Winchester Group Practice

Winchester Group Medical Practice (Marchwood, Winchester and Worthy Down)

Worthy Down, Winchester SO21 2RG

Defence Medical Services inspection

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

Overall rating for this service	**Requires improvement**	
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?	**Requires improvement**	

Contents

Summary

About this inspection

We carried out this announced comprehensive inspection on 14 February 2023. We visited all 3 locations on the day.

As a result of this inspection the practice is rated as requires improvement overall 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? - requires improvement

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

This inspection is one of a programme of inspections that 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:

Patient feedback about the service was positive. It showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment. Patients told us they received appointments at a time that suited them.

Staff induction and training processes were unclear. Whilst some staff confirmed they had received and induction there were no records to confirm this. The management of staff training was not robust.

Medicines management required improvement.

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

The practice had good lines of communication with the unit, welfare team, local NHS, the Local Medical Council, social services, and the Department of Community Mental Health to ensure the wellbeing of service personnel.

All staff knew how to raise and report an incident and were fully supported to do so. The systems and management of significant events needed improvement.

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

An inclusive whole-team approach was supported by all staff who worked collaboratively to provide a consistent and sustainable patient-centred service.

A programme of quality improvement activity was in place and this was driving improvement in services for patients.

Staff were aware of 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). Examples we reviewed showed the practice complied with these requirements.

The management of governance systems should be strengthened to ensure all relevant information is captured to monitor service performance.

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

In 2020 the group practice partnered with the Public Health collaboration (who delivered Patient Participation Group education for NHS practices) to offer interested Type 2 diabetics and pre diabetics the chance to participate in a 12-week programme consisting of weekly group education sessions focussed around a low carbohydrate and non-processed food healthy diet. This included regular monitoring of the patients' Body Mass Index and their blood sugar levels. The results showed that at 12 weeks 87% of patients had improved blood sugar levels (HBA1c), 43% maintained HBA1c improvement at 1 year (similar to NHS practices). This was important since good diabetic control was key for each patient and their operational work. Moving forward the plan was to begin training the facilitators (medically trained) with the intent that practice groups could offer the 12-week intervention from this summer. A step-by-step guide for the facilitators guiding what should be covered in each of their group sessions had been written. The practice had engaged with training providers and sourced funding via DPHC HQ for this education. This initiative had been shared nationally.

The status of safeguarding and vulnerable patients was discussed at the weekly meetings with the Welfare Officers. The needs of vulnerable patients were discussed at monthly Unit Health Committee meetings, prior to these meetings a Unit Support Committee was held to pick up details of vulnerable patients' unknown to the unit.

The practice had helped organise several regimental events with external speakers / chefs to educate soldiers about how to eat healthily – including how to eat lower carbohydrates and processed food. A chef demonstrated several healthy recipes using easily obtainable low-cost ingredients. They have also linked with a Fijian nutritionist so they could be included with healthy cultural alternatives. Alongside this one of the doctors attended some of the Defence Health and Wellbeing Advisor training. The practice team were rethinking

their approach to obesity (which was being discussed with the unit as well as being presented alongside the Defence Nutritionist at this year's Civilian Medical Practitioner conference), and the reinvigoration of other initiatives to help the unit tackle unhealthy behaviours.

One of the doctors had a specialist interest areas in addiction / alcoholism and although they worked closely with Department of Community Mental Health in the acute stages, it was apparent that sustained sobriety was dependant usually on peer support. Usually, the advice given was to approach Alcoholics Anonymous or Narcotics Anonymous for support which did not suit all uniformed personnel. The doctor, through their external work with an addiction organisation, became aware of the Self-Management and Recovery Training (SMART) and found that there were online groups for military and veterans already in place. They also found that one other practice had funded their own SMART meetings and were happy nationwide for patients to attend. The practice helped promote these nationally via a series of education meetings both in house, but also at national quality improvement (QI) forum. The doctor also promoted this at Practitioner Health and BDDG (British Doctors and Dentists Group) in house and at regional events, as sources of support for doctors and nurses suffering with mental health or addiction problems.

Noticing the bespoke needs of a cohort of soldiers in Marchwood the practice partnered with the unit to develop a course aimed at teaching some resilience skills. It was a 2-week course, led by the unit, and included some education in the morning, followed by resilience activities in the afternoon (meditation, mindfulness, group exercise, Reiki etc). Other themes included demystifying the DCMH process (including signposting which symptoms must prompt medical help), chronic pain and ways of coping, nutrition, and stress management including the normal and helpful stress response. The results showed almost 100% improvement in physical and mental wellbeing scores at the close of each course. There were steps to roll this out to Worthy Down. This would be presented at the national QI forum in July. Marchwood planned to deliver a bespoke course for senior staff this year (those responsible for managing people) so they could be helped to understand resilience (and neurodiversity) and so support soldiers more effectively.

The Chief Inspector recommends to Defence Primary Healthcare (DPHC):

Ensure the risk register is in accordance with DPHC policy. This should include a full range of risk assessments for the group practice and they should be reviewed to ensure they are up to date.

A review of staff induction and the management of the training programme needs to be undertaken to ensure staff have the skills and knowledge to deliver effective care and treatment.

Review systems and processes for medicines management to ensure they are fully effective. In line with DPHC policy and being followed. This should include a review of systems and processes for the management of patient safety notices and the transporting of medicines in the cold chain.

Review how complaints are managed including effective recording.

Review the process to ensure recruitment, checks of professional registration and the Disclosure and Barring Service checks (DBS) are completed and recorded appropriately.

Improve the facilities and monitor the cleaning arrangements in line with the Health and Social Care Act 2008: 'Code of practice on the prevention and control of infections and related guidance'.

The process for the management of significant events should be reviewed to ensure it is in accordance with DPHC policy, including how lessons learnt are shared and recorded.

The process of managing internal referrals should be reviewed with a view to considering a central monitoring process in line with how external referrals are managed.

Review the requirements to ensure that staff at Winchester Medical Centre are working and patients are seen within an acceptable temperature range. Where staff feel cold at work, risk assess to ensure that they are supported to stay warm.

Ensure there is a fully functioning and tested alarm system.

