Dhekelia Group Medical Practice

Dhekelia Group Medical Centre

Dhekelia Station, BFPO 58

Defence Medical Services inspection report

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

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

Contents

Summary

About this inspection

We carried out this announced comprehensive inspection across 3 dates: 25, 26 and 31 July 2023.

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

Are services safe? – inadequate

Are services effective? – requires improvement

Are services caring? – requires improvement

Are services responsive to people's needs? – inadequate

Are services well-led? – inadequate

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 improve patient and staff safety and will ensure implementation of 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.

We immediately escalated concerns following this inspection to Commander Defence Primary Healthcare (DPHC) and to the DMSR. DMSR undertook urgent enforcement action in support of the profession and with a view to ensuring that patients receive safe and effective care. Where we identified individual patients who could be at risk of harm, we shared their details with DMSR in order that these patients could be urgently reviewed.

At this inspection we found:

- Some patients confirmed to us that they were able to access an appointment when they needed it. However, a number of patients who used Ayios Nikolaos Medical Centre told us that they were no longer able to see a GP face to face close to where they lived and worked. Several patients from both Dhekelia and Ayios Nikolaos medical centres told us they had concerns around obtaining medicines on the day they needed them due to limited dispensing hours.
- Patient feedback about the service was mixed. Some patients we spoke with confirmed that they felt comfortable coming to the medical centre to seek support and treatment and that clinicians had gone the extra mile to provide excellent care. Other patients raised concerns about the way the medical centre team communicated with them and

challenges in accessing convenient appointments outside working hours. Some patients raised concerns to us about the quality of care provided to them including delays in communication, a shared issue around a dismissive consultation style and missed flags during triage.

- A quality improvement programme was in place but, there were some gaps in DPHC mandated audits (partly due to de-prioritisation under red OPAL status). Some additional audit work targeted to be meaningful for the patient population had been undertaken.
- Arrangements for managing medicines, including high risk medicines, needed work. Printing problems and handwritten prescriptions had increased the risk of errors. Read (clinical) coding and the use of alerts for patients prescribed high risk medicines were not used effectively. Some patients were not receiving the monitoring they required for safe management of their high-risk medicine.
- The practice had recently adapted a best practice chronic disease management tool which guided clinicians to access the most recent care pathway and guidelines for patients with a long-term condition. There were some missed opportunities in this area with evidence of some patients who were not achieving optimal outcomes being missed on occasion by clinicians. The team explained that this was partly resultant from the OPAL status of the medical centre.
- We were concerned to hear from some staff that the safety culture needed to be improved. Not all staff felt able to raise a concern and some staff told us that when they had tried to, they had not been listened to.
- There were gaps in the safe management of vulnerable adults and children. Ineffective use of Read coding and alerts meant that the risk register for vulnerable adults was inaccurate and incomplete. There were vulnerable adults and children who had not been recently discussed or reviewed.
- Blurred lines of accountability at a senior leadership level, unclear risk escalation pathways and a failure to fill key leadership roles posed risks to the safe delivery of the service.

We found the following areas of notable practice:

- Patients requiring minor surgery were given a leaflet which gave comprehensive information around what to expect and how to access support if they needed it. This was bespoke to the island and was particularly informative.
- The team were committed to streamlining processes and reducing the amount of waste cause by printing documents unnecessarily. The introduction of the use of quick response (QR) codes throughout the medical centre to manage resuscitation trolley checks, equipment care, daily Pre-hospital emergency care checks, referral non-availability proformas and training codes had enabled the medical centre to reduce waste whilst ensuring checks were evidenced using the Microsoft forms platform. The team were considering submitting this work as a quality improvement project to be shared more widely.

The Chief Inspector recommends to Defence Primary Healthcare (DPHC) and British Forces Cyprus (BFC):

- Urgently increase clinical and leadership capacity at Dhekelia Group Medical Practice such that expectations on staff are reasonable and individuals feel adequately supported to provide primary healthcare, out-of-hours care, urgent care, prison healthcare, refugee health checks, occupational healthcare and care to patients at the satellite practice. Clinical staff should not be routinely called upon to work hours in excess of either the Defence Instruction and Notice (DIN) or the Working Time Regulations (1998).
- The application of red 'Opal Status' in March 2023 by DPHC to Dhekelia Group Medical Practice created risks to patients. OPAL definitions in DPHC policy meant that chronic disease management was not to be prioritised and could be delayed, the staff team had been asked to reduce audit activity, contributions to Unit Healthcare Committee Meetings were to be made remotely or in advance and health checks for over 40s checks were not required. There should be clear target timelines for return to normal service where opal status requires a reduction in primary healthcare activity, coupled with risk assessment for patients with more complex needs and alternative provision arrangements at other facilities to mitigate these risks.
- Given that nursing staff arrive on the island with different clinical backgrounds, skills currency and experience (some with no background in primary healthcare and a number with limited experience working with children); clarify and formalise the training and support requirements for nursing staff who are required to deliver paediatric assessment and treatment. Nurses should be competent and confident to deliver this care before they are asked to work independently.
- The contractor must provide evidence of assurance around water, legionella, gas and electricity safety.
- Expediate work to review BFC civilian human resources policy so that staff with the most appropriate and desirable skills, qualification and experience can be recruited, essentially clinicians with primary health care and paediatric experience.
- BFC to review the secondary healthcare concerns presenting as a trend in ASER (system for reporting and managing significant events) submission and provide feedback to the medical centre team.
- Clarify lines of accountability at a senior leadership level (DPHC/Single Service/British Forces Cyprus) such that risk escalation pathways are clear, risk ownership is understood, and key staffing gaps are filled to mitigate risks to the safe delivery of the service.
- Given the continuous use of the Dhekelia building it should be seismic compliant to protect the safety of people who use the building in the event of earthquake activity.
- Senior leaders must gain assurance that the Unit Major Incident Plan is fit for purpose.
- Review and expand protocols to the medical team for the safe and effective delivery of prison healthcare.

The Chief Inspector recommends to the medical centre:

- Urgently work with the entire staff team to build and embed a safety culture which encourages and supports individual staff to raise concerns and to report through the ASER system without fear of reprisal. Ensure that all staff (including locums) have their own ASER login.
- Through widened attendance at practice and healthcare governance meetings, broaden shared learning through ASER management.
- Improve communication around and root cause analysis of all medicines management ASERs. Ensure that learning is shared widely and include the pharmacy technicians.
- Urgently resolve access to an alarm system such that staff can summon support in an emergency if they need it.
- Ensure that all staff have terms of reference so that they are clear about their working accountabilities and any lead roles.
- Review the approach to safeguarding vulnerable adults to ensure that all children and adults (including dependants) thought to be vulnerable are routinely discussed and reviewed and that concerns are shared with stakeholder agencies. Accurate Read coding and use of alerts must be kept up-to-date for all vulnerable adults and children. Facilitate clinical attendance at Unit Health Committee meetings where possible.
- At the time of inspection, the medical facility had been graded as being OPAL Red. OPAL Red means that DPHC had directed that priorities 1 and 2 only were to be conducted. Attendance at UHC was at priority 8. This meant that stakeholder engagement was on hold during the period of pressure on the facility. All risks for not conducting activities outside priority 1 and 2 should be transferred formally to DPHC RHQ who would then hold the risks.
- All clinicians who assess and treat children must have appropriate training, competency assessment and clinical supervision in paediatric care such that they are confident and competent to provide this care.
- Comprehensive training for all staff who are required to triage must be provided and staff asked to confirm that they have received all the support they require to feel competent and confident in triage activity. Ongoing work around standard operating procedures and terms of reference should be expedited to provide a framework to support staff who deliver remote triage.
- Urgently address the gaps in mandatory training for medical emergencies management including basic life support, use of an automated external defibrillator, anaphylaxis, sepsis and thermal injury.
- Use peer review of consultations and clinical records to broaden learning and improve quality of record keeping across teams.
- Ensure that induction processes for all staff roles deliver sufficient shadowing opportunities and competency assessment. The induction process should be completed to the satisfaction of the new staff member before staff start to work independently and particularly before they lone work at night.

