ESBA Combined Medical Practice

Dhekelia Medical Centre, Dhekelia Station, BFPO 58

Ayios Nikolaos Medical Centre, BFPO 59

Defence Medical Services inspection report

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information given to us by the practice and patient feedback about the service.

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

Contents

Summary

About this inspection

We carried out an announced comprehensive inspection of Dhekelia Group Medical Practice on 25, 26 and 31 July 2023. The practice was rated inadequate overall, with a rating of inadequate for the safe, responsive and well-led key questions. The effective and caring key questions were rated as requires improvement.

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

https://www.cqc.org.uk/dms

We carried out this announced comprehensive inspection of the Eastern Southern Base Area (referred to as ESBA) Combined Medical Practice on 26 and 27 June 2024. The name of the practice had been changed since the initial inspection in July 2023.

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

Are services safe? – good

Are services effective? – good

Are services caring? – good

Are services responsive to people's needs? – good

Are services well-led? – good

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

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

At this inspection we found:

- Feedback was routinely sought from patients about the service. It showed patients were treated with compassion, dignity and respect. Where possible, patients were involved in decisions about their treatment and care.
- The service had developed to form a 'Combined Medical Practice'. Patients residing at Ayios Nikolaos expressed concern about the loss of services at the medical centre

there. The senior leadership team regularly engaged with patients and with the Commanding Officer to ensure patients were involved in the change process and future development of the service. Clinics at Ayios Nikolaos Medical Centre had increased based on patient feedback.

- Effective safeguarding arrangements were in place. Practice staff worked collaboratively with internal stakeholders, including the welfare team, SSAFA (Armed Forces charity) and the Department of Community Mental Health.
- The arrangements for managing medicines, including obtaining, prescribing, recording, handling, storing, security and disposal minimised risks to patient safety.
- The practice was well-led and the leadership team had the vision, capability and commitment to provide a patient-focused service. At the time of the inspection, staffing levels were adequate. The leadership considered succession planning to ensure sufficient capacity and capability.
- The electronic organisational-wide system (referred to as ASER) was used to record significant events, incidents and near misses.
- DMICP (patient electronic clinical record) was not consistently reliable and was slow to upload eConsults.
- Quality improvement was embedded in practice, including various approaches to monitor outputs and outcomes used to drive improvements in patient care. There was scope to develop clinical audit based on population need.

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

- A drop-in cervical screening clinic was recently held at both medical centres. No appointment was needed and patients could just turn up for a smear test. This offered patients an alternative option especially if they were out-of-date for a smear. Five people attended and had a smear test.
- Prison healthcare had been extensively revised in line with National Institute for Health and Care Excellence guidance and key performance indicators for healthcare in prison. Each prisoner received a range of medicals. Within the first 24 hours of arrival any immediate medical needs were met, including screening for substance dependency and blood borne viruses The second level medical considered routine medical needs and the third level reviewed any long-term health needs, such as screening and over-40 health checks. Prisoners with a long-term condition were monitored and recalled using the same system for the practice patient population.

  Many of the prisoners already had access to a specialist on the island so, where appropriate, practice clinicians liaised with the prisoner's existing healthcare providers. A stakeholder group was held monthly and the health of all prisoners was discussed. Sovereign Base Area police were invited to join the later part of the meeting to discuss any concerns. When released, prisoners received a release medical and care summary and a 7 day supply of medicine.

  A prison healthcare local working policy for clinical supervision and support was being developed with the input of the Royal College of Nursing Professional Lead for Justice

and Forensics. Two members of staff were awaiting a start date for a World Health Organisation endorsed international training course bespoke to overseas prison healthcare.

- Due to the location and climate, there was a high risk of heat illness. To ensure patients received care in a timely and safe way, the practice created a 'heat illness grab bag' with all the equipment needed to treat the patient. This included the full kit for taking blood and pre-written blood test request forms. This was raised as a quality improvement project in February 2023.
- After each in-service training session, staff were asked to provide feedback on the training session. This was facilitated using a quick reference or QR code. It meant those presenting the session could review the material and delivery based on feