and carers. There was a monthly meeting held where vulnerable patients were discussed. For safety and thoroughness the practice had developed a template that was a checklist for concerns such as whether the patient held a firearms licence and if the Chain of Command was aware. This template was on DMICP and had been shared for general use across all Defence Primary Healthcare (DPHC) practices. Our search of clinical records showed there were 8 care leavers under the age of 25, 30 carers and 59 personnel under 18. In addition, there were 120 personnel coded as vulnerable adults and 7 vulnerable children. These were historic cases and or service personnel who were still under 18, this provided an extra safety net to indicate that some patients were still considered vulnerable as minors.

All doctors had information given to them with regard to safeguarding arrangements and this was included in their induction pack. The SMO also spent time with new doctors to ensure they were fully aware of all safeguarding requirements.

Notices advising patients of the chaperone service were displayed in each room, in the practice leaflet and in the reception area across both sites. A chaperone audit was completed in September 2024 and it showed 93% of consultations showed the offer of a chaperone had been made. Staff who acted as chaperones 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 full range of recruitment records for permanent staff was held centrally. The practice could demonstrate that relevant safety checks had taken place for the staff at the point of recruitment, including a DBS check to ensure staff were suitable to work with vulnerable adults and young people. There were a small number of staff that did not have a DBS recorded either because they were new in post, were on long-term sick leave or because they had expired; for those, we saw evidence showing a replacement had been requested, it had been added to the risk register and an appropriate risk assessment was in place. All staff had crown indemnity and all clinical staff held a professional registration which was recorded on the staff database.

There was a dedicated lead for infection prevention and control (IPC) and they had had completed the IPC link practitioner training. The staff training database indicated that 5 members of staff were out-of-date for the annual DPHC mandated IPC training.

Measures were taken to minimise the spread of infectious diseases. Staff received updates that kept them informed of any trends or new training requirements. Personal protective equipment and hand gel was readily available throughout. Regular IPC audits had been undertaken including hand hygiene and equipment hygiene, the findings and actions were discussed at the practice meetings.

Environmental cleaning was provided by an external contractor twice daily. We visited both sites and both were clean and tidy throughout. Arrangements were in place for deep cleaning. The practice manager at Minley was having ongoing meetings with the external contractor to increase the level of cleaning from an office clean standard to a clinical clean standard. Whilst the negotiations were ongoing, the practice manager checked weekly the standard of cleaning and raised any issues with the cleaning manager and a record of this was kept.

The management of healthcare waste was in line with policy. Clinical waste was bagged, secured and marked with the practice code before being recorded in a waste log held in a dry store. Consignment notes were held at both sites and clinical waste audits completed.

Risks to patients

There was a good balance of well-trained civilian and military staff which afforded continuity of care. However, staffing levels were depleted across both sites, a number of vacant clinical posts posed a challenge to consistently deliver all aspects of the required healthcare. The practice was established for 6.8 full time equivalent civilian doctors plus the SMO. At the time of the inspection there were 5 doctor long-term vacancies, this was partially mitigated by the provision of locum doctors providing 3 full time equivalent posts spread throughout the working week. There was no deputy SMO and there were vacant civilian administrative posts.

The doctors we spoke with said they felt there were sufficient doctors when the practice was fully staffed. However, it was felt that large proportion of doctors new to the military and temporary healthcare workers impacted on the output of the practice. Not all doctors could complete occupational health reviews. A number of the larger units had Regimental Medical Officers and medics but they were only available intermittently and at short notice. There was collaborative working across both sites with the SMO often working from Minley when the civilian doctor was absent. From a patient perspective, patient feedback suggested they had had prompt access to a clinician when they needed an urgent appointment.

Not all staff within the staff team had received updated training in emergency procedures, including basic life support (BLS), automated external defibrillator (AED) and anaphylaxis. We noted on the day that 3 staff members were out of date with their annual BLS update (1 was on long term absence). Clinical staff had completed hot/cold injury mandatory training. Sepsis training was planned for all staff the following week. There was regular simulation training to supplement training. For example, most recently there was a

scenario on how to manage a patient with a heat illness. It was hoped that the next training would also involve some of the regimental medics to further build on relationships.

All staff undertaking vaccinations received training annually. Information and medicines were in all clinical areas for management of anaphylaxis.

Unplanned admissions to hospital were managed well, including effective communication and monitoring between the practice and the hospital itself. Upon discharge from hospital the patient was given a follow up appointment with a doctor.

All staff knew where the emergency medicines were located. We found all medicines on the emergency trolleys were appropriate and in-date and a risk assessment was in place.

