

Nepal Combined Practice

Headquarters British Gurkhas, Kathmandu, Nepal

Defence Medical Services inspection report

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

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

Contents

Summary	3
Are services safe?.....	8
Are services effective?	19
Are services caring?	26
Are services responsive to people’s needs?	28
Are services well-led?	30

Summary

About this inspection

We carried out this announced comprehensive inspection at Nepal Combined Practice on 6 and 7 May 2024.

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

Are services safe? – requires improvement

Are services effective? –good

Are services caring? – good

Are services responsive to people's needs? – good

Are services well-led? – requires improvement

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

This inspection is one of a programme of inspections that 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:

- A person centred culture was embedded to ensure patients received quality and compassionate care to meet their individual needs. The permanent staff knew their patients well and provided a high level of personalised care.
- Patients received effective care reflected in the review of screening and vaccination data where the supply chain was effective. However, the longstanding lack of availability of some vaccines left patients at risk, in particular protection against rabies.
- Measures were in place to identify patients who were considered vulnerable, coding was applied to identify vulnerable patients although codes given to the team were not consistently used throughout Defence Primary Healthcare (DPHC).
- Staff had completed safeguarding training appropriate to their role and had a joined up approach to identification and management of patients where there was a concern.

- The practice had forged close working relationships within military healthcare, with host nation organisations, the Chain of Command and with the regional team in planning how services were provided to ensure that they meet patients' needs.
- Multidisciplinary team meetings were held in the medical centre and there was a cohesive approach between the 2 sites. This approach supported timely information sharing and a resilient governance system.
- There was a safe system for the management of specimens and referrals.
- Arrangements were in place for managing medicines, including obtaining, prescribing, recording, handling and disposal in the practice but processes required strengthening to make them fully effective.
- The practice had suitable health and safety arrangements in place to ensure a safe service could be delivered.
- Risks to the service were recognised by the leadership team. The main risks outside of the practice's control had been escalated and workarounds implemented. However, more detail in the practice's own assessments would help categorise risks identified and better support decisions on mitigation.
- Facilities and equipment at the medical centre were sufficient to treat patients and meet their needs. However, there was a need to clarify the responsibilities for the monitoring and maintenance of equipment and medicines to be used in response to a disaster such as an earthquake.
- Staff were aware of the requirements of the duty of candour and monitored compliance. Examples we reviewed showed the practice complied with these requirements.
- The practice sought opinion and comments from patients which it acted on. Feedback from patients indicated that they were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.

We found the following area of notable practice:

- Patients having to attend a hospital were accompanied in person by the hospital liaison officer (HLO). Feedback from the patients had been very positive with the access to a translator and quick resolution about funding and onward referral highlighted.

The Chief Inspector recommends to the wider Defence organisation:

- Acknowledging the global supply concern for some vaccines; work to ensure safe and timely vaccine supply to all patients registered in Nepal, including civilians and eligible children. Guidance around travel vaccination requirements should align to the Green Book publicised on the National Travel Health Network and Centre (NaTHNaC) website and this should include civilians who are staying longer than one month.
- Continue to investigate and mitigate concerns around the supply chain for medicines and vaccines, including assurance around cold chain and resolutions around delays and errors during dispatch. Ensure that only medicines and vaccines with maximum expiry buffer are allocated for dispatch overseas.

- Ensure that Nepal Combined Practice are directed to use the common set of clinical codes for safeguarding and vulnerable patients as directed in the DPHC standard operating procedure for managing vulnerable patients.
- Challenges around timely access to accurate patient records occur as DMICP 'Deployed' (the clinical operating system referred to throughout this report as DMICP) is a system with reduced functionality and some outage periods. Headquarters should review the functionality of DMICP and deliver solutions to improve access to up-to-date records.
- Consider ways to improve continuity of care to patients and consistency of leadership (including supervision and appraisal for staff) at Pokhara and Kathmandu Medical Centres.

The Chief Inspector recommends to the medical centre:

- Medicines management process are strengthened by having:
 - All medicines supplied or administered to a patient through a Patient Group Direction must be dispensed from the dispensing queue to accurately account for the medicines,
 - rolling stock checks completed to minimise stock discrepancies,
 - monthly stock checks run one month in advance and stock due to expire within the month separated from the main stock to minimise the risk errors,
 - clarification on who is responsible for the replacement of the medicines and medical consumables held in the paramedic Bergens (module 586 and 587).
- The out of hours (OOH) assessment protocol must be reviewed to ensure that only staff with the appropriate skills, qualification, experience and current competency assess patients. The protocol must accurately reflect when patients should be referred OOH to the SMO and staff must follow this guidance. The protocol must state the arrangements for who can see children OOH. An entry must be made into DMICP on every occasion that a patient makes contact OOH, and this must outline the concern reported and any treatment given.
- All nursing staff involved in delivering care to patients with a long-term condition must receive training specific to the management of chronic disease. Staff also required training in running clinical searches.
- Ensure that all patients are aware of the arrangements to access care when the medical centre is closed.
- Designate the PHEC modules clearly as 'for use in disaster relief only' with a formal agreement between HQ BGN and DPHC that delegates responsibility for checks and controls.

- Strengthen the process around risk management to ensure appropriate escalation of risk, owners are clearly identified and there is clarity in the way risks are written.

Chris Dziki

Interim Chief Inspector of Healthcare

Our inspection team

The inspection team was led by a CQC inspector. The team comprised specialist advisors including a primary care doctor, a practice manager, a primary care nurse and a pharmacist. A CQC inspection manager and a member of the Defence Medical Services Regulator team were also in attendance.

Background to Nepal Combined Practice

With sites in Kathmandu and Pokhara, Nepal Combined Practice provides routine primary care and occupational health care service to a patient population of approximately 142 (serving personnel and their families). There are 2 medical centres in the group practice, the headquarters in Kathmandu and a second in the city of Pokhara (approximately 1 hour by air or 8 hours by road). There is no primary care rehabilitation Facility (PCRF) situated in Nepal. Physiotherapy needs are met through a contract with a host nation provider or by returning to the UK.

The medical centre is open from 08:00 to 16:30 hours Monday to Friday. Same day and urgent care appointments, referred to as 'sick parade', are available between 08:00 and 08:30 each weekday, routine clinics are then held from 09:00 to 12:30. Routine appointments for school children are provided outside of core school hours between 15:30 and 16:30. Outside of these hours, a 24 hour, 7 day a week primary care service (response within 1 hour) is provided for medical advice on urgent problems that cannot wait until the next working day. Patients can access this service by calling a duty phone that has the registered nurse or Senior Medical Care Assistant as the first point of contact supported by the Senior Medical Officer and Senior Nursing Officer. Due to the patient population being small, call outs are minimal and respite time for the clinicians is facilitated at times by signposting patients to the local hospital accident and emergency department (both in Kathmandu and Pokhara).

The staff team

Doctors	1 Senior Medical Officer (SMO, based in Kathmandu)
Nurses	1 Senior Nursing Officer (SNO, based in Pokhara)

	2 Practice Nurses (1 based in Kathmandu, 1 in Pokhara)
Senior Medical Care Assistant Medical care advisor	2 (1 based in Kathmandu, 1 in Pokhara) 1 (based in Pokhara)
Practice manager Deputy practice manager Hospital liaison Receptionist	1 (based in Kathmandu) 1 (based in Pokhara) 1 (based in Kathmandu) 1 (based in Kathmandu)

Are services safe?

We rated the medical centre as requires improvement for providing safe services.

Safety systems and processes

The medical centre worked to the British Gurkhas Nepal (BGN) safeguarding policy that covered both vulnerable adults and children. The policy was accessible to all staff and, last reviewed in March 2024 included a clear process in the form of a flowchart to guide on how concerns should be escalated. Support and advice was provided by the Global Safeguarding Team with contact email addresses and telephone numbers displayed clearly for staff in clinical rooms. Safeguarding information and guidance for patients was available in the waiting areas. Staff interviewed during the inspection were fully aware of the policies and knew how to report a safeguarding concern.

A review of safeguarding and vulnerable patients was discussed at quarterly unit health committee meetings attended by the Senior Medical Officer (SMO) and nurse. Overseas social work was delivered by British Forces Social Work Service (BFSWS) overseas with a named social worker allocated to BGN (based in Brunei Medical Centre as this was the closest location with specialist staff). A monthly call was held to discuss vulnerable patients and those where concerns had been raised. This call involved the SMO and social worker. The regional nurse advisor (RNA) overseas (who also acted as the regional safeguarding lead) provided on call support when needed. Unit health committee and safeguarding meetings were held quarterly. Due to the regular change of SMO, the practice nurse at Kathmandu attended to provide continuity of patient care. There was also a nominated point of contact in Brunei who would provide advice and guidance where there was safeguarding concerns that involved children.

