Episkopi Medical Centre

Episkopi Station BFPO 53 Cyprus

Defence Medical Services inspection report

This report describes our judgement of the quality of care at Episkopi Medical Centre. 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	Requires improvement	
Are services safe?	**Requires improvement**	
Are services effective	**Good**	
Are service caring?	**Good**	
Are services responsive to people's needs?	**Requires improvement**	
Are services well-led?	**Good**	

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Summary

About this inspection

We carried out this announced comprehensive inspection on 11 October 2023.

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

Are services safe? – requires improvement

Are services effective? – good

Are services caring? – good

Are services responsive to people's needs? – requires improvement

Are services well-led? – good

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

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

At this inspection we found:

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

The practice had good lines of communication with the Regional Team, welfare team and the Department of Community Mental Health (DCMH) to ensure the wellbeing of service personnel.

The arrangements for managing medicines, including the management of medicines given under Patient Group Directives (PGDs), Patient Specific Directive (PSDs) and High-Risk Medicines (HRMs) was good.

Mandated training for staff was not up-to-date, including safeguarding training.

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

The nursing team had worked hard to ensure the programme in place to manage patients with long-term conditions was good with proactive recalls and a register in place.

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

The management of referrals was good, with a robust process in place for monitoring.

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

Staff were aware of the requirements of the duty of candour, (the duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). Although there was a duty of candour register on the Healthcare Governance workbook this was not fully completed and patients had not always been informed when needed.

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

We found the following area of notable practice:

A nurse led audit had been completed which aimed to reduce the waiting time for the secondary reports to return from the UK for patients following their mammogram. The patients had their mammogram in Cyprus and due to the nature of the imaging, the results had to be sent via a disc by post to the UK for secondary reporting, causing considerable delays in the result being given to the patient. The nurse initiated a new process whereby the initial mammography report was sent back electronically. This significantly reduced waiting time for secondary reports and reduced the risk of error by discs being damaged in transit. This new process was shared with the other medical centres on the island resulting in shared improvement.

The induction of PCRF staff had been improved through the development of a clinical handbook which was bespoke to the Episkopi practice.

Episkopi medical centre had adopted a ‘Sway’ platform which provided Quick Reference (QR) codes of useful information for patients whilst resident in Cyprus. The QR codes were posted at various strategic locations around the Medical Centre and Station Welfare Facilities. The document itself was comprehensive and encompassed information not only required for Primary Care provision but went further to include information about OOH care on the island, Cyprus essentials, Aeromedical evacuation and self-help information. Patients in BFC did not always have all the additional services provided in the UK from the NHS such as pharmacies, NHS 24 helpline, Minor Injuries etc, this practice leaflet acknowledged this gap and was responsive to the unique patient needs in Cyprus. The document was presented in a user-friendly manner: it followed an easy read format, it contained links to various websites and platforms, was widely available regularly updated.

The paramedics (employed by the PHEC service) provided regular training during the 24-hour shift, some of which was suggested by the medics. Recent training included how to read ECGs (electrocardiogram , a test to detect heart problems) and complications of childbirth. The SMO also delivered training to the medics.

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

Urgently increase clinical and leadership capacity at Episkopi 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, and occupational healthcare. 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).

Without delay, BFC should undertake a review of secondary health care (SHC) provision, this should include a review of the secondary care approval process which has risks associated with it. The review should actively engage patients who have experience of SHC provision, practice clinicians and the practice leadership team. In addition, an analysis of complaints and significant events should be undertaken to identify trends in relation to SHC. Feedback and the development of an improvement plan should involve a wide-range of stakeholders, including patients and practice staff.

Given the continuous use of the Episkopi building it should be seismic compliant to protect the safety of people who use the building in the event of earthquake activity.

Given that clinical 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 of working with children); clarify and formalise the training and support requirements for staff who are required to deliver paediatric assessment and treatment. Clinicians should be competent and confident to deliver this care before they are asked to work independently.

BFC to review and hasten the processes for staff who require a Disclosure and Barring Service (DBS) checks .

Networking of the DMICP sites on Island would significantly improve resilience by adding the possibility of remote GP consultations during the out of hours period by clinicians based at any site. Networking with servers in the UK would allow access to full medical records of transient personnel.

Consideration should be given to ensure access to an OOH CAMHS service. Currently there are no crisis/OOH service available to under 18s.

Consideration be given to providing enough space so that patients can access a gymnasium for rehabilitation classes at more optimal times during the working day.

Concerns regarding the service provided by Team Leidos (TL) had led to shortages of essential healthcare medicines and materials. Defence should ensure that medical contingent operational stock and medicine requirements are explicitly and irrefutably understood and that all medical stock and medicinal supply issues are reported by appropriate means so that the Executive are fully aware of the impact medical stock and medicinal supply issues have on primary care delivery.

The Chief Inspector recommends to the medical centre:

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. Whilst work had recently been undertaken to improve clinical staff's competence and confidence in undertaking triage activity, there was scope to ensure that all staff who are required to triage have been provided with all the support they required. There was scope to further strengthen this through the introduction of triage software.

A review of the staff training programme and management needs to be undertaken to ensure staff have the up-to-date skills and knowledge to deliver effective care and treatment. This should include safeguarding training as mandated by DPHC

Induction should include more formalised and structured programme to work towards gaining named practical primary healthcare nurse competencies, and the system must have consistency within the induction period and good governance.

Improvements be made to the cover for the staff management of blood results. Ideally the practice should adopt the PATHLINKS process in line with firmbase practices. Where this is not possible improvements are required to ensure that staff cover arrangements allow for the safe management of blood results.

Complaints management requires improvement. The medical centre must work to Defence Primary Healthcare policy ensuring patients' complaints are investigated and responded to in a timely manner.

Duty of candour needs to be upheld and managed appropriately.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Healthcare

Our inspection team.

The inspection team was led by a CQC inspector and comprised a secondary CQC inspector, specialist advisors including a primary care doctor, practice manager, nurse, physiotherapist a pharmacist and a representative from Defence Medial Services Regulator.

Background to Episkopi Medical Practice

Located in the Western Sovereign Base Area (WSBA) of Cyprus, Episkopi Medical Centre provides a routine primary care and GP out of hours service to a patient population of 2218, during summer months, an additional 1000+ patients register. This includes service, personnel, family members, MOD employees and other entitled civilians.

The medical centre provides routine care, dispensing, occupational health, Force health protection, travel health, health promotion, women's health, family planning and has a Primary Care Rehabilitation Facility. The medical centre also provides OOH care and an ambulance service with nurses providing a 112-dispatch service. There are other areas of specialist sub-specialist work that make up part of the practice including Aeromed , authorising secondary care procedures and the FME/police surgeon role.

Secondary care is provided primarily by the American Medical Centre in Nicosia and Limassol General and subcontracts to Hippocratean and Archbishop Makarios. Patients can also be referred to the UK to access NHS services if required.

The medical centre is open to patients from 07:00hrs to 13:30hrs Monday to Friday with an after-school clinic on a Wednesday. The medical centre also provided a 24/7 OOH service. A Pre-Hospital Emergency Care (PHEC) service is provided by an ambulance crew co-located in the medical centre and this service has been inspected and a separate report produced. We reference any issues around the PHEC provision in this report solely to highlight any impact on the primary provision at Episkopi.

The staff team.