Ambient temperature monitoring was being completed in accordance with the DPHC SOP for temperature monitoring. Oxygen was held and was accessible with appropriate signage in place. There was an AED kept at each site.

The layout of both waiting rooms allowed patients to be observed whilst waiting for their appointment.

Information to deliver safe care and treatment.

There was a thorough process in place for the summarising of patients notes. The team was using the new DPHC referrals database, the office manager and 2 other team members (one in Minley) shared the workload of managing the referrals, with a rota in place to ensure all knew who was responsible that day. Administrative staff were tasked by clinicians when a referral was completed, then the administrative team actioned it appropriately. Urgent referrals were managed in the same way and reviewed frequently. The office manager held a separate spreadsheet to monitor the number of referrals and rejections for auditing purposes.

Clinicians used peer review to measure and ensure quality of care delivery across the staff team at both sites There was an annual audit of doctor’s clinical record keeping. There was a process in place for the peer review and audit of nursing records. Clinical supervision and protected time for continual professional development was in place.

Staff confirmed that access to patient records was only occasionally a concern and did not pose a significant risk to continuity of patient care. In the event of a DPHC-wide outage, the practice would refer to the business continuity plan seeing emergency patients only and routine clinics maybe cancelled. Appointments were printed out at the end of each day for the following day and hard copy forms were held for use in this scenario and documentation would be scanned onto DMICP when available.

The Defence Community Mental Health team were located within the same building as Aldershot medical centre, staff said there was good communication between the 2 teams with easy access for advice and support.

Following prolonged significant workforce shortages across both sites new staff were recruited. This resulted in around 50% of the workforce being new to DPHC. They also

continued to require a significant number of locum staff. In order to facilitate new staff's ability to find the information that they needed to facilitate safe and efficient care, the SMO used the SharePoint site and the healthcare governance workbook and developed new desk top instructions for the administrative team. The whole team came up with ideas on what useful information to include.

An effective process was in place for the management of specimens and this was supported by a detailed local working practice (LWP). Samples taken were recorded on a spreadsheet and results were returned via the PathLinks (electronic link between the pathology laboratory and healthcare services) inbox. These were then reviewed by the nursing team who updated the spreadsheet to confirm receipt before allocating to the requesting doctor for action. Pathology specimens were taken to the local NHS Hospital (Frimley Park). The nurses were responsible for checking that all the results had been returned and sent results on PathLinks to the requesting doctor. All results were reviewed by the duty doctor and any emergencies were dealt with on the day as required. In a recent audit it was noted that 10% of results had to be manually chased and approximately 5% of patients needed recall to repeat the test. The SMO and the SNO had a meeting booked with the hospital to discuss this issue. This issue had not led to any serious issues but had led to a delay in diagnosis. A significant event had been raised.

Safe and appropriate use of medicines

There was a dedicated lead for medicines management and the day-to-day tasks were delegated to the pharmacy technician. This was reflected in the terms of reference (ToRs). The ToRs were signed electronically and were in date.

Arrangements were established for the management of controlled drugs (CDs), including destruction of unused CDs. However, a review and update of daily practice in line with the most recent controlled drug policy should be undertaken. We found internal monthly checks had not all been completed.

The CD keys were kept separate from the dispensary keys. There were clear processes in place for the access to CDs out of hours.

The medical emergency trolleys and medicines were checked weekly across both sites these were recorded. We checked all the emergency medicines and kit and these were in-date.

The pharmacy technician was registered to access the Medicines and Healthcare products Regulatory Agency and the Central Alerting System website for alerts. These were actioned by the most appropriate person and information was shared and discussed at practice meetings. For example following MHRA advice notices in June 2024, Topiramate (used to treat epilepsy) was added to the monthly practice searches (in addition to the already searched Valproate) to ensure that the appropriate precautions were in place for patients taking these medicines.

Medication requiring refrigeration was monitored twice a day to ensure it was stored within the correct temperature range. Fridges were locked in the treatment rooms and the ambient temperature in these rooms was monitored.

Patient Group Directions (PGDs) had been signed off to allow appropriately trained staff to administer medicines in line with legislation. The PGDs were current and signed off by the authoriser. Medicines that had been supplied or administered under PGDs were in-date. A spreadsheet had been developed that was maintained by the dispensary that informed all staff of what vaccination PGDs they were in date for. Patient Specific Directions were not used.

There were clear and thorough processes in place for the requesting and issuing of repeat medication. Through discussion and review of DMICP records, it was evident that there was a clear audit trail for the request of repeat medication.