- Staff who chaperone must have received the appropriate training, so they clearly understand their role and know how to record the task.
- Implement a system to assure the registration status of staff members who are required to hold a professional registration.
- Where DBS checks to ensure staff are suitable to work with children and vulnerable adults are pending, escalate to the Regional Headquarters safeguarding lead to ensure that staff can work with patients in the interim period.
- Ensure that patients in waiting areas can be observed at all times and in all areas.
- Ensure that the contracted deep clean takes place.
- The management team should appraise itself of any backlog in notes summarisation so that remedial action can be taken as required.
- Given the disparity across the staff team around whether a policy and risk assessment for lone working is in place, ensure that all staff are aware of arrangements and know how to access support.
- Review the reception triage protocol to ensure that it reflects the agreed thresholds for children under the age of 2 years being seen urgently by a doctor and includes the NHS flag symptoms for stroke (referred to as FAST). Consult with nursing staff around their individual training needs for the safe and effective provision of patient telephone assessment. Provide clear protocols for nurses who are providing assessment over the telephone.
- Continue to engage with the patient population registered at Ayios Nikolaos Medical Centre to get to the heart of their experiences, concerns and requirements. Build on existing mechanisms to proactively work with patients who can assist with resolving issues surrounding communication, access to doctor appointments, convenient hours of provision, transport issues and ambulance access.
- Ensure that chairs provided in the waiting area are suitable for patients attending with an injury and are sufficiently robust. Some should provide arm support.
- Ensure that Patient Group Directive (PGD) authorisations are completed and up to date and ensure all annex E's are legible.
- It would be best practice to ensure that Fmed296 prescriptions are generated for all supplies of over-labelled medicines supplied against a PGD.
- Patient Specific Directives (PSDs) must be completed in accordance with DPHC policy (JSP950 9-2-1) stating the clinic date before medics use the PSDs. Use of PSDs must be coded by the prescriber writing the PSD in each patient record. No corrector fluid should be used to change any details documented on a PSD.
- Implement written local working practice for the management of information about changes to a patient's medication out-of-hours or by secondary care.
- Ensure that printers are available and in working order for prescribers to use.
- All patients prescribed a high risk medicine (HRM) should be reviewed by a doctor and the HRM register updated. HRM searches should be run monthly.

- Complete the emergency medicines risk assessment.
- Audit antimicrobial prescribing and penicillin use/allergy.
- Re-organise policies and standard operating procedures so that staff can easily access them.
- Offer NHS over 40 health checks to patients who have not been seen for routine medicals (this had been de-prioritised due to the red OPAL state of the practice a the time of our inspection).
- Ensure that patients with a long term condition (including high blood pressure and asthma) are recalled in line with national guidelines.
- Facilitate bowel and cytology screening for all patients who are eligible.
- All patient complaints must be acknowledged and investigated, and a response provided to the patient in line with DPHC policy. Implement a protocol with Regimental staff and Station staff such that any complaints involving the medical service are shared.
- Where feedback is received about the consultation style of a clinician, this should be investigated and customer care training provided as appropriate.

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Chief Inspector of Healthcare

Our inspection team

The inspection team was led by a CQC inspection manager and comprised specialist advisors including a primary care doctor, practice manager and a pharmacist. A member of the DMSR team provided input around nursing. DMS were unable to secure a physiotherapist specialist advisor and so we did not inspect the primary care rehabilitation facility on this occasion. The whole team were on site on 25 and 26 July, and a clinical records review was completed off site on 31 July.

Background to Dhekelia Group Medical Practice

Located in the Eastern Sovereign Base Area (ESBA) of Cyprus, Dhekelia Group Practice comprises 2 medical centres approximately a 25-minute drive from each other. Dhekelia Medical Centre is the main practice with Ayios Nikolaos Medical Centre identified as the satellite practice. All clinical services are based at Dhekelia Medical Centre and support the satellite practice on a sessional basis. There is a dispensary at Dhekelia Medical Centre.

At the time of the inspection the group practice provided a routine primary care and rehabilitation service to a patient population of approximately 3,100 (across both sites) including service personnel, families, dependents and contractors. Urgent care was also provided out-of-hours for this cohort of patients. Occupational health was provided for service personnel only. The Group Practice team also provided prison health care to HMP Dhekelia and clinicians were called upon to review the healthcare of refugees landing nearby.

At the time of this inspection, red ‘Opal Status’ had been applied by DPHC to Dhekelia Group Medical Practice. In line with OPAL definitions in DPHC policy, this meant that chronic disease management was not to be prioritised and could be delayed, the staff team had been asked to reduce audit activity and health checks for over 40s checks were not required.

Secondary care was provided primarily through a contract with the American Medical Clinic (AMC) and other government hospitals were sometimes used, including Larnaca General, Paralimni and Nicosia General. Patients could also be referred to the UK NHS services if required.

Although not within the scope of this inspection, the group practice was also responsible for the provision of Pre-Hospital Emergency Care (PHEC) covering the whole of the ESBA and to a population of 9,000 and 112 ambulance cover for ESBA.

The staff team

Medical team	**Establishment (3.5 FTE) Actual (1.5 full time equivalent (FTE))** One Senior Medical Officer (SMO) – VACANT POST One Deputy Senior Medical Officer (DSMO) – VACANT POST One Unit Medical Officer (UMO) – Army One Civilian Medical Practitioner (CMP) – DPHC (0.5 FTE) One General Practice Trainee – Starts August 23
Nursing team	**Establishment (14 FTE) Actual (9 FTE)** One Senior Nurse Officer (SNO) – Army One Nurse Warrant Officer (NWO) - Army Three Corporal Nurses (OR4) One Corporal Nurse (OR4) – (Maternity leave) Four Band 6 nurses - civilian Three Band 6 nurse - currently locums One Band 6 nurse post – VACANT POST
Medics	**Establishment (13 FTE) Actual (13 FTE)** 12 Combat Medical Technicians (CMTs) – DPHC 5 x CMT OR3 1 x CMT OR2/3 1 x CMT OR4 1 x RN MA OR4 1 x RAF Medic OR4 1 x RAF Medic OR2 1 x CMT OR5 1 x Paramedic OR7 One practice manager CMT – DPHC 1 x OR7
Practice management Practice Administration	**Establishment (7 FTE) Actual (7 FTE)** One Chief Administration Officer Six administrative staff Administration staff are a mixture of UKN/UKFM and LEC

Pharmacy	**Establishment (2 FTE) Actual (2 FTE)** One civilian Band 5 pharmacy technician One Sergeant OR5 pharmacy technician
PCRF	**Establishment (3 FTE) Actual (3 FTE)** One lead physiotherapist – Army. Started 31 July One physiotherapist/healthcare governance lead One Exercise Rehabilitation Instructors (ERI) - DPHC

Are services safe?

We rated the practice as inadequate for providing safe services.

Safety systems and processes

Staff confirmed that the Senior Medical Officer (SMO) was the safeguarding lead. As there was no SMO or deputy SMO (DMSO) in post at the time of this inspection, the Unit Medical Officer (UMO) had been nominated. There were no terms of reference in place to state this.

We saw evidence from the UMO that they had undertaken Level 3 training to safeguard children and vulnerable adults, but practice training records did not capture this. A safeguarding adult/child policy was held by the Group Practice and was last reviewed in January 2020 and was due review in May 2022. The policy included contact telephone numbers for the various agencies within Dhekelia such as the social workers and SSAFA (Armed Forces Charity). Staff could contact the Regional Nursing Advisor who was the safeguarding lead in Regional Headquarters. The annex to the safeguarding policy contained a flow chart and contact details were displayed in several of the consultation rooms throughout the facilities.

The Defence Medical Welfare Service (DMWS) and Primary Healthcare (PHC) teams attended monthly safeguarding meetings to discuss vulnerable children on the island. Minutes from the PHC meeting were unavailable at the time of the visit and could not be provided following the inspection. Therefore, checks on whether patients were identified by their DMICP (electronic patient record system) number on the meeting minutes and whether their DMICP record was updated during the meeting could not be confirmed. The lead social worker for Dhekelia had left earlier in 2023 so support was being provided from across the island. Attendees at the PHC meetings included Children and Adolescent Mental Health Service (CAMHS) staff, the school nurse, the children's nurse, health visitors, the midwife and the UMO. At the time of this inspection there was no welfare representation. Due to capacity constraints and the application of OPAL status red, clinicians at the medical practice were unable to attend Unit Health Committee (UHC) meetings in person but provided remote support. There was no formal forum for multi-agency discussion of vulnerable dependent adults.

A safeguarding register for adults was held but was last updated in 2020. There was no evidence that vulnerable adults were routinely reviewed and discussed. Our review of DMICP showed gaps in Read coding and we saw that alerts had not been routinely applied for swift recognition by any clinician opening a vulnerable patient's clinical record. Patients serving in the military who were under the age of 18 were not identified with the relevant alert. Care leavers were also not identified with the relevant alert – whilst this cannot be mandated and remains the choice of the patient, it is helpful to prompt consideration around patient needs e.g. vulnerability through having no home to return to during periods of leave and sickness.

A safeguarding register for children was held and was last updated in July 2023. A clinical search for vulnerable children did not align with the children included in the register for vulnerable children. We reviewed records for some children coded as vulnerable and saw that they had not been routinely discussed and reviewed.