The governance arrangements should be reviewed with a view to fully integrating all systems and processes to support the group practice arrangements.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

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

Our inspection team

The inspection team was led by a CQC inspector. The team comprised an additional CQC inspector, specialist advisors including a primary care doctor, a practice manager, a physiotherapist, senior pharmacy technician and a nurse. In addition, 5 new specialist advisors shadowed this inspection.

Background to Winchester Group Practice

Winchester Group Practice consists of 3 medical centres located across three sites: Winchester, Worthy Down and Marchwood. The patient population was variable but at the time of the inspection was 2,476.

Winchester Medical Centre serves a diverse population including army recruits undertaking basic training (the first 14 weeks of army training). There is an in-house physiotherapy service for military patients although this is located in a separate building.

Worthy Down Medical Centre provides care to six hundred permanent members of staff and eight hundred students. In addition, approximately 10,000 personnel are treated at the medical centre each year whilst attending courses at Worthy Down. The courses vary in duration of between 6 weeks and several months.

Marchwood Medical Centre is a field army establishment on the edge of the New Forest. The practice provides primary care for local military staff working at Southampton Hospital and also Southampton University Officer Training Corps staff. Rehabilitation for

Marchwood patients is currently enabled at Worthy Down whilst options to re-locate the Primary Care Rehabilitation Facility (PCRF) at that location are under discussion.

Each of the practices are open from 08:00 hours to 16:30 hours Monday to Thursday and from 08:00 hours to 16:00 hours on a Friday. Between 16:30 hours and 18:30 hours cover is provided remotely by a duty healthcare worker. A memorandum of understanding is in place with the local urgent care treatment centre stating that all referred military patients will be seen from16:30. Outside of these hours, including weekends and bank holidays, NHS 111 provides cover.

The staff team

Senior Medical Officer (SMO) (military)	1
Civilian Senior Medical Officer	2
Medical Officers	1 (deputy SMO based out of Worthy Down)
Civilian medical practitioner	7
Practice manager	3
Nurse	11 plus one health care assistant
Senior Pharmacy Technicians	2
Exercise rehabilitation instructors (ERI)	5
Physiotherapists	5
Administrators	7

Are services safe?

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

Safety systems and processes

One of the doctors was the lead for safeguarding and in addition each location had a lead doctor for safeguarding. All staff had received up-to-date safeguarding training at a level appropriate to their role. Face-to-face updates and safeguarding training was delivered by one of the doctors to any staff requiring an update within the group practice. This included mental capacity training updates. The practice standard operating procedures (SOP) for both adult and child safeguarding had been reviewed and included contact details for local safeguarding teams. All staff had the NHS safeguarding app on their phones which provided details of out-of-area contacts. Staff we spoke with all had in depth knowledge of the requirement to safeguard.

Safeguarding concerns were discussed at the monthly clinical meetings. A vulnerable persons register, including patients under the age of 18, was maintained and a search of DMICP (electronic patient record system) was undertaken monthly. If the group practice was made aware a patient was a care leaver then a code was added to their clinical record for ease of identification.

The doctors had strong links with the Primary Care Rehabilitation Facility (PCRF) team, welfare teams, the Multi Agency Safeguarding Hub the Portsmouth Safeguarding Network, and the local clinical commissioning groups. The practice was inclusive and invited outside agencies to unit committee meetings if they believed it was in the best interests of the patient.

The status of safeguarding and vulnerable patients was discussed at the weekly meetings with the Welfare Officers. The needs of vulnerable patients were discussed at monthly Unit Health Committee meetings, prior to these meetings a Unit Support Committee was held to pick up details of vulnerable patients unknown to the unit.

Notices advising patients of the chaperone service were displayed in every practice. There was a list of trained chaperones and group chaperone training was last held in May 2022. We noted this training was not in line with Defence Primary Healthcare (DPHC) guidance, staff were sent a PowerPoint presentation to read and they then completed a locally produced questionnaire. A chaperone audit had been competed in January 2023 to assess whether chaperones were routinely offered and if this was recorded appropriately in the patient's records. The results showed chaperones were routinely offered but coding was sometimes inconsistent. This work was ongoing with staff reminded of the correct coding to use and a re-audit was planned this year.

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. Alongside a staff database, there was a separate spreadsheet for monitoring security clearances and DBS certificates and there were anomalies between the 2 registers. A DBS certificate (known to be out-of-date) was recorded on the risk register and accompanied with a risk assessment in place, had been recorded on both

registers with a different date on each, one recording that it was in date. There were also some anomalies with recording Nursing and Midwifery Council registrations where they appeared to be confusing revalidation dates with annual registrations. General Medical Council registrations were not seen to be checked or recorded on the staff database.

We visited all 3 locations and all were clean and tidy throughout. The Group Senior Nursing Officer (GSNO) was the infection prevention and control (IPC) lead and had completed the IPC link training. Each location had a designated nurse lead who fed back to the group lead. Annual IPC audits were undertaken in each location, the last being in January 2023. These audits showed good results but with some areas of non-compliance mostly regarding the infrastructure. Uncertainty about the future of the Winchester practice had affected investment in the building. All 3 locations had issues identified with sinks and taps not being IPC compliant. At the Winchester practice, this had been addressed and a statement of need was due to be raised for improvement. At the other 2 locations, funding had previously been an issue so improvements had not yet been initiated. We spoke with the GSNO who had recognised this and was actively seeking funding for improvements. These issues were added to the risk register following the inspection.

A contract was in place for environmental cleaning. Cleaning staff worked to cleaning schedules with non-clinical areas cleaned throughout the day and clinical areas in the evening. We were told these areas were monitored but there were no records to show how or when this was being done.

There were systems in place for managing healthcare waste. On the day of the inspection there was no clinical waste log found so we were unable to reconcile the record with the consignment notes, the log was provided to us following the inspection. We saw clinical waste was secured in lockable waste skips at each location. Clinical waste and pre-acceptance audits were carried out annually with the most recent in October 2022.

The medical centre had a system in place to distribute Medicines and Healthcare Products Regulatory Agency . Not all alerts had been recorded, specifically the field safety alerts where no action was required. This would provide assurance that every alert had been reviewed. Alerts were discussed and minuted in practice meetings.

