Winchester (Winchester Group Medical Practice) (WGMP)

Winchester (WGMP) Marchwood, Winchester and Worthy Down

Worthy Down, Connaught Road Winchester SO21 2RG

Sir John Moore Barracks, Andover Road Winchester Hants SO22 6NQ

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Defence Medical Services inspection

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

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

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Summary

About this inspection

We previously carried out an announced comprehensive inspection of Winchester Group Medical Practice in February 2023. We found the practice was caring and responsive in accordance with CQC's inspection framework. However, improvements were required in the safe, effective and well-led domain. A further announced comprehensive inspection was undertaken on 17 January 2024 to see if the recommendations made at the previous inspection had been met.

A copy of the report from the previous inspection can be found at:

www.cqc.org.uk/dms

We carried out this announced comprehensive inspection on 17 January 2024. We visited all 3 locations on the day. We did not inspect the Primary Care Rehabilitation Facility due to the non-availability of a physiotherapist specialist advisor.

As a result of this inspection the practice is rated as good overall in accordance with the Care Quality Commission's (CQC) inspection framework.

The key questions are rated as:

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

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 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 good. The management of staff training was robust.

The arrangements for managing medicines was good.

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.

The Group Practice worked collaboratively with internal and external stakeholders and 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 was good.

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 comprehensive 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 was comprehensive, all relevant information was captured to monitor service performance.

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

An informative leaflet was devised to offer staff support in the workplace. The premise being that workplace wellbeing should be at the front of people's minds. This could be individuals experiencing problems or supporting colleagues. This was initiated from a staff questionnaire and their request for more resources to support them.

An Inflammatory bowel disease audit was undertaken– audited against National Institute for Health and Care Excellence (NICE) Clinical Knowledge Summaries standards it was identified as best practice to consider osteoporosis and fracture risk at annual reviews. It was identified by the audit that this was not routinely documented so an alternative was created to facilitate the process. A teaching session in inflammatory bowel disease was also planned.

Patient education around a low carbohydrate diet had been rolled out. This was identified at the last inspection due to the increasing numbers of patients with diabetes / pre-diabetes being diagnosed and the lack of educational information from local health services. This quality improvement initiative remained a week-by-week educational package which could be delivered by any healthcare professional. The information had been updated to reflect some of the advice around ultra processed food. Training had

been delivered at practice level and in some GP forums, alongside Defence dieticians. One of the doctors had also visited HMS Queen Elizabeth and were present to help answer questions at a recent education session with their chefs and hoped to work to help implement a version on board this year.

One of the nurses was new to the smoking cessation advisor role and found that they were not able to give structured consultations due to the design of the questions. . There were templates on DMICP to capture data but there were no templates on key questions and this affected the way smoking cessation was delivered. They had therefore devised a new tool that included pertinent questions to ask patients in a more structured way. The National Centre for Smoking Cessation Training was used to inform best practice and the nurse used this information to devise the template. This had been used for 2 patients to date and was working well.

Resilience training was delivered to doctors following a doctor colleague discussion noting the increasing burnout rates of doctors. One of the doctors had presented at several GP forums and was about to adapt the presentation to include how to set boundaries.

One of the regiments had regular deployments of small teams sent all around the world (often at short notice) which made medical force preparation challenging. One of the nurses regularly attended the Regimental Operations meeting to better understand the Regiment, their upcoming commitments and also educated the Operations teams on the medical preparation process. They maintained regular communication with the Regimental and Squadron Operation teams and requested access to the live statement of requirement (SOR) document in order to pre-emptively provide sub-units with the details of the preparation required for the individuals aligned, as well watching for additional personnel changes that could require medical input. They had implemented a system that provided feedback to the Regimental Operations team on the medical status of the soldiers on the SORs, greatly reducing the workload for all involved in the pre-deployment assurance process. They have also on multiple occasions managed to get access to tuberculosis and rabies vaccines at very short notice for soldiers deploying to high-risk countries. Additionally, they have implemented an initiative to give each Squadron a dedicated day a month to access appointments in the practice.

Changes had been made to the clinic structure with amendments to timings for appointments. One of the issues raised by some of the nursing staff was that a 15-minute phlebotomy appointment would be ample time if there was a label printer to save handwriting specimen labels. There had also been significant events raised before about the incorrect labelling of samples and the laboratory not processing samples because of writing being illegible or NHS numbers being incorrect. The practice requested a label printer, however due to logistics and DMICP (electronic patient record system) compatibility, this was not possible. To find an alternative the nurse visited another practice who had created an auto populating template that they printed on (provided by Portsmouth hospital). The nurse adapted the template and managed to print out accurately using a normal standard printer on normal standard labels. They then added the auto populating identifiable data and were able to print out as little or as many labels as needed.