A mental health team was based at Akrotiri and provided a weekly outreach clinic at Dhekelia. The UMO had forged a strong working relationship with this team and discussed individual patients if they had any concerns. Remote access to the DPHC Overseas Psychiatric team was available if required and any patient in need of complex support would require aeromedical evacuation back to the UK. Prior to being assigned overseas, families were screened by the Global Practice for medical supportability and to ensure that there were no medical concerns that might put them at risk.

As part of our inspection, we spoke with a welfare officer, a padre, 2 officers working in Station Command, 2 midwives and a member of staff from the hospitals liaison team to solicit their views and active involvement with the Group Practice team around safeguarding. Midwives confirmed that they attended monthly PHC team meetings and that the clinical engagement from the medical team was excellent with detailed discussion of vulnerable children. Station staff were aware of staffing capacity concerns within the medical team and confirmed to us that input was given remotely or in advance of UHC committee meetings. There was a concern that non-attendance in person reduced the speed with which downgraded staff could be brought back into the workplace.

We saw evidence that where patients attended a hospital emergency department (ED) (and the medical centre were made aware), the team followed up with the patient. Where a child was seen in ED, details were shared with the child nurse. The Hospital Liaison Officer was involved when patients were admitted in an emergency.

According to the training register, chaperone training had not been conducted since May 2019 and there had not been anyone qualified to perform chaperone duties since May 2020. The chaperone policy was last amended in August 2022 and a poster offering this service was displayed on the patient information board opposite the main entrance. As there were no trained chaperones within the practice, no register was held to identify personnel who could perform these duties.

There was no system in place to continually review all members of staff who were required to hold a professional registration. For locum staff, the competency pack was reviewed by the practice manager via the ‘patchwork hub’ to ensure all the necessary recruitment checks were in place prior to commencing work.

All Disclosure and Barring Service (DBS) certificates were checked for compliance and updated in the staff database. At the time of the visit, 5 members of staff were out of date with their DBS certificates, although applications to process new certificates had been made. The required line manager’s risk assessment waiver had not been submitted to the Regional Headquarters’ safeguarding lead to ascertain whether they were content to accept the risk for individuals to continue performing their duties. All medical centre staff were covered by crown indemnity.

A nurse was the designated lead for infection prevention and control (IPC) and had received the appropriate training. The Defence Primary Healthcare (DPHC) mandated 12 IPC audits were approaching completion and improvements were being actioned.

There was a cleaning contract in place through the contractor, Sodexo. This included a deep clean every 6-12 months. However, the management team were unable to confirm when the last deep clean took place and they knew it had not happened in the last 18 months. The cleaning management team conducted weekly spot check inspections. There was scope for the medical centre management team to conduct their own checks against cleaning standards. The medical centre was visually clean on the day of our inspection, although we noted stained chairs in use at Ayios Nikolaos. Management of waste was overseen by the IPC lead. Consignment notes were maintained. The last pre-acceptance waste audit was undertaken in November 2022 but was only 10% complete. Another audit was scheduled for the autumn.

The last fire risk assessment was conducted in October 2021 and was due for review in October 2026. No observations were raised at the time of the assessment. Requests had been made to the contractor to ensure the safety of facilities and equipment. No information had been provided by the contractor to the Group Practice team around water, legionella, gas and electrical safety. Station staff maintained a log of portable appliance testing undertaken.

Risks to patients

Clinical capacity and leadership capacity were known longstanding issues across the medical team. Staff worked hard to deliver the best that they could within limited resources but at times some tasks had to be de-prioritised (in accordance with the DPHC OPAL policy) such as occupational grading assessments (which could only be done by the UMO) and chronic disease management. The team had been asked by DPHC to prioritise urgent care and pre-hospital emergency care. Continuity of service was a challenge due to a high reliance on locum staff. The UMO confirmed that they were working on average 100 hours a week (including working and on-call hours) which created risk in terms of exhaustion and clear decision making. It is widely accepted that on-call hours do not afford the rest and recuperation afforded by off duty hours.

No SMO had been in post since 2020, although the previous DMSO (who assumed the acting rank of SMO) left in November 2022. The net impact has been insufficient leadership capacity to deliver effective healthcare governance, to maintain a comprehensive oversight of long term conditions management, to create working protocols for the safe management of patients in prison and to ensure that all potentially vulnerable patients were adequately safeguarded.

Nursing staff arrived on the island with different clinical backgrounds, skills currency and experience. Some had no background in primary healthcare and a number had limited experience working with children. Whilst a UK Nurse post had been agreed to provide continuity, the SBA/BFC requirement for spousal employment created a barrier for the team as they were unable to employ candidates with the most appropriate skillset. It had not been possible to provide nurses with the training and competency assessment required for them to feel confident and competent delivering paediatric assessment and

treatment, particularly at night when they worked alone with a medic (who was on sleeping shift). Doctors could be contacted out-of-hours and were obliged to see all children aged 2 years and under (our review of clinical records indicated that this was not always the case however). Some nurses reported that not all doctors attended in the same prompt way and that at times nurses were asked for some extensive justification for requesting a doctor to attend at night.

The practice team had recognised the need to improve and update the induction pack for staff (including locums) joining the service. However, the nursing induction was aimed at the military nurse role based in Dhekelia and so did not cover some areas that would be useful for civilian staff and staff working out of Ayios Nikolaos. We asked some staff to share their induction packs with us and noted that several had not been completed. Several staff members confirmed that they had not had the opportunity to shadow for as long as they required before being required to deliver care. This included nurses being asked to undertake night shifts (with a sleep-in medic) after only 1 night for shadow learning and competency assessment. There is clear risk where staff feel daunted.

The emergency trolleys were accessible and regular checks were undertaken. We reviewed the medicines on the trolleys and found them to be appropriate and in-date. Defibrillators were located in the Group Practice. Oxygen was held and was accessible and appropriate signage was in place.

We reviewed the staff database and training register. Statistics for medical emergency related training were as follows:

- Basic life support (BLS) - 22 personnel out of date.
- Automated external defibrillator (AED) - 24 personnel out of date.
- Anaphylaxis - 21 personnel out of date.
- Sepsis training was last conducted in September 2017.
- The Institute of Naval Medicine delivered training on heat related injuries in July 2023. There was no record of this training on the training register, therefore statistics could not be obtained to ascertain how many members of staff attended. Some nursing staff confirmed that they had not been able to attend.
- The practice had recently introduced moulage (scenario-based training) for the duty staff which was attended at the start of the day shift by the Duty Medical Officer, paramedic, medic and whoever else was available. Nursing staff confirmed that they were unable to attend as they were required to prepare for clinics and provide telephone consultation at 08:00 hours. However the management team contacted us following the inspection to tell us that clinic start times were adapted 12 months ago to enable all clinical staff to attend morning moulage training.
- The training log for the medical centre did not include a forecasted trade (in-service) training programme to inform staff what training was scheduled in the weeks / months ahead.

Doctors had completed advanced life support training. The UMO and civilian medical practitioners (CMPs) had experience of paediatric assessment and treatment as all had experience working in family or NHS Practices. Some nurses had undertaken paediatric immediate life support (PILS) training and some had completed immediate life support (ILS) training in the past but not all. However, most were now out-of-date for both ILS and PILS with some nurses never having accessed the training. The Practice Team confirmed that PILS and ILS training are not a mandated requirement for nurses as per DPHC policy. Three combat medical technicians (CMTs) had returned to the UK in July 2023 to undertake ILS/PILS training and staff told us there were plans to fly an instructor in to deliver M-PHEC and BATLS courses to CMTs in the future. Staff told us that there were unclear lines of accountability around whether CMTs should be caring for families and civilians – they were trained in military care models designed with military personnel's needs in mind. Practice leaders confirmed that CMTs at Dhekelia were not required to see civilians – although they might be called upon to do so in an emergency.

There was a policy for heat illness management which doctors knew how to access. A heat illness management pack was kept on standby in the fridge and doctors discussed any heat injury cases during handovers.

There was no sepsis policy in place. Sepsis red flag posters were displayed in several of the consultation rooms but not all. During the inspection, a sepsis poster was printed and placed in reception.

Receptionists working across the group practice had received training in July around recognising and reacting to emergencies. However, we noted that only 1 member of the reception team attended this training. Reception staff worked with a telephone triage protocol which had recently been implemented and included a RAG rating (traffic light colour coded) for condition priority. However, whilst we were advised that all children under 2 years must be seen by a doctor, the reception triage prompts contradicted this stating that only children under 1 year old needed to be urgently seen by an MO. There was scope to include all 4 of the NHS flag symptoms for stroke which include Face, Arms, Speech and Time (FAST test). When speaking with staff, there was some ambiguity over what was deemed to be telephone triage and what was clinical assessment. Calls were frequently passed to the nurses to conduct telephone assessment and to decide whether a patient needed to be seen. There was no standardised protocol for nurses to use as part of their assessment and dependence was placed on the individual nurse's experience. There were clear risks with this approach. An audit of triage notes was undertaken by the SNO in March 2023 and concluded that whilst the review uncovered no serious concerns with the triage of patients by telephone, there was scope to ensure that appropriate standard operating procedures (SOPs) and terms of reference (TORs) were in place.