The dispensary door was not always secured to allow nurses in for vaccines. The door to the dispensary should be locked at all times.

Valproate (medicine to treat epilepsy and bipolar disorder) searches were regularly undertaken, at the time of the inspection.

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

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

Track record on safety

Measures to ensure the safety of facilities and equipment were in place. The garrison conducted inspections and held the details on a spreadsheet, health and safety audits were completed and sent back to the health and safety team. Electrical safety checks were up-to-date. Water safety checks were regularly carried out. A legionella risk assessment had been completed in February 2022.

A fire risk assessment of the building was undertaken annually. Firefighting equipment tests were current. Staff were up-to-date with fire safety training and were aware of the evacuation plan.

Portable appliance testing (PAT) had not been completed at the Aldershot site with all equipment yet to be tested. PAT testing had been completed at Minley.

There were a range of both clinical and non-clinical risk assessments were in place including lone working.

Both locations had had a mixture of fixed and portable alarms. Aldershot had a built-in alarm system. However, downstairs the system was currently not working (there was no

lone working in this area allowed), all staff had personal alarms and alarms were tested on a 2 weekly basis and recorded on the healthcare governance workbook.

Lessons learned and improvements made

All staff worked to the DPHC policy for reporting and managing significant events (SE), incidents and near-misses, which were recorded on the electronic organisational wide system (referred to as ASER). They were discussed at the ASER meeting every month but sooner if more urgent. An ASER register was maintained. All staff had completed ASER training to access the system. All staff we spoke with knew how to raise an SE or incident.

The SMO has developed a quality improvement project programme to identify issues which may be a theme. Every person had a quick reference or ‘QR’ code to log any issues no matter how minor. It led them to a Microsoft forms page which asked 3 short questions to describe the issue. This was monitored by the practice manager to see if there were any themes emerging and if necessary to raise as an ASER.

Are services effective?

We rated the practice as good for providing effective services.

Effective needs assessment, care, and treatment

Clinicians had opportunities to attend regional forums, such as regional governance meetings and nurse development forums. All doctors were signed up to receive the National Institute for Health and Care Excellence (NICE) and the Scottish Intercollegiate Guidelines Network (SIGN) clinical update emails. Defence Primary Healthcare (DPHC) standard operating procedures (SOPs) were shared with all staff via emails as updates happened. Any new updates were discussed in the clinicians meetings and then shared with the wider team as needed.

There were nominated leads for various long-term conditions. They were responsible for updating other clinicians regarding new guidelines (NICE and SIGN) in their particular areas and these were presented at the monthly governance meetings and clinical staff meetings. In addition, there was a practice WhatsApp group which was used to disseminate more urgent information

The practice policy was that patients with complex medical needs were coded as vulnerable. Therefore, these cases were discussed at the monthly clinical team meetings. There was also a fortnightly doctors meeting where patients of concern could be discussed. All of the doctors informally met with their colleagues during the day and the doctor from Minley also regularly attended meetings at Aldershot.

Monitoring care and treatment

The Senior Nursing Officer (SNO) was in the process of taking over the role of recalling patients with long-term conditions. The use of templates was encouraged in accordance with the new DPHC policy for managing chronic disease. The aim of the practice was to introduce a one stop shop and align all reviews for those with multiple conditions to reduce the number of attendances required by patients.

New chronic disease templates were used and diseases coded appropriately in patient's notes. There was no chronic disease register, instead this was monitored by using the built-in searches on the clinical system (DMCIP). Patients were notified via text and they were invited to book in with nurse. Following the initial appointment a follow up was made with the appropriate clinician for review including advice and guidance.

There were 42 adult patients on the diabetic register. For 26 patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For 35 patients with diabetes, the last blood pressure reading was 150/90 or less which is an indicator of good blood pressure control.

One hundred and nineteen patients were identified as having hypertension (high blood pressure) and 115 all had a record confirming their blood pressure was checked in the past 12 months.

Forty-two patients had a diagnosis of asthma and 32 had an asthma review in the preceding 12 months. Of the patient records we reviewed, 2 had a history of childhood asthma and were coded incorrectly, the Senior Medical Officer (SMO) agreed to review both cases with haste. The asthma template within the chronic disease DMICP menu was consistently used and patients had been repeatedly recalled. The annual asthma reviews had been enhanced by the use of QR codes as educational tools for patients to optimise their inhaler techniques. These were also used at the dispensary when inhalers were dispensed.