The Central Alerting System alert log was held on health governance workbook including detail of action taken. Alerts were also discussed at the practice meeting as a standing agenda item.

For Primary Care Rehabilitation Facility (PCRF) clinicians practising acupuncture, arrangements were in place for the safe provision of this treatment, including a SOP that referenced national guidance and a consent form signed prior to any treatment. Sharps boxes in treatment rooms were in date and correctly stored.

Risks to patients

The staffing establishment for the Group Practice was satisfactory but the inability to recruit nurses and a lack of locum backfill and the limited dispensary staff could impact the Group Practice’s ability to deliver all care; nursing staff moved around the Group Practices to cover critical elements. A rota managed absence of key staffs’ leave to ensure continuity.

There was a good balance of civilian and military staff which afforded continuity of care and also injections of new ideas. The group model allowed clinicians to take on specialist roles for small cohorts of patients and to work closely with them to deliver the best possible care e.g., diabetes and pre-diabetes. Currently the SMO post was vacant at Winchester, but the group model provided resilience and shared resource.

The PCRF waiting area could be observed at all times and there was live feed CCTV from the main waiting room to reception. There were televisions in the main waiting room although the sound was not on at the time of the inspection. There was a radio on reception, adjacent to the PCRF waiting area, although it was not in use on the day of the inspection.

An automated external defibrillator (AED) was available and all staff were clearly able to identify where it was located. Oxygen and emergency medicines were stored safely. There was an additional AED situated adjacent to the PCRF. Its location was well signposted throughout the PCRF and gym.

The arrangements in place to check and monitor the stock levels and expiry dates of emergency medicines were effective. The practice staff were fully trained in emergency procedures, including basic life support and the use of an AED and anaphylaxis training. Staff had recently completed thermal/climatic injury training and sepsis training. Training in emergency scenarios took place.

At Worthy Down, the PCRF gym was used for patient's unsupervised individual programmes and they were recorded as a virtual DMICP entry. However, no acknowledgement of attendees was always possible. Although the door was left open there was risk associated with patients working alone or unsupervised. There was no CCTV or alarm and there was no risk assessment in place to mitigate against the risk.

Information to deliver safe care and treatment

A SOP was in place to ensure summarisation of patients' records was undertaken in a safe and timely way; 97% had been completed. Patients registering at the practice completed a new patient questionnaire, which was submitted to the nursing team for scrutiny and summarising. This process identified any actions that required follow up.

Peer review of doctors DMICP consultation records was undertaken regularly and a consistent methodology was used. There was evidence of patient handovers between clinicians. In November 2022 a peer-to-peer audit was undertaken to measure if the clarity and accuracy of patient documentation was good enough to provide effective communication between healthcare professionals and patients. Doctors across the Group Practice were given a list of 10 patients notes to review. The results overall were good showing the appropriate alerts were used, consent had been gained and follow up or recall was made if necessary.

The GSNO audited nursing records of all nursing staff. A nurses' peer review programme was planned to be introduced in the near future.

The physiotherapists undertook peer to peer notes reviews, we saw 4 had been completed in the past 6 months.

A failsafe process was in place for the management of specimens. A record was maintained of all samples sent so when results were returned, they could be tracked and any missing results identified.

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 revert to seeing emergency patients only. Hard copy forms were held in the practice for use in this scenario and documentation would be scanned onto DMICP when available.

We saw that adequate heating had been an issue at the Winchester practice with no heating at times and standalone heaters having to be brought in. This made it difficult for staff to work effectively.

The management of referrals required strengthening. The majority of external referrals were made via the NHS electronic referral system (eRS). A referrals tracker with limited access was maintained and 2 week wait and urgent referrals were highlighted so were easily visible. The referrals register was held in a limited access folder on Sharepoint and was password protected. Upon review of the register for the last 6 months, there were 6 patients who had been referred for an urgent referral (within 2 weeks) and an appointment was not recorded on the register. The business manager reviewed all those patients on DMICP during the inspection and provided assurance that the patients had been seen. However, it was clear that the register was not being kept up-to-date. The register included both internal and external (secondary care) referrals.

Safe and appropriate use of medicines

There was one full time member of staff and one part time post (18.5hrs). When the full-time member of staff was off duty the dispensary was only open from 10:00-1400 hours, this was due to limited staff. Patients were asked to collect between these times only, Part One orders were used to notify service personnel. The pharmacy dispensed for two locations making dispensing a higher risk. No risk assessment was in place associated with limited staffing and its effects of care delivery.

One of the doctors was the practice lead for medicines management. They had initiated some training and learning for prescribers. This included when to add a prescription to the dispensing queue, how to use a paper prescription, how to ensure that deployed staff were given sufficient medicines to cover their deployment.

Dispensing was managed at Worthy Down and supplied Winchester and Worthy Down practices. Marchwood was currently outsourced to a local pharmacy. Medicines were transported to Winchester by using a plastic crate which was sealed with zip ties, these were not secured with a numbered tag so no assurance could be given that these were not tampered with during transit. Also, medicines requiring refrigeration did not have suitable containers to keep them in the cold chain during transit or have a method to assure security as they could not be locked. There was no SOP in place to support this or to describe how the risk could be mitigated.

All the emergency medicines and equipment we checked were in date and fit for use. The treatment room at Winchester (where the emergency trolley has held) was not temperature controlled, although it was monitored, and could get very hot or cold at times. As a work around, some of the emergency drugs were being held on the trolley and most were in a series of grab boxes inside the medication room. A risk assessment was in place to support this.

Arrangements were established for the management of controlled drugs (CD), but this required strengthening. Controlled drugs could be issued monthly up to 3 times before review. One patient's record showed that, although in receipt of a controlled drug, they had not been seen within the usual review schedule but had been given a longer review date; this was not in line with current policy. We were told an audit of CDs had been done but this could not be found on the day. Following the inspection, we were advised audits had been completed and were on the Sharepoint system but they just had not been located on the day.

Patient Group Directions (PGD) had been signed off to allow appropriately trained staff to administer medicines in line with legislation. Medicines that had been supplied or administered under PGDs were in-date.