The UMO had completed the Sports and Underwater Medicine Course (SUMC) and so could offer diving medicals to patients requiring them.

Waiting patients in the main reception area could be observed at all times by staff working on the front desk. This included patients who had received vaccinations. However, there were 2 additional waiting areas which were not overlooked by staff and where there was no CCTV in place. We were told that these additional waiting areas were not routinely used. The risk was captured on the risk register and installation of CCTV was being

considered. Whilst on site we noted that a prison patient was left alone seated in an unobserved area whilst their accompanying officer attended to tasks in another area.

Information to deliver safe care and treatment

Staff and patients confirmed that access to patient records was a concern and sometimes prevented patients from accessing timely care. We spoke with 36 patients during our inspection and 5 confirmed that they had been impacted by the computer system not working when they attended their appointment. Three told us that their appointment had been cancelled and they had been asked to re-attend the following day. This was particularly inconvenient for working patients based at Ayios Nikolaos and for patients without transport. Two patients confirmed that the clinician had been able to see them but that they could not prescribe medicines due to the system not working. They had been asked to re-attend the following day to collect their medicines. Staff confirmed that patients with an urgent care need would be seen regardless.

In the overseas space, teams are required to use DMICP Deployed/Fixed (a version of the patient records system which is updated periodically rather than immediately). Noting that access to the current patient record is optimal, the UMO had managed to secure access to DMICP Fixed, for reference when a full patient history was needed in order to provide treatment. The team confirmed a concern around the arrival of temporary visitors from the UK who were entitled to care at the medical centre but who were not registered as such and so access to notes was not provided. When families arrived from the UK, there was a known period of risk between the registration of the new patients and the arrival of their notes from the UK.

There was a robust system in place for requesting, receiving and summarising new civilian patient records into the practice. As new civilian records can take between 1-2 months to arrive, the LaSCA NHS Agency was tasked with forwarding a patient summary via email of the requested record to be scanned onto DMICP. NHS records were hastened in a timely manner and on receipt the ‘new patient’ spreadsheet was updated accordingly and the notes were given to the nurses to summarise. Notes awaiting summarising were held in a locked cabinet within the nurse’s reception which was staffed 24/7. Once summarised, the records were held in a secure room with only a few individuals aware of the combination for the simplex lock to access the room. However, there was no system in place to conduct a 3 yearly review of notes that required summarising and no search was created to ascertain any summarisation backlog.

Weekly case discussions took place between doctors and this included a shared view of records. Peer notes review audits were not being undertaken at the time of this inspection. Our review of the clinical notes as part of this inspection suggested that ongoing peer review of notes would be prudent given that we identified a number of issues with Read coding errors, missed action during triage, poor clinical note keeping for a clinician who no longer works at the practice and an ongoing concern around out-of-hours prescribing and dispensing.

Some nurses were able to provide phlebotomy for children over 5 years, but there was no clear documentation to show who had been signed off as competent to do so. Patients could also be sent to the American Medical Centre (AMC) for bloods to be taken. We

reviewed the tracker for specimens and test results and noted that in April 2023, a partial return had been recorded for a patient but this had not been followed up with the patient and the log had not been closed down. After our inspection, practice leaders confirmed that this patient had left the practice in May 2023. Nevertheless, the results should have been chased by the requesting doctor before the patient left. This indicated that improvement was required to ensure that the management of specimens and test results was failsafe.

Prior to May 2023 a paper system was in place to manage cytology (this system was not failsafe as the paper books were not available to all sample takers and the receipt dates of some results were not recorded). In May 2023 an electronic cytology system was adopted. A recent audit by the practice indicated that 93 out of 428 eligible patients were in-date for screening. The accuracy of this was not clear as the last cervical sample dates had not always been added during summarising, just the next due date. We reviewed the records for 5 patients who were eligible for cytology screening and noted that 3 were due screening but had not been recalled. We shared our concern with the Defence Medical Services Regulator (DMSR) who took enforcement action.

A failsafe referrals process was embedded and managed well by a designated referral team of 2 civilian administrative staff. All referrals raised by a doctor were tasked on DMICP to a referrals mailbox. At the time of referral, the patient was presented with a QR code which they completed to inform the referral staff of their availability, personal email address and a suitable contact number. All referrals were sent to the AMC where waiting times were generally 2 weeks for urgent referrals and 8-10 weeks for routine. The referral register was located on SharePoint and managed by the referral team. The referral team also managed internal referrals to the DCMH and external referrals to the AMC. Urgent referrals were colour coded and, on review of the spreadsheet, all patients were seen within the stipulated period. The referral team also monitored each referral to ensure that hospital letters were received in a timely manner and hastened all outstanding reports. The referral team offset their leave to ensure that the department was staffed at all times.

The Group Practice team were required to provide healthcare to patients detained in a prison facility. A nurse with some experience of prison healthcare led the delivery of this service, supported by doctors. There had been incidents where medical staff had been required to intervene in suicide attempts, to provide support to patients refusing food and to assess patients with drug and alcohol addiction. The team had proactively provided the best support they could, but there was a need for clinical leaders to review and expand protocols bespoke to the safe and effective management of detained patients.

Safe and appropriate use of medicines

The SMO would ordinarily be the lead for medicines management. In the absence of an SMO and a DMSO, the task had fallen by default to the UMO. Two pharmacy technicians were responsible for the day-to-day management of medicines: generic TORs for the role were in place but these were not signed.

Practice nurses used Patient Group Directives (PGDs) for immunisations and primary care treatments. Some nurses had stopped using the PGDs because the SMO had left and the annex E authorising PGD use had not been updated. For the nurses that had an updated

annex E, the Rotarix PGD that expired in June 2023 had been authorised for use in July 2023 and some of the annex Es stating the vaccinations were very difficult to read There was a cupboard holding over-labelled medicines for supply of PGD medicines. On 30 June 2023 it was identified that there should be 330 co-codamol tablets in the PGD cupboard. The stock check found 60 in the cupboard. The 270 could not be accounted for. The over-labelled co-codamol has now been moved to the dispensary to improve accounting of this medicine.

Patient Specific Directives (PSDs) were being used. Our review found that all the relevant sections had been fully completed, however, the date of authorisation had been changed on 3 PSDs using correction fluid. Medics were vaccinating patients using PSDs on the day of the inspection. During the clinic, it was identified that the PSD had not been completed in accordance with DPHC policy as the authorisation date was missing from the PSD. There was a post-it note on the PSD that stated “dates of clinic”. A review of two DMICP records found the Read code to authorise a medication under a PSD had not been applied.

There was no local working practice for the management of information about changes to a patient’s medication out-of-hours (OOH) or by secondary care. Pharmacy staff confirmed that all written communication from OOH or secondary care were handed to reception. A hard copy was given to the duty doctor to action and then the document scanned onto the DMICP record. Evidence of this was not seen in action during the inspection.

Printing problems and handwritten prescriptions were increasing the risk of errors. For example, a handwritten prescription for ibuprofen (pain relief medicine) was created for the wrong patient. This was identified by the pharmacy technician and changed before issuing to the correct patient. Another example was the prescription of fusidic acid 2% cream to the wrong patient. This was identified by the pharmacy technician and changed before supply to the patient. Practice leaders confirmed post inspection that the printing issue has now been resolved.

Evidence was seen that one prescription generated out-of-hours did not comply with DPHC policy (JSP 950 9-2-1). There was no handwritten medical centre address and no date on the prescription. This is a legal requirement for all prescriptions. The patient had been intentionally supplied with 250mg tablets as there were no 500mg tablets available. There was no documentation of this change on DMICP. There was a handwritten message on the Fmed296.

All blank prescriptions were stored safely. There was a logbook for receiving new blank prescriptions. Date of supply, quantity supplied and a running total could be calculated.

A process for the safe processing of repeat prescriptions was in place. Where appropriate, medication reviews were taking place and were Read coded. Prescriptions were authorised by doctors or nurse prescribers.

Uncollected prescriptions were checked monthly and a note was made on the patient’s record and the medicine destroyed including the prescription serial number. The prescriber was alerted if the medicine was high risk.

A temperature log was maintained for the medicine fridges and the ambient temperature of the dispensary. A SOP was in place and we saw that recently recorded temperatures were within appropriate parameters.

The practice was not always following the DPHC protocol and local SOP for high risk medicines (HRMs). We reviewed the clinical records for several patients who were taking HRMs and saw that some had not been monitored appropriately. Application of Read codes and alerts was sometimes missing. The list of high risk medicines the practice were using to inform their management of HRM was not in line with the lists recommended by DPHC.