One of the nurses explored and utilised all the information that was available from the NHS and also service women’s platforms to create a user-friendly document regarding

pregnancy. This document contained both links, if emailed, and quick response or QR codes, if printed, so that service women were able to easily access all the information by several methods of technology. The document was emailed to all the Group Practice staff and was also saved to both DMICP and the Group Practice SharePoint so clinicians had a variety of ways of accessing this information.

A document “Chronic Disease Management Tool” had been devised by a doctor that outlined review periods, appointment requirements (who with, length of appointment) also what lab tests and prelims required, for example spirometry, urinalysis, blood pressure, body mass index. In addition to Long Term Condition (LTC) reviews it included several other conditions requiring monitoring or review, for example coeliac/pre and gestational diabetes and gout.

At the Winchester practice a new scheme for Initial Medical Assessments(IMAs) had been rolled out. A spreadsheet had been created ahead of the IMAs and specific groups (under18s, females) were identified ahead of their IMA to ensure their specific needs were not missed. A lower threshold for referral to physiotherapy was in place to enable rapid review during the first few weeks of training. Weekly recruit management board meetings were attended by the training team, the Commanding Officer, medical and welfare. This was to discuss recruits who were struggling in training for whatever reason helping with holistic management of the recruit.

A document “Guidance on the structure and delivery model for nursing service in Winchester Medical Practice had been initiated. It was a local working practice making clear what the expectation of each nurse role was. It standardised the length of time each appointment should take for each presentation across all sites ensuring clarity, consistency and fairness. It also gave some way to protect the role of civilian nurses against everchanging military leadership.

The Chief Inspector recommends to the Group Practice

Consider undertaking a staff surveys to gain staff views.

Ensure systems are fully embedded for the distribution of alerts by the Medicines and Healthcare Products Regulatory Agency including ensuring all staff have access to the group mailbox.

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 specialist advisors including a primary care doctor, a practice manager, a pharmacist and 2 nurses.

Background to Winchester Group Medical Practice

Winchester Group Medical Practice consists of 3 medical centres located across 3 sites: Winchester, Worthy Down and Marchwood. The patient population was variable but is approximately 3,500 at any one time.

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 undertaken at Marchwood, a new purpose built Primary care Rehabilitation facility (PCRF) is forecasted to be built in 2 years.

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

The staff team

Group Senior Medical Officer (GSMO) (military)	1
Senior Medical Officers (SMO)	3 (1 x military SMO Worthy Down, 2 x civilian SMOs in Marchwood and Winchester)
Civilian medical practitioner	8
Practice manager	3
Business Manager	1
Nurse	11
Health care assistant	1
Medics	5
Senior pharmacy technicians	2

Exercise rehabilitation instructors (ERI)	5
Physiotherapists	5
Administrators	7

Are services safe?

Following our previous inspection, we rated the practice as requires improvement for providing safe services. We identified shortfalls in processes to keep patients safe including shortfalls in:

- risk assessments
- some issues with medicines management
- referrals management
- alarms and their testing
- adequate cleaning arrangements.
- inconsistencies with the ASER system

At this inspection we found the recommendations we made had been actioned.

Safety systems and processes

One of the doctors was the lead for safeguarding and another was the deputy. Staff had received up-to-date safeguarding training at a level appropriate to their role, we noted one doctor was out of date with safeguarding level 3 but this training was scheduled for the following week. The Group Practice standard operating procedures (SOP) for both adult and child safeguarding had been reviewed and included contact details for local safeguarding teams. Staff we spoke with all had in depth knowledge of the requirement to safeguard and several examples were discussed.

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 was undertaken monthly.

Patients coded as vulnerable were not allowed to be taken off the register without discussion at the meeting, patients that had left could then be identified to ensure a handover took place. 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.

A new health self-declaration questionnaire was sent to all new joiners. These were currently reviewed by either the medics or nursing staff (dedicated time weekly). IMA included a structured mental health assessment, any issues identified were sent through to a doctor for action.

At Winchester, a weekly Recruit Management Board meeting was held, this was where the company OC, Adjutant, the training leads, welfare and a doctor discussed any of the patients that were requiring extra support.

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 Commander Case Review meetings.

The doctors had strong links with the Primary Care Rehabilitation Facility team, welfare teams, the Multi Agency Safeguarding Hub the Portsmouth Safeguarding Network, and the local clinical commissioning groups. The Group Practice was inclusive and invited outside

agencies to unit committee meetings if they believed it was in the best interests of the patient.

Notices advising patients of the chaperone service were displayed in every practice. There was a list of trained chaperones and all staff had received update training. A chaperone audit had been recently completed to assess whether chaperones were routinely offered and if these were seen to be recorded appropriately in the patient's records. We noted that this audit only searched for the presence of a chaperone code on patients notes instead of those patients who had an intimate examination.

At the previous inspection we saw some anomalies with recruitment records and the registration status of staff. At this inspection records were clear and up-to-date. The full range of recruitment records for permanent staff was held centrally. However, the Group Practice could demonstrate that relevant safety checks had taken place at the point of recruitment, including Disclosure and Barring Service (DBS) checks to ensure staff were suitable to work with vulnerable adults and young people. A process was in place to monitor the professional registration and vaccination status of staff.

We visited all 3 locations and all were clean and tidy throughout. The Group Senior Nursing Officer was the infection prevention and control 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 Worthy Down in August 2023, Marchwood in December 2023 and Winchester in December 2023. These audits showed good results but with some areas of non-compliance mostly regarding the infrastructure. There was no sluice at Marchwood Medical Centre and therefore the only option to dispose of urine specimens was to carry the specimen down the corridor to dispose of it in the toilet. This toilet was used for both patients and staff. There was a risk of splash injury and this process increased cross infection and cross contamination. After researching an alternative the practice decided to use absorbent granules that can be put in urine specimen bottles which makes the liquid a solid gel and therefore can be disposed of in clinical waste at the point of processing.

Uncertainty about the future of the Winchester practice had affected investment in the building.

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. Deep cleans were carried out in each location. These were monitored and recorded.

Healthcare waste was well managed and included a clinical waste log. 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 December 2023.

The Central Alerting System alert log was held on health governance workbook including detail of action taken. They were also updating the Group Practice SOP to ensure those responsible for sharing the information knew and their responsibilities. Alerts were also discussed at the practice meeting as a standing agenda item.

Risks to patients

There was a good balance of civilian and military staff which afforded continuity of care and also injection 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, such as diabetes and pre-diabetes. A recent workforce review had been undertaken and showed nursing hours met current population need. Working within a Group Practice had improved resilience by mobilising staff between sites to manage increased demand when increased capability was required, for example, for an intake of new recruits. Routine clinics were reduced when required to respond to increased demand. A local working practice “guidance on the structure and delivery model for nursing services in WCMP” had been devised and introduced to direct how nursing services were to be delivered in all 3 practices across the group. This document offered guidance on hierarchical structure, roles and responsibilities and operational delivery and provided a clear outline of expectations of all nurses.

An automated external defibrillator (AED) was available in each practice and all staff were clearly able to identify where they were located. Oxygen and emergency medicines were stored safely.

The staff team was up to date with training in emergency procedures, including basic life support, anaphylaxis (a life-threatening allergic reaction) and the use of an automated external defibrillator (AED). Administration staff had completed sepsis training and triage training. We saw scenario-based training was used to practice these skills, with the last being in February 2023 focusing on a of patient with chest pain. There was a plan in place to continue with these sessions. All required staff completed the mandatory heat illness protection and cold injury prevention training online, the medics completed additional training.

Waiting patients could be observed at all times by staff working on the front desks at each practice.

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; 98% had been completed. Patients registering at the Group 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. A group audit of nursing records had been completed and showed positive outcomes.

Medics at Winchester (there were no medics at Marchwood or Worthy Down) saw patients autonomously but did have access to advice if they needed to. There was a formal debrief with the duty doctor to capture overnight cases. Progress was being made in terms of improving supervision for the medics, encouraging better notation and there was an intent to start some random case analysis in the near future to capture unknowns. The practice had started to send a nurse alongside the medics when they went on exercise with the recruits. This was initially to provide support to a junior medic new to the practice but was

going to continue as it was found to be beneficial and provided good support to clinical decision making for the medics with better treatment and escalation. The GDMO had been providing teaching every week which had been well received. We looked at 10 DMICP records checked from sick parades over the last 3 weeks. In all cases the medics had managed appropriately and actively referred to nurses or doctors when needed.

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. The duty doctors at each practice were responsible for checking global pathology links daily. Abnormal results requesting action were then identified and actioned immediately. Routine results were forwarded to the requesting clinician. There was an electronic specimen register in use at all 3 practices which was checked twice weekly by the nursing team. The local lab was contacted if results were not received. All patients were offered a call back for results at the time of the sample taking.

We saw that adequate heating was still an issue at the Winchester practice with no adequate central heating. Standalone heaters were evident throughout the building and on the day of the inspection the building was warm.

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 practices would revert to seeing emergency patients only. Government Wi-Fi was in place and most staff had laptops to ensure clinics could continue. The clinic details were printed daily and there were packs of paper forms to use in the event of an unplanned outage. Hard copy forms were held in the practice for use in this scenario and documentation would be scanned onto DMICP when available.

At the previous inspection we found the management of referrals required strengthening with the register not being fully kept up-to-date. At this inspection we found the management of referrals was good. 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.