Audiometry assessments were in date for 82% of the patient population. A review of patient records indicated appropriate Hearing Conservation Programme recalls were in place and patients were being managed in line with DPHC policy. Over 40 health checks were completed opportunistically or by direct patient request. The practice were not able to actively recall patients for the checks due to staffing constraints but every effort was made to review these patients when possible.

Patients with mental health needs were managed and supported in line with standard practice. Step 1 of the mental health intervention programme was provided mainly in relation to anxiety and depression. This included use of the appropriate assessment tools. Medical staff described a good relationship with the Department of Community Mental Health. Our review of records for patients with a mental health need showed they were appropriately supported and managed. The practice had devised a self-help handbook available for patients, with information about mental health issues as well as contact for local support agencies such as Safehaven (local NHS service). There were lists of various online tools in each clinician's room with QR codes. They were all aware of the ability to refer to the unit welfare officers. Each room also had details about the bullying and harassment hotline.

There was a comprehensive audit programme in place alongside an annual schedule kept on the healthcare governance workbook. This was overseen by the SMO and all clinical staff were involved in the audit process. Clinical audit was used to ensure care and treatment followed evidence based guidelines. Audits were discussed at monthly governance meetings. Nearly all audits had completed more than one cycle.

When Medicines and Healthcare products Regulatory Agency (MHRA) or similar advice was issued, it was discussed in the monthly meeting and the practice routinely responded to relevant alerts by conducting audits to ensure that advised practice in these areas was adopted. For example:

B12 deficiency in patients on long term Metformin (used to control blood sugar) (MHRA advice issued June 22). The initial audit was conducted following release of this advice and showed that 24% of at risk patients had B12 levels checked. A repeat audit showed improvement and at the last cycle (September 2024) 93% of at risk patients had monitoring in the last year.

A Boostrix in pregnancy (Pertussis vaccine) audit was initiated because due to NHS and Defence Medical services (DMS) IT compatibility issues, DMS practices were not routinely informed by NHS midwifery teams when vaccines were given (the NHS midwifery team used an IT system called RAVS (NHS Record a Vaccine Service). The practice felt that it was important to have assurance that pregnant patients were receiving this as part of their antenatal care, so an audit was conducted. Of the 28 pregnancies over the 6 month retrospective review there was no evidence of vaccination in 57% of eligible patients. As a result a local system was established between the patients, the practice and the NHS midwifery team to ensure more effective communication was received for assurance purposes.

Nurses undertook many audits including, yellow fever, patient group directives and infection prevention and control. A recent blood grouping audit was undertaken by the nurses. This was initiated as it was found that 42 phase 1 and 2 soldiers had arrived at the garrison with no blood group recorded. The nurses added a prompt regarding blood grouping onto the summarisation screen on their clinical record. A second audit was undertaken 4 months later and it showed all patients had their blood group recorded.

Effective staffing

There was an extensive and bespoke induction programme, with a separate induction for locum staff. There was an induction register on SharePoint. Both DPHC and workplace inductions were recorded on the staff database. The group practice manager monitored induction to completion and induction checklists were retained. There were also comprehensive tabletop instructions available for all departments.

Mandatory training was recorded on the healthcare governance workbook which captured internal and external trainings. At the time of the inspection the log showed 91% of training had been completed. Protected time was allocated for mandatory training as well as continuing personal development (CPD).

The doctors all completed regular appraisal and revalidation. The nurses had completed their revalidation. All clinicians were aware of the CPD requirements and used clinical meetings, mandatory training, and practice meetings to support with meeting this requirement. Clinical supervision took place regularly with good supportive cross working between Aldershot and Minley.

Aldershot is a GP training practice but did not have a registrar at the time of inspection. The Senior Medical Officer was a trainer. The practice also had General Duties Medical Officers but were tasked away from the area at the time of the inspection.

Coordinating care and treatment

Aldershot was co-located with NHS practices and organisations in a building owned by the local authority. This lent itself to easy transfer of information when patients were leaving the military especially to live in the local area. Most of the locum doctors were local GPs with good local knowledge of the area.

The transfer of complex patients to other military medical centres was usually done via email and if necessary, would lead to an online case conference with relevant professionals attending. For patients leaving the military, pre-release and final medicals were offered. During the pre-release phase, the patient received an examination and a medication review. A summary print-out was provided for the patient to give to the receiving doctor, and a letter if the patient was mid-way through an episode of care. In addition to this, a thorough service user leavers' healthcare guide was given to the patient, this contained comprehensive information to help the patient access different sorts of help to support them as a civilian. This was a bespoke locally developed initiative in collaboration with another local practice, to enhance the onward care of service patients leaving the military.