Controlled drugs were managed in line with the JSP 950 leaflet and the Misuse of Drugs (safe custody) regulations 1973. This included the dispensing and destruction of controlled drugs.

An emergency trolley at each medical centre contained drugs and equipment which was checked monthly by both pharmacy technicians and nurses. All items were in date. There was scope to complete the emergency medicines risk assessment to ensure that the contents of the emergency trolley were in line with what might be required.

An audit on antimicrobial prescribing had not been undertaken. This is an oversight, given the differences in antibiotic sensitivity in Cyprus and advice of local hospital microbiologists. Locums arriving from the UK may not be aware of the local arrangements around antibiotic use. There was also scope to undertake an audit around the management of penicillin use / allergy.

Track record on safety

Active and retired risk registers were held on the healthcare governance workbook and adopted the 4 Ts (treat, tolerate, transfer or terminate) approach to risk management. The risk register contained both clinical and non-clinical risks and all risks were frequently reviewed by the practice manager. The top 3 risks were discussed during the monthly healthcare governance meeting. The practice team previously held quarterly risk meetings but due to capacity issues, no meeting had been held for some time. We reviewed the issues register and saw that it had not been managed for some time. There were 7 issues logged between August 2019 to November 2022 but no updates had since been made.

The practice manager had completed the Institution of Occupational Safety and Health course in 2020 and a risk assessor's refresher course in 2021. A suite of risk assessments were in place and in date. A decision had been made that a lone worker policy and risk assessment were not required because staff never worked in isolation. However, nurses could work alone at night (when the CMT was either sleeping or called out to answer a 112 call) and so there was a requirement for both a policy and a risk assessment to be implemented. After the inspection, we were told that both a risk assessment and lone working policy were already in place. This contradicted what we were told on the day of the inspection.

There was no fixed alarm system in place and we were told that handheld panic alarms were therefore provided. We checked in 5 consultation and clinical rooms and could not

find these. We asked clinical staff whether there were alarms and they confirmed that the front desk alarm to summons assistance from the Sovereign Base Area (SBA) Police was not working. Nurses who worked waking shifts at night reported feeling apprehensive as, whilst OOH appointments were pre-booked via a phone call, they were required to answer the reception door alone and were not reassured that support could be easily secured. It could take up to 15 minutes for guardroom staff to arrive at the medical centre.

Lessons learned and improvements made

Significant events and incidents were being reported through the electronic organisational-wide system (referred to as ASER) in line with the DPHC ASER policy. However, where new staff joined and did not have immediate ASER log-ins, they were asked to request paper print-outs (which meant that submissions were not anonymous). There was therefore a secondary manual ASER tracker in place to capture these paper submissions. We noted a discrepancy between the 2 systems that required resolution:18 ASERs were active on the online system and over 25 were active on the manual ASER tracker. Some locum staff did not have an ASER log-in even though some had been post for 12 months – 1 told us that they used someone else's login and another raised them on paper.

Our interviews with staff across the whole team and our review of the ASERs raised and investigated to date, indicated that the safety culture was not entirely conducive to staff feeling confident to raise concerns in the knowledge that they would be listened to and that improvement would ensue. Some staff stated that the ASER system was used as a punishment tool. Some staff told us that they had been told not to raise issues they had (we discussed these issues and they have led to recommendations in this report). ASERs were a standing agenda item at practice and healthcare governance meetings. However, attendance at these meetings was poor. The medical practice team comprised 62 (37 PHC staff) of staff at the time of this inspection, but attendance at the practice meeting in June was 18 and 20 in July. Attendance at the healthcare governance meeting was 11 in June and just 7 in July. Staff confirmed that this was due to reduced meeting attendance requirements whilst the red OPAL rating was in force. Whilst some staff had an understanding of the shared learning from ASER management, it was clear that many staff were unclear about what learning had resulted from ASERs. We noted a trend in ASERs raised around secondary healthcare The team confirmed that these concerns had been escalated to British Forces Cyprus but that no remedial action or communication had been forthcoming. The mandated DPHC ASER analysis audit due in quarter 2 (April to June) was yet to be submitted for the medical centre. The DPHC Healthcare Governance Team confirmed that audit requirements were currently under review as many would not be required in future.

The dispensary did not have a current near miss log. This was rectified shortly following our inspection.

Processes were in place for the management and action of Medicines and Healthcare products Regulatory Agency (MHRA) and National Patient Safety alerts. Evidence was seen of an in-date electronic MHRA alert register and that the practice had a system in place to ensure that they were receiving, disseminating, and actioning all alerts and

information relevant to the practice. The register documented what action (if required) had been taken. Evidence was seen that the alerts were discussed in the practice meeting and there was a link to the MHRA register in the minutes for non-attendees to access and view.

Are services effective?

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

Effective needs assessment, care and treatment

National Institute for Health and Care Excellence (NICE) guidance was a standing agenda item for practice meetings. However, on review of the minutes for June and July 2023 only a reference link was recorded. There was no record of which guidance was either relevant or had been discussed. Doctors confirmed that NICE guidance, clinical pathways, current legislation, standards and other practice guidance were discussed at doctors' meetings. It usually fell to the GP trainee to review NICE guidance and any relevant publications but there was currently no trainee at the practice. There were no minutes of the doctors' meetings available for us to review. Staff confirmed that the overseas pharmacist sent through alerts from the Central Alerting System and these were discussed at the doctors' meeting if relevant to primary care.

Nursing staff did not attend practice meetings or clinical meetings, only nurse meetings Sometimes updates were discussed at the monthly Pre-Hospital Emergency Care (PHEC) meetings, but nurses were not invited to this. Nursing staff confirmed that new guidance and updates were sometimes discussed at the nurse meetings, but that these were not standing agenda items. There was no formal process for the dissemination of up-dates to all clinical staff.

The secondary care clinics used on the island sometimes recommended treatments which fell outside British national guidance. These instances were discussed at doctors' meetings and reach back to the Defence Consultant Advisor (DCA) was used if required. NICE guidelines, the GP notebook, British National Formulary and Dermnet were used as reference.

Monitoring care and treatment

The Senior Nursing Officer (SNO) held the lead role for chronic disease management and leads for each condition were listed on the chronic disease register. The practice had recently adapted a best practice chronic disease management tool which guided clinicians to access the most recent care pathway and guidelines for patients with a long term condition. Discussions around managing patients had just commenced at healthcare governance meetings. The team followed a chronic disease management protocol which gave guidance around when to run clinical searches to inform the recall of patients. Whilst 'Popman' (a search facility in DMICP) was not available on DMICP Deployed, a standardised set of clinical codes was in use.

We reviewed a number of records for patients with a long term condition and found that, in the main, recalls were being done appropriately. There were some missed opportunities in this area with evidence of some patients who were not achieving optimal outcomes, being missed on occasions by clinicians.

There were 39 patients recorded as having high blood pressure. Twenty-seven patients had a record for their blood pressure taken in the past 9 months. Thirty patients had a blood pressure reading of 150/90 or less which is an indicator of positive blood pressure control.

The practice team confirmed that as the medical centre was operating on 'red opal status', chronic disease management was not being prioritised and delays to care were considered to be justified.

There were 19 patients on the diabetic register. For 18 patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For 17 patients, the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.

There were 55 patients with a diagnosis of asthma. Fifteen of these patients had had an asthma review in the preceding 12 months which included an assessment of asthma control using the three RCP (Royal College of Physicians) questions. An asthma standard operating procedure (SOP) was followed by clinicians. Whilst a consistent asthma review template was in use, there was scope to utilise it more fully.

77% (DHEK) and 50% (AYN) of patients were in date for audiometric assessments (within the last 2 years). During COVID-19 routine audiometry had ceased in line the April 2020 Defence Primary Healthcare (DPHC) directive. The practice had resumed audiometry as restrictions relaxed and were working to reduce the backlog.

Patients with a mental health need were supported by the practice with initial interventions which included sign posting to mental health resources and support, the padre service, third sector support, welfare support and routine prescriptions. Staff did not have DPHC mental health booklets to pass on to patients, but they said that they would look to secure some. Adults (including dependants) could be referred to the mental health team at Akrotiri and children could access the Child and Adolescent Mental Health Service (CAMHS) in the same building as Dhekelia Medical Centre. Access to CAMHS was good and children were seen promptly. We reviewed 7 patients who were taking anti-depressants. For 2 patients, some of the note taking was very poor and for 1 patient there was no alert in place to flag up their vulnerability.

A quality improvement programme was in place but we noted that some DPHC mandated audits have not been completed. Staff confirmed that this was due to the OPAL status and because direction had been given to halt some audits by DPHC HCG HQ. Some additional audit work targeted to be meaningful for the patient population had been undertaken.

We saw a nurse led audit from December 2022 which aimed to improve patient education access for those with a chronic disease. The work had been shared with another practice on the island with positive feedback received.