There were good processes in place for sharing information internally including a newsletter for all staff and a frequent and regular meeting structure.

Safe and appropriate use of medicines

At the previous inspection we found a review of systems and processes for medicines management was required to ensure they were fully effective. This included a review of systems and processes for the management of patient safety notices and the transporting of medicines in the cold chain. We found at this inspection that improvements had been made and systems had been reviewed.

Dispensing was managed at Worthy Down and supplied Winchester and Marchwood practices. Medicines were transported securely using a pelicase (secure case) secured with a numbered tag or coded padlock and assurance could be given that these were not

tampered with during transit. For cold chain items a credo cube (to keep them in the cold chain during transit) was used, this was secured in a code locked wired net.

The emergency medicines and equipment we checked at Worthy Down were in date and fit for use. We were unable to check the stock medicines and equipment at Winchester and Marchwood due to time constraints on the day.

Arrangements were established for the safe management of controlled drugs (CD), including destruction of unused CDs and a yearly audit.

All staff who administered vaccines had received the immunisation training as well as the mandatory anaphylaxis training. 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.

There was a system in place to distribute Medicines and Healthcare Products Regulatory Agency alerts. We saw all but one alert had been recorded and reviewed, we discussed this and no harm had come to any patient. This system was being reviewed to ensure completeness and ensure the pharmacy technician had access to the group mailbox. Alerts were discussed and minuted in practice meetings.

Prescription forms were effectively managed. Prescriptions and related documentation were locked away in the dispensary and entered onto a log sheet upon receipt and upon issue to individual prescribers. A register for prescriptions for controlled drugs (medicines with a potential for misuse) was maintained and the prescriptions were kept in the safe. All details were recorded as specified in the controlled drug (CD) book for receipt and issue. This included a record of who had collected the item when not the patient prescribed to. A check showed that the running total correlated with the physical balance. Quarterly and annual CD returns had been completed. Destruction of CDs had been carried out in accordance with policy and certificates were retained.

We saw evidence to show that patients' medicines were reviewed regularly and the doctor's notes in DMICP around medication changes were comprehensive. A process was established for the management of and monitoring of patients prescribed high risk medicines (HRM). The register of HRMs used was held on SharePoint 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 or had shared care agreements in place. An audit of HRMs was completed every 6 months.

Arrangements were in place for the annual monitoring and auditing of antibiotic prescribing in line with local and national guidance. There was a monthly search in place to identify any women of childbearing age who were taking sodium valproate (a medicine used for epilepsy).

Track record on safety

The Group Practice manager was the designated health and safety lead. Each practice had an information board displayed near the reception and was regularly externally audited. Electrical safety checks were up-to-date. Water safety checks were regularly carried out and records were made available to us. A legionella risk assessment was carried out for each practice. A fire risk assessment of each practice was undertaken annually. Firefighting equipment tests were current. Staff were up-to-date with fire safety training and were aware of the evacuation plan.

At the previous inspection we found the risk register to not be up to date and had not captured all risk. At this inspection we looked again at the practice's arrangements for the provision of a safe service. The risk register was well 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. The Control of Substances Hazardous to Health (COSHH) risk assessments were reviewed and all COSHH items had been captured.

There were fixed alarms in clinical rooms and handheld alarms at Worthy Down. Winchester and Marchwood had portable alarms, simple records were in place to record that alarm checks had been completed.

Lessons learned and improvements made

Previously we found some inconsistencies with the ASER system with confusion as to who had received training and who had an ASER log in. At this inspection it was clear that all staff had access to the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events and incidents. All incidents reported were logged through the ASER system. They were discussed at the practice meetings and an ASER register was maintained.

From interviews with staff and evidence provided, it was clear there was a culture of reporting incidents. Both clinical and non-clinical staff gave examples of incidents reported through the ASER system including the improvements made as a result of the outcome of investigations. There was a sentinel event (a serious unexpected occurrence involving death or serious physical injury) ASER that came from Marchwood that we discussed in some detail. It was related to the lack of the ICE system (not used by the military) this system allows pathology and radiology results held by secondary care to be viewed by NHS clinicians in primary care, meaning that clinicians can see all the information they require when caring for a patient. The hospital assumed that the military practices would have ICE so did not pass on their concerns regarding a patient. The anomaly was noted as part of a robust leaving medical done by the SMO in Marchwood, action was immediately taken. The SMO at Marchwood has regularly liaised with the lead at Regional Headquarters to ensure that this issue is not overlooked by Defence Primary Healthcare (DPHC).

Are services effective?

Following our previous inspection, we rated the practice as requires improvement for providing safe services. We identified shortfalls in processes to keep patients safe including shortfalls in:

- staff training and induction
- recruitment checks.