We contacted the welfare team, Padre and Pandit (a Nepali leader who provides spiritual and cultural support where it is needed) as part of this inspection. They told us that they provided a welfare service to some vulnerable individuals and praised the collaborative approach and communication with both administrative and clinical staff from the medical centre. Informal communication took place continuously and patients were well known to the staff in part due to the small number of registered patients but also helped by the continuity of civilians employed in the medical centre. The SMO attended the BGN welfare meetings and the Deputy Commander and senior leaders' weekly meeting.

The SMO was the safeguarding lead with the Senior Nursing Officer (SNO) acting as deputy. Both had completed level 3 safeguarding training for both adults and children. All other staff had completed safeguarding training appropriate for their role (all clinical staff were level 3 trained, administration staff level 2). Training was delivered through a combination of 'eLearning for healthcare', online and face-to-face training courses. A local working practice (LWP) was in place and included both host nation support and reach back to the UK.

The team were capturing all safeguarding information within DMICP (the patient record system) and alerts were placed onto the record of anyone deemed to be vulnerable. This included any patients aged under 18. However, the team had stopped using/searching for

the 'Vulnerable Adult/Child' codes and were using the safeguarding codes instead. This posed a risk that vulnerable patients will be missed by searches when they move between medical centres.

The staff made regular contact with all patients considered vulnerable. They communicated with a network of contacts. These included internal and external services such as the BFSWS, welfare officers at Kathmandu and Pokhara, school principals from both sites, Pandit and Padre. The SMO and welfare officer had visited both primary and secondary schools and held meetings with the leadership team. The schools had their own counsellor and had forged links with a host nation paediatric psychiatrist. We reviewed an example of a recent safeguarding record to find that information sharing had been effective through engagement with the network of healthcare professionals.

Vulnerable patients were identified during consultation, DMICP searches and on referral from another department such as the welfare team. Coding was applied to clinical records to identify patients considered vulnerable and urgent appointments were offered. There was a vulnerable patient register on DMICP under practice documents. Searches were run monthly by the nurses at both sites and vulnerable patients were a standing agenda item on each practice meeting agenda.

The likelihood of mental health presentations was minimised by military personnel and their families being screened for appropriateness to be supported in country. There was a minimum grading for those assigned to Nepal so patients arrived in good health. Reach back to the overseas mental health team was in place, this included a named consultant psychiatrist. There was an LWP for mental health overseas and consideration was a requirement of the Commander's Health Committee. Resources were freely available; British Forces Brunei was used as a resource to discuss the complex cases. Mental health advice, guidance and support was a continuous feature displayed on the television screens in the patient waiting areas. We reviewed patients through a search on 'low mood' and 'hypertension' and found an example of persistent engagement with a patient who had disengaged repeatedly. Good practice was shown by the medical team when trying to bring the patient in for review. However, this was reliant on the knowledge among staff and we highlighted that adding a vulnerable adult Read code would have made them less likely to have been lost to follow-up. During out of hours (OOH), any patient displaying mental health problems could attend Medicity Hospital (15 minutes' drive away from the Kathmandu camp) for immediate assessment and stabilisation. The hospital also provided emergency ambulances with a range of pre-hospital emergency care (PHEC) specialists if requested.

Chaperone training had been completed by all staff; the most recent refresher course was held in March 2024. The management team monitored the healthcare governance (HcG) workbook and informed personnel when their refresher training was due to expire. Posters were displayed prominently throughout the building, including in each clinical room, to advise patients on their rights to a chaperone (as well as the clinicians' rights to a chaperone). These were displayed in both English and Nepali. Information included in the patient information leaflet was also in both English and Nepali. We noted that there was a mix of male and female chaperones available, those we spoke with were confident when describing what the role of a chaperone involved.

The full range of recruitment records for military staff was held centrally. This included both the SMO and SNO who rotated frequently. Locally employed civilians underwent a Nepalese police check prior to employment. This was controlled and managed by the unit's human resources based within the BGN Camp. All nurses working at both sites were registered with the Nurse and Midwifery Council.

Staff were up-to-date with their hepatitis B vaccination and there was a hepatitis B register available to view. The nurse was reviewing the recent National Institute of Clinical Excellence (commonly referred to as 'NICE') guidelines on vaccinations for measles, mumps and rubella and planned a catch up to immunise all staff.

A process was in place to manage infection prevention and control (IPC). The current IPC lead had completed specific training for the role (the 2 day link practitioner course), updated their knowledge annually via online training and participated with the quarterly IPC link forum led by the DPHC IPC lead (listened to a recording due to the time difference and raised any questions, issues or concerns with the RNA). There was a named deputy lead at Pokhara who had also completed role-specific training. IPC training for staff was included as part of induction. All employed personnel were currently in-date with training. IPC was a standing agenda item for the RNA meeting to enable the overseas nurses opportunities to feedback issues.

Regular IPC audits were carried out including the DPHC mandated audits. The most recent audit completed in March 2024 highlighted an issue with flaking paint in the nurse's room at the Pokhara site. This had been resolved by the room having been repainted. A walk around the buildings at both sites carried out as part of the inspection highlighted a high level of cleaning standards. There were a number of minor issues at Pokhara that staff were aware of and had mitigated. For example, there was no sluice so an unused toilet was used to dispose of any samples. Some toilets at the back of the building were metal as opposed to ceramic (therefore presenting a risk of corrosion). However, these were used by recruits, not by medical centre patients nor staff.

Environmental cleaning was provided by BGN staff. A written cleaning schedule was in place, available on SharePoint and updated as required by the practice manager. Check sheets were available for each room and these had been signed by cleaning staff to evidence completion. Any issues with cleaning standards were reported to the Quartermaster (QM). Cleaners worked elsewhere on the camp after completing their allocated time in the medical centre buildings so could be called back during the day if required for any extra cleaning. A deep clean of the premises was completed quarterly with the last one carried out in March 2024. Concerns had been raised at Pokhara during a time when cover was needed for the cleaner. The nurse at Kathmandu reported that due to changes in staff, the cleaner had changed and standards in the medical centre were not consistent. The new cleaner had not worked in a medical environment before and their comprehension of written English was not good, so the team translated the NHS cleaning standards into Nepali along with providing some specific training to ensure understanding. This had been formally raised as a significant event and better cleaning standards achieved as a result.

Healthcare waste was appropriately managed and disposed of with the responsibility of collection held by the QM at Kathmandu and a civilian contractor at Pokhara. At the Kathmandu site, the waste was disposed of at a local hospital and the yellow clinical waste

bin was found to be locked and secured when in situ. At Pokhara, the QM carried out annual reviews to ensure the service was being provided in accordance with the contract. The outdoor clinical bin was locked but not secured to a fixed object. Neither site held copies of consignment notes for clinical waste but an audit trail could be provided through the invoices submitted by the receiving hospitals. All items disposed of were recorded on the clinical waste log. Annual waste audits were carried out with the most recent being in March 2024.

Risks to patients

Resilience was built into the staffing establishment at both sites by means of locally employed civilians who were in permanent posts. The small number of registered patients allowed same day access including OOH. Clinical staff felt that the skill mix was adequate for the current patient population. However, in periods of long-term absence, they had been unable to get locum nurse cover. These absence periods had been managed by the nurses alternating between sites on a weekly basis (easier for transport and planning clinics). The nurses deconflicted and confirmed leave periods (longer than 1 week) as far ahead as they could to allow cover.

We found that an appointment system was in place which facilitated same day face-to-face appointments with a doctor or nurse when needed. The patient list size being so small allowed for this.

Arrangements were in place to check and monitor the stock levels and expiry dates of emergency medicines (there was an emergency medicines list on DMICP to facilitate time expiry management). We saw evidence to show that an appropriately equipped medical emergency kit and trolley was in place, regularly checked and staff were aware of where the emergency trolley was located. The trolley was secured with a serialised tag and there was a log for access. The ambient temperature monitoring was being completed in accordance with the DPHC standard operating procedure (SOP). We identified a number of minor issues that did not present a risk to patients and were rectified on the day. Testing on the emergency equipment was in line with policy and the blood glucose monitor was being calibrated. The oxygen was locally purchased so it was not possible to check the volume of oxygen nor the expiry date (related to the cannister not the oxygen). Oxygen cylinders had been requested from the UK but these had not arrived and therefore the risk of having no oxygen was mitigated by that which had been sourced locally. The Entonox (a gas used as a pain medication) cylinder had been sourced from the UK, was in-date and at least half full. Appropriate 'Hazchem' signage was displayed on the doors to the area where medical gases were stored and the external store had the appropriate 'no smoking' sign displayed.