All prescription pads were stored and managed safely by the dispensary, although we noted that the format used to record these needed review. Requests for repeat prescriptions were managed in person or by e Consult in line with policy. A process was in place to update DMICP if changes to a patient's medication was made by secondary care or an out-of-hours service. The process for obtaining repeat prescriptions was detailed in the practice leaflet but there was nothing in the waiting room or on the pharmacy hatch for patients to refer to. A recent nurse-led medication audit of the Winchester site identified that prescriptions were not being fulfilled within an appropriate timeframe. A review of 20 prescriptions was undertaken to review waiting times for medication collection. Overall, 35% of medications were never collected. Of the remaining prescriptions 65% were collected on the same day, 25% within 2-5 days and 10% over 5 days. Recommendations from the audit were to consider another preparation, consider outsourcing to local pharmacy or await order of medication if clinically appropriate. It was found that using the text messaging service had reduced the number of uncollected medicines in other locations. Additional recommendations were given for urgent medication. Feedback from staff and patients has been that this has significantly reduced delay. A second cycle audit was planned for April 2023.

The practice followed the DPHC protocol and local SOP for high-risk medicines (HRM). One of the doctors used a traffic light spreadsheet system to monitor all patients on HRMs. The register of HRMs used at the practice was held on DMCIP and all doctors and relevant clinicians had access to this. We looked at 4 patient records who were prescribed HRMs; both were up-to date and had been reviewed.

Track record on safety

The group practice manager was the designated health and safety lead and a board was displayed near the reception and was regularly externally audited. Electrical safety checks were up-to-date. We were told that water safety checks were regularly carried out; these records were not available to us on the day. Following the inspection these were sent through, they accurate and in date. A legionella risk assessment was carried out in September 2019. 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.

Weekly equipment checks (usually done on paper) had been trialled electronically by building a coded digital format. The trial started at Marchwood over a 3-month period and was found to be effective, giving a better audit trail and no paper copies needed. This initiative was in its early stages and more training for staff was required. This will be shared nationwide in the future.

We looked at the practice's arrangements for the provision of a safe service. A risk register was maintained that took account of the 'four T's' (transfer, tolerate, treat, terminate) to clearly indicate where and how risks were being managed. There were active and retired risk registers and issues logs on the healthcare governance workbook. There were risk assessments in place for all rooms which included both clinical and non-clinical risks. However, the Control of Substances Hazardous to Health (COSHH) risk assessments were overdue review and not all COSHH items had been captured. Not all risks declared by the group practice were included in the risk register such as the closure of Marchwood PCRF and the inability to recruit nursing staff including locums.

There were fixed alarms in clinical rooms and handheld alarms in other rooms. There was a simple record in place to record that alarm checks had been completed but it did not include any detail such as which alarms had been checked, any issues identified or response times as a learning exercise. At Winchester PCRF lone working was more frequent. The fixed alarm was not working, staff had personal alarms but these had not been tested to assess the response.

The PCRF facilities were well provisioned to meet the specific needs of the patient population. A range of physical training, rehabilitation and medical equipment had been procured and was managed within servicing agreements. A faults register was in place and any work needed had been undertaken. Wet-bulb globe temperature (WBGT – a heat stress index) readings were taken in hot weather and activity managed accordingly.

Lessons learned and improvements made

The Group Practice used the Automated Significant Event Reporting (ASER) DMS-wide system to report a significant event (SE). A local ASER SOP was in place. We talked with staff who gave us several examples of SEs that had been raised, the most common issue being with the transport of samples not reaching the laboratory in good time and subsequently patients not receiving their treatment/medicines on time. As a result of this a memorandum of understanding had been implemented and transport was forthcoming. Another example given was an SE raised due to a urine sample being left for collection

and not processed for a prolonged amount of time. This SE was used as an opportunity to consider National Institute for Health and Care Excellence (NICE) and other clinical guidance. The staff training database showed that staff had received up-to-date training in the ASER system. However, it was not dated and not clear if all staff had completed the required training annually or if they had an ASER login. It was not clear who had the appropriate access to the ASER system to complete root cause analysis and identify lessons learned. SEs were discussed at the healthcare governance meetings and identified by ASER number in the minutes but the narrative was limited and any lessons learned were not included. There was no ASER log to monitor progress and completion and no lessons learned documented.

Are services effective?

We rated the practice as good for providing effective services.

Effective needs assessment, care, and treatment

Clinical staff had a forum to keep up-to-date with national clinical guidance, including National Institute for Health and Care Excellence (NICE) and the Scottish Intercollegiate Guidelines Network guidance. For example, we saw discussion had been undertaken about updates regarding tobacco, treating dependency and updated guidance on supporting people to stop smoking.

The Defence Primary Healthcare (DPHC) team produced a newsletter that was circulated to clinicians providing further information and a summary of relevant safety updates. The regional nursing advisor sent out weekly updates that included any new guidelines.

Clinicians had opportunities to attend regional forums, such as regional governance meetings and nurse development forums. The Senior Medical Officer (SMO) facilitated weekly heads of department (HoDs) meetings where all group practice issues were discussed for the week ahead. The nursing team met weekly on a Monday following the weekly HoDs meeting where information was disseminated and discussed with the wider nursing team. Whole group nurse meetings occurred twice monthly and included a clinical supervision session where clinical cases were discussed. The Primary Care Rehabilitation Facility (PCRF) team met weekly to discuss clinical issues and to plan ahead.

The PCRF was spread across two locations, Worthy Down and Winchester. All staff were familiar with Department of Defence Rehabilitation Guidance and provided examples of treatment provided based on evidence-based guidelines and care pathways. The PCRF used MyRecovery (software for rehabilitation exercise therapy) and, if appropriate, was documented in the clinical records we looked at. Both PCRFs had a treatment room and gym. The space and equipment available were bespoke to meet patients' needs.

Monitoring care and treatment

We found that chronic conditions were managed well. Standard operating procedures (SOPs) outlining the management and monitoring arrangements of long-term conditions were in place. A supplementary long-term condition register was in use to identify patients potentially missed by searches. Each long-term condition had a named nurse to oversee. The nursing team actively engaged with patients and utilised text messaging to improve uptake in annual reviews.