Medical Team	**Establishment (3.5 FTE) Actual (3.5 full time equivalent (FTE) including the Regimental Medical Officer (often away and not formally part of the medical centre)** One Senior Medical Officer (SMO) One Deputy Senior Medical Officer (DSMO) Two Civilian Medical Practitioners (CMP) DPHC (1.6 FTE) There is an established

	pattern that the 0.6 GP does one day per week on call (equivalent to 0.3 FTE on current rotas.
Medics	**Establishment (3 FTE) Actual (3 full time equivalent (FTE)** Three Combat Medical Technicians (CMTs)
Practice management Administration	**Establishment (9 FTE) Actual (9 full time equivalent (FTE)** One Practice Manager CMT One Deputy Practice Manager CMT One Administration Manager (Civilian) Six Administrators (Civilian)
Nursing Team	**Establishment (12 FTE) Actual (11 full time equivalent (FTE)** One Senior Nurse Officer (SNO) – Civilian – VACANT POST One Nurse Warrant Officer (NWO) Four Nurses (military) Seven Band 6 nurses – civilian (6 FTE) Four locum nurses.
Pharmacy	**Establishment (2 FTE) Actual (1 full time equivalent (FTE)**

	One Pharmacy Technician (civilian) One post vacant.
PCRF Team	**Establishment (3 FTE) Actual (3 full time equivalent (FTE)** One OC Physiotherapist One Band 6 Physiotherapist – Civilian One Exercise Rehabilitation Instructor (military)

Are services safe?

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

Safety systems and processes

There were good links with the SSAFA (SSAFA is a not-for-profit organisation providing welfare and support for serving personnel in the Armed Forces and their families. In Cyprus SSAFA provides community services through a contract which is owned and managed by Headquarters (HQ) British Forces Cyprus, referred to as BFC), unit welfare and the children's nurse service. There were monthly multi-disciplinary meetings where safeguarding issues were discussed and the Senior Medical officer (SMO) fed into the Commander Medical BFC who attended safeguarding board meetings.

There was a named safeguarding lead and deputy lead for the practice. Staff, including Regimental Aid Post (RAP) staff working at the practice, had received safeguarding training but some required update training at a level appropriate to their role (RAP staff are clinicians who are attached to units rather than employed to work directly at the medical centre).

Safeguarding information was clearly displayed, this included local contact details in clinical rooms, safeguarding displays and poster campaigns throughout the building. Coding and alerts were used to highlight vulnerable patients. A vulnerable patients register was held on the electronic patient record system. Safeguarding was a standing agenda item at the weekly doctor's meeting. Monthly primary care meetings to discuss vulnerable children were held with SSAFA and the child nurse services. Patient records were updated during the meeting and a monthly search was run to ensure the register was current. The SMO shared information with the Sovereign Base Area (SBA) safeguarding board.

There was a list of trained chaperones which was linked in the healthcare governance workbook. Administrative staff were not used as chaperones. There were both male and female chaperones available and group training was last conducted in October 2023. There was information regarding chaperones in the practice leaflet and displayed in clinical rooms, in the Primary Care Rehabilitation Facility (PCRF) and the waiting room. We looked at a selection of patient records and saw that patients that had been offered or used a chaperone had been appropriately recorded.

Staff had been subject to safety checks to ensure they were suitable to work with young people and vulnerable adults. The practice had a system in place for recruitment checks which included a check on the criminal record through the Disclosure and Barring Service (DBS). One member of staff was without a DBS check. Their renewal application had been submitted several times and hastened regularly but had been stalled in the human resources system. A line manager risk assessment was in place and this had been forwarded to the Overseas region Safeguarding Lead.

There was a contract in place with the Staff Managed Service who conducted pre-employment checks for all staff bank workers and ensured the agency supplying staff had completed the same checks for their workers. The checks were conducted at point of

recruitment and before any extension of a post was agreed. To date, assignments had been requested at 6-month intervals, therefore checks were completed every 6 months for workers that had been in location longer than this period. The practice manager was issued the completed compliance pack prior to accepting the worker as suitable for the post.

Arrangements were in place to monitor the registration status of clinical staff with their regulatory body. All staff had professional indemnity cover. Information was in place to confirm staff had received all the relevant vaccinations required for their role at the practice.

There was a lead and deputy responsible for infection prevention and control (IPC) who were appropriately trained for the roles. Other members of the staff team were not up-to-date with IPC training. The medical centre followed the DPHC mandated monthly IPC audit timetable. This audit was subject to external peer review by colleagues from Akrotiri Medical Centre in September 2023. It was unclear where the actions were recorded and monitored for completion. Since the inspection, the practice has told us that they done some work in this area and we will review this when we return to re-inspect.

Environmental cleaning was provided by an external contractor. Cleaning schedules and monitoring arrangements were established. A weekly check of cleaning standards was carried out by the deputy practice manager. Deep cleaning of the premises was carried out weekly by a separate team of cleaners. The management of clinical waste was good. Consignment notes were maintained and a pre- acceptance waste audit was competed in September 2023.

The physiotherapist practised acupuncture and arrangements were in place for the safe provision of this treatment, including an acupuncture health screening assessment and patient information sheet. Within the PCRF, all physical training equipment was serviced and up-to-date.

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 with limited resources but at times some tasks such as chronic disease management had to be de-prioritised. The team had been directed by DPHC to prioritise urgent care and pre-hospital emergency care. The medical centre had been allowed to recruit some locum paramedic staff above their current establishment to deliver the ambulance service alongside the medics. Staffing levels were on the risk register and the risk has been transferred to Med Branch and DPHC.

A lack of staff had led to excessive hours being worked by the doctors. There were 3.6 whole time equivalent (WTE) doctors at the medical centre. The 0.6 WTE doctor had an established working pattern of one OOH shift per week but did not work weekends or Fridays (equivalent to 0.3 FTE on current rotas). There was no period of standdown following overnight shifts due to the requirement to continue to deliver daytime primary healthcare and for the SMO a considerable workload associated with running the Medical Centre. With the majority of OOH shifts covered by the SMO and DSMO, they reported 80-

100 hour working weeks regularly. The intensity of work increased the risk and likelihood of errors. The RMO, whilst flexible and an asset to the medical centre, was often away and could not be included in the long-term rota.

The PCRF had to source cross island cover before requesting temporary healthcare workers (THWs). They had developed a Memorandum of Understanding to support this. The PCRF often found they were not allowed to request THWs for staffing gaps that were less than 3 weeks due to the budget being given priority to elsewhere in the medical centre. As a result there had been times when there had been only 1 physiotherapist in the department (due to leave and courses) and the referral rates had been large resulting in longer working days. The PCRF staff had also found that their usual working hours had increased because the Infantry worked early hours, the headquarters staff worked normal office hours and the civilians, such as teachers, could only be seen outside of school hours. This was being reviewed to accommodate patient need. Increased working hours had resulted in some impact to PCRF staff's health and well-being.

Usually there was one paramedic and one CMT(who work for the pre-hospital emergency care (PHEC) service) present in the building during the OOH periods as well as the nurse.

When the ambulance was deployed, the nurse remained in the medical centre alone and potentially would have to deal with patients presenting at the medical centre without support until the doctor arrived. There was concern about a lack of training and confidence in the management of paediatric emergencies was low. A new Local Working Practice (LWP) policy had been introduced in early October 2023 that gave guidance to clinical staff. It stated all clinicians who see, assess, and treat children must feel confident and competent to do so. This should be within their scope of practice. Within Episkopi Medical Centre, different trade groups may be expected to manage children. Where clinicians had received specific paediatric training, their scope of practice was extended to incorporate this training. Until further notice, nurses who had not received formalised paediatric training would need to demonstrate competence to the Senior Nursing Officer to be authorised to see, assess and treat children. Medics were authorised to see only serving soldiers aged under 18 in primary care.