Staff were suitably trained in emergency procedures, including basic life support (BLS), automated external defibrillator (AED), anaphylaxis and choking. Training had been completed with initial theory followed by scenario and simulation based training. Non-clinical staff had also participated in situation based training for awareness of their role during a medical emergency. Annual refresher training in BLS, AED and the use of emergency equipment was mandated for all staff. Staff had received training in the management of thermal injuries and dealing with suspected spinal injuries. A thermal

injury simulation session was held in March 2024 with an additional heat illness injury management session conducted in April 2024. Sepsis training had been completed and was last refreshed in March 2024. There was an SOP for treating sepsis and red flag posters displayed at both sites. The SMO had completed immediate and advanced life support training (ILS and ALS) and nurses had completed ILS as well as paediatric immediate life support training. An eLearning course in 'spotting the sick child' had also been completed by some of the clinical team.

Requirements for PHEC qualifications (battlefield advanced trauma life support or BATLS, military PHEC or MPHEC, ALS) were unclear for the SMO post, they had not been detailed so the default was to hold the routine qualifications required for a DPHC doctor. The current SMO was in-date for ALS but not BATLS or MPHEC. MPHEC was on the proposed job specification for the new SMO but this had yet to be approved. It was confirmed later in the inspection that this has been removed from the job specification by the Regional Clinical Director. The PHEC modules (owned by HQBGN) needed designating clearly as 'for disaster relief only' and, a memorandum of understanding established to formalise for the delegation of checks and controls to DPHC.

The layout of the Kathmandu and Pokhara buildings was open and the central position of the reception desks allowed patients to be observed whilst waiting.

Information to deliver safe care and treatment

There was an LWP for summarising notes, patients registered using the e-registration process, dependants registered via the overseas team (prior to arrival) and their notes were summarised onto DMICP. The administration staff requested NHS GP notes once dependents registered and these could take up to 1 month to arrive. These notes were stored in a locked cabinet in reception and on leaving the practice were sent for onward transfer to NHS practices. A search was completed each month and time allocated to the nurses for summarising. The practice manager completed a quarterly audit of notes summarising. At the time of inspection, 90% of notes had been summarised, 21 sets of recently joined patients were awaiting completion.

Links had been developed with Brunei Medical Centre and the SMO held a peer support meetings with a doctor from Brunei to peer review clinical consultation notes and share clinical cases. Audits of consultations were also carried out during assurance visits and handovers. The SNO conducted a nursing notes/consultation audit of the practice nurses' notes in February and March 2024, this was recorded on the HcG workbook. In addition, nurses also conducted quarterly clinical supervision. A Patient Group Directive (PGD) audit has been conducted, this was on the SharePoint site and linked to the HcG Workbook. The 'PANDO' application or referral by email was used to consult with specialist advisors of Defence Consultant Advisors. PANDO is a secure communication solutions for healthcare teams to collaborate.

Co-ordinated by the administration team, a comprehensive and effective system was in place for the management of both internal and external referrals. Each referral was added to a tracker and all staff granted access could review the document. The administration team monitored the referral tracker daily and a review was included in the Monday morning huddle. Urgent referrals (all went to the UK) were sent to and managed by the

Aeromedical Liaison Officer who also organised the logistics. The hospital liaison officer (HLO) was the point of contact for payments to local healthcare providers and mediated between organisations to ensure there was no delay to patients' treatment. In the event of medical evacuation in/ from Nepal, the HLO would liaise with the hospital and transporting company to ensure prompt payment was processed to prevent any risk to the patient. Within Nepal, all care for military personnel was done via credit so the HLO acted as a point of contact between BGN and the hospital to ensure the account was paid. Every patient (military, families/ dependents and civilian contractors) would have healthcare provided but required proof of where they were working along with a credit letter. This again was facilitated by the HLO.

An effective process was in place for the management of specimens. Blood samples were logged on a sample tracker held on DMICP. These were handed to reception, packed inside a transport bag and then placed into a sealed container (marked bio-hazard). Military transport was then contacted to arrange for collection from the medical centre. The testing laboratory could not automatically send results so were contacted by staff to request the report. The administration team contacted the laboratory daily for results and used an electronic diary entry to serve as a reminder. Military transport was dispatched to collect the results. On receipt of the results, the SMO or nurse reviewed them, updated DMICP and the sample tracker before informing the patient.

On review of patients' notes, results received used local Nepali hospital values which differed slightly to the UK values. These could appear abnormal due to the location/ laboratory values and testing. The practice used 'Smartdoc' software to upload the results so that the actual values on the results could be seen along with the UK DMICP values to prevent any possible confusion and errors.

On completion of cytology sampling, the nurse documented on the patients' records, entered onto the specimen register and packed the sample up in a special delivery kit. The sample was taken to the post office on camp and expedited via special tracked delivery. Samples were sent to a UK laboratory with results normally received within 6 to 8 weeks. A copy of the tracking number was added onto the sample register. Results were forwarded to the practice from the overseas team and a copy given to the patient. The overseas team received the results directly from the laboratory and updated DMICP along with scanning the results onto the patient records. In Nepal, there was a cervical screening management system in place to help manage the process (similar to the Cervical Screening Management System used in the UK).

Staff reported issues with patient records and the accuracy of the information held due to the fragility of DMICP. The practice manager, deputy practice manager (Pokhara) and administration reported issues and functionality with the system, this included the raising of a number of ASERS related to IT failures. The slow operating speed of DMICP had also been recorded on the issues log. Administration staff stated that patients often left the site but did not book out, this caused inaccuracies with the patient list and future care on return to the UK. Searches seen appeared to exclude unique identification numbers and there also appeared to be several users no longer based within the sites still registered for use on DMICP. We discussed the benefit of staff members attending the relevant course to upskill and address a training deficiency in the use of DMICP. We were also told about 'glitches' in the system that resulted in information entered being lost. One example of an

out of hours call that had not been recorded was attributed to this. However, it was not possible to determine whether this was a system or human error.

An uninterrupted power supply provided mitigation against short power outages to mitigate against data loss and protect equipment against surges. Staff reported the slow speed of the system in particular at Pokhara and it was not uncommon for the system to be down for a day. Although this resulted in inefficiencies, it had not impacted directly on patient care due to the size of the population across both sites being so small. These issues had been escalated to the single point of contact and region.

Safe and appropriate use of medicines

The SMO was the named lead for medicines management and this was reflected in their terms of reference (TORs). The day-to-day management was delegated to the SMCA (Senior Medical Care Assistant), this was reflected in their TORs. The SMCA had completed the NVQ (National Vocational Qualification) level 2 and 3 in pharmacy services and had completed the dispensing assistant course.

Arrangements were in place for the safe management of controlled drugs (CDs), including destruction of unused CDs. We saw that internal monthly checks and external quarterly checks had been completed; the CD specimen signature list had been completed accurately by all those involved in the accounting of controlled and accountable medicines. The CD cabinet was compliant with the Misuse of Drugs (safe custody) Regulations 1973 and access controlled. There was a key safe log and a key safe (to keep keys inside the dispensary). Destruction certificates had been completed and witnessed by an appropriate individual external to the practice.

Emergency medicines were easily accessible to staff in a secure area of the medical centre and all staff knew of their location. The storage of oxygen and Entonox cylinders was safe and the area was clear of clutter. Appropriate signage was displayed on the doors of rooms containing medical gases.

Medication requiring refrigeration was monitored twice a day to ensure it was stored within the correct temperature range. Storage arrangements for the vaccinations were secure, sufficiently spaced out away from the fridge walls to allow air to circulate and all stock was found to be in-date.

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

Prescription stationery was stored securely in the dispensary and the serial numbers of the prescriptions (referred to as Fmed296 in the military) documented in a bound book. There was a system to track their issue and usage to the individual prescriber. We discussed a 6 monthly stock check of the Fmed296 forms as an additional check for best practice.