A new working local practice document had been written in order to ensure timely recognition of long-term conditions, ongoing medical problems for newly registered patients by utilising an e-registration process. An easy-to-read flow chart enabled simple progression through the process for both staff and patients.

All patients over the age of 40 were invited to a full health check including bloods and identifying risk factors. Lifestyle and health advice was provided as appropriate both verbally and written. This check was repeated every 3 to 5 years unless identified as a risk when patients were recalled annually for blood testing. All patients with a chronic disease had an annual screening including blood tests or more frequently if required.

There were 10 patients on the diabetic register and their care indicated positive control of both cholesterol control and blood pressure. Patients at risk of developing diabetes were identified through the over 40's screening, which included relevant testing (HbA1c - average blood glucose (sugar) levels). The group practice audited compliance of diabetes management against NICE standards regularly. We reviewed audit work undertaken in August 2022 which demonstrated that patients were receiving appropriate support to actively manage their condition.

In 2020 the group practice partnered with the Public Health collaboration (who delivered Patient Participation Group education for NHS practices) to offer interested Type 2 diabetics and pre diabetics the chance to participate in a 12-week programme consisting of weekly group education sessions focussed on a low carbohydrate and non-processed food healthy diet. Included were regular monitoring of the patients' Body Mass Index and their blood sugar levels. The results showed that at 12 weeks 87% of patients had improved blood sugar levels (HBA1c), 43% maintained HBA1c improvement at 1 year (similar to NHS practices). This was important since good diabetic control with few medicines was key for patient and for deployability. Moving forward the plan was to begin training the facilitators (medically trained) with intent that practice groups could offer the 12-week intervention from this summer. A step-by-step guide for the facilitators guiding what we should be covered in each of their group sessions had been written. The practice had engaged with training providers and sourced funding via DPHC HQ for this education. This initiative had been shared nationally.

There were 63 patients recorded as having high blood pressure. All were recorded as having a blood pressure check in the past 9 months.

There were 23 patients with a diagnosis of asthma and all had an asthma review in the preceding 12 months.

Audiology statistics showed 86% of patients had received an audiometric assessment within the last 2 years.

Through discussions with the doctors, we were assured that the care of patients with a mental illness and/or depressive symptoms was being effectively and safely managed, often in conjunction with talking therapies, charities and with the Department of Community Mental Health. An audit was undertaken by one of the doctors as an issue had been found with inconsistent coding on patient's records, only 40% were found to be correctly coded. Staff have been supported to code correctly and were now found to be using a consistent approach, a re-audit was planned. We discussed a case where unclear consent and rank issues were a concern for a patient. This had been promptly dealt with including a referral to the Multi Agency Safeguarding Hub and engagement with the Chain of Command. The group practice played a key and effective role in safeguarding young and vulnerable staff.

An audit was undertaken looking at the care given to patients with post-traumatic stress disorder against NICE standards. Specifically, the audit identified if patients with ongoing

care needs were routinely given a review appointment between 10-56 following diagnosis. The audit showed full compliance in line with good practice and was to be taken to the next healthcare governance meeting for discussion.

One of the doctors had a specialist interest areas in addiction / alcoholism and although they worked closely with Department of Community Mental Health in the acute stages, it was apparent that sustained sobriety was dependant usually on peer support. Usually, the advice given was to approach Acholic Anonymous or Narcotics Anonymous for support which did not suit all uniformed personnel. The doctor, through their external work with an addiction organisation, became aware of the Self-Management and Recovery Training (SMART) and found that there were online groups for military and veterans already in place. They also found that one other practice had funded their own SMART meetings and were happy nationwide for patients to attend. The practice helped promote these nationally via a series of education meetings both in house, but also at national quality improvement (QI) forum. The doctor also promoted this at Practitioner Health and BDDG (British Doctors and Dentists Group) in house and at regional events, as sources of support for doctors and nurses suffering with mental health or addiction problems.

An extensive and comprehensive quality improvement programme was in place across the practices which had been designed for optimal relevance to the patient population. We saw many audits were in place spanning clinical, administrative, and managerial topics. More than one cycle had been undertaken in many instances and there was evidence of positive outcomes for patients.

There was no specific audit calendar in place for the PCRF that was driven by the needs of the patient population. A physiotherapy and exercise rehabilitation instructor (ERI) notes audit was completed annually and recorded in the healthcare governance workbook. However, examples of audits seen did not include planning for a second cycle. Recommendations and actions were not detailed so they served as a log of findings but did not demonstrate action for change or improvement. The closure of the Marchwood PCRF required patients to travel 40 minutes by car each way. PCRF staff suggested that this had cause higher non-attendance (referred to as DNA) rates or difficulty booking appointments and patients could be held up in traffic and then arrive late. However, the DNA rates did not appear to be monitored. Audit had not been planned to evaluate the before and after effect of the closure nor a mitigation to advise on travel times or consider allocation of appointments when road traffic may be less congested.

Effective staffing

The staff database showed all staff had completed an induction. However, there was no recorded individual induction evidence to corroborate this. Some staff we spoke with described their induction process another said they had not had a workplace induction even though it had been recorded as completed. There was a detailed nurse role specific induction for new members of the nursing team which had been introduced in September 2022 and an evaluation of the induction document was in progress .

All staff could access the staff database and record their own training, some also kept their own training certificates. Training was monitored and staff were notified by email when training needed to be completed. A copy of the staff training was also available in the staff room. The staff database included links to each training course. Protected time for

mandatory training was included in the staff rota. It was noted during the inspection that some data had been entered incorrectly on the staff database and did not correlate to the training certificates provided. Some staff did not have their own training certificates for review and advised that the these were held by the practice. The process could not be validated.

The doctors, PCRF staff and nurses had the appropriate skills for their role and were working within their scope of practice. Clinical staff kept up to date with their own continual professional development and revalidation. Performance appraisals were conducted by line managers for all staff. All doctors were in date for appraisal and all doctors and nurses had completed timely revalidation.

Internal and external training sessions were available to staff. For example, the practice manager was had completed the National Examination in Occupational Safety and Health course.