From the medics' perspective, their team was not sufficiently staffed mainly because of one medic providing 24-hour 112 (PHEC) cover at least once a week. Although the medic on the 24-hour shift slept at the medical centre, they supported with paramedic call outs. Medics said they regularly stayed behind after the 24-hour shift (often until lunchtime) to catch up on administrative/lead role activities. They were not required to do this but were asked and could refuse without repercussion. Most chose to stay rather than fall behind on administrative tasks. Administrative roles included updating vaccination statistics, updating the training register, store stock checks and statistics for the Unit Healthcare Committee (UHC) meeting. A nurse based at the medical centre on a waking shift provided triage for the 24-hour shift. A duty doctor based at home provided medical cover for each shift. Medics said the duty doctor was very rarely called now that the service was paramedic-led. Doctors confirmed that they were rarely called to respond to a PHEC requirement, but that call-outs for OOH GPs happened regularly.

The medics coordinated the emergency clinic in the morning but did not triage children. They confirmed they worked within their scope of practice and to medication issuing protocols.

The paramedics (employed by the PHEC service) provided regular training during the 24-hour shift, some of which was suggested by the medics. Recent training included how to read ECGs (electrocardiogram , a test to detect heart problems) and complications of childbirth. The primary healthcare team delivered training to the medics.

Doctors had completed advanced life support (ALS) training. They were instructors in Battlefield Advanced Life Support (BATLS) and the SMO was also an instructor in ALS. All nurses and medics had received training in these. Two nurses were trained in Paediatric Immediate Life Support (PILS). Medics confirmed they received a wide range of training in medical emergencies including military pre-hospital emergency care level 4, First Responsibility emergency care and major incident management. Medics confirmed that they had received training in recognising the deteriorating patient and spinal injuries.

The induction process for nurses included standard DPHC induction and also 4 weeks working alongside another nurse with orientation to the Medical Centre. The induction was not completely formalised or fully structured and did not include ensuring timely access to the relevant SharePoint sites. This had been recognised and working alongside the new LWP improvements were being worked towards. Nursing support within the team was transparent and vocalised how well they felt supported. It was evident that nurses felt they could and would ask for support and advice when required.

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 medical centre.

Moulage training was held daily and all available staff could attend. We reviewed the staff database and training register on the day and it showed 6 staff were out-of-date in basic life support (BLS), 9 staff were out-of-date in automated external defibrillator (AED) and 2 were out- of-date for anaphylaxis. Shortly after the inspection, we were provided with evidence that these were not out-of-date but the training record did not reflect this on the day. Sepsis training was last conducted in August and September 2023, it was noted 1 medic had not completed this training.

An area of considerable risk was of both for equipment and also for medication resupply. The chain to get equipment repaired was extremely long affecting patient care. Medications took months to arrive and when they did arrive often medicines were going out of date imminently. Typically an 8-week resupply could take up to 12-16 weeks.

There were also protracted MDSS servicing and equipment checks that required many items to go back to the UK for months at a time for calibration – this included hyfrecators, ECG machine, spirometry and audio machine. These pieces of equipment mostly required annual checks at a minimum. This year a number of items were taken at the same time across island at the timelines for return were as follows:

- Hyfrecator (use in electrosurgery) – 13 months
- ECG machine – 4 months
- Spirometry – broken with no replacement, waiting for a part medical centre had been told was12 months
- Audio machine – this had been away for 8 months and no sign of return.

There was a sepsis policy in place. Sepsis red flag posters were displayed in consultation and reception. There was a policy for heat illness management which clinicians 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.

Waiting patients in the main reception area could be observed at all times by staff working on the front desk.

Information to deliver safe care and treatment.

Each medical centre on the island had its own individual DMICP(D) (electronic patient record system) server and so clinical teams were unable to see notes of patients at another practice. In addition, there were high numbers of transient patients due to units transiting or posted to Cyprus for operational needs and due to the need for records to be "sent" to DMICP, there was a delay of several days before the full patient record was available. Networking of the DMICP sites on Island would significantly improve resilience by adding the possibility of remote GP consultations during the OOH period by clinicians based at any site. Networking with servers in the UK would allow access to full medical records of transient personnel. Patient care episodes were recorded on DMICP. A small selection of records were examined and were of good quality, with clear history, examination findings, management plan and safety netting recorded. Within the PCRF, DMICP caused issues with the inability for cross island referral, the UK could not refer to Episkopi and the tasking system did not work. This caused issues with communication across the island but also with the Regional Rehabilitation Unit in the UK and the Defence Medical Rehabilitation Centre (DMRC).

A meeting was held with the staff each morning for all staff, it was divided into 2 parts, clinical and non-clinical. It included clinical handover of patients including NOTICAS and safeguarding. There was also a senior leadership huddle where all heads of departments checked in including duty staff, all issues were discussed including the risk register, any issues for the day or reminders. These meetings were recorded on Sharepoint.

The administrative team managed referrals. We reviewed the process for both referrals to local services and referrals to the UK. One of the administrators received a task from the doctor and consulted with local secondary care services (mainly the American Medical Centre (AMC) to secure an appointment. Another administrator had a patient-facing role and consulted with the patient regarding the appointment, including regular reminders to ensure the patient attended the appointment. A comprehensive spreadsheet was maintained, and the status of referrals was checked daily, including urgent and 2-week-wait referrals. The administrators reported that urgent referrals were addressed promptly by AMC with appointments confirmed within 2 weeks.

The medical centre had to adhere to a Secondary Care Approval Process. This is because an overseas Defence Primary Care Medical Facility was utilising the secondary care of a Cypriot private medical centre. The doctors at Episkopi had the responsibility to ensure that the care being provided from elsewhere on the island was in line with what the patients would expect from the NHS. Doctors would ask for the opinion of a Cypriot specialist but would then have to decide if that advice/opinion was appropriate. To aid them in this they could reach back to the DCA (Defence Clinical Advisor) who would help

with the decision. Some staff felt that this was a cumbersome process and open to potential error and delay. Also, when a Cypriot consultant prescribed a medication or treatment that would routinely be used in the UK, the doctors had to decide on an alternative which would be used by the NHS. The pharmacy, on the whole, would only stock medication that would be used routinely in the UK. This often-caused problems with patients who perceived they were not getting the precise treatment the consultant had advised. This secondary care approval process is not new to British Forces Cyprus, however it was felt that requests had increased in number since the new secondary contract came into place.

Aeromed was coordinated by the administrative team. Requests for Aeromed were made using the digital request platform (DARP). The administrative team managed class 4 and 5 Aeromed requests. Class 1 to 3 were coordinated from Akrotiri Medical Centre. Clinical input by a medic or doctor (depending on class) was required for Aeromed requests. Flights were booked on the military aircraft or, if unavailable, a civilian airline.

The administrative team described how referrals to the UK and affiliated Aeromed requests had more than doubled over a 2-year period. Statistics collated by the practice showed 136 (68 class 4 and 68 class 5) Aeromed requests for the time frame September 2021 to August 2022. For September 2022 to August 2023, the administrative team had dealt with 348 Aeromed requests (69 class 4 and 239 class 5). The reason for this significant increase was linked to the move to secondary provision by AMC (previously provided by the Poly Clinic). AMC provided less clinical specialties than the Poly Clinic hence the need to return patients to the UK.