PGDs which allow sufficiently trained practice nurses to administer medicines in line with legislation, were in place. These were current and had been signed off by the authoriser. The only exceptions were for rabies, tick borne encephalitis and Varicella Zoster (a highly contagious herpes virus that causes chickenpox). These had expired but were scheduled

to be updated and signed off by the new SMO. A review of DMICP consultations found that the correct template was being used and referred to when immunising or supplying medicines through PGDs. Medicines that had been supplied or administered under PGDs were in-date. However, we found discrepancies between the physical stock and DMICP stock. A process for accurate and timely DMICP accounting was agreed during the inspection. Time expiry reports were being run but because they were done at month end, medicines that expired in that month had not been removed from stock. Patient Specific Directions were not used at the practice.

There was an effective process to manage requests for repeat prescriptions. Requests were managed in person or by email and not accepted by telephone in line with policy. Although there was no clear electronic audit trail of the medicines requested by patients, hard copies (repeat paper slips) of requests for repeat medicines were kept in a folder for 12 months in case needed for reference. A spot check of the dispensed repeat prescriptions found that all had been dispensed within 8 weeks. This showed that the staff were effectively informing patients that their prescriptions were ready for collection and were efficiently returning uncollected medicines to stock if they were not collected within 8 weeks (in such cases, the prescriber was always informed). A process was in place to update DMICP if changes to a patient's medication was made by secondary care. This was detailed in an LWP last updated in April 2024. There was scope to better communicate information on the repeat prescription process by inclusion in the patient information leaflet and by having a poster at the dispensary hatch.

The 5 patients on repeat medication we checked had all been managed appropriately. We saw evidence to show that patients' medicines were reviewed regularly and the doctor's notes in DMICP around medication changes were comprehensive. There were plans in the records for patients with asthma.

We were told that reviews of patients prescribed antibiotics were carried out annually. However, a review of the audit tracker showed the most recent audit as being in December 2022.

A process was established for the management and monitoring of patients prescribed high risk medicines (HRM). We saw that there was a collaborative approach between the incoming and outgoing SMOs who reviewed all patients on HRMs as part of the handover. Clinical searches were run monthly and supported by annual audits with the most recent carried out in March 2024. We looked at a sample of patient records and saw that all had been coded and patients were monitored within the recommended timescales. There was 1 patient where there was no evidence of prescribing history, this was attributed to a glitch in DMICP and the patient was called in for a review. Shared care agreements between primary and secondary care did not exist in Nepal. However, the medical centre tracked all prescribing done in secondary care and checked that patients were monitored. The review of patient records highlighted a patient prescribed an HRM in hospital that the medical centre had captured for monitoring.

There was evidence that the search on DMICP to identify any patients prescribed sodium valproate (treatment for epilepsy and a mood stabilising medicine) was being run monthly. The search was last run in May 2024 and identified no patients prescribed valproate. The dates of searches were documented on the chronic disease register. The SMCA was aware of the recent changes to full pack dispensing for valproate.

Track record on safety

Measures to ensure the safety of facilities and equipment were in place. Electrical safety checks were in-date and there were no gas installations at either site that required certification. Water safety measures were carried out weekly at both sites. Legionella inspections of both sites had been conducted in March 2024. A fire risk assessment of the buildings was undertaken annually and firefighting equipment tests were current. Staff were up-to-date with fire safety training and were aware of the evacuation plan. A land equipment audit completed in June 2023 highlighted 2 areas of non-conformance and 1 minor observation. Both areas of non-conformance had been actioned.

A system for monitoring and recording the servicing of all clinical and non-clinical equipment was established.

Staff had adopted the current risk template as per DPHC guideline and used the 4Ts (treat, tolerate, transfer or terminate) to manage risk. The practice manager was due to take the lead for risk management after completion of the DPHC practice manager's course (schedule to be completed in May 2024, the course included risk management).

The HcG workbook contained active and retired risk registers. The active risk register was reviewed regularly with risk management being a standing agenda item at the monthly practice and HcG meetings.

A business continuity plan (BCP) was in place for the medical centre, this had last been reviewed in May 2023. The BCP was held on the medical centre SharePoint so could be accessed remotely if required. The plan was comprehensive in covering the most likely causes of a major incident and included risk assessments for each room, an action plan check list and a list of key personnel together with their contact details. There was also a floor plan of the buildings. A disaster contingency medical plan was also in place and this covered the wider area around the medical centres and detailed the roles of staff in response to a major incident, for example, an earthquake. The 'scheme of manoeuvre' referred to checking emergency medical equipment annually and to ensuring personnel were in-date for training in emergency care. Both plans were supported with face-to-face training where staff would be briefed on how a response would be coordinated and carried out. However, discussion with staff highlighted that clarity was needed on responsibilities and training requirements. For example, emergency medical equipment and medicines were not being checked by medical centre staff and were not all in-date. Nepal Combined Practice did not view this as their responsibility. Training for medical personnel in the disaster contingency medical plan included battlefield casualty drills, advanced life support and battlefield advanced life support. However, this had not been incorporated into training plans.

The medical centre had no fixed alarm system but each clinical room had a handheld alarm which allowed staff to summon for assistance in an emergency. There was 1 missing at Pokhara but a replacement had been ordered together with additional devices for the administrative staff across both sites.

Staff generally had the information they needed to deliver safe care and treatment to patients. However, there were examples of missing information that was attributed to 'glitches' in the system. Examples included an absence in the prescribing history of a

patient. We also identified issues with patient records and the accuracy of the information held due to using DMICP. Staff at both sites reported issues and functionality with the system and highlighted that patients often leave the site but do not book out thus causing inaccuracies with the patient list and future care on return to the UK. Searches seen appeared to miss the unique identification number or 'UIN' (which may improve the quality of the search data) and there were several users no longer based within the sites still registered for use on DMICP.

If there was an unplanned DMICP outage, the medical centre would undertake urgent care only as per DPHC direction. The BCP detailed workaround steps should problems with connectivity continue. Paper records would be used and scanned onto DMICP once access had been reestablished.

Lessons learned and improvements made

All staff had access to the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events and incidents. There was no named ASER lead but through the work we reviewed, it was clear that the practice manager ensured processes were followed. The staff database showed that staff had completed ASER training and discussion around learning took place at the monthly practice and HcG meetings with input from all staff across both sites. A record of ASERs was maintained on the HcG workbook by the practice manager. We saw these had been completed in a timely manner and included a completion date, a note of any lessons learnt and outcomes.

From interviews with staff and evidence provided, it was clear there was a culture of reporting incidents for all staff. 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. 'After incident discussions' were held after the reporting of any incident to explore if improvement could be made.

Audits of significant events and recorded incidents were completed annually. A recent audit on ASER log in for staff highlighted that the 9 individuals checked across both sites had successfully logged into the system. A total of 7 ASERs had been recorded since January 2024 (4 at Kathmandu, 3 at Pokhara). There were no thematic patterns but it was clear that the system facilitated improvement. For example, a substitute cleaner sent into Pokhara to cover an absence was not aware of IPC protocols. An ASER was raised after clinical and non-clinical waste had been mixed together. Following review, it was agreed that all new cleaners would receive basic IPC training from the IPC lead before commencing work. This training included instruction around waste management. A second example followed an incident when a patient admitted to hospital had treatment delayed due to their credit and debit card not working. Following this, the medical centre produced a standard letter (copies kept in the clinical rooms and given to the patient to hand in to the hospital when required OOH) which stated that the patient was eligible for treatment and care.

An electronic near miss log was maintained in the dispensary. The medical care assistants understood the importance of using a near miss log and shared the learning with the wider team. Near misses recorded in 2023 evidenced that the system was used appropriately. There had been no near misses recorded in 2024.

Evidence was seen of effective processes for the management and action of Medicines and Healthcare products Regulatory Agency (MHRA) and National Patient Safety alerts. The Senior Medical Care Assistant at Kathmandu had overall responsibility for the management of medicine and safety alerts with support from their counterpart at Pokhara. Alerts received by the medical care advisors were distributed internally. Any alert was discussed daily and at the formal meetings and documented in the HcG workbook together with a record of relevant actions taken.

Are services effective?

We rated the medical centre as good for providing effective services.

Effective needs assessment, care and treatment

In order to provide assurance to the care that was provided to patients in Nepal, it was necessary for the Senior Medical Officer (SMO) to have an integrated approach across primary and secondary care. This involved more extensive review of secondary care notes and liaison with the UK through the Defence Consultant Advisors, PANDO and through the network of peer support to ensure that the care being provided in country was safe, effective and in line with UK current practice. In addition to this, Nepal Combined Practice was robust in their approach to ensuring secondary care appointments for routine conditions were typically provided in the UK, although there needed to be cultural considerations and careful discussion with patients around if treatment was to be delivered in the host nation or back in the UK.