The General Duties Medical Officer had undertaken an audit on vasectomy complications and the findings had been shared with British Forces Cyprus Commander Med to ensure wider learning across the island. There were plans to provide feedback at the secondary health care forum, but recent meetings had been cancelled.

An audit cycle had been completed on the high risk medicines (HRM) register. This showed that initially only 39% of patients on a HRM had the correct alert on their records. This increased to 80.8% on repeat audit. Of the patients with no alert at the repeat cycle stage, 61% were new to the practice or newly started on medication, but 9 were re-audit patients. Practice recommendations were that a new method of improving patients being added to the risky medicines tracker was needed including consideration of a HRM lead. The recommendations were still to be actioned.

Effective staffing

The medical centre team met with barriers when recruiting clinicians, and particularly nurses with the required skills, experience and qualifications to deliver primary healthcare. Current British Forces Cyprus (BFC) civilian human resources (HR) policy mandated the employment of dependants rather than the most appropriately skilled candidates. Consequently, clinicians without any primary healthcare experience frequently worked with the team. Providing the appropriate training and support was a significant challenge in a healthcare environment where staff were already stretched.

All new members of staff were required to complete the DPHC mandated induction programme which had been adapted to include role specific elements and information relevant to the unit. According to the staff database, 3 members of staff had not completed their induction programme and, on review of several induction programmes that were deemed as completed, it was evident that there were numerous actions still outstanding.

There was a written induction programme for doctors joining the practice. This included orientation around the practice, administration, pharmacy brief, resuscitation room, ambulance and doctors care familiarisation, blue light driver training and other topics.

In the absence of a suitable nursing induction programme and protected time for comprehensive training nursing staff had proactively worked together to identify training and reference materials that might assist them to gain the competency they required, especially in order to assess and treat children. Nurses attended monthly nurse meetings but did not have protected time to join practice nor clinical nor healthcare governance meetings. No clinical supervision was undertaken by nurses. There was no nurse peer review system in place to ensure continued improvement in quality of note keeping and consultations. The SNO confirmed they had undertaken a notes audit and triage notes audit with some immediate reminders to staff, although dedicated feedback to each staff member had not been given nor a copy of the audit provided for their revalidation portfolio.

Tabletop instructions were held on SharePoint which all members of staff were given access to on arrival. However, locating these was time consuming and challenging and there was no folder containing hard copies of the relevant policies.

Performance appraisals were conducted by line managers for all staff and uploaded to HR systems. An appraisal spreadsheet was maintained to show which military and civilian staff were in-date.

Mandatory training was recorded on the staff database. Staff told us that there was a lack of protected time for the completion of mandatory training and attendance at training. On

review of the training staff database, it was noted that 13 members of staff were not in-date with ‘safeguarding adults’ and 12 members of staff were out-of-date for ‘safeguarding children’. According to the training staff database the designated safeguarding lead and deputy were both out-of-date with their mandated training. The safeguarding lead provided evidence directly to us to show that they had been trained.

Following the inspection, staff confirmed that the staff database had been inaccurate and incomplete on the day of the inspection. The team told us that all staff were in date for their safeguarding training. We will verify this information when we return to re-inspect in 6 months.

Coordinating care and treatment

The medical centre team had forged effective links with station commanders, welfare staff, padres and the mental health team based at Akrotiri. We were told that a mutually supportive communication stream was in place. We interviewed 2 welfare officers, a padre and 2 station command staff as part of our inspection. Command staff noted the constraints that doctors were currently operating with, but voiced their preference for medical attendance in person at unit health committee meetings and medical boards so that downgraded personnel could be supported back into work as soon as was safe and appropriate. Welfare staff confirmed that if a patient required urgent access to a doctor, this was provided swiftly whatever the time of day or night. They confirmed that doctors provided a personalised and holistic service for patients in crisis and that patients appreciated being treated like ‘more than a number.’

The medical centre team had established strong links with SSAFA as they were co-located in the same building. Both teams described a meaningful 2-way conversation with midwives, the children’s nurse and health visitors around the needs of vulnerable patients. A Hospital Liaison Officer (HLO) was based at the AMC as well as DMWS and this provided a useful link for patients using secondary care. The HLO also engaged with other hospitals on island and was approachable with queries.

Helping patients to live healthier lives

Health promotion information was made available on notice boards although we noted that some of the boards had not been updated since 2018. We saw a number of health promotion boards in the waiting area and corridors and these included information around sexual health, hydration, smoking cessation and continence. Staff confirmed that condoms were usually available in toilets but there were none on the day of this inspection.

There was a genito-urinary (GU) nurse on the island who ran clinics at various locations which included Dhekelia Medical Centre on Mondays and Fridays. The GU nurse was informed of any sexually transmitted infection results. The medical centre team were generally able to contact the GU nurse and make appointments for a patient to be seen promptly.

Health screening was encouraged by the medical centre, but there was a gap for patients eligible for bowel screening. Practice leaders confirmed that bowel screening is currently unavailable in overseas locations and that the risk is noted on the DPHC RHQ risk register.

There were 3 patients eligible for abdominal aortic aneurysm (AAA) screening, 2 had been screened, one had not responded but the practice were following this patient up.

There were 41 patients eligible for breast screening and 38 had been screened. Three were being followed up.

Seventy-six percent of women who were eligible for a cervical smear had received one in the last 5 years which was below the NHS target of 80%.

There were 531 registered patients who were eligible for an over 40s NHS health check. Only 63 had been coded as receiving this health check in the last 5 years. This included dependants who would not be subject to the routine occupational health medicals that military personnel benefit from. There was therefore a risk that underlying health conditions might not be picked up.

Immunisations were regularly reviewed and administered to military patients when they were required. Our review of records showed that the vaccination programme was delivering what patients required:

- 92% (AYN) and 89% (DHK) of patients were recorded as being up to date with vaccination against diphtheria.
- 92% (AYN) and 89% (DHK) of patients were recorded as being up to date with vaccination against polio.
- 89% of patients were recorded as being up to date with vaccination against hepatitis B.
- 90% (AYN) and 100% (DHK) of patients were recorded as being up to date with vaccination against hepatitis A.
- 92% (AYN) and 89% (DHK) of patients were recorded as being up to date with vaccination against tetanus.
- 98% (AYN) and 99% (DHK) of patients were recorded as being up to date with vaccination against MMR.
- 73% (AYN) and 86% (DHK) of patients were recorded as being up to date with vaccination against meningitis.

Childhood Immunisations

- 100% of children aged 1 had completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB)
- 100% of children aged 2 had received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster)

- 100% of children aged 2 had received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster)
- 100% of children aged 2 had received immunisation for measles, mumps and rubella (one dose of MMR)
- 100% of children aged 2 had received a Tuberculosis immunisation.
- 100% of children aged 5 had received immunisation for measles, mumps and rubella (two doses of MMR).

Consent to care and treatment

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. They had a good understanding of the Mental Capacity Act (2005) and how it would apply to the patient population. Mental capacity training was delivered in June 2023 but we noted that some nurses and doctors had not been able to attend.

Consent was appropriately recorded in the clinical records we looked at for minor surgery.

Staff confirmed that an audit of nurse consultations was undertaken April 2023. It was clear from the results that there was scope to improve recording of consent in nurse notes.

Staff we spoke with were aware of Gillick competence (young people under 16 with capacity to make a decision) and would ask children over 13 years whether they wanted to be seen alone of with a guardian. We saw examples of this recorded in patient notes.

Are services caring?

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

Kindness, respect and compassion

We interviewed 36 patients as part of the inspection across both sites and feedback indicated that the majority of medical centre staff treated patients with kindness, respect and compassion at all times. However, 8 patients we spoke with outlined concerns with the consultation style of a clinician. These patients told us that they felt that they were either not listened to or that their concerns were dismissed as trivial. Where patients did not feel that the healthcare professional was treating them with gravitas and this left them with a sense of mistrust and feeling disenfranchised.

Twelve patients completed written CQC comments cards as part of this inspection. All but 1 described staff who went the extra mile to support them. One patient wrote about a healthcare professional who had not listened to them and who they did not wish to see again.

We interviewed the majority of staff working across the group medical practice through this inspection. Around two thirds of the staff we spoke with told us that the Dhekelia Group Medical Practice was a good 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. However a number of staff used the word ‘fearful’ and ‘blamed’ to describe how they felt at work and stated that they would not be confident that an issue they raised would be actioned.

Medical Centre staff confirmed that they had a close working relationship with the Garrison Hive in Dhekelia which was located next to the practice. The HIVE had a designated Facebook page for all personnel and their families which the medical centre used to inform patients of any changes that impacted service provision or to advertise any relevant and useful information. However, a number of patients who used Ayios Nikolaos told us that they were unable to access Facebook whilst at work and so would not receive timely communication if the medical centre service was affected. Some patients told us that the Facebook pages were numerous and hard to navigate.