The Aeromed process was considered time consuming and the increased volume of requests caused extra pressures for staff. Staff indicated the practice manager and SMO were supportive and advised that the issue had been escalated by the SMO to the commander Med at HQ. After the inspection, the overseas Regional Nurse Advisor confirmed the Regional Warrant Officer had a plan to review Aeromed at all the Cypriot practices both individually and collectively. The RHQ will then be presented with options to improve service delivery and decrease staff workload. This review was scheduled to take place in the next 6-8 weeks.

There was a safe 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 (part of the Primary Care Support Services for NHS England) was tasked with forwarding a patient summary via email of the requested record to be scanned onto DMICP. Notes were summarised by the clinical staff and there were only 4% left outstanding on the day of the inspection.

A standard operating procedure (SoP) was in place to ensure samples were taken safely, appropriately recorded on DMICP and results reviewed and actioned by the appropriate clinician. There was no electronic link available with the laboratory, so the practice used a manual system with sample request forms stamped to create a check list completed at each stage of the process. In addition, there was a ‘tracker’ used to follow up samples taken. Whilst there was a system in place for blood sample management, the use of printed labels would decrease the risk of inaccurate labelling of personal information and would decrease the chances of the laboratory rejecting samples due to illegible or inaccurate labelling. One member of staff managed the incoming results well, but the

process in place for staff absence was not failsafe meaning results may not be seen in a timely manner.

The medical centre were required to provide healthcare to patients detained in a prison facility. Where patients required assessment they were brought to the medical centre. The team had proactively provided the best support they could, but there was a need for clinical leaders to provide staff with appropriate protocols bespoke to the safe and effective management of detained patients.

Peer review of doctors DMICP consultation records was undertaken every 6 months and a consistent methodology was used. Nurses' records were also peer reviewed. Each nurse was provided with a minimum of 1 hour each month of protected time for clinical supervision. This allocated time ensured effective preparation and active participation in the session. The nurses talked together frequently about clinical cases as they arose. A collaborative training session was also held every three months with Akrotiri Medical Centre staff in which nurses had clinical supervision as well. A peer review of 10% of medics' clinical record keeping was conducted shortly before the inspection. This was the first such peer review. The senior nurse confirmed regular peer review of medics' records had been added to the practice audit schedule. The physiotherapist and the exercise rehabilitation instructor (ERI) also had their notes peer reviewed annually.

Safe and appropriate use of medicines

The pharmacy technician was responsible for the day-to-day management of medicines and was aware that the management and working practices was delegated to them. This was reflected in their terms of reference (TORs).

The pharmacy technician had access to the electronic organisational-wide system (referred to as ASER) and demonstrated that they could log in and record an ASER. However, there was no evidence that the ASERs had been discussed nor the learning shared with the wider team. A Quality Improvement Plan (QIP) had been submitted for improving medicines out of hours and by looking through transaction reports it was evident that the local working practice implemented as part of the QIP had improved practice.

A near miss log was in place. Through discussion, staff clearly understood the importance of using a near-miss log in the dispensary. There was evidence that some near misses had been recorded in the last two months, but the near misses before August 2023 stated, 'various picking errors and labelling'. Near misses must be recorded in detail to enable trend analysis.

Evidence was seen of effective processes 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. Evidence was seen that the alerts were discussed in the practice meeting for the last three months and there was a link to the MHRA register in the minutes for the non-attendees to access and view.

Searches were run on DMICP to identify any women of child-bearing age prescribed sodium valproate. Staff were aware of the recent changes that sodium valproate must be dispensed as a full pack and was able to locate the patient information leaflets as part of the pregnancy prevention programme.

There was one non-medical prescriber (NMP) in the medical centre. The NMP was listed on the NMC register as an Independent Prescriber. Evidence was seen that the DPHC HQ authorisation to prescribe was completed in January 2023. The NMP had a clinical supervisor in place but the NMP was currently not prescribing for chronic conditions. Through discussion, it was assured that the NMP knew to prescribe within their own self determined prescribing competency. The NMP felt supported and would reinstate supervision/peer review when returning to running clinics.

All repeat prescriptions were requested by email, eConsult or by patients dropping off their repeat slips. There was a local working practice in place stating the different ways that patients could order their repeat medicines. Through discussion, it was confirmed that no repeat requests were completed by telephone. A spot check of the dispensed repeat prescriptions found that all had been dispensed within eight weeks. This showed that staff effectively informed patients that their prescriptions were ready for collection and was efficiently returning uncollected medicines to stock if they were not collected within 8 weeks.

The procedure for medication review for patients with long-term conditions was effective and staff had good awareness of their responsibilities and knew when requests should be tasked to a senior clinician. Staff knew that they should only re-issue repeat prescriptions if the patient's review date was in-date and there were available repeat counts on the patients prescribing record. The process for handing out prescriptions to patients was discussed and witnessed and was in-line with the DPHC SoPs. Looking through five prescriptions that had been dispensed from the dispensary, there was evidence of a treatment review and a clinical medication review. All entries had been coded.

We saw evidence to show that patients' medicines were reviewed regularly and the doctors' notes in DMICP around medication changes were comprehensive. A process was established for the management of and monitoring of patients prescribed high risk medicines (HRM). The register of HRMs used at the medical centre was held on DMCIP and all doctors and relevant clinicians had access to this. We looked at a sample of patient records and saw that all had been coded or had shared care agreements in place.

Patients were informed of side effects to ensure they take their medicines safely. The dispensary held appropriate warning cards. Evidence was seen of comprehensive medication counselling when prescriptions were collected. Evidence was seen that patients were informed of the patient information leaflet in the medicine's container.

Arrangements were established for the safe management of controlled drugs (CD), including destruction of unused CDs. The CD cabinet was not compliant with the Misuse of Drugs (Safe Custody) 1973 Regulations but the controlled drugs schedule two were held in the inner compartment to mitigate this. A CD audit had been completed annually.

There was a local working practice in place to advise on assessing the dispensary and the CD cupboard if required out of hours. There was a locked box containing the keys and

alongside this there was a safe log controlling/ documenting the access of the dispensary and CD keys.

Emergency medicines were easily accessible to staff in a secure area of the medical centre and all staff knew of their location. Gases were at least half full and in-date. The medical gas store was clean and the empty cylinders were segregated from full in date cylinders. Correct HazChem signage was in place for the medical gas stores but not on the doors holding the oxygen and Entonox (a gas used to control pain or anxiety) in the treatment rooms or the medical centre.

There were well defined processes in place for the ordering and receiving of vaccines. All vaccines were in-date and evidence was seen that the vaccines were stored correctly. We saw pharmaceutical thermometers were in place and the temperature were monitored twice daily.

A process was in place to update DMICP if changes to a patient's medication were made by secondary care or an OOH service. The repeat prescription process was detailed in the medical centre leaflet.

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

Prescription pads were stored securely. There was a system to track their issue and usage so all prescription numbers could be traced to the prescriber.

Practice nurses used Patient Group Directives (PGDs) for immunisations and primary care treatments. Evidence was seen that the nurses were authorised to use the PGDs using the correct Annex E form. A review of 3 DMICP consultations found that the PGD template was being used and the batch number and expiry of the medicine supplied was being recorded in the template. Through discussion, the nurses were fully aware of the requirements around the use of PGDs. A PGD audit had been completed in October 2023. The clinicians completing the PGD audit were independent of the PGD users being audited. Through discussion, it was confirmed that the findings from the audit had been shared with the nursing team.

A review of five Patient Specific Directions (PSDs) found that all the relevant sections had been fully completed and the PSDs were being completed in accordance with policy. A review of five DMICP records found that that the DMICP records had not been coded with the correct code that showed the individual had authorisation for medication under a PSD.