The clinical team referred to clinical guidelines and some guideline updates were documented in the practice meeting minutes. There was no specific clinicians' meeting but the planned closer working practices with Brunei would provide opportunities for this in the future. Supported by region, the Nepal Combined Practice were in the process of establishing regular communication with colleagues at Brunei Medical Centre that would include reference to clinical guidelines.

Our review of clinical records for the nursing team demonstrated that clinicians carried out assessments and provided care and treatment in line with national standards and guidance. A recent example was the vaccination of staff for measles, mumps and rubella. Staff records on immunisation status had been reviewed by a nurse and a plan implemented to immunise those who had not received this vaccination.

Staff were kept abreast of clinical and medicines updates through the Defence Primary Healthcare (DPHC) newsletter circulated to individual staff each month. Participation with regional events and forums also provided an opportunity for clinicians to keep up-to-date.

Monitoring care and treatment

Long-term conditions (LTCs) were overseen by the SMO, managed by the nurse at Pokhara and the main LTC registers divided between the team to evenly distribute the workload. Nurses managed their own monthly searches and alternated this monthly. They also coordinated patient recall supported by administration staff. Although protected time was set aside for the nurses, they had not received formal training on how to set up clinical searches (the searches available on DMICP in the UK were not accessible on DMICP deployed). We found that Read codes were used consistently but these did not always correspond with the correct code for LTCs. We discussed the benefits of a training session that would include a review of the mandated DMICP searches so that information captured would be accurate. The recalling of patients for treatment was reliant on the knowledge of

the team as diary dates for reviews were not set. Although this was effective when working with a small patient population, use of diarised dates would introduce resilience into the system and serve patients better when moving between medical centres.

Nurses had not completed formal training in LTCs but had gained knowledge from online eLearning for health modules and support from the SMO. We discussed the possibility and benefits of having protected time with the SMO to review the LTC patients as this would provide formalised supervision, support and clinical oversight. We looked at a sample of patients' notes; they were comprehensive and in good order. The medical centre provided us with the following data:

- The small number of patients on the diabetic register were regularly monitored in accordance with best medical practice guidance. Processes were in place to identify and monitor patients at risk of developing diabetes. Five of 6 patients had cholesterol levels of 5mmol/l or less and all 6 had a BP of 150/90 or less. This evidenced good management of patients with or at risk of diabetes.
- There were 11 patients on the hypertension register who were regularly monitored in accordance with best medical practice guidance. All 11 patients had a record of their blood pressure taken in the past 12 months and had a blood pressure reading of 150/90 or less (an indicator that hypertension was being well managed).
- There were a small number of patients with a diagnosis of asthma, all had received an asthma review in the preceding 12 months using the asthma review template. Utilisation of the template had improved following an asthma audit and action plans were now in place for all patients. The SMO had delivered some training that included documenting that patients had the 'exposure to pollution' Read code (due to the poor air quality particularly in Kathmandu).
- Audiology statistics showed 73% of patients had received an audiometric assessment within the last 2 years. The nursing team had an effective recall process in place, however, despite a number of attempts supported by the administration team (all documented on the patient records), there was a history of poor attenders. We discussed alternative ways to engage and ensure patients attended for the screening, for example, opportunistic screening when the patient was in the medical centre for another reason.

Through a review of clinical records and discussions with the doctors, we were assured that the care of patients with a mental illness and/or depressive symptoms was being effectively and safely managed. Serving personnel were screened prior to deployment for mental health either through being a soldier, it was expected that they would have had an associated grading review or otherwise be lower risk. Families were required to be screened to minimise the risk of presentations, higher risk behaviours and/or more deeply pathological presentations. There was still a requirement for the SMO to treat mental health in Nepal often caused by being away from home, isolation, culture shock and cultural oppression. Stage 1 care was provided within practice (with online support depending on the experience of the GP). In addition, doctors had access to online resources, for example, liaison back to the UK Overseas psychiatrist for discussion, reassurance or advice. Staff had visited a local child and adolescent psychiatrist with a view to using them initially for diagnostic assessment. Referrals could be made to the Department of Community Mental Health back in the UK although there had been no recent examples.

An audit and quality improvement lead and deputy were assigned and there was an audit calendar incorporated into the healthcare governance (HcG) workbook. The wider team was engaged with the calendar and discussed the programme and findings at practice meetings. Clinical audits that had been completed included a hyperthyroid annual audit (no actions identified), an NHS health check audit (identified that incorrect Read coding had impacted recall and the benefits of the screening could be better communicated) and an asthma audit (identified that the correct templates and Read coding were not being used). Non-clinical audits included Caldicott breaches, workplace inspection checks, clinical waste pre-acceptance and disability access.

Effective staffing

There was an induction pack for all new staff that included role specific sections. All inductions were held on the HcG workbook and the process was overseen by the practice manager. The induction pack included role specific elements, for example, staff who participated in the out of hours rota were required to complete training in how to spot a sick child. The medical centre would see UK locally employed contractors (LECs) if they were unwell. If the LEC had a chronic disease, they would be expected to bring all their medication requirements with them.

There was a training calendar and a record of mandatory training. The training lead monitored the status for staff and discussed required training activity in the practice meetings. Protected time was afforded to staff every Wednesday afternoon to complete training. Compliance levels for training were high across the team with clinicians encouraged and supported with protected time to engage in continued professional development (CPD). This was monitored via the appraisal system for doctors and nurses. However, we discussed the arrangements for the annual appraisal of staff due to the short tenure of each SMO. The team had expressed a desire to have their reporting completed by the SMO but we fed back to the Chain of Command and to region that this arrangement was not effective. For example, a previous SMO had declined to complete the annual reporting due to the limited time spent with staff members. There were no issues with staff performance but should this change, the timescales were likely to be too short for the SMO to effectively utilise performance management within their 4 month rotation.

The meeting schedule supported CPD and revalidation requirements through clinical updates, guideline reviews and safeguarding updates.

There was role-specific training for relevant staff. For example, nurses at Pokhara had received basic life support, advanced life support and immediate life support training that included a course specific to children. The SNO was trained in cytology and carried out smear testing at both Pokhara and Kathmandu. The SNO had previously worked in a sexual health clinic and was sexual health (STIF) trained (levels 1 and 2) and had a diploma in family planning. The SNO had received training in minor injuries, minor illnesses and musculoskeletal injuries and felt confident and competent to treat. The nurses were Nepalese and trained in Nepal to Nepal Nursing Council standard. They had also completed the International English Language Testing System (IELTS) test and Observed Structured Clinical Examination (OSCE) in Oxford to gain Nurse and Midwifery

Council PIN numbers. Further training completed by the nurses included, chaperone, choking, ASER, climate injury, sepsis, telephone triage and disaster contingency.

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

Coordinating care and treatment

Practice staff attended meetings with the Chain of Command and the welfare team. Regular meetings included the quarterly Unit Health Committee and safeguarding meetings. In addition, affiliated staff we spoke with reported on good communication lines, and throughout the inspection it was clear that medical centre staff retained a detailed knowledge of their patients. Although the civilian staff members provided continuity, we highlighted a number of areas where coding and alerts would provide a more failsafe solution.

It was unusual for patients to leave the military from Nepal Combined Practice. However the Gurkha Welfare Trust was supported by the military although not part of DPHC. They picked up on Gurkhas who left the military from a UK post and returned to Nepal. Any patient leaving from a Nepal post would receive the same support as was provided in the UK. During the pre-release phase, the patient received an examination and a medication review. A summary print-out was provided for the patient to give to the receiving doctor, and a letter if the patient was mid-way through an episode of care. A few months' supply of medicine was given to those on repeat prescriptions to ensure that the transfer did not result in any gaps.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs when patients were referred or after they were discharged from hospital. Information was shared between services and we saw that a full copy of findings from investigations and any further treatment requirements were sent to the medical centre to update the patient's records. The system in Nepal was manual but effective in that a hard copy record of treatment provided in a hospital setting was given to the patient on being discharged. Due to the cultural sensitivities, the SMO utilised the Ghurka Major to liaise with hospitals or outside agencies as we were told this built relationships better than approaching them directly. Pregnant patients were repatriated to the UK from 22 weeks gestation. Initial scans could be arranged via Medicity in Nepal and the medical centre could book patients for blood tests. If the patient chose to stay in Nepal, they did so against medical advice and lost their entitlement to DPHC healthcare.