Helping patients to live healthier lives

There was a named lead and deputy for health promotion. There was a structured programme of health promotion activity with a yearly planner aligned with the DPHC calendar. The health promotion displays were comprehensive, clear and positioned in the waiting area and outside of the dispensary. Staff has been involved in supporting health fairs and linked in with station health promotion work such as the annual 'health and wellbeing day'.

Quick response codes were available throughout the practice for patients to use and including information on sexual health. Three nurses had specific training (STIF) in sexual health and provided sexual health support and advice. Patients were signposted to a local NHS sexual health clinic for procedures not undertaken at the practice. Patients could obtain a self-test kit online and condoms were available from the practice (discreetly positioned in the private exit corridor).

There was a detailed local working practice to support NHS screening. All eligible female patients are on the national cervical screening database and were recalled by the nurse. The latest data confirmed an 91% uptake, the NHS target was 80%. Regular searches were undertaken to identify patients who required screening for bowel, breast, and abdominal aortic aneurysm in line with national programmes. Alerts were added to their DMICP record which allowed for opportunistic discussion with a health professional. DMICP searches had been created for all national screening.

The practice conducted additional vaccination searches each month to ensure that specific demographics of patients had the appropriate vaccine protection. These included pneumococcal vaccination, HPV (Human Papilloma Virus) vaccination for catch up programmes, shingles in appropriate personnel over 50 years of age, and Boostrix vaccination in pregnancy. An audit was undertaken and a quality improvement was underway to look at developing a more efficient/robust system of communicating this information, enabling DMS system compatibility with NHS RAVS (Record A Vaccine Service) system.

Vaccination statistics were identified as follows:

- 92% of patients were in-date for vaccination against diphtheria.

- 92% of patients were in-date for vaccination against polio.
- 94% of patients were in-date for vaccination against hepatitis B.
- 94% of patients were in-date for vaccination against hepatitis A.
- 92% of patients were in-date for vaccination against tetanus.
- 98% of patients were in-date for vaccination against MMR.
- 88% of patients were in-date for vaccination against meningitis.

Consent to care and treatment

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. Written consent was taken for invasive procedures and implied consent for non-invasive examinations. Consent was included within the chaperone audit undertaken in September 2024 and showed good compliance.

Clinicians understood the Mental Capacity Act (2005) and how it would apply to the patient population group. They had received training recently in mental capacity. Clinicians were aware of both Gillick competence (young people under 16 with capacity to decide) and Fraser guidelines (advice/treatment focussed on a young person's sexual health).

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect, and compassion

In advance of the inspection, patient feedback cards were sent to the combined practice, feedback was from patients that had been seen by the Primary Care Rehabilitation Facility (PCRF), the dispensary and the medical and administrative staff. A total of 67 patients from both sites responded and feedback was positive, reflecting a general theme of kind and caring staff.

We were given several examples where staff went above and beyond to help and support patients. For example all patients with terminal illness had direct access to a named doctor with another clinician as a 2nd point of contact to ensure optimisation of continuity of care. In some cases, where necessary, regular liaison occurred.

In addition to a mental health and wellbeing notice board in the waiting room the practice created a ‘What’s on in Aldershot’ board with details of local events and opportunities (in addition to signposting to ‘The Hive’ and families office), in an attempt to signpost to alternative activities instead of patients being at risk of isolation sitting in their rooms.

The last patient survey, undertaken by the combined practice, showed 64 patients had provided responses through the DPHC Patient Experience Questionnaire between January and June 2024. Overall the responses were positive with 81% confirming they are satisfied with their healthcare. Where any negative responses were received these were discussed and actions made to address these. Patient feedback was used positively and as a tool for improvement.

Patients could access the welfare team and various support networks for assistance and guidance. Information regarding these services was available in the waiting areas and the clinical staff were fully aware of these services to signpost patients if required.

Involvement in decisions about care and treatment

Carers were identified when the patient registered at the practice. There were also posters around the garrison asking carers to identify themselves. There were 32 carers on the register with appropriate alerts, monthly searches were undertaken to ensure any new carers were recognised. They were offered flu vaccines and health checks when appropriate. There was information for carers included in the practice leaflet and on the notice boards at both sites.

Supported by a standard operating procedure, a translation service was available for patients who did not have English as a first language. There was also information available in different languages, for example Nepalese.

Privacy and dignity

Consultations took place in clinic rooms with the door closed. Patients were offered a private room if they wanted to discuss something in private or appeared distressed. Telephone conversations were undertaken in private to maximise patient confidentiality.