At this inspection we found the recommendations we made had been actioned.

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. We saw examples of several good audits that had been instigated because of updated guidelines. For example:

Inflammatory bowel disease (IBD) audit – audited against NICE Clinical Knowledge Summaries standards it was identified as best practice to consider osteoporosis and fracture risk at annual reviews. It was identified by the audit that this was not routinely documented so an alternative was created to facilitate the process. A teaching session in IBD was also planned.

Rheumatoid arthritis audit - the NICE recommendation identified that that cardiovascular disease and osteoporosis risk were also checked for psoriatic (a form of arthritis with a skin rash) and spondylarthritis, a column has been added on the chronic disease register to prompt this line of questioning at annual reviews.

A doctors' referrals audit identified that there was a lack of documented shared decision making for referrals. A synonym had been developed to prompt clinicians to document shared decision making.

Interesting or complex patients were discussed at clinical governance meetings, for example there was good evidence of better management of more complicated women's' health problems using the regional doctor's expertise.

Clinicians had opportunities to attend regional forums, such as regional governance meetings and nurse development forums. The Group Senior Medical Officer 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 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.

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 (LTC) register was in use to identify patients potentially missed by searches. Each LTC had a named nurse to oversee. The nursing team actively engaged with patients and utilised text messaging to improve uptake in annual reviews.

A document 'Chronic Disease Management Tool' had been devised by a doctor that outlined review periods, appointment requirements (who with, length of appointment) also what lab tests and prelims required, for example spirometry, urinalysis, blood pressure, body mass index. In addition to LTC reviews, it included several other conditions requiring monitoring or review, for example coeliac/pre and gestational diabetes and gout.

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 8 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).

There were 65 patients recorded as having high blood pressure, 64 were recorded as having a blood pressure check in the past 9 months. We saw 55 of these patients had a recorded blood pressure of 150/90 or less.

There were 26 patients with a diagnosis of asthma, 18 of these patients had received an asthma review in the preceding 12 months.

Audiology statistics showed 82% 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 talk therapies, charities and with the Department of Community Mental Health (DCMH). Searches were conducted regularly for patients suffering with Depression (new diagnosis in last year) and post-traumatic stress disorder: we looked at a random 5 sets of for both and saw that all had been actively followed up with appropriate use of vulnerable adult codes and Joint Medical Employment Standard (referred to as JMES) changes.

Any new or urgent cases were seen by the duty doctor – they maintained good contact with the Chain of Command to maintain holistic management and this was in accordance with DCMH unified care pathway. All 3 practices had good links with unit welfare and the divisional system to provide holistic support to all patients. An information sheet had been put together for patients listing all the mental health resources that were available.

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.

Effective staffing

At the previous inspection there was some inconsistencies found with the recorded induction and ongoing training of staff. At this inspection we saw the staff database clearly showed all staff had completed an induction. There was recorded individual induction evidence to corroborate this. We spoke with one member of staff who described their induction process, they described it as full and detailed.

Internal and external training sessions were available to staff. For example, the practice manager had completed a degree in adult social care, had completed a DMICP systems administrator course and held a National Examination Board in Occupational Safety and Health. All staff had protected time to complete mandated training and the practice ran regular group training sessions. Clinical staff had clinical supervision sessions. Staff were routinely offered development and training opportunities via DPHC and regional headquarter announcements. One doctor told us how they were very well supported in accessing continuing professional development (CPD). Following their appraisal they were supported to join the Red Whale leadership programme. The Group Practice had supported this to provide cover for them to attend. They were also granted CPD funding and time to attend face-to-face “You are not a frog” conference (resilience in leadership topics). Cover was also provided so they could provide teaching to interested groups around the country, this was a real benefit of the grouping of the practice which they said had revolutionised their job satisfaction.

Individuals were issued with a mandatory training passport which clearly articulated the required training and includes links to the training material. Staff were further reminded of any required training via email or at practice meetings. There were 2 sessions per month of protected time to complete mandatory training. Compliance with mandatory training was good.

The doctors 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 CPD 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.

Staff could navigate around policies and processes using the practice Link Library on SharePoint. There were more than 60 standard operating procedures (SOPs) listed on the Link Library.

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. 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. A veteran's pack had been developed and was provided to patients at their leaving medicals to help and support them with practical as to what support was available to them.

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 3 practices, some example topics covered included sepsis, smoking, alcohol, and safeguarding. All new recruits got a health brief on arrival to raise awareness of what the practices could offer. Health promotion was discussed at the nurse's meetings and a health promotion tracker was in use and reflected subjects that were relevant to the patient population needs and the seasonal risks. The tracker held information about where resources can be ordered.

There were plans for specific ethnicity groups to be invited to some focus groups for nutrition awareness this is particularly due to their genetic disposition and increased risk of some chronic disease.