Involvement in decisions about care and treatment

We spoke with 36 patients as part of this inspection. Twenty-four said that medical staff involved them well with decision making and planning their care. Twelve patients told us they had some concerns about the way a clinician had either dismissed their concerns or told them that they didn’t need treatment, but without additional explanation.

Patients with a caring responsibility were identified through the patient registration process and welfare teams were involved in supporting people to access the services and advice that would help them. The clinical code to denote patients’ potential vulnerability had not been assigned to their records.

An interpretation service was available for patients who did not have English as a first language.

Privacy and dignity

Some patients and some staff we spoke with raised a concern around whether the practice always kept information about them confidential. We were told that in advance of this inspection, some boxes of patient records that required summarisation had been held in an insecure area. This issue had been rectified.

On the day of our inspection, we noted that there was a folder containing sensitive information pertaining to patients held in the reception area. Interviews with the padres, welfare officers and Commanding Officers confirmed that medical staff only shared information about patients with the patient's consent and that only necessary information was disclosed. Medical staff took care to protect the healthcare information of patients during meetings to discuss vulnerable patients – information was only divulged to mitigate a risk to a patient or those around them.

Patient identity checks were completed prior to any information being disclosed. Consultations in the medical centre took place in clinic rooms with the door closed.

There were no notices in reception advising patients they could speak with a member of staff in private if required. However, the reception team would offer this option to any patients who appeared to need it. The waiting room was large and meant that patients speaking with staff at the welcome counter were not easily overheard.

Patients were able to see clinicians of either gender according to their preference. Patients we spoke with did not raise concerns about this.

Are services responsive to people's needs?

We rated the practice as inadequate for providing responsive services.

Responding to and meeting people's needs

The medical centre at Dhekelia was dated and was not seismic compliant which was a concern for staff working in an area with known earthquake tremor activity. Leaders confirmed that Project Apollo sought to replace the building. However no fixed date had been set at the time of the inspection and it was still in the discussion phase. The building at Ayios Nikolaos was purpose built to withstand seismic movements. The clinical facilities were well provisioned to meet the specific needs of the patient population, including access for patients using a wheelchair. Patients we spoke with did not report any concerns with accessing the facilities. An Equality Access Audit for both buildings had been carried out and no barriers had been noted. There was scope to improve the seating provided at Dhekelia which was not suitable for patients attending with any frailty or injury. The inspection team left the building in the dark and noted that the kerb outside the Dhekelia building was difficult to see due to poor lighting.

The medical centre team had a nominated diversity and inclusion representative, although 16 team members were due to receive training in this area. Information was available in waiting areas and corridors around the inclusive nature of the team ethos. Non-gender toilets were provided.

Patient feedback had been sought by the team. They had issued patient surveys and also arranged town hall talks to engage with patients and understand their concerns and issues. However, a number of patients told us that they were not seeing sufficient improvement in response to the feedback they had given. The team told us that extended appointments were being provided to patients on the back of feedback, but patients were not aware of this and the information on the medical centre doors and in the practice leaflet had not been updated.

Timely access to care and treatment

We spoke with 36 patients as part of this inspection and 14 confirmed that they had found it difficult to get through by telephone to the medical centre at times. Staff and patients confirmed that the telephone system was sometimes not available. We also received feedback from 12 patients who confirmed that their appointment had been cancelled at very short notice, either because the computer system was down or a clinic had been cancelled. This was inconvenient for patients who had travelled with children or had left work to attend and sometimes distressing for patients experiencing discomfort. Some patients had already travelled the 25 minute journey from Ayios Nikolaos to Dhekelia and on arrival were asked to come back the following day. One patient told us that they were asked to sit in the waiting room and that they approached the reception desk twice to remind the team of their presence. They confirmed that after 90 minutes, the reception team stated that they had not noticed the waiting patient and they were requested to come

back the following day. A number of patients told us that they had contributed to surveys sent out by the medical centre team and that they had provided their contact details so that staff could contact them about the concerns they raised. These patients said that they had not been contacted and that they had not noticed any improvement as a result of the feedback they had given.

Urgent and routine appointments with either a doctor or a nurse were available on the same day. However, working patients and patients attending school had not been offered appointments around their daytime commitments. Appointments were only available between 08:00 hours and 13:00 hours. Whilst the staff team confirmed that extended appointments (until 16:00) had been made available to accommodate those with working and school commitments, patients we spoke with were unaware, the practice leaflet did not state this and there was conflicting information around opening hours on the medical centre door in Ayios Nikolaos.

Patients we met with at Ayios Nikolaos raised concerns about access to a doctor. Before the Covid-19 pandemic, GP-led clinics had been available for patients at Ayios Nikolaos, but these had been cancelled and not re-instated. All patients we met with at Ayios Nikolaos cited concerns about the need to travel to Dhekelia to see a GP including:

- A minimum of 90 minutes during working hours to attend the appointment
- Arriving at Dhekelia to find that the appointment had been cancelled
- Travelling with small children along a road with poor telephone signal in high temperatures
- No access to transport
- We were told that 30 school children had travelled to receive immunisations rather than one clinician travelling to them.

Combat medical technicians ran a sick parade (emergency clinic) each day for all service personnel. The practice also offered a 24/7 out-of-hours service: patients could contact a registered nurse for advice and signposting to a doctor was undertaken if needed.

Where there was a clinical need, home visits were triaged by the duty doctor and accommodated if appropriate. Telephone consultations were available, and doctors and nurses used them.

As there was only one military doctor available to conduct occupational medicals, the practice was only performing operationally essential medicals. These could generally be accommodated within 2 days.

Listening and learning from concerns and complaints

The practice manager was the lead for complaints. There was information regarding the complaints process in the practice leaflet and a signed poster displayed on the main patient information board opposite the entrance.

Eleven complaints had been received in the last 12 months. The complaints were still held within the email system and had not been uploaded to the DPHC webpage: this was rectified during our visit. The complaints analysis audit that was due in Quarter 2 (April to June 2023) had not been conducted, so it was not clear how complaints management was driving improvement.

Patients were made aware of the complaints process through the practice information leaflet and a poster in the waiting room. We spoke with 36 patients and 5 told us that they had submitted a written complaint (either by email directly to the medical centre or to the Station Commander or to the recent Regimental Medical Officer) but that they had not received a response. Practice leaders confirmed that where emails had not been passed to the complaints manager, these complaints did not sit within the DPHC complaints process. However, it would be good practice to implement a protocol such that any complaints involving the medical service were shared.

Are services well-led?

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

Leadership, capacity and capability

The Group Practice team had been placed in a difficult and compromising position with the posts of the Senior Medical Officer (SMO) and deputy SMO (DSMO) having been vacant since 2020. The failure of the Single Service to provide staff to fill these positions was a key barrier to clinical leadership capacity and meant that the Unit Medical Officer (UMO), Senior Nursing Officer (SNO) and practice manager had been obliged to assume a level of accountability that was outside their rank and pay grade. Staff did not have agreed terms of reference for their main role and separate terms of reference for any key lead roles that they undertook. Desk top instructions to ensure that staff understood their daily responsibilities were also lacking.

The team was delivering a broad service which extended well beyond the parameters of a standard primary care Practice. The Out-of-hours (OOH) and urgent care requirements meant that many staff were working night and weekend shifts and doctors were providing on call hours which were extensive at times. These duties were required in addition to the provision of a comprehensive primary care service for military personnel, their families and children; occupational health services; prison healthcare; refugee health checks and primary healthcare to a separately and uniquely placed satellite population. Some staff's clinical working hours exceeded the safe working hours outlined in both the DIN (Defence Instruction & Notice) and the WTD (Working Time Directive 1998). This left no reasonable additional capacity for leadership and management of the service.

The team had well established links with the regional team and staff confirmed that input and support was provided whenever possible. However, the key staffing gaps and training requirements were issues that the regional team had been unable to resolve as they did not hold the levers to influence change.

Vision and strategy

The team's vision was to provide a safe, high quality, accessible and patient-centred primary care service to the population, and also provision of out-of-hours and emergency cover within the Eastern Sovereign Base Area. However, due to capacity constraints, the team were unable to deliver all these commitments and so, on the instruction of Defence Primary Healthcare (DPHC), had prioritised urgent care delivery. This meant that it was no longer possible for a doctor to see patients in person at Ayios Nikolaos (only urgent occupational health medicals could be undertaken and a number of staff were working very long hours to provide OOH cover).

We noted that the practice was working to a previous version of the DPHC mission statement. The team confirmed that they would update staff's terms of reference to include the current statement.

The medical centre held a version of the practice development plan named ‘Quality Improvement’ located within the healthcare governance (HcG) workbook. This document required development.