Helping patients to live healthier lives

The practice had a named lead and deputy for health promotion and used the DPHC programme to produce a structured programme of health promotion activity with additions that catered for local issues and awareness; an example was Dengue fever. The

programme was formatted into a yearly planner and calendar on the HcG workbook. Health promotion advice and guidance delivered by the clinicians was supported by strategically positioned information leaflets designed to target the most relevant cohort of patients. Quick review or 'QR' codes were utilised in reception to link patients to number of patient resources that included advice and guidance on cancer and sexual health. Staff had been involved in supporting health fairs and linked in with station health promotion work. The last health fair had been held in December 2023 and member from the medical centre team had attended with multiple stands to promote multiple topics that included smoking cessation, high blood pressure and sexual health.

The nurse at Pokhara had completed level 2 STIF training and provided sexual health screening, support and advice. The nurse at Kathmandu was in the process of completing level 1. Due to the small number of patients, there were relatively few patients presenting with sexual health concerns. The SMO was available for advice and reach back was available to the specialists in the UK via PANDO. Secondary care providers in Nepal offered sexual health services and access to sexual health consultants.

There was a higher prevalence of patients eligible for the over 40s health check due to the patient demographic. A total of 73 patients were eligible for this health screening designed to spot early signs of stroke, kidney disease, heart disease, type 2 diabetes or dementia. All of the eligible patients had been sent an invite to attend for a check and 53 had been completed. A monthly search on patients provided regular oversight, up to 3 invite letters were sent and these were supported by emails and telephone calls. Where any issues or abnormalities were identified, the SMO was tasked to review the patient.

The number of eligible women whose notes recorded that a cervical smear had been performed in the last 3-5 years was 86%. The NHS target was 80%. The practice nurses were not cervical cytology trained due to the low numbers of eligible patients that made it difficult to maintain currency. The incoming SNO was trained and current and the sample taking process was coordinated by overseas headquarters who when required, sent nurses from the UK to undertake screening.

Regular searches were undertaken to identify patients who required screening for bowel, breast and abdominal aortic aneurysm (AAA, a way of checking if there is a bulge or swelling in the aorta, the main blood vessel that runs from the heart to the stomach) in line with national programmes. At the time of the inspection, a small number of patients that met the criteria for screening had been identified. A recall system was in place that monitored uptake and those eligible were in-date for screening. AAA and colposcopy patients would be seen in the UK. Colposcopy patients were referred from the laboratory and the process overseen by the practice manager. Faecal immunochemical tests (FIT, used as a screening test for colon cancer) were not used in Nepal so eligible patients were encouraged to be screened whilst in the UK. Patients could be referred to a host nation secondary care health provider (Nepal Mediciti) for mammograms (screening for breast cancer). Reports were reviewed by the SMO, uploaded to DMICP and sent together with a paper copy to another military doctor in the UK for a second review. The same process was used for diabetic retinopathy (a complication of diabetes caused by high blood sugar levels causing damage to the back of the eye or retina).

Patients due a vaccination were identified when summarising patient notes. Force protection performance was high with vaccination statistics identified as follows:

- 100% of patients were in-date for vaccination against polio.
- 91% of patients were in-date for vaccination against hepatitis B.
- 94% of patients were in-date for vaccination against hepatitis A.
- 100% of patients were in-date for vaccination against tetanus.
- 98% of patients were in-date for vaccination against typhoid.
- 98% of patients were in-date for vaccination against MMR.
- 97% of patients were in-date for vaccination against meningitis. *
- 100% of patients were in-date with vaccination against diphtheria.
- 97% of patients were in-date with vaccination against Japanese encephalitis.
- 100% of patients had received one dose of the rabies vaccine.
- 98% of patients had received two doses of the rabies vaccine.
- 95% of patients had received three doses of the rabies vaccine.

* there was no requirement for the medical centre to undertake a pro-active catch up programme for permanent staff. However, they did a periodic vaccine recall and push in line with NHS guidance.

The percentages of civilian dependents vaccinated was lower. For example, 15% had not had any rabies vaccines, 9% had not been vaccinated against Japanese encephalitis and 23% of those eligible had not had their MMR vaccine.

Vaccination rates for civilians, including families were particularly low for rabies. The Green Book was clear that anyone staying in Nepal for more than one month should be risk assessed for rabies. There had been 4 incidents of dog bites on personnel in Pokhara (although these patients were attending a course and not DPHC BGN patients). We discussed this with the medical team and they explained that patients were advised to arrange vaccinations in the UK as part of their posting recommendation. However, some patients found that they were unable to access vaccinations in the UK (there was a shortage of both rabies and JE vaccines) and some patients chose not to be vaccinated. We also discussed some issues around the logistical supply chain for vaccines to reach Nepal:

- supply of vaccines with low expiry,
- transport delays at Donnington,
- transport delays at Brize Norton, and
- failed assurance around the cold chain in transit resulting in destruction of vaccines.

Consent to care and treatment

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. The recording of consent was made via the use of

templates or as free text and monitored through audits carried out by the SMO (although no documentation was available to show the findings). The chaperone training module included a section on obtaining and recording consent.

Clinicians had a good understanding of the Mental Capacity Act (2005) and how it would apply to the population group. Staff received training as part of their in-house programme. Assessments for all patients were made when consulting to ensure they had the capacity to make their own decisions and participate in discussion around their treatment and care.

Clinicians were aware of 'Gillick competence' and 'Fraser guidelines' (used to assess whether a child was mature enough to consent to treatment). Staff had not had an actual case where competence and guidelines were discussed but had completed training and could give examples of when an assessment should be made. The SMO stated that an assessment would be made on a case to case basis and that engagement would take place with the school councillor or welfare team (to help with an understanding of the wider cultural differences) if the child refused to involve a parent in their decision.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

In advance of the inspection, patients were invited to give feedback using comments cards. A total of 14 patients responded and feedback was positive. The overriding theme was that staff were caring and professional.

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

A continuous patient questionnaire had been in place but the number of returns was low. The practice manager carried out a review of the comments and the feedback was positive.

Involvement in decisions about care and treatment

Patients with caring responsibilities and cared for patients were identified through the new patient registration form and at new patient medicals. Patients identified as having a caring responsibility should have an alert on their notes and be captured on a DMICP register. However, a review of the records showed that the only patient coded as having carer responsibilities did not have an alert in place. Staff had knowledge of the patient as the list was so small but an alert would always be recommended to inform new staff or medical centres where the patient may move onto in future.

There was a carers' lead and deputy for the practice. Staff had access to a carers' policy and carers' register standard operating procedure. These included how to identify a carer, appropriate Read codes and support measures such as annual flu vaccinations. Carers' posters were displayed at both sites and encouraged those patients with caring responsibilities to identify themselves. However, there was no information for carers on the patient information leaflet.

Staff had no need for a translation service as only Nepali and English language was required. Signage within the waiting rooms was displayed in both English and Nepali.

Privacy and dignity

Screening was provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. Clinic room doors were closed during consultations.

The reception area was well laid out with the waiting area set back from the desk allowing conversations between patients and reception to be private and not overheard. If patients wished to discuss sensitive issues or appeared distressed at reception, they were offered a private room to discuss their needs. This was supported by signage adjacent to the main entrance (although this would better serve the need of a patient if on or at the reception desk). Telephone consultations were undertaken in private to maximise patient confidentiality. Calls were fielded in the main office that was behind the reception desk. There was a telephone on reception but a privacy screen was in place to promote privacy. The dispensary hatch could only accommodate one patient at a time and the door was closed when a patient was in attendance.

The staff team were in-date with their information governance training to ensure awareness when handling personal information.

The mix of male and female staff allowed the medical centre to facilitate patients who wished to see a clinician of a specific gender. If requests could not be met by the medical centre, they would be accommodated by signposting patients to a local contracted host nation provider. At the time of inspection, was a mix of clinicians with a female Senior Medical Officer and a male Senior Nursing Officer in Pokhara.

Are services responsive to people's needs?

We rated the practice as good for providing responsive services.

Responding to and meeting people's needs

The practice used an appointment system where patients could be seen in person or have a consultation by telephone. Home visits were not routinely offered but had been provided in rare circumstances when a patient was house bound through ill health or unable to attend the practice in person. Requests for a home visit were assessed by the Senior Medical Officer (SMO) or Senior Nursing Officer (SNO) on a case to case basis. The eConsult service was used to provide more convenient access to information and advice whilst prioritised patients in need of urgent care could be seen in person.