Both a doctor and a nurse had the appropriate sexual health training and provided sexual health support and advice. Sexual health screening was available across the 3 sites. 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 92% 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 13 patients identified that met the criteria for bowel screening and 2 for breast 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.
- 86% of patients were in-date for vaccination against hepatitis B.
- 92% of patients were in-date for vaccination against hepatitis A.
- 92% of patients were in-date for vaccination against tetanus.
- 99% of patients were in-date for vaccination against MMR.
- 92% of patients were recorded as being up to date with vaccination against diphtheria.
- 100% of patients were in-date for vaccination against meningitis.

The practices were represented at the unit health fairs within the camp. At the last event one of the doctors talked to the soldiers about healthy eating. This was because they had noted an upward trend of people being confused about diet. A presentation was delivered focusing around reducing ultra processed foods and a veteran come to discuss their experience of reversing type 2 diabetes.

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 formal 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.

Are services caring?

We rated the practice as good providing caring services.

Kindness, respect, and compassion

We spoke with 4 patients on the day of the inspection. They were all complimentary about the care they received. We saw many examples whereby the clinicians and staff across all 3 practices had gone above and beyond to ensure the best care for their patients. Some examples were:

The practice was contacted by patient's spouse, their partner had spent significant amount of time on operations and was about to draft to a new unit but was currently on a long period of post operational tour leave. The patient was exhausted it was felt it not appropriate to make them go to another practice a longer distance away whilst on leave to seek medical care so one of the doctors registered them at Worthy Down and had taken on their care. The doctor had maintained liaison with the patient's own unit doctor to ensure links with the unit welfare systems were maintained and the patient was not disadvantaged by seeking care distant from their unit.

A patient with acute stress and burnout related to operational exhaustion was not registered in the practice but requested to be seen locally as their own unit was some distance away. The practice had regular engagement with the patient and ensured onward referral to DCMH.

A patient struggling at times with pain was unable to drive to Worthy Down to collect medicines. On one occasion a doctor delivered medications to their home, they also arranged for a dressing to be changed at a closer practice so that the patient did not have to drive too far.

A patient due to be leaving the military requiring ongoing care received a comprehensive and thorough handover of care, the doctor coordinating made urgent referrals between 2 hospitals in 2 countries for 2 separate illnesses. They ensured proper handover to the new care provider and arranged for dressing supplies to be sent to the patient to cover the gap in provision.

The Group Practice across all 3 locations had good links with welfare team, they regularly had meetings, updates, and discussions. 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.

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.

Involvement in decisions about care and treatment

The clinicians and staff across the Group 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. Each site had a bespoke 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 information kept about them remained 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. 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.

The waiting rooms in Worthy Down was away from the reception desk and had a television for patients to watch. The reception at Winchester was segregated by a glass partition and at Marchwood the waiting area was small but had a radio playing to give some privacy to patients checking in. All waiting rooms were clearly visible to staff.

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 Group 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.

The Group 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.

One of the regiments at Marchwood had regular deployments of small teams sent all around the world (often at short notice) which made medical force preparation challenging. One of the nurses regularly attended the Regimental Operations meeting to better understand the Regiment, their upcoming commitments and also educated the Operations teams on the medical preparation process. They maintained regular communication with the Regimental and Squadron Operation teams and requested access to the live statement of requirement (SOR) document in order to pre-emptively provide sub-units with the details of the preparation required for the individuals aligned, as well watching for additional personnel changes that could require medical input. They had implemented a system that provided feedback to the Regimental Operations team on the medical status of the soldiers on the SORs, greatly reducing the workload for all involved in the pre-deployment assurance process. They have also on multiple occasions managed to get access to tuberculosis and rabies vaccines at very short notice for soldiers deploying to high-risk countries. Additionally, they have implemented an initiative to give each Squadron a dedicated day a month to have access to appointments in the practice.

Marchwood had been given extra staffing to cope with demand. However, there was very limited space and extra space was needed for 2 extra staff to do mainly administrative but sometimes clinical work. As a workaround they ordered noise cancelling headphones and microphones and they utilised a space so that nurses could provide increased clinical hours for patients, for example patient triage or administrative tasks such as medicines queries.

There was regular examination of upcoming movement of troops, comparing workforce resilience with patient demand. Part of this was to ensure clinical workload matched with staff resource, including moving staff within the group. Patients could also move between practices if necessary to meet clinical need. Across the practices staff could remotely cover each other for telecons and eConsult. COVID vaccination hesitancy briefs were developed to meet needs of the population. Specific health promotion activities were

developed to meet the demographic of the population, for example higher rates of metabolic syndrome at Marchwood so a low carbohydrate strategy was developed for that population).

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 dedicated member of 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 leaflets.