The reception area at Aldershot was large and well laid out with the waiting area was at a distance from the reception in a separate room meaning that conversations between patients and reception would unlikely be overheard. At Minley the waiting room was in view of the reception and conversations could also not be overheard.

All staff had completed the Defence Information Management Passport training which incorporated the Caldicott principles.

Are services responsive to people's needs?

We rated the practice as good for providing responsive services.

Responding to and meeting people's needs

Econsult was the favoured route for patients when requesting an appointment, once triaged by a clinician, they were then offered a telephone or face-to-face appointment. The practice found this system to be effective for patients to gain access to appointments. Appointments were offered to patients with the most suitably trained clinician.

The practice provided occupational health reviews for patients. A monthly search was done to identify those personnel who were either overdue or about to go out-of-date. These lists were pushed out to the units who were then given the responsibility to ensure that patients were booked in with a doctor.

The practice was implementing a new process whereby the Senior Medical Officer or the Senior Nursing Officer (SNO) carried out the recall searches. Patients were then informed via text through 'gov notify'. The patient then booked in with nurse for blood tests and monitoring. One week after these tests, they were booked for a nurse appointment to discuss the results and any lifestyle guidance. If required the patient would then have an appointment booked in with the doctor for any further care, for example a medication review. This system worked on the recall system rather than individual conditions so all the nurses were being trained to look after all chronic disease, apart from asthma, these patients care was overseen by the advanced nurse practitioner.

There were approximately 100 females over the age of 40 at the practice and it was felt that addressing the specific needs of this demographic could be improved. A specific women's health clinic was established to include this demographic. Two doctors with special interest in women's health and post reproductive health ran a weekly clinic. The clinic was in high demand and patient feedback was good. The clinic was also utilised by patients from other practices who could not access this area of care at their own practice. The practice had supported several 'Menopause at Work' events within the garrison which were well attended by both male and female patients and their line managers. The practice supported this cohort of patients to establish a self-run support group within the garrison.

An Equality Access Audit as defined in the Equality Act 2010 was completed at both sites within the past year. Any points identified were discussed and put onto the issues register.

A dedicated member of staff was the lead for diversity and inclusion, there was good communication with the unit leads. There was a notice board with information and contact details for patients at both sites.

Issued by the Defence Medical Services Regulator in April 2024, we asked about the Regulatory Instruction, 'Training for staff in learning disability and autism' and how it was being implemented. Staff were unaware of this instruction at the time of the inspection and said they would ensure the instruction was reviewed and the training provided.

Staff were familiar with the new Defence Primary Healthcare (DPHC) transgender standard operating procedure. A small number of patients were being supported with gender reassignment and their doctor regularly liaised with the secondary care services involved.

Timely access to care and treatment

Feedback indicated patients were satisfied with access to a doctor or nurse. To ensure the streamlining of appointments and access to clinics the Deputy SNO had created a booking guide which showed which nurse could deliver what intervention and how long was required for each appointment. The guide was created to support, primarily the reception staff and was used to support appointment booking undertaken by clinicians for cross-site intervention and helped to ensure the patient was seen by the right person at the right time. Since its introduction nurses felt is had helped and improved patient flow and accessibility to appointments.

Details of how patients could access a doctor when the practices were closed were available through the garrison helplines and was outlined in the practice information leaflets and in the unit orders.

An urgent appointment with a doctor or nurse could be accommodated on the same day. Routine appointments with a doctor could be facilitated within 2 weeks and for a nurse within 5 days.

The patient information leaflet, answerphone message and patient information board outside of the medical centre provided details about opening times and access to medical care out-of-hours. There was a memorandum of understanding (MoU) in place between Pirbright and Aldershot Combined Practice. The aim of the MoU was to formalise the agreed arrangements for the provision of acute primary healthcare outside normal working hours for specified medical practices in the region. This MoU described alignment of out-of-hours acute primary healthcare provision for DPHC.

Listening and learning from concerns and complaints

The group practice manager was the lead who handled all complaints in the practice. The practice had implemented a process to manage complaints in accordance with the DPHC complaints policy and procedure, 5 complaints had been recorded within the past 12 months. Complaints were discussed in the monthly practice meetings.

Information was available to help patients understand the complaints system, including in the patient information leaflet and in the waiting rooms.

Are services well-led?

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

Vision and strategy

Staff we spoke with were clear that their remit was to support patients to benefit from the best possible healthcare outcomes which, in turn, supported operational capability.

The practice worked to the Defence Primary Healthcare (DPHC) mission statement which was:

> 'DPHC is to provide safe, effective healthcare to meet the needs of our patients and the chain of command to support force generation and sustain the physical and moral components of fighting power'.