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

Coordinating care and treatment

The practice met with welfare teams and line managers to discuss vulnerable patients. Staff told us that they had forged some good links with other stakeholders, including the local NHS, social services, and voluntary organisations. Some positive and impactful links with Wessex Local Medical Council (LMC) had been made. One of the doctors sat on the LMC and this enabled them to keep updated with current care pathways (e.g., cancer) This knowledge was shared with clinicians within the Group Practice allowing patients to receive comparable care to that of the NHS.

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 and electronic notes were sent to the NHS practice. If the patient was deemed vulnerable the practice staff worked with them and the welfare department to help them register and access the NHS services they needed. An example was discussed that described very supportive care for a patient who was being discharged, this included engagement with their family, daily contact with the patient, the welfare team and padre and the unit.

Patients were referred to the multi-disciplinary injury assessment clinic when required and staff commented that the wait to be seen was currently around 10 weeks due to staffing issues at the local Regional Rehabilitation Unit (RRU). We noted that multi-disciplinary discussion took place for any patients awaiting assessment and that this involved physiotherapists, ERIs, doctors and nurses. Patients were offered interim support to manage any injury in the interim and Chain of Command were made aware if personnel needed to be downgraded whilst they awaited assessment and treatment.

Patients who were considered vulnerable were discussed at least monthly in multi-disciplinary meetings. Those moving to new units were handed over as part of a case conference with the receiving unit (clinicians from both units also attended this and

additional clinical handover took place if required). Monthly vulnerable adult searches were cross checked with the vulnerable adults register to highlight any patients who had deregistered with the practice to identify any who might have been missed.

Helping patients to live healthier lives

One of the nurses was the lead for health promotion. We saw information leaflets were available in the treatment rooms. There were notice boards located in various places around the practice, some example topics covered included sepsis, smoking, alcohol, and safeguarding.

The practice had helped organise several regimental events with external speakers / chefs to educate soldiers about how to eat healthily – including how to eat lower carbohydrates and processed food. A chef demonstrated several healthy recipes using easily obtainable low-cost ingredients. They have also linked with a Fijian nutritionist so they could be included with healthy cultural alternatives. Alongside this one of the doctors attended some of the Defence Health and Wellbeing Advisor training. The practice were rethinking their approach to obesity (which was being discussed with the unit as well as being presenting about alongside the Defence Nutritionist at this year's Civilian Medical Practitioner conference), and the reinvigoration of other initiatives to help the unit tackle unhealthy behaviours.

Noticing that many soldiers in Marchwood seemed to lack resilience towards life events, the practice partnered with the unit to develop a course aimed at teaching some resilience skills. It was a 2-week course, led by the unit, and included some education in the morning, followed by resilience activities in the afternoon (meditation, mindfulness, group exercise, Reiki etc). Other themes included demystifying the DCMH process (including signposting which symptoms must prompt medical help), chronic pain and ways of coping, nutrition, and stress including the normal and helpful stress response. The results showed almost 100% improvement in physical and mental wellbeing scores at the close of each course. There were steps to roll this out to Worthy Down. This would be presented at national QI forum in July. Marchwood planned to have bespoke course delivered for senior staff this year (those responsible for managing people) so they could be helped to understand resilience (and neurodiversity) and manage soldiers more effectively.

Both a doctor and a nurse had the appropriate sexual health training and provided sexual health support and advice. Patients were signposted to local sexual health services for procedures not undertaken at the practice.

All eligible female patients are on the national cervical screening database and were recalled by the nurse. The latest data confirmed a 93% uptake. Regular searches were undertaken to identify patients who required screening for bowel, breast, and abdominal aortic aneurysm in line with national programmes. At the time of the inspection, there were no patients identified that met the criteria for bowel screening. 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.

An effective process was in place to recall patients for their vaccinations. Vaccination statistics were identified as follows:

- 91% of patients were in-date for vaccination against polio.
- 92% of patients were in-date for vaccination against hepatitis B.
- 92% of patients were in-date for vaccination against hepatitis A.
- 91% of patients were in-date for vaccination against tetanus.
- 99% of patients were in-date for vaccination against MMR.
- 91% of patients were recorded as being up to date with vaccination against diphtheria.

Consent to care and treatment

Staff had a good understanding of the Mental Capacity Act (2005) and how it would apply to the patient population, although no training in the Mental Capacity Act had been recorded.

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. There was a group practice policy to describe the principles of consent and how these were applied. Clinicians advised us that implied consent was accepted for basic procedures such as the taking of blood pressure. Written consent was taken for more intimate examinations and this was regularly audited. Minor surgery was undertaken by one doctor, we saw consent was obtained and recorded. The last audit of 10 notes chosen at random showed 100% compliance.

Are services caring?

We rated the practice as good providing caring services.

Kindness, respect, and compassion

We spoke with 2 patients on the day of the inspection and 10 patients by email after the inspection. They all described their care as good and all said staff were patient, friendly and kind. The group practice across all 3 locations had good links with welfare team, they regularly had meetings, updates, and discussions. They had a detailed poster 'talk to us' with names, telephone numbers of different departments internal and external in all areas including waiting rooms and staff offices. Patients were offered a private room if they wanted to discuss something in private or appeared distressed.

We interviewed a cross section of staff working across all 3 practices. All staff 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. They spoke about colleagues who were supportive, compassionate, and caring.

One of the doctors described conversations they had with trainees many of which in relation to home sickness and not being able to leave camp. In these instances, the doctor was able to access trainee's phones for them and get them talking to their families. The practices were considered to be safe places for patients to say how they were feeling and trainees were supported to be open and honest. The units had identified staff members particularly selected for their empathy and compassion, they worked with medical staff to understand and mitigate the concerns that young people felt when confined.

If a trainee had to be medically discharged, parents or carers would be involved so they could understand their role once the trainee arrived home again. When a care leaver was discharged, the practice and the unit worked with social services to ensure that a package of support was available to them once they left the military.

We spoke about a young patient who was described as struggling during their training (injury meant they were in a rehabilitation platoon) A multi-disciplinary approach was taken to ensure this young person had all the support they needed both whilst at work and at home keeping them safe. A risk conference was held that included the medical practice, welfare, the unit, their Commanding Officer and the Adjutant and a plan was put in place to look after them moving forward.