There were cupboards holding over-labelled medicines for the supply of over-labelled medicines out-of-hours. A stock check of five medicines found the stock levels to be correct and through looking at the transaction reports there was evidence of good stock accounting and stock management.

Requests for repeat prescriptions were managed in person or by email in line with policy.

The pharmacy technician said they felt included and integrated within the medical centre. Looking at the attendance list for the practice/healthcare governance meeting, it appeared that there was limited attendance by them. When the second pharmacy technician post

was filled, at least one pharmacy technician should attend both the practice and Healthcare Governance meetings.

Track record on safety

There was a designated health and safety lead and a board was displayed which was regularly externally audited. Electrical safety checks were up-to-date. Water safety checks were regularly carried out and a full legionella risk assessment was carried out in March 2020. A fire risk assessment of the building was undertaken annually. Firefighting equipment tests were current. Staff were up-to-date with fire safety training and were aware of the evacuation plan. At the time of the inspection, the appropriate Control of Substances Hazardous to Health (COSHH) risk assessments were not available but have since been produced and were up-to-date.

The medics were responsible for the management of equipment. Various spreadsheets were maintained to support with monitoring the servicing and calibration of equipment. We reviewed the spreadsheets and it was evident the servicing of equipment was up-to-date. Any new equipment was subject to an initial check by the Medical Device Safety Service. Portable appliances were tested in September 2023.

Because of the location, procuring new equipment was a challenge. Medics said it could take up to 5 weeks for a new piece of equipment requested to arrive. When the practice had been short of important equipment, they borrowed from another medical centre as a short-term solution. Medics indicated the regional equipment lead had been instrumental in procuring equipment quicker than the practice.

The deputy practice manager was the risk manager and was scheduled for Institution of Occupational Safety and Health training in February 2024, they had been risk assessor trained and had completed building custodian training. The medical centre had current and retired risk registers and an issues log in place. Risks were reviewed in the monthly Healthcare Governance meetings. There were a range of clinical and non-clinical risks in place and risk assessments mostly in paper form were being transferred to the new e-form at review.

There was a fixed alarm system in place in the pharmacy, triage bay, all gender toilet and the corridor. All other staff in the medical centre and the PCRF had handheld alarms which we were told were tested although these tests were not recorded.

The medical centre had recently been assessed for seismic risk assessment and was not compliant. This was on the risk register and has been transferred to Med Branch. There were warning notices for staff and patients to advise them what to do in the event of an earthquake. This was scheduled to be resolved under project Apollo which would see a new compliant medical centre at Episkopi.

Lessons learned and improvements made.

All staff in the medical centre and the PCRF had access to the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events and incidents. All incidents reported were logged through the ASER system. They were discussed at the practice meetings and an ASER register was maintained.

From interviews with staff and evidence provided, it was clear there was a culture of reporting incidents. Both clinical and non-clinical staff gave examples of incidents reported through the ASER system including the improvements made as a result of the outcome of investigations. For example, the deputy practice manager was trying to cover both the practice management roles and doing shifts on ambulance cover; after several busy days attempting to cover both roles, an ASER was submitted about the fatigue and personal impact on the individual and the risk to patient care. Since then 4 locum paramedics had been recruited to deliver the PHEC service, they worked alongside medics on the ambulance to reduce the workload on other staff and enable them to focus on their primary role and reduce the safety risk to patients.

The medical centre had a system in place to distribute alerts from the MHRA. Discussion took place at clinical meetings and was recorded in the minutes.

Are services effective?

We rated the practice as good for providing effective services.

Effective needs assessment, care and treatment

Patient records informed us that clinicians carried out assessments and provided care and treatment in line with national standards and guidance, supported by clear clinical pathways and protocols. Arrangements were established to ensure staff were up-to-date with current legislation, research and guidance, including NICE (National Institute for Health and Care Excellence) and the Scottish Intercollegiate Guidelines Network (SIGN). These were discussed at the weekly meetings for clinicians and, if relevant to the wider staff team, at learning forums and healthcare governance meetings. Most recently the team discussed the NICE Obesity update.

Primary Care Rehabilitation (PCRF) staff attended multi-disciplinary meetings to share and discuss evidence-based guidance, including NICE & SIGN. They were also an integral part of the practice meetings where clinical issues were discussed. Cross island learning also took place, for example, most recently all PCRF staff critically reviewed three anterior cruciate ligament articles and fed back to the wider team. The PCRF were part of the weekly MDT meetings.

The medical centre had subscribed their multiuser email account for monthly NICE guidance updates which they were alerted to accordingly and discussed them at the next arranged meeting. Staff were also kept informed of clinical and medicines updates through the Defence Primary Health Care (DPHC) newsletter circulated to staff each month.

The PCRF staff were familiar with Defence Rehabilitation Best Practice Guidance and provided examples of treatment delivered based on evidence-based guidelines and care pathways. Our review of PCRF patient records showed Rehab Guru, was used for exercise programmes for some patients (Rehab Guru is an exercise prescription software that allows medical professionals to send structured exercise programmes and educational information to individuals).

The PCRF ensured that it took a holistic view of patients. As part of the new patient questionnaire, there were prompts to ask about sleep, mood, diet and stress. Patients were referred to the dietician, smoking cessation and the medical centre when needed.

The PCRF did not have sufficient space it needed to deliver rehabilitation to more than 1-2 patients within the department as the gym was very small. With more space, additional services could be offered to patients, such as group therapy with the ERI or pre or post-natal classes. The ERI held reconditioning / rehabilitation physical training sessions in the station gym from 06:30-07:30hrs on a Tuesday, Thursday and Friday as this was the only slot in the gym that was available. Unfortunately the patients' feedback was negative about these times as it was difficult to fit in before they started work and often not part of their working day.

Monitoring care and treatment

The medical centres on the island have been working to the OPAL ratings, these were in relation to the DPHC Op Order which was published by Commander DPHC. This outlined the 12 DPHC priorities that they foresee for the year. The reason for the OPAL rating is to ensure patients were safe and so were the staff. Episkopi was rated as 'Amber'. It was often workforce pressures caused by long and short-term gaps in staffing causing it. Urgent care was seen as usual but despite the staff's best efforts, routine care, such as the recall of patients with long term conditions (LTC) was not quite up to date. There was a process and clear lines of responsibility for the management of chronic diseases with the nurses taking on responsibility for certain LTC conditions. The practice has taken on good practice from Leuchars and there was a plan in place for the improvement and regain of their management.

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

There were 10 patients on the diabetic register and their care indicated positive control of both cholesterol control and blood pressure. Patients at risk of developing diabetes were identified through the over 40's screening, which included relevant testing (HbA1c - average blood glucose (sugar) levels). Additional to this, there were 10 patients with Gestational Diabetes that were being managed well.

There were 68 patients recorded as having high blood pressure. Forty-eight were recorded as having a blood pressure check in the past 9 months.

There were 59 patients with a diagnosis of asthma and 51 had an asthma review in the preceding 12 months.

92% 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 worked hard to reduce the backlog.

A quality improvement programme was in place. Some additional audit work targeted to the patient population had been undertaken, for example an antimicrobial audit that showed a standard of 95% and an audit on 112 (the emergency telephone number in Cyprus equivalent to 999 in the UK) documentation that achieved a standard of 90%.

There was a specific audit calendar in place for the PCRF that was driven by the needs of the patient population, for example, an acupuncture audit. A physiotherapy and exercise rehabilitation instructor (ERI) notes audit was completed annually and recorded in the healthcare governance workbook. Examples of audits seen included planning for a second cycle.