An Access Audit as defined in the Equality Act 2010 had been completed for the premises in March 2024. Actions identified in the audit had been progressed. These included signposting patients to a disability access toilet in the transit accommodation at Kathmandu and in Pokhara where there was no handrail in the toilet, a statement of need had been submitted to the Quartermaster. The building and surrounding area including the car park supported access for those with reduced mobility. The front doors were not automatic but clearly visible from reception. Inside the building, there was an accessible toilet and baby changing facilities.

There was no hearing induction loop available at reception but staff informed us that there had never been a requirement. Wheelchairs were available for any patient that may need support due to limited mobility.

Dependant on the patient's clinical need, the option of a telephone or face-to-face appointment or e-mail reply could be offered. The practice found this system to be effective for patients and a telephone call was the preferred method. Telephone consultations had become commonplace and a doctor's routine daily clinic was a mix of face-to-face and telephone conversations. Appointments for children (routine clinics) were being offered on set days and after 4pm to support the child's school attendance. This was implemented after parents had reported that having to take their children out of school to attend an appointment had impacted on their education. Patients having to attend a hospital asked if a member of the team could support them as they struggled during appointments as processes in Nepal were very different than the UK. The hospital liaison officer (HLO) now accompanied patients for appointments and feedback had been very positive as questions about funding/ onward referrals could be resolved quickly by the HLO. The HLO was also able to translate when required.

The practice had a diversity and inclusion (D&I) lead role filled by a member of staff at Pokhara. The practice managers at both sites had applied to complete a course tailored for D&I leads but British Gurkhas Nepal staff had been given priority. All staff had completed the mandatory D&I training and told us that patients were treated equally regardless of ethnicity, gender and age.

The practice had taken a number of measures to have a positive impact on the environment. During health promotions, leaflets had previously been printed off but these were now being sent digitally. Record keeping was also digitalised when possible to reduce the printing requirement. An energy warden was appointed for the buildings to ensure all lights were switched off when not in use.

Timely access to care and treatment

The practice opened Monday to Friday 08:00-16:00 hours although Wednesday afternoons were protected for training with only urgent appointments available. Clinics extended until 16:30 on a Tuesday and Thursday to accommodate routine appointments for children. Patients were able to use the eConsult for correspondence and these would be responded to the same day or the next working day. Medical cover was provided 24/7 by a nurse or Senior Medical Care Assistant. The standard operating procedure required each call to be relayed to the SMO except in the monthly respite period during which any urgent patients were signposted to the local hospital's accident and emergency department.

Details of how patients could access the doctor when the practice was closed were available through the patient information leaflet, from the guard room and were displayed on the main entrance to the buildings. These details included the duty telephone number to be used for the out of hours service, instruction on when to use the number and the process for assessment of medical requirement. Nevertheless we spoke with 2 patients in Pokhara who told us that they had not known that they could access care OOH at the medical centre and so had sought out care locally when ill at night.

There was good availability of appointments for all clinicians. Routine and urgent slots with a doctor or nurse were available on the day.

Appointments were offered outside of school hours to support families with children.

Listening and learning from concerns and complaints

There was a named lead and deputy for the management of complaints. The process followed was in accordance with the Defence Primary Healthcare complaints policy and procedure. Written and verbal complaints were recorded and discussed at the monthly practice meetings together with any compliments that had been received. As part of the healthcare governance, the practice manager submitted an audit to regional headquarters. Two verbal complaints had been recorded in the preceding 12 months and no trends were identified. We reviewed both of the complaints in detail. These had been managed appropriately and in accordance with policy.

Information was displayed in the patient waiting area and included a flow chart to detail the process when making a complaint. The complaints process was also detailed in the patient information leaflet.

Are services well-led?

We rated the medical centre as requires improvement for providing well-led services.

Vision and strategy

The medical centre worked to the Defence Primary Healthcare (DPHC) mission statement which was: "DPHC is to provide safe, effective healthcare to meet the needs of our patients and the chain of command to support force generation and sustain the physical and moral components of fighting power".

Nepal Combined Practice had written their own mission statement which was specific to their role on station. This was "to deliver Gurkha recruitment, provide local support to the soldier and ex-servicemen and maintain disaster resilience preparedness within resources, in order to ensure firm base operations in Nepal in support of UK Defence strategy".

Leadership, capacity and capability

A key feature for Nepal Combined Practice was that the Senior Medical Officer (SMO) post was a rotation position with a planned 4 month duration. The SMO had joined the medical centre in May 2024 and was the fifth different SMO in 2024. The civilian staff and Senior Nursing Officer (SNO) provided some continuity. Although this had not impacted service delivery, a number of governance issues presented a challenge. For example, the writing of annual staff reports and the continual updating of lead roles, policies and protocols. However the low number of patients allowed for more administration time.

The Pokhara team worked under the guidance and leadership of the Kathmandu SMO. The SMO was a short flight away which presented obvious challenges, nevertheless, the reception team at Pokhara worked hard to always advise patients when the SMO's monthly visit was approaching in case they needed an appointment. We spoke with 7 patients and received 13 comments cards from patients registered at Pokhara, they did outline the fact that the doctor in post changed very frequently. Several patients commented that they had seen 4 different doctors in the space of 5 months. Some patients confirmed that seeing a different doctor at each appointment meant that they needed to re-explain their history frequently and that they did not always feel that continuity of care was as seamless as it might be.

There was a comprehensive meeting structure that underpinned the governance structure and promoted an inclusive leadership approach. Staff we spoke with praised the leadership and this was echoed in the feedback from affiliated staff and patients.

The SMO was allowed 1 weekend in 4 as leave when the Senior Nursing Officer (SNO) provided clinical cover. However, the SMO remained contactable by telephone for emergency situations and doctor cover was available at Medicity private Hospital. The nurses deconflicted their leave and a temporary nurse would be provided to cover any longer period of absence, for example, to attend training. The practice manager and the

deputy practice manager covered each other during periods of leave and other absences to ensure there was always a constant managerial presence within the medical centre. Staff felt that the skills and capacity was sufficient to meet the needs of the patients. Tasks and lead roles were delegated throughout the team.

Job descriptions and terms of reference were mostly in place for members of staff. There was a list of roles and responsibilities which involved a wide range of staff and each lead had an appointed deputy. However, there was clarity required on who was responsible for reporting on staff. We fed back that the short-term SMO posting would make it difficult for them to manage underperforming staff (this could not be done by the practice manager as they were on the same grade as other staff in the practice). It was recorded by a previous SMO that they were not willing to write reports on individual staff members due to the short time spent working with them. There were no issues with staff performance but should this change, the timescales were likely to be too short for the SMO to manage the processes within their 4 month rotation.

Staff engaged regularly with the regional team and the working arrangements delivered both support and assurance. Staff commented that it proved a very useful resource for help and guidance. This included a fortnightly call between the practice manager and regional Warrant Officer. There was a monthly call for the nursing team with the Regional Nurse Advisor for overseas.

The number of long-term condition patients was very low therefore the nurses did not get much exposure. Regional headquarters (RHQ) were looking to rotate the nurses for a month every 2 years to give more exposure to chronic disease patients and experience of working out of hours (OOH). An initial date of June 2024 was being worked on. However, fewer patients allowed closer management and all were screened prior to arrival through the MASO (multiagency supportability overseas that included social worker, chain of command, medical and education) that decided if the patient was supportable (the ultimate decision lay with the Chain of Command who would facilitate the move back to the UK if that was decided). Reach back available through PANDO and through RHQ who could link to a specialist outside or someone within DPHC. For example, for women's health.

RHQ support included a monthly senior nurse meeting (laid on in the morning and afternoon to allow for the time zones). This had been implemented early 2024 following a feedback request from singleton posts. There were quarterly meetings chaired by the Regional Healthcare Governance (HcG) Lead and Regional Operations Manager, these were attended by the SMO, SNO, practice manager and medical care assistants. The SMO was single-handed so RHQ were developing links with Brunei Medical Centre to build resilience into the practice. The Regional Warrant Officer conducted a one to one meeting with the practice manager fortnightly and the Regional Pharmacist supported staff in the dispensary. Visits from BGN Command were coordinated so that they were joint visits with RHQ. The visit in early 2023 led to the change in SMO working pattern with the introduction of the one in 4 weekends off.

Culture

Staff were consistent in their view that the practice was patient-centred in its focus.