The practice also worked to its own philosophy

- Focus on delivering optimal clinical care – safe, holistic, evidence-based
- Working in partnership with all stakeholders, patients, executives, NHS etc
- Aim for clear articulation of priorities, understood throughout practice
- combined working, working practices and resilience
- Encouraging continuous quality improvement across all departments

Leadership, capacity, and capability

All staff we spoke with were happy with the leadership of the practice. The Senior Medical Officer (SMO) was very experienced and had a wealth of knowledge. However, it was felt that they were taking on a huge burden to provide line management, clinical overview and military guidance. There had been a significant turnover of staff in recent years and a number of locum doctors who had limited military experience so were not able to assist with much of the occupational health aspect of the workload. The SMO had no deputy SMO to support them. While some of the units have medics, there were no DPHC medics. The unit medics could only assist occasionally so the majority of audiometry checks were being completed by the nurses instead of using their skillset in other areas. All staff felt that the combined practice was working together well.

The staff spoke of a supportive working relationship with the regional nurse advisor and the regional clinical director visited regularly. The staff teams across both sites worked hard to deliver the best possible care to patients.

The group medical practice was an approved training practice and had a good training ethos that considered the population it provided care for. There was protected time for

practice meetings and training although not all staff had completed or recorded their training adequately. Staff we spoke with had a positive attitude towards learning.

To address environmental sustainability one of the doctors initiated the 'Greener Practice Project'. The aim of the project was two-fold, to optimise sustainability but also to provide a whole team project. This involved all staff across both sites promoting a healthy team culture. As part of the project they had altered their inhaler prescribing, introduced a system to recycle inhaler cartridges. The next steps were to develop a safe hormone patch disposal service and initiate bicycle racks so staff could ride to work. There were also plans to try block booking force health preparation clinics by providing 'bulk transport' it was also encouraging the recycling of empty pill packets. They had asked for patient feedback which would help to develop the direction of further travel with this project.

Culture

It was clear from patient feedback, interviews with staff and quality improvement activity that the needs of patients were central to the ethos of the practice. Staff felt that their contributions to the development of the service were valued. All staff attended the practice meetings where they could put forward suggestions or raise concerns.

We interviewed a cross section of staff, and all told us that it was a happy place to work and that they could rely on their work team to discuss and mitigate any concerns they faced. Due to the large number of relatively new staff to the practice a 6 monthly staff satisfaction survey was conducted to ensure that any issues with team development and cohesive working were identified early. Any issues raised were then addressed effectively in the appropriate time frame.

Staff said they would feel comfortable raising any concerns and were familiar with the whistleblowing policy, they had access to the whistleblowing local working practice as well as online and telephone civil service and MOD bullying and harassment helplines. An anonymous staff suggestion box was also in place at both sites, for staff to place concerns and/or ideas into

Processes were established to ensure compliance with the requirements of the duty of candour, including giving those affected reasonable support, information, and a verbal and written apology. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.

Governance arrangements

Communication across both sites was strong and an appropriate meeting structure and healthcare governance approach was in place. There was a healthcare governance workbook in place for monitoring governance activity.

There was a range of Standard operating Procedures (SOPs) in place for all key processes and these were kept under review. There was an SOP tracker in place which identified the document owner and the required review date for monitoring purposes.

A thorough rotation of a range of meetings was in place to ensure effective communication and information sharing across the staff team. Other meetings included heads of department, healthcare governance, clinical, administrative and the practice meeting.

An understanding of the performance of the practice was maintained. The system took account of medicals, vaccinations, cytology, and non-attendance.

Managing risks, issues and performance

There was an active risk register, the was also an issues log. All the known key risks and issues were recorded on the registers. The 4Ts process' (transfer, tolerate, treat, terminate), were clearly applied to risks and a review date was evident. However, it was not evident if risk had been accepted or transferred to RHQ. We discussed this with the group practice manager and they agreed to action this. There were a range of both clinical and non-clinical risk assessments in place.

A management action plan had been developed using the internal assurance visit as a baseline, this was easily accessible and was kept up to date and review was ongoing.

Staff who were not performing would be supported initially to identify any underlying cause and implement support structures. If performance did not improve then formal performance management processes, military or civilian, would be followed.

The business continuity plan was in place and this had been reviewed, it detailed the action to be taken in the event of loss of any services.