Culture

Many staff we spoke with described a strong team ethic with patients’ individual requirements held at the centre of all decision making. We observed examples of staff going the extra mile to provide a comprehensive service to their patients, often working well beyond contracted hours to provide out of hours and urgent care to anyone in need. However, we also met with staff who felt unsupported, who felt that their concerns had not or would not be listened to and acted upon. Several staff described a safety culture that was not conducive to ensuring the delivery of safe care at all times.

It was clear that the medical centre team worked to a culture of ‘being proactive with what we have’. Staff were aware of suboptimal resourcing, including key gaps in the workforce, but their commitment to deliver for their patients was paramount and so they continued to strive to deliver against the odds. Capacity concerns had been escalated to the regional team, but due to constraints around Single Service personnel, leadership capacity gaps had been carried for an excessive amount of time. This put frontline staff in an impossible position as they had no levers to influence change to their predicament.

Due to capacity constraints, the practice team meeting culture centred around the attendance of only a few key personnel, meaning that many staff were excluded from key learning resulting from ASER review and healthcare governance initiatives.

Staff were aware of the whistleblowing policy and were also aware of the Freedom to Speak Up (FTSU) process within the region. Many staff confirmed that they would be confident to raise any issues they had. Nevertheless, some staff told us that they would be afraid to speak up about their concerns.

FTSU and OP Inclusion mandated courses were omitted from the staff database and so it was not clear what percentage of staff had undertaken this training.

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 care and treatment. We were given examples of when duty of candour had been applied appropriately.

Governance arrangements

There was a detailed leads list displayed throughout the medical centre which was last updated on 24 July 2023. All leads were fairly distributed throughout the team with a few members of staff taking on multiple associated duties due to their particular expertise. However, we noted that the safeguarding lead was named as the ‘SMO’ even though there had been no SMO in post since 2020. Best practice would see deputies assigned to each

role to ensure business continuity in the absence of the lead. In addition to this, all terms of reference and job descriptions required update to reflect the keys roles and responsibilities of the leads and their deputies.

All staff had access to the HcG workbook which included various registers and links such as: risk, quality improvement register (Practice Development Plan), training register and the issues log. The practice manager was responsible for reviewing the HcG workbook each month and updating all staff on any changes to the relevant areas during the monthly practice and HcG meetings. However, attendance at these meetings was not optimal and nurses were unable to attend. Some of the spreadsheets such as the issues register and training register had been neglected within the HcG workbook.

The SNO was the nominated audit lead for the medical centre. Despite the medical centre adopting the revised DPHC audit policy, 6 mandated audits were overdue: peer review of DMICP consultations (for both doctors and nurses), PEQ audit, complaints analysis audit, DNA audit and the ASER audit. A peer review of nurse DMICP Consultations had been completed.

The practice had recently adapted a best practice chronic disease management tool which guided clinicians to access the most recent care pathway and guidelines for patients with a long term condition. There were some missed opportunities in this area with evidence of some patients who were not at target being missed on occasions by clinicians.

Communication across the clinical teams could be improved. Attendance at practice and HcG meetings was low and meant that shared learning opportunities were missed. We looked at the minutes for recent HcG meetings and noted that the attendance record for 1 meeting was only 1 person. There were no clinical meetings attended by both doctors and nurses: once again, a missed forum for shared learning and patient discussion.

Managing risks, issues and performance

Active and retired risk registers were held on the healthcare governance workbook and adopted the 4 Ts (treat, tolerate, transfer or terminate) approach to risk management. The risk register contained both clinical and non-clinical risks and all risks were frequently reviewed by the practice manager and the top 3 risks were discussed during the monthly HcG meeting. The practice team used to hold quarterly risk meetings but due to capacity issues, no meeting had been held for some time. We reviewed the issues register and saw that it had not been managed for some time. There were 7 issues logged between August 2019 and November 2022 but no updates had since been made.

Pathways for the escalation of risk and subsequent ownership of risk at senior levels were not delivering what was needed. Lines of accountability were blurred. For example, key staffing gaps were clearly identified as a key risk but escalation to the regional team, DPHC, Single Service and British Forces Cyprus (BFC) had not resulted in resolution, rather the issue had remained a concern for over 2 years.

A business continuity plan was in place and was last reviewed in May 2023 and was scheduled for review in December 2023. The Unit Major Incident Plan (MIP) and the Communicable Disease Outbreak Management Plan (CDOMP) for the Group Practice

were unavailable at the time of the visit. The CDOMP was subsequently shared following the inspection. However, it could not be ascertained what involvement the medical centre had in the unit's MIP. Staff confirmed that, on a bi-annual basis, the Unit conducted a tabletop exercise to test how the different organisations would respond to a major incident. The most recent exercise related to an earthquake. Action taken by the medical centre was to recall all off-duty personnel to the medical centre until they were called upon to respond to any incidents in accordance with their 112 emergency response duties.

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.

Appropriate and accurate information

The HAF (Health Assurance Framework) 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. On review of the HAF, it was noted that the key lines of enquiry were last reviewed in June 2022. There were 30 ongoing actions recorded in the HAF management action plan.

The medical centre had received a Health governance assessment visit in November 2022 and assurance awarded was substantive.

Systems were in place that took account of data security standards to ensure the integrity and confidentiality of patient identifiable data (PID), records and data management. Nevertheless, we did note that some PID was held in an insecure area.

Engagement with patients, the public, staff and external partners

In April 2023, to sustain the emergency 112 service within the Eastern Sovereign Base Areas, a decision was taken to close the Ayios Nikolaos practice to protect the Dhekelia staff from potential burn out. Clinics were reduced at Ayios Nikolaos to 1 nurse lead clinic per week and patients based in Ayios Nikolaos were advised that they would be able to access:

- 24/7 access to 111 nurse triage service and signposting to a GP as required.
- Increased availability through the telephone consultation service.
- Patients could be seen at Dhekelia Medical Centre.
- Prescriptions were to be dropped off to Ayios Nikolaos by the front line ambulance crews during handover with dedicated collection times on Monday, Wednesday and Fridays.
- Dhekelia medical centre planned to begin holding Patient Participation Group (PPG) meetings following the monthly Unit Health Committee (UHC) meetings to increase

communications and listen to the concerns of its satellite unit. These PPG meetings had not yet taken place.

Patients who waited to meet with the inspection team at Ayios Nikolaos cited a number of concerns, specifically around accessibility of care, access to medicines, communications from the medical centre and some concerns around the consultation style of individual clinicians. Several patients who worked told us that the appointment times at Dhekelia meant that they needed to take time out of work to travel to see a doctor – this could be anywhere between 90 minutes to 3 hours depending on delays. Some patients had had appointments cancelled whilst they were waiting and asked to return the following day. Patients also described their concerns around last minute cancellations of some clinics and the fact that this had not been communicated to them in advance. Some patients had encountered issues with accessing their medicines promptly due to the pharmacy closing early and the additional day to transport medicines to Ayios Nikolaos. Some patients found that the consultation style adopted by individual clinicians was not always conducive to building a trusting relationship with their healthcare provider.

The team had invited patients to provide feedback on the service through a survey. Patients had also been invited to Town Hall meetings in Ayios Nikolaos to give their view on their healthcare provision and 6 patients attended this. A suggestions box was available in the waiting room. However, 18 patients who came to meet us on the day of the inspection, told us that they had either provided written feedback, contributed to surveys or written complaints, but had not been contacted by the practice and had not seen any action taken to resolve the concerns they raised.

The practice team were divided in their views around communication across the staff team. Most nurses did not attend practice or HcG meetings and so missed important discussion and learning opportunities. There was also no clinical meeting for all clinicians to come together – a missed opportunity for team cohesion, discussion and learning. Welfare staff told us that their relationship with the medical centre team was positive and trusted. However, capacity constraints meant that clinical attendance at UHCs was remote and this was not optimal for occupational health management. Communication channels with SSAFA services, including midwifery, health visitors, dietetics, hospital liaison and child nursing were optimal and afforded swift access to integrated care pathways for patients.

Medical centre staff attended the following meetings when they had capacity but recently gaps in attendance have been unavoidable due to capacity constraints:

- Quarterly Garrison Meeting
- MACR Exercise
- Unit Executive meeting
- Garrison Welfare Meetings
- Unit healthcare committees
- The medical centre had fostered a good working relationship with the American Medical Centre liaison officer within BFC. Any concerns regarding the provision of secondary healthcare were escalated.

Continuous Improvement and Innovation

The team were committed to streamlining processes and reducing the amount of waste cause by printing documents unnecessarily. The introduction of the use of QR codes throughout the medical centre such as resuscitation trolley checks, equipment care, daily Pre-Hospital Emergency Care checks, referral non-availability proformas and training codes had enabled the medical centre to reduce waste whilst ensuring checks were evidenced using the Microsoft forms platform. The team might consider submitting this work as a quality improvement project to be shared more widely.