A nurse led audit had been completed which aimed to reduce the waiting time for the secondary reports to return from the UK for patients following their mammogram. The patients had their mammogram in Cyprus and due to the nature of the imaging, the results

had to be sent via a disc by post to the UK for secondary reporting, causing considerable delays in the result being given to the patient. The nurse initiated a new process whereby the initial mammography report was sent back electronically. This significantly reduced waiting time for secondary reports and reduced the risk of error by discs being damaged in transit. This new process was shared throughout the other medical centres on the island and staff there had also changed their practice.

Effective staffing

Nursing support within their team was transparent and nurses vocalised how well they felt supported. It was evident that nurses felt they could and would ask for support and advice when required.

The medical centre used the DPHC mandated induction which included cadre specific elements. Permanent staff had a more in-depth induction to include elements which were specific to Cyprus. Completed induction checklists were retained by the practice management. Staff told us that timely access to the relevant SharePoint sites for the arrival of new staff could be problematic because of IT challenges. New staff did not have a mentor which they said would be helpful. There were mixed views amongst the 3 medics. One medic had a 2-week handover from the previous medic and received detailed instructions regarding the role. It included the duty nurse shadowing the medic who was coordinating the emergency clinic. The medic also spent a week shadowing the paramedic on 112 calls during which they familiarised themselves the ambulance and equipment. The other 2 medics said they did not have this level of detailed induction and learnt the role more through ‘word of mouth’. Training facilitated by the paramedics and in-service training for the whole team was held each week.

The PCRF staff felt the induction for new PCRF staff could be improved so they developed a clinical handbook for new staff which was bespoke to the Episkopi practice.

The nurses said they had received ample training in the 112 service and praised the paramedics, who were always available to help out and advise. Mandated staff training across the staff group had not been fully completed with gaps showing throughout, the medical centre OPAL grading had meant that staff focussed on clinical delivery and not always updating their training as priority. The medical centre were working hard to ensure their training was updated. Staff were reminded at the practice meetings of the requirement to complete mandatory training. There was protected time every other week for staff to complete mandatory training and additional ad hoc time when required such as during the recent redecoration of the medical centre. There was group training every other Monday and daily moulage training for all available staff. Staff submitted training certificates to the deputy practice manager who then updated the staff database and retained certificates in staff training folders. The deputy practice manager facilitated a medics’ meeting each week.

Staff were encouraged to manage their own personal development and were helped and encouraged to do so. For example, the SMO and DSMO had supported two medics with applying for the paramedic degree and the nursing degree. They were due to leave next year to pursue these degrees.

Performance appraisals were conducted by line managers for all staff. All doctors were in date for appraisal and all doctors and nurses had completed timely revalidation.

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 interviewed the welfare officer as part of our inspection and they told us the medical centre were very responsive if a patient required urgent access to a doctor. They confirmed that the staff team were caring and always available to help.

The medical centre team had established strong links with SSAFA as they were co-located in the same building. We spoke with one of the team and they confirmed that communication was consistently good and that working relationships between the two were strong and to the benefit of the patient group.

The PCRF had good relationships with the Regional Rehabilitation Unit Halton in the UK for referral to RRU and Multidisciplinary Injury Assessment Clinic (MIAC). Patients could select where they attended courses and the PCRF found the RRU Course Dashboard a great source of information for determining waiting times for patients as currently no courses were running at RRU Halton due to workforce constraints. The wait time to attend MIAC was approximately 1 week to triage and then patients were usually seen within 4 weeks. The PCRF staff attended Unit Healthcare Committee meetings and Resident Infantry Battalion meetings that also covered more welfare related issues.

Helping patients to live healthier lives.

One of the nursing team was the lead for health promotion and had the appropriate experience for the role. We saw information leaflets were available in the treatment rooms.

There were notice boards located in various places around the medical centre, some example topics covered included smoking and alcohol.

Unit Health Fairs were undertaken annually and medical centre staff, including the PCRF, were involved. There was a health promotion board in the PCRF, with topics changed every month.

Two nurses had the appropriate sexual health training and provided sexual health support and advice. Patients were signposted to local sexual health services for procedures not undertaken at the medical centre. They worked to the Local Working Practices guidance.

It was recognised that cervical smears uptake required improvement and so the team created a health promotion campaign with a stand at the station health fair and improved communication through social media and local station channels and extended the opening times of the clinics to facilitate attendance. Uptake has improved to just below the national target (76%, the NHS target was 80%) Compassionate care was shown with the changes to the cervical smear follow up process with a personalised approach to informing patients

of abnormal results. The tracking of cervical smear samples was simple and clear to ensure timely follow up.

Patients with a mental health need were supported by the medical centre with initial interventions which included sign posting to mental health resources and support, the padre service, third sector support, welfare support and routine prescriptions. Adults (including family members) 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 Episkopi Medical Centre. Access to CAMHS was good and children were seen promptly. We reviewed a sample of patients notes and found that note taking was good and they had been clinically coded correctly.

Regular searches were undertaken to identify patients who required screening for bowel, breast, and abdominal aortic aneurysm in line with national programmes. Alerts were added to their DMICP record which allowed for opportunistic discussion with a health professional. DMICP searches had been created for all national screening.

- 99% of patients were recorded as being up to date with vaccination against diphtheria.
- 99% of patients were recorded as being up to date with vaccination against tetanus.
- 99% of patients were recorded as being up to date with vaccination against polio.
- 100% of patients were recorded as being up to date with vaccination against hepatitis B.
- 99% of patients were recorded as being up to date with vaccination against hepatitis A.
- 99% of patients were recorded as being up to date with vaccination against typhoid.
- 100% of patients were recorded as being up to date with vaccination against MMR

Childhood Immunisations

Data provided by SSAFA

- 98% 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)
- 98% of children aged 2 had received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster)
- 98% of children aged 2 had received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster)
- 98% of children aged 2 had received immunisation for measles, mumps and rubella (one dose of MMR)
- 98% of children aged 2 had received a Tuberculosis immunisation.
- 98% 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. However, mental capacity training had not been delivered to staff. Consent was appropriately recorded in the clinical records we looked at for minor surgery. 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. Clinicians fully also understood the principles of Fraser Competence.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

We spoke with staff about the specific needs of the patient population and how they differentiate from the UK. Families were often away from all their support networks and lived very much in close proximity to their peers who become their friends and support network. Staff were very sensitive to this and did all they could to help support and signpost patients to get the information they needed outside of primary care. Medics said they often stayed with patients once they were taken to hospital. They were not required to do this but did so, time permitting, to ensure a detailed clinical handover to hospital clinicians and support for the patient.

An information network known as HIVE was available to people living on the camp. Situated nearby, the HIVE provided information about facilities available to families along with SSAFA and welfare services.

To ensure patient's views contributed to the inspection, we offered patients various opportunities to provide feedback on the service. Views were shared through CQC feedback cards completed by patients prior to the inspection, by email and through interviews with patients on the day of the inspection. We spoke with 2 patients as part of the inspection, they described their frustration with their particular experience of care they had received and the lack of response from the complaints they had raised. Alongside this they also gave examples where they had received really good care on other occasions. We received 14 patient comment cards, 9 were very positive about the care they had received and described the doctors and nurses as caring and said they felt listened to.

Eighteen registered patients responded to the DPHC patient satisfaction survey from January to August this year which complemented this inspection. We saw 61% of the patients said yes when asked if they were satisfied with their healthcare, 39% said they were not. A total of approximately 61% of patients said they were treated with kindness and compassion. During this period of time, the medical centre also received 21 compliments complimenting the staff on the service they provided, this included doctors, nurses, physiotherapist, medics and administrative staff.