Appropriate and accurate information

Following the recent uplift in workforce after a period of chronic staffing vacancies the group practice aimed to ensure that the governance framework was developed and adjusted to re-optimize safety processes and ensure that these become efficiently and firmly embedded within the new team by December 2024. The practice had completed the transition to the new SharePoint site necessary prior to populating the HAF (health assessment framework). Presently, transfer of healthcare governance to HAF had been paused due to the shortage of staff, this was hoped to be completed by the end of the year. There were arrangements at the practice in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

Various options were available to prompt patients to provide feedback on the service and the practices acted on feedback received, including the DPHC online survey. There had been 64 responses in the past 6 months. These responses were audited by the SNO in

July 2024 and as a result improvements were made to the availability of urgent appointments.

Good and effective links were established with internal and external organisations including the welfare department, NHS, Department of Community Mental Health and local health services. The practice had partnered with SmokeStop Hampshire to enable the patients access to further support with smoking cessation, for example prescribing eCigarettes.

Continuous improvement and innovation

The team were working to improve understanding of quality improvement projects (QIPs) and relevant audit. There was an active QIP register in place with input from across the team. The group combined practice operated a whole team approach to improvement through open team discussions and meetings. Of note:

To protect patient's privacy and dignity a private corridor at the exit of the practice was identified as a key location for patients to engage with more sensitive health promotion materials and obtaining condoms, and most specifically an opportunity to pause and scan QR codes to obtain current health promotion materials. A noticeboard was put up and a defence approved QR code was sought that did not request patient personal information.

QR codes for resources were produced and printed onto posters. While patients may not have always actively used these QR codes, the titles highlighting the content would serve to make patients aware of opportunities for health promotion they may not have been aware of (breast and testicular cancer risk calculators) and additional services offered by the medical practice such as the delivery of home sexually transmitted infections test kits to the medical practice for those who struggled to receive post within the garrison.

The group practice held a monthly meeting to discuss all patients on the practice's

vulnerable adults list. This ensured dynamic development of safety plans for individuals

according to their needs, in addition to informing wider clinician situational awareness.

A template was developed to ensure all areas of safeguarding were captured for each case.

Introduction of a booking guide which showed which nurse could deliver what intervention and how long was required for each appointment. The guide was created to support, primarily the reception staff and was used to support appointment booking undertaken by clinicians for cross-site intervention and helped to ensure the patient was seen by the right person at the right time.

A Boostrix in pregnancy (Pertussis vaccine) audit was initiated because due to NHS and Defence Medical services (DMS) IT compatibility issues, DMS practices were not routinely informed by NHS midwifery teams when vaccines were given (the NHS midwifery team used an IT system called RAVS (NHS Record a Vaccine Service). The practice felt that it was important to have assurance that pregnant patients were receiving this as part of their

antenatal care, so an audit was conducted. Of the 28 pregnancies over the 6 month retrospective review there was no evidence of vaccination in 57% of eligible patients. As a result a local system was established between the patients, the practice and the NHS midwifery team to ensure more effective communication was received for assurance purposes.

The transfer of complex patients to other military medical centres was usually done via email and if necessary, would lead to an online case conference with relevant professionals attending. For patients leaving the military, pre-release and final medicals were offered. During the pre-release phase, the patient received an examination and a medication review. A summary print-out was provided for the patient to give to the receiving doctor, and a letter if the patient was mid-way through an episode of care. In addition to this, a thorough service user leavers' healthcare guide was given to the patient, this contained comprehensive information to help the patient access different sorts of help to support them as a civilian. This was a bespoke locally developed initiative in collaboration with another local practice, to enhance the onward care of service patients leaving the military.

One of the doctors initiated the 'Greener Practice Project'. The aim of the project was two-fold, to optimise sustainability but also to provide a whole team project.

Introduction of a mental health local resource booklet information booklet.

Introduction of the service leavers healthcare guide.

Improving information accessibility for staff by re- designing the team Sharepoint site, and healthcare governance workbook and alongside this developed new desk top instructions.

It was noted at the significant event working group that the number of incidents reported was decreasing. Despite regular prompting to submit significant events on the formal system, it was evident that smaller problems were not being reported, for example clinic letters not returned, blood result not returned from laboratory and appointment booking errors. As new staff were employed, it was vital to capture issues as they arose in practice to ensure timely and responsive management. To facilitate timely capture of issues they decided to trial a new simple reporting method to ensure that issues could be simply reported and trends analysed. The group practice developed a QR code via MS Forms with 3 very simple questions. Using this simple reporting tool provided evidence to develop improvements projects to address wider problems. Examples of quality improvement established from utilising this tool included improving access to NHS systems (for letters, radiology reports and lab results), a review of the referrals systems and training needs analysis.