We heard from staff that the culture was inclusive with an open-door policy and everyone having an equal voice, regardless of rank or grade. All were familiar with the whistleblowing policy and said they would feel comfortable raising any concerns. A poster was displayed on the staff noticeboard and included contact details for external contacts. Throughout the inspection it was clear that there was a strong team ethos supported by joint training across both sites and regular social events. Wednesday afternoons were protected for personal development and sport. In addition, there had been a sports and development week held at Pokhara in April 2024. Individuals spoke highly of the time they had spent together and the event was used as an opportunity for the staff across both sites to develop professionally and integrate as 1 team.

Meetings were inclusive with all staff encouraged to attend. Staff felt involved in decisions made and were comfortable in raising any concerns or issues within their department. Group team building exercises were held regularly.

Processes were established to ensure compliance with the requirements of the duty of candour, including giving those affected reasonable support, information and a verbal and written apology. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. We were provided with examples of when duty of candour had been applied. It was a standing agenda item at the healthcare governance meeting and a duty of candour log was kept on the HcG workbook.

A Pandit was available to work with serving personnel and their families to provide cultural and spiritual support, lead on morning and evening prayers and worship as well as visiting family homes.

Governance arrangements

An understanding of the performance of the practice was maintained. The system took account of medicals, vaccinations, cytology, summarising and non-attendance. The last Healthcare Governance Assurance audit took place in May 2023 and an overall grading of 'limited assurance' was achieved. A management action plan was formulated after the visit which defined and allocated lead roles and deputies which supported the rotation of SMO and SNO. For example, the permanent practice nurse became the healthcare governance lead for continuity. The practice manager took on the Caldicott lead from the SMO to provide continuity of reporting.

The HAF (electronic health assurance framework) was used to document and evidence governance activity and had been extensively populated by the practice management and other key staff members.

The Regional HcG Lead had provided a plan of tasks that required completion and this was broken down by frequency. The practice manager used the plan as an aide memoire and marked as completed so that regional colleagues had visibility.

There was a clear staffing structure in place and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. Terms of reference (ToR) were mostly in place to support job roles (an update was taking place with the

change of the SMO), including staff who had lead roles for specific areas. Resilience was provided by appointed leads having named deputies who were sufficiently trained to deputise.

We highlighted that the out of hours (OOH) assessment protocol required review to ensure that only staff with the appropriate skills, qualifications, experience and current competency could assess patients. The protocol should accurately reflect when patients should be referred to the SMO OOH and state the arrangements for who can see children OOH. An entry must be made into DMICP on every occasion that a patient makes contact OOH, and this must outline the concern reported and any treatment given.

All staff had access to the HcG workbook which included various registers and links such as the risk register, ASER tracker, duty of candour log, IT faults and cleaning issues log. A range of information was accessible through quick links from the HcG workbook. These included a standard operating procedure and policy index. The workbook was continually being developed and was managed by the SNO, practice manager and deputy practice manager.

An audit programme was in place and we saw examples of both clinical and administrative audits where repeat cycles were carried out to monitor standards and quality. Action plans were drawn up from audit. For example, an action plan was produced after each IPC audit. Learnings from a scanning audit resulted in file naming and dates being added to allow you to process the documents in chronological order.

A range of meetings with defined topics for discussion were held to ensure a communication flow within the team. The practice had a designated meeting matrix in place which included the following:

- Monday morning brief for all staff.
- Monthly meeting (practice manager led with Pokhara staff joining using Microsoft Teams).
- Healthcare governance meetings held monthly (discuss risk, ASERs, alerts, equipment care, safeguarding).
- Monthly clinical supervision nursing meetings internal and a monthly regional nurse meeting.
- Monthly peer to peer support for the SMO with the SMO in Brunei (commenced in April 2024).
- Unit healthcare meeting held quarterly.
- Safeguarding meeting held quarterly or sooner if needed.
- In-house training held (protected time allocated weekly on a Wednesday afternoon).

A weekly huddle was held on a Monday morning to discuss updates on a day to day basis. A task tracker sets a plan for the coming days. Discussions included staffing, training, communications, IT issues, current and future exercises. This was led by the practice manager at Kathmandu and deputy practice manager at Pokhara.

The practice manager had a fortnightly call with the Regional Warrant Officer and informal peer to peer discussion with the practice manager in Brunei.

Managing risks, issues and performance

Processes were in place to monitor Central Alerting System (CAS) alerts and equipment safety alerts and incidents. The practice received a monthly ASER newsletter to share learning across the region. The Regional HcG Lead held a quarterly regional healthcare governance meeting where ASERS were a standing agenda item.

An effective process to identify, understand, monitor and address current and future risks including risks to patient safety was in place. Risks were actively monitored internally and managed in line with DPHC policy and through the ongoing review and revision of a risk register held on the HcG workbook. However, the risk register did not follow the standard DPHC format. Risks that had been transferred had no reference numbers for the risk register of the new risk holder. Quarterly risk management meetings were held and any new risks together with the top 3 risks were discussed at the monthly HcG meetings. We highlighted that some risks should be escalated when appropriate to the Chain of Command, DPHC or beyond. An example was vaccine supply which we recommended was highlighted to the Chain of Command. We also fed back that there could be more clarity in the way risks were written and this would support better risk scoring. The practice manager was about to receive training which would facilitate improvement.

A business continuity and disaster medical plan was in place and reviewed annually as a minimum. The plan was available for remote access and to all staff through inclusion on SharePoint. A tabletop exercise to test the response to a major incident was included as part of the 2023 medical centre team building activity. In 2024, a combined response was included as part of the annual training and development week (held in May 2024 at Pokhara).

Appropriate and accurate information

Quality and operational information was used to ensure and improve performance. The DPHC electronic health assurance framework (referred to as HAF) was used to monitor performance. The HAF is an internal quality assurance governance tool to assure standards of health care delivery within defence healthcare.

There were arrangements at the medical centre in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. The DPHC information courses for protecting personal data, information and knowledge awareness and record management awareness were part of the mandatory training for all staff (all staff were in date with their mandatory training).

Engagement with patients, the public, staff and external partners

The practice had been utilising the new DPHC patient feedback survey introduced in January 2024. However, at the time of inspection, there had only been 6 patients return with feedback. The questionnaire was promoted through routine orders, QR codes in reception and through the families welfare clerk who had posted in the WhatsApp group.

A 'you said, we did' display was documented on a noticeboard in the waiting area. An example was the request for air conditioning in the patient waiting area. A statement of need had been produced and evidence produced to show that temperatures exceeded what is seen as the acceptable level (25 degrees Celsius) so the request was to be resubmitted through the health and safety perspective now that summer months were in. This request had also been made at Pokhara. Efforts had been made to establish a patient participation group (in conjunction with the Regional Clinical Director (RCD) visit where face to face meeting was offered) but there had been a lack of interest among patients. However this had been done during the recruitment period so the practice planned to repeat at least annually. Patients had fed back that conversations in the practice manager's office could be heard in the SMO's room as there was a door between the rooms. The door has been blocked up to make both rooms quieter and maintain confidentiality.

Good and effective links were established with internal and external organisations including local host nation healthcare providers, the Regional DPHC team, and the welfare team. Working relationships were being developed with Brunei Medical Centre to provide opportunities for peer support and sharing of good practice. Doctors received 360 degree feedback as part of their appraisal process. The nurses said they used visits from the Regional Nurse Advisor and RCD as opportunities to give feedback.

Continuous improvement and innovation

We identified that the medical centre had an audit programme improvement and a quality improvement project (QIP) programme that were driving improvement. Examples included:

- The exposure to air pollution audit resulted in a Read code added to any patient who had been in Kathmandu for 6 months or more to keep track of the long-term effects.
- The 'G1 to G9' weekly huddle (G1 to G9 is military term for the categories such as personal and administration, intelligence and security, current operations and exercises, equipment and logistics, future operations and exercises, communication information system, training, resources and finance, policy and media).
- After action reviews implemented, to be conducted after any significant event or ASER. This resulted in credit letters being placed in the emergency Bergens and on the crash trolley as a safety net in case the patient was unable to provide payment at the hospital.
- Use of the PANDO application to provide a remote physiotherapist consultation with the patient and nurse in Kathmandu, SMO in Pokhara and physiotherapist in the UK.

- An OOH register had been introduced so that all calls were recorded. This is updated by the clinician receiving the call and then discussed at the Monday morning huddle. There were plans to audit the data in 6 months to identify any trends or patterns in patient presentation and to review the appropriate management of OOH calls.