Patients expressed mixed views about their experiences of the care provided by staff in secondary care services.

We were given some examples whereby the medical centre and PCRF staff had gone the extra mile for patients. For example, a patient with hip pain, struggling with rehabilitation with symptoms compounded by pressures at home, could not manage the stairs to their office. The physiotherapist signposted the patient to groups in which they could get some support and managed to get their office moved to the ground floor to save them from climbing the stairs which aggravated their pain.

Another example was an ongoing safeguarding case. That had been escalated to BFSWS, but the response from them did not feel completely proportionate to the referring doctor or

the family who raised the issues. This prompted close working with the family, a full MDT approach with all doctors discussing the case and then subsequently with defence unions, advice and information shared in both directions with health visitor and also paediatric nurse. There was also a review of NSPCC current guidelines including the use of a scoring systems for sexual allegations and this package of evidence was then taken back to BFSWS in a professional discussion. They listened and were able to convince them that the evidence was worthy of reexploring. Subsequently this was happening significantly reducing the risk to harm

We reviewed the records for a number of patients who were experiencing poor mental health. It was clear that clinicians were responding to patients with kindness and compassion, ensuring that patients had the space and time to talk when they needed to.

Involvement in decisions about care and treatment

The clinicians and staff at the medical centre recognised that the personnel they provided care and treatment for could be making decisions about treatment that could have a major impact on their military career. Staff demonstrated how they gauged the level of understanding of patients, gave clear explanations of diagnoses and treatment, and encouraged and empowered patients to make decisions based on sound guidance and clinical facts. Of the 18 patients who responded to the DPHC patient satisfaction survey, 11 stated that they had been given clear information, 7 said they had not. The medical centre had discussed the patient feedback and had acknowledged this was not ideal. Without specific detail it had difficult to address but all clinical staff were aware and aimed to give patients all the information they needed to make decisions about their care.

The Senior Medical Officer (SMO) was the Carers Champion for the medical centre and they used the Defence Primary Healthcare Carers Standard Operating Procedure as their guide. All carers were coded on DMICP and generally identified during registration at the medical centre. There was a carers board in the waiting room and further information in the online practice leaflet.

The medical centre had access to The Big Word translation service which the medical centre accessed daily for either verbal translation or written translation of hospital letters.

Privacy and dignity

All consultations were conducted in clinic rooms with the door closed. All clinical rooms had a separate screened area for intimate examinations.

Arrangements were in place to maintain patient privacy when arriving at the medical centre. A room in the reception was available should patients request confidential conversation away from the desk.

All physiotherapists had separate and private clinical rooms for assessment and treatment.

The medical centre had doctors and nurses of both genders so patients could choose if they wanted to see a specific doctor. Patients were offered a chaperone routinely.

Are services responsive to people's needs?

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

Responding to and meeting people's needs

The medical centre at Episkopi 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. An Equality Access Audit as defined in the Equality Act 2010 had recently been completed and, as a result, the requirement for a hearing loop had been added to the medical centres issues log for resolution. The Deputy Practice Manager also did a functional review of the facility with a pushchair and made changes to the seating layout in the waiting room to make it easier for pushchairs and wheelchairs. Some of the chairs in the waiting room had been replaced for higher seats with arms. Some posters had been lowered to eye height when seated. The reception desk was too high for wheelchair users and this had been added to the issues log.

The medical centre staff understood the needs of its patient population and tailored services in response to those needs. Appointments slots were protected to meet the needs of specific population groups. For example, appointments were made available for teachers and children after school hours.

Facilities were available for families, including a private room for breast feeding and baby changing facilities.

The medical centre held an emergency clinic between the hours of 07:00-09:00 (otherwise known as 'sick parade') for military patients requiring to be seen urgently on the day. This was run by the medics supported by a supervising doctor to support and advise as required.

The eConsult service had been implemented and was used to support patient choice as appropriate.

The medical staff team were aware of the need to quickly identify and treat patients with mental health needs in order to ensure the best possible outcome. The welfare service could refer patients for a same day appointment.

Timely access to care and treatment

Details of how patients could access services when the medical centre was closed were clearly displayed at the front entrance so could be easily seen when the practice was closed. In addition, the information was relayed in a comprehensive patient information leaflet. Episkopi medical centre adopted a 'Sway' platform for the leaflet which they provided Quick Reference (QR) codes as a link to. These links were posted at various strategic locations around the Medical Centre and Station Welfare Facilities. The

document itself was comprehensive and encompassed information not only required for Primary Care provision but went further to include information about OOH care on the island, Cyprus essentials, Aeromed but most importantly self-help information. Patients in BFC did not always have all the additional services provided in the UK from the NHS such as pharmacies, NHS 24 helpline, Minor Injuries etc, this practice leaflet acknowledged this gap and was responsive to the unique patient needs in this atypical environment. The document was presented in a very user-friendly manner, it was easy to read, it contains links to various websites and platforms, it was widely available and it was regularly updated.

Urgent doctor and nurse appointments were available on the day. Routine doctor appointments were available within 1 week. Routine appointments to see a nurse were available within a few days.

The Primary Care Rehabilitation Facility (PCRF) offered direct access for military staff to appointments. A new patient or routine physiotherapy appointment was available within one week. There was capacity to see patients urgently on the same day if required. Appointments to see the exercise rehabilitation instructor (ERI) or a new or routine appointment were available within three days. There was no waiting list for rehabilitation classes. All patients were assigned a named physiotherapist who managed their care at every appointment.

Outside of routine clinic hours, patients were encouraged to use eConsult to access OOH care. The inbox was monitored 24 hours a day by the duty nurse, so responses could be made in real time rather than waiting for the next working day.

There was access to a small selection of prescribable medicines in a lockable cupboard that was accessible with a key that had to be signed out by the prescriber, and access to the pharmacy was possible with two signatures. Medicines could also be given by the nurse under Patient Group Directives.

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 displayed in the waiting room.

The complaints management process was not robust. There were 3 complaints that were unactioned in the group complaints mailbox. Others had been sent to Med Branch as they related to secondary care and although a holding response has been sent to the patient, the complaint has not been added to the Defence Primary Healthcare (DPHC) log. There was no way of monitoring or hastening the complaints. Some patients attended the facility to speak to CQC team and others submitted emails, these complaints could not be identified on the complaints log. No complaints analysis audit had been conducted, so it was not clear how complaints management was driving improvement.

Are services well-led?

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

Leadership, capacity and capability

The balance of civilian and military clinical input provided the best possible care for patients. The medical centre had a good leadership strategy and vision that all staff championed. 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 and prison healthcare. 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 Primary Care Rehabilitation Facility (PCRF) was managed well with high staff satisfaction. The PCRF felt that leadership from within the medical centre was more focussed on the 112 service and PHEC delivery, and less so on musculoskeletal, governance and assurance. The Officer in Command (OC) attended Heads of Department meetings so was able to provide additional leadership and support in these areas.

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.

The team were committed to delivering the best care through a culture of constant learning and improvement. The medical practice was an approved training practice and had a well-established training ethos. The medical centre had their last re-approval visit in June 2022. They described the training environment provided as

- A well-established, very organised and supportive training practice with education embedded within the daily running of the practice.
- Provides a diverse range of learning opportunities with the provision of pre-hospital care being particularly notable.

Both practice managers were new to practice management but had received little formal training. Both had support from the Group Practice Manager and said this had been beneficial.

Vision and strategy

The medical centre had a clear vision and credible strategy to deliver high quality, sustainable care. Their mission statement was:

‘Episkopi Medical Centre will provide safe, effective and accessible care to our population.’