Involvement in decisions about care and treatment

The clinicians and staff at the practice recognised that the personnel receiving care and treatment could be making health care decisions that could have a major impact on their military career. Staff demonstrated how they gauged the level of understanding of patients, gave clear explanations of diagnoses and treatment, and encouraged and empowered patients to make decisions based on evidence-based guidance and clinical facts.

The e-referral service had been implemented and was used to support patient choice as appropriate. (e-referral is a national electronic referral service which gives patients the choice of date and time for their first outpatient appointment in a hospital).

Patients identified with a caring responsibility were captured on a DMICP register, it included what had been discussed at the monthly practice/clinical meeting and any actions identified. The practice has a practice leaflet which included information for carers.

Staff explained that they occasionally saw patients who spoke English as a second language. They could access a translation service if they needed it. Staff told us about a recent instance where 'The Big Word' was used to provide a translation service during consultation. A translated practice leaflet has been devised for Nepalese patients.

Privacy and dignity

All patients we spoke with stated that they were confident that the practice would keep information about them confidential. All stated that they felt that their dignity and privacy were upheld by medical centre staff. Consultations took place in clinic rooms with the door closed (including all physiotherapy assessments). Patient identity checks were completed prior to any information being disclosed. There were privacy curtains in all clinical rooms, although some marked with renewal dates were incorrect. There was a notice on reception advising patients they could speak with a member of staff in private if required. All staff had completed the Defence Information Management Passport training which incorporated the Caldicott principles.

Patients were able to see clinicians of either gender according to their preference. All patients who responded to the patient survey stated that they were able to see a clinician who suited their needs. We noted there were no physical barriers or tape on the floor to guide patients to stand back at the reception desk. There was a radio available but was not in use at the time of the inspection meaning it was easy to hear what was being said at reception by patients waiting for their physiotherapy appointments.

The waiting room was away from the reception desk and had a television but this had no sound on the day of the inspection.

The dispensary at Worthy Down had a designated room next to the dispensary for giving out medication and supporting patients. The other two locations had to find an empty room to offer the service.

Are services responsive to people's needs?

We rated the practice as good for providing responsive services.

Responding to and meeting people's needs

The practice understood the needs of its patient population and tailored services in response to those needs. Appointments slots were organised to meet the needs of specific population groups. Telephone consultations and eConsult appointments were alternative options for patients who required an appointment. Following feedback from instructors and recruits, telephone consultations were identified as 'not working for units'. Recruits were not permitted to have telephones and contacting them was difficult, resulting in delays and the recruits having to use instructors' personal phones for health-related contact calls. The decision was made to return all consultations to face-to-face once COVID-19 restrictions were relaxed. Also. it emerged that young recruits often forgot to inform their units about their medical appointments so the group practice created a form to keep the unit trainers informed. Following good practice at Pirbright, initial medicals were undertaken online meaning important information was more easily and promptly accessed.

The practice was constantly ready to respond to the occupational needs of patients. Phase 1 recruit's needs were discussed with the Chain of Command and the Occupational Health medical requirements such as vaccinations, initial medical assessments, and pre-release to phase 2 medicals were scheduled into a training program. This information was held on the rota and was shared with the doctors and nurses that were to be involved. The group practice also offered urgent appointments twice a day for trainees to attend. Also available were clinics relevant to the patient population. For example, sexual health clinics were offered to the younger population at Winchester and smoking cessation clinics were offered across all sites.

An Equality Access Audit as defined in the Equality Act 2010 was completed for individual sites within the past year. Any points identified were discussed and put onto the risk register. There was a gender-neutral toilet at Winchester practice.

A member of unit staff was the lead for diversity and inclusion, there was good communication with the unit leads and nominated individual within the Group Practice. There was a notice board with information and contact details for patients in the main reception.

A policy was in place to guide staff in exploring the care pathway for patients transitioning gender. One of the doctors was undertaking some personal development to support the appropriate and effective care of patients moving forward.

Timely access to care and treatment

Details of how patients could access the doctor when the medical centre was closed were available through the base helpline. Details of the NHS 111 out of hours service was outlined in the practice information leaflet.

Urgent doctor and nurse appointments were available on the day. Routine doctor appointments were available within 2 working days. Routine appointments to see a nurse were available within a few days.

Direct Access Physiotherapy clinics were available for patients. Patients we spoke with reported using the direct access clinic and that they had found it beneficial to them. Rapid access to Primary Care Rehabilitation Facility support was available with patients being seen well within the key performance indicators. Routine, urgent and follow up appointments, to see the physiotherapist or the exercise rehabilitation instructor were available on the same day or within one working day.

We spoke with 12 patients who had recently received care from the staff at the practice. They all told us that they could secure appointments when they needed them and were confident that they would be seen quickly if they had an urgent concern.

Listening and learning from concerns and complaints

The business manager was the designated responsible person who handled all complaints in the practice. The practice had implemented a process to manage complaints in accordance with the Defence Primary Healthcare complaints policy and procedure. However, despite being given an example of a complaint we saw no complaints had been recorded within the past 12 months.

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

Are services well-led?

We rated the practice as requires improvement 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 group practice worked to Defence Primary Healthcare's (DPHC) mission statement 'Provide and commission safe and effective healthcare which meets the needs of the patient and the chain of command in order to contribute to Fighting Power'. In addition, the team had also created their own vision statement:

'EPIC'

Equitable

Patient Centred

Innovative

Compassionate

The team strove to deliver a preventative approach which involved proactive health promotion support, lifestyle advice and prompt barrier-less access to mental health provision. Care was delivered to patients through an integrated multi-disciplinary approach.

Leadership, capacity, and capability

The balance of civilian and military clinical input appeared to provide the best possible care for patients. In line with the terms of reference set down by the British Medical Association, Civilian Senior Medical Officers at the Group Practice were afforded 40% of their time to undertake clinical leadership and management tasks. Civilian doctors felt well supported in their clinical and leadership development. Military clinical leaders who changed jobs more frequently had enhanced the delivery of care with new innovations brought from previous experience. As a result, patients were receiving enhanced care routinely.

The practice had a strong leadership strategy and vision that all staff championed. The current Group Senior Nursing Officer (GSNO) has been in post for 6 months and during this time they has introduced several initiatives to support and provide leadership including the introduction of clinical supervision sessions and peer reviews. Staff reported feeling supported within their roles and listened to when suggesting change or raising concerns. The civilian nurse had recently been promoted from Band 6 to Band 7 to provide ongoing leadership, stability, and resilience to the group practice. They worked closely with the GSNO; their post was being developed to provide senior leadership of the nurse team.

The GSNO reported a good working relationship with regional headquarters who offered support and guidance if required.

The team were committed to delivering the best care through a culture of constant learning and improvement. They had a positive attitude towards learning from planned activity, experience, and feedback. There were ongoing quality improvements evident that were driven by the team.

Units at Worthy Down and Winchester had a frequent turnover of staff and the group practice was often not aware of what their patient intake would be until two days prior to those staff arriving. The medical teams worked with the Chain of Command to best understand the needs of the patients by going to them in advance and planning ahead, this would often require intense periods of work for all team members who needed to ensure that medicals were undertaken promptly.

Primary Care Rehabilitation Facility (PCRF) staff team indicated an improved support and direction. The team said the development of the group practice had enhanced communication and the further addition of Marchwood staff has promoted a team ethos. Training/appraisal and communication was well structured. Organisational leads were recently given to all staff but this needed to be fully integrated

The terms of reference (ToRs) we were able to view were in date for review and clearly articulated the main role for the person and all assigned secondary/lead roles. However, the ToRs were not stored collectively and not all those requested could be found or viewed including the ToR for Group Senior Medical Officer (GSMO). Following the inspection, we were told they were held collectively on Sharepoint.

The practice management team said they felt well supported by the regional teams and felt able to draw on their support when required.

Culture

A responsive and patient-centred focus was clearly evident with this ethos embedded in practice. Staff continually looked at ways to improve the service for patients.

All staff described an approachable and supportive leadership team that was committed to ensuring cohesion, equality, and inclusion. It was clear from discussions with staff 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 heard from staff that the culture was inclusive with an open-door policy with everyone having an equal voice, regardless of rank or grade. All were familiar with the whistleblowing policy and said they would feel comfortable raising any concerns.

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

Governance arrangements

We found gaps and or shortfalls across the governance structure, including clinical and non-clinical processes, which have been highlighted throughout the report. The healthcare governance workbook (HGW) was the overarching system used to bring together a range of governance activities, including the risk register, training register, standard operating procedures, quality improvement activity (QIA) and complaints. Its content was fairly limited but the practice also used a 'Link Library' for accessing information. The library had role specific areas and was mapped to the CQC Key Lines of Enquiry.

There was a staff data base and a spreadsheet which were disjointed and inefficient. For example, actions in relation to staff induction, training and professional registration checks were conflicting. We noted that some actions identified as completed were incomplete, such as a DBS check.

The Group Practice model afforded flexibility, specifically the sharing or specialist skills across the 3 sites, flexibility of cover, the ability to access training and impactful doctor's supervision (discussion of complex patients). Staff said they had been supported to develop and deliver quality improvement programmes.

Lead roles were in place and were shared across the team and included representatives from all 3 practices within the group. Work had recently been undertaken to reallocate these roles due to change in staff. There were a number of gapped nurse posts but staff were willing to work flexibly and at other sites to ensure key patient care was not adversely affected.

Communication across the practice was strong and an appropriate meeting structure and healthcare governance approach was in place. This included regular clinical, practice, healthcare governance and unit healthcare committee meetings, safeguarding and PCRF meetings.

The PCRF contributed to the medical centre's eHAF (Healthcare Assurance Framework) document which was reviewed with the PCRF regularly. The PCRF were involved in all key relevant meetings. The PCRF also attended the Regional Rehabilitation Unit (RRU) training sessions and the lead physiotherapist attended the RRU meetings.

Managing risks, issues and performance

The leadership team was mindful of risks to the service. There were active and retired risk registers and issues logs on the HGW. However, not all risks were included in the risk register such as the closure of Marchwood PCRF and the inability to recruit nursing staff including locums.

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.

All staff were in date for 'defence information passport' and 'data security awareness' training. When a member of staff left, smart cards were returned to the guard room and they were removed from having access.

Appropriate and accurate information

The eHAF commonly used in Defence Primary Healthcare services to monitor performance is an internal quality assurance governance assurance tool to assure standards of health care delivery within defence healthcare.

National quality and operational information were used to ensure and improve performance. Quality and operational information was used to ensure and improve performance.

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

Options were in place for patients to leave feedback about the service including information in the practice leaflet. All feedback was collated and discussed at the practice meetings every month. The Governance Assurance Performance and Quality (GPAQ) dashboard was used to monitor and analyse patient feedback.

The practice had a “You said we Did” board in the waiting room that showed improvements made following patient suggestions. For example, patients asked for baby changing facilities which have now been sourced.

Continuous improvement and innovation

There was much evidence of continuous improvement in the practice.

In 2020 the group practice partnered with the Public Health collaboration (who delivered Patient Participation Group education for NHS practices) to offer interested Type 2 diabetics and pre diabetics the chance to participate in a 12-week programme consisting of weekly group education sessions focussed on a low carbohydrate and non-processed food healthy diet. Included were regular monitoring of the patients’ Body Mass Index and their blood sugar levels. The results showed that at 12 weeks 87% of patients had improved blood sugar levels (HBA1c), 43% maintained HBA1c improvement at 1 year (similar to NHS practices). This was important since good diabetic control with few medicines was key for patient and for deployability. Moving forward the plan was to begin training the facilitators (medically trained) with intent that practice groups could offer the 12-week intervention from this summer. A step-by-step guide for the facilitators guiding what we should be covered in each of their group sessions had been written. The practice had engaged with training providers and sourced funding via DPHC HQ for this education. This initiative had been shared nationally.
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low-cost ingredients. They have also linked with a Fijian nutritionist so they could be included with healthy cultural alternatives. Alongside this one of the doctors attended some of the Defence Health and Wellbeing Advisor training. The practice were rethinking their approach to obesity (which was being discussed with the unit as well as being presenting about alongside the Defence Nutritionist at this year's Civilian Medical Practitioner conference), and the reinvigoration of other initiatives to help the unit tackle unhealthy behaviours.

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