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.

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 and improvements had been made since the last inspection.

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?

At the previous inspection we rated the Well-Led domain as Requires Improvement. This was in relation to better management of governance arrangements. Since the last inspection in February 2023 the Group Practice had developed a comprehensive management action plan. All areas of non-compliance have been addressed. 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 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.

The Group Practice was passionate about the protection of the environment. They actively promoted the need to recycle and there were many recycling bins around the building. They also were actively promoting the change to Chlorofluorocarbon (CFC) free inhalers. Printing had greatly reduced with most information now sent electronically.

Leadership, capacity, and capability

The Group Practice, across all 3 sites, had a strong leadership strategy and vision that all staff championed. Staff reported feeling supported within their roles and listened to when suggesting change or raising concerns.

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.

The terms of reference were in date and clearly articulated the main role for the person and all assigned secondary/lead roles.

The Group 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.

Staff we spoke with described a strong team ethic across the medical centre whereby the patient's requirements were held at the centre of all decision making. The whole staff team operated an open and honest meeting culture where all staff were encouraged to attend and offer suggestions or raise concerns. Leaders operated an open-door policy for staff to use. Staff were aware of the whistleblowing policy and were also aware of the Freedom to Speak Up process within the region.

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 given examples of when duty of candour had been applied appropriately.

Governance arrangements

At the last inspection we found gaps and or shortfalls across the governance structure, including clinical and non-clinical processes. At this inspection we found great improvements had been made and there were effective governance structures in place.

The Group Practice model afforded flexibility, specifically the sharing of 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.

The leadership team had defined responsibilities, roles and systems of accountability to support good governance and management. The Group Practice had built in more resilience with leads and deputies in most areas. The healthcare governance workbook (HGW) was the overarching system used to bring together a range of governance activities, including the risk register, ASER tracker, training register, quality improvement projects and complaints.

The Link Library ensured quick and effective access to all key policies and processes and there are more than 60 SOPs in place which were linked to the HGW.

Staffing levels were appropriate for the population at risk and staffing levels are still improving. Lead roles were shared across the Group Practice and were well advertised to all staff.

There was an extensive meeting structure in place at both individual practice and Group level which included all staff with all key areas discussed regularly and at an appropriate level.

Joint working with the welfare team, pastoral support and Chain of Command was in place with a view to safeguarding vulnerable personnel and ensuring co-ordinated person-centred care for these individuals.

Group Practice leaders had reviewed, introduced and implemented a suite of policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. There were a wide range of standard operating procedures in place and available on the HGW.

A meeting schedule was established, and this included weekly Heads of Department meetings, weekly clinical meetings and monthly healthcare governance, safeguarding, practice and Unit Health Committee meetings. Quarterly meetings were held with DPHC Headquarters. Discussion at each meeting was recorded and made available to those unable to attend.

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.

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.

The Business Continuity Plan (BCP) was last reviewed in August 2023 and included an updated outbreak plan which was subject to tabletop review with key unit personnel in October 2023. The BCP included all the necessary risks to service delivery.

Appropriate and accurate information

The eHAF commonly used in DPHC 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 Group 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. During the period October to December 2023, 58 patients responded through the DPHC Patient Experience questionnaires. All patients were satisfied with the overall healthcare delivery provided (100%) which was a 7% improvement since Q3 (93.33%). We spoke with 4 patients and received 7 feedback cards all were highly complementary about the care they received.

The Group Practice had not run a recent staff survey but the practice manager and business manager were not aware of any concerns. The Group Practice ran team building events to build team ethos. The management team operated an open-door policy and an inclusive meeting structure. They had attempted to run 3 patient participation groups in the past but there was nil attendance at all of them.

One of the doctors was working within Wessex and Dorset NHS looking into healthcare inequalities faced by the military population. They also still sat on the Local Medical Council and liaised regularly about the difficulty with military access to services, in particular due to lack of ICE and negotiating access to NHS Tier 3 weight management. They also plan to meet with the Wessex Cancer Alliance to discuss how they could provide training and support to improve cancer diagnosis rates specifically within the military population. They planned to provide some training to the Group Practice and introduce the Wessex Cancer Alliance GP Toolkit, this included up to date 2 week wait proformas at our next doctors meeting.

One of the doctors was delivering resilience training to Southampton anaesthetics department having had discussions with some Army anaesthetists who felt it would be useful following some significant events at the Trust.

Continuous improvement and innovation

There was much evidence of continuous improvement across the Group Practice.

An informative leaflet was devised to offer staff support in the workplace. The premise being that workplace wellbeing should be at the front of people's minds. This could be individuals experiencing problems or supporting colleagues. This was initiated from a staff questionnaire and the request for more resources to support them.