‘We will place our patients at the centre of what we do, working closely with the Chain of Command and our community to ensure we meet the population’s needs. We will exploit opportunities to optimise force readiness, routine primary health care, chronic disease management, out of hours care and emergency ambulance care.’

‘We will maintain a happy and cohesive team, supporting each other, valuing diversity and ensuring that delivery of care is balanced alongside opportunities for personal and professional development.’

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. Episkopi had been critically short of staffing for the last 18 months and this was known by DPHC. The OPAL ratings were introduced a tool to explain this to command. For the last 8 months, the medical centre had been graded variously as amber then red for a considerable period of time. This was on the basis of:

- Gapped Matron
- Gapped Regimental Medical Officer (RMO)
- Gapped pharmacy technician
- Gapped receptionist
- Gapped administrative staff
- Gapped nursing posts
- Gaps in supporting staff workforces (SSAFA and BFSWS)
- Less than full time employment of staff with no back-fill
- Staff having to work across Pre-Hospital Emergency Care and Primary Care (including very significant hours worked by many)
- Locum staff in many areas of the practice including paramedics and nurses
- Reliance of medics recruited to provide the L4 PHEC cover, in particular ‘placement medics’ many of whom had no previous clinical experience.

Environmental sustainability was upheld wherever possible. The PCRF were mindful of the use of personal protective equipment. They had asked for smaller sharps bins to avoid plastic waste. They conducted air conditioning checks at the end of the day to make sure it was turned off and outcome measure sheets were laminated so there was less paper waste and exercise sheets were emailed to patients. The medical centre had individual recycling bins in the kitchen area where waste was sorted.

Culture

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

Staff said morale has improved in the last 6 months now that both practice managers were in post and they have worked well together to provide a structure for the medical centre alongside the SMO, DSMO and the Warrant Officer, lead nurse. There was a staff suggestion box and a 'Brave Zulu' board to thank colleagues for help and support. The management operated an open-door policy. They have an inclusive meeting structure and have open staff forums to raise concerns and offer suggestions.

The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. There was a duty of candour register on the healthcare governance workbook and it was cross referenced to the ASER register. However, a number of entries on the register had not been completed with details of whether affected patients have been made aware of the issue.

Medics said senior ranks were receptive to the views and suggestions of junior ranks. They said senior ranks acknowledged the work they did. Medics were familiar with the whistleblowing policy and would not hesitate to speak up if they witnessed suboptimal patient care.

The practice team participated in social/team building activities including hikes, bingo and cultural lunches whereby team members bring in dishes to represent their culture.

Governance arrangements

The leadership team had defined responsibilities, roles and systems of accountability to support governance and management. The practice had built in more resilience with leads and deputies in most areas. The HG workbook was the overarching system used to bring together a range of governance activities, including the risk register, ASER tracker, training register, quality improvement projects and complaints. However, as identified throughout this report work was needed to provide full assurance that these systems are effective.

The practice had a system to monitor all patients on high-risk medicines (HRMs). Shared care protocols were in place for patients taking high risk drugs. Regular clinical searches were carried out to monitor patients on HRMs.

Joint working with the welfare team, pastoral support and the other medical centres on the island was in place with a view to safeguarding vulnerable personnel and ensuring co-ordinated person-centred care for these individuals.

A meeting schedule was established, and this included daily coordination meetings, weekly clinical meetings and monthly healthcare governance, safeguarding and practice

meetings. Discussion at each meeting was recorded and made available to those unable to attend.

Managing risks, issues and performance

The leadership team was mindful of risks to the service. A system was in place to monitor performance target indicators. The system took account of medicals, vaccinations, cytology, summarising and non-attendance. Risks to the service were recognised and logged on the risk register. The PCRF recorded all risks on the medical centre healthcare governance workbook.

Processes were in place to monitor national and local safety alerts and incidents.

There was a business resilience plan and a major incident plan that was last reviewed in September 2023. All staff were informed of updates to the business continuity plan.

The leadership team was familiar with the policy and processes for managing staff performance. They provided an example of how the process was applied to address underperformance, activating a range of options to support the process in a positive way, including increased support and opportunities for further experience.

Appropriate and accurate information

The Healthcare Assurance Framework (HAF) commonly used in Defence Primary Healthcare to monitor performance is an internal quality assurance governance assurance tool to assure standards of health care delivery within defence healthcare. The HAF had been used to assist with mapping documents into the correct domain on SharePoint. The lead nurse manager was the healthcare governance and the main user of the HAF. It was well referenced and linked, and all staff used some elements of the workbook.

There was a HAF Management Action Plan in place, but within it there were no defined process to monitor feedback following reports from audits or inspection. For example, actions required from the Infection Prevention and Control audit or the Equality Access Audit. This meant that capturing oversights and target areas for quality improvements was sometimes missed.

An Internal Assurance Review was undertaken in November 2022. This graded the medical centre with limited assurance in Safe and Well Led and substantial assurance in Caring, Responsive and Effective. Following this a management action plan was entered into the HAF by the regional quality assurance lead.

The nurse lead was the audit lead and there were audits completed from all cadres and recorded on the HG workbook. Audits were discussed at the Healthcare Governance meetings.

Systems were in place that reflected data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. However, some staff were out of date for Defence Information Management Passport training which included Caldicott principles.

Engagement with patients, the public, staff and external partners

In response to patient feedback about confidentiality at reception, the medical centre put a radio in the area to minimise patients being overheard. Patients were unclear about what local pharmacies to use so the practice provided information for patients about local pharmacy arrangements. A 'you said, we did' board was displayed in the waiting room.

Staff had opportunities to provide feedback to leaders. A feedback box was located in the staff tearoom for staff to share their views, including if they wished to do so anonymously. Changes had been made to the duty medic sleeping arrangements as a result of feedback.

Continuous Improvement and Innovation

A nurse led audit had been completed which aimed to reduce the waiting time for the secondary reports to return from the UK for patients following their mammogram. The patients had their mammogram in Cyprus and due to the nature of the imaging the results had to be sent via a disc by post to the UK for secondary reporting, causing considerable delays in the result being given to the patient. The nurse initiated a new process whereby the initial mammography report was sent back electronically. This dramatically reduced waiting time for secondary reports and reduced the risk of error by discs being damaged in transit. This new process was shared throughout the other medical centres on the island and staff there have also changed their practice.

The induction for new PCRF staff was the basic DPHC induction which was felt to be too simple and not fit for purpose. This led to the PCRF developing a clinical handbook which was an in-depth Episkopi PCRF induction plan.

Episkopi medical centre had adopted a 'Sway' platform for the leaflet which they provided Quick Reference (QR) codes as a link to. These links were posted at various strategic locations around the Medical Centre and Station Welfare Facilities. The document itself was comprehensive and encompassed information not only required for Primary Care provision but went further to include information about OOH care on the island, Cyprus essentials, Aeromed but most importantly self-help information. Patients in BFC did not always have all the additional services provided in the UK from the NHS such as pharmacies, NHS 24 helpline, Minor Injuries etc, this practice leaflet acknowledged this gap and was responsive to the unique patient needs in this atypical environment. The document was presented in a very user-friendly manner, it was easy to read, it contains links to various websites and platforms, it was widely available and it was regularly updated.

The paramedics (employed by the PHEC service) provided regular training during the 24-hour shift, some of which was suggested by the medics. Recent training included how to read ECGs (electrocardiogram, a test to detect heart problems) and complications of childbirth. The SMO also delivered training to the medics.