Inflammatory bowel disease audit – audited against National Institute for Health and Care Excellence (NICE) Clinical Knowledge Summaries standards it was identified as best practice to consider osteoporosis and fracture risk at annual reviews. It was identified by the audit that this was not routinely documented so an alternative was created to facilitate the process. A teaching session in inflammatory bowel disease was also planned.

Low carbohydrate patient education

This this was identified at the last inspection due to the increasing numbers of diabetes / pre-diabetes being diagnosed, lack of education from local NHS teams / patient feedback

the NHS education was not suitable. This quality improvement initiative remains a week-by-week education package which could be delivered by any healthcare professional. The information has been updated to reflect some of the advice around ultra processed food. Training has been delivered at practice level and in some GP forums, alongside Defence dieticians. They had also visited HMS Queen Elizabeth and was present to help answer questions at a recent education session with their chefs and hope to work to help implement a version on board this year.

One of the nurses was new to the smoking cessation advisor role and the found that they were not able to give structured consultations because there was no pre-structured way of delivering the service, based on the questions asked. There were templates on DMICP to capture data but there were no templates on key questions and affected the way smoking cessation was delivered. A new tool was devised that included pertinent questions to ask patients in a structured way. The National Centre for Smoking Cessation Training was used to inform best practice and the nurse used this information to devise the template. This has been used for 2 patients to date and was working well.

Resilience training was delivered to doctors following a doctor colleague discussion noting the increasing burnout rates of doctors. One of the doctors had presented at several GP forums and was about to adapt the presentation to include how to set boundaries.

One of the regiments had regular deployments of small teams sent all around the world (often at short notice) which made medical force preparation challenging. One of the nurses regularly attended the Regimental Operations meeting to better understand the Regiment, their upcoming commitments and also educated the Operations teams on the medical preparation process. They maintained regular communication with the Regimental and Squadron Operation teams and requested access to the live statement of requirement (SOR) document in order to pre-emptively provide sub-units with the details of the preparation required for the individuals aligned, as well watching for additional personnel changes that could require medical input. They had implemented a system that provided feedback to the Regimental Operations team on the medical status of the soldiers on the SORs, greatly reducing the workload for all involved in the pre-deployment assurance process. They have also on multiple occasions managed to get access to tuberculosis and rabies vaccines at very short notice for soldiers deploying to high-risk countries. Additionally, they have implemented an initiative to give each Squadron a dedicated day a month to have access to appointments in the practice. This was recognised by the regiment and the regional headquarters as exceptional work and the individual was given an award.

Changes had been made to the clinic structure with amendments to timings for appointments. One of the issues raised by some of the nursing staff was that a 15-minute phlebotomy appointment would be ample time if there was a label printer to save handwriting specimen labels. There had also been significant events raised before about the incorrect labelling of samples and the laboratory not processing samples because of writing being illegible or NHS numbers being incorrect. The practice (Marchwood) requested a label printer, however due to logistics and DMICP compatibility, this was not possible. To find an alternative the nurse visited another practice who had created an auto populating template that they printed on (provided by Portsmouth hospital). The nurse adapted the template and managed to print out accurately using a normal standard printer on normal standard labels. They then added the auto populating identifiable data and was able to print out as little or as many labels as needed.

One of the nurses explored and utilised all the information that was available from the NHS and also service women's platforms to create a user-friendly document regarding pregnancy. This document contained both links, if emailed, and QR codes, if printed, so that service women were able to easily access all the information by several methods of technology. The document was emailed to all the Group Practice staff and was also saved to both DMICP and the Group Practice SharePoint so clinicians had a variety of ways of accessing this information.

A document "Chronic Disease Management Tool" has been devised by a doctor that outlined review periods, appointment requirements (who with, length of appointment) also what lab tests and prelims required, for example spirometry, urinalysis, blood pressure, body mass index. In addition to LTC reviews it included several other conditions requiring monitoring or review, for example coeliac/pre and gestational diabetes and gout.

At the Winchester practice a new scheme for Initial Medical Assessments(IMAs) had been rolled out. A spreadsheet had been created ahead of the IMAs and specific groups (under18s, females) were identified ahead of their IMA to ensure their specific needs were not missed. A lower threshold for referral to physiotherapy was in place to enable rapid review during the first few weeks of training. Weekly recruit management board meetings were attended by the training team, the Commanding Officer, medical and welfare. This was to discuss recruits who were struggling in training for whatever reason helping with holistic management of the recruit.

A document "Guidance on the structure and delivery model for nursing service in Winchester Medical Practice had been initiated. It was a local working practice making clear what the expectation of each nurse role was. It standardised the length of time each appointment should take for each presentation across all sites ensuring clarity, consistency and fairness. It also gave some way to protect the role of civilian nurses against everchanging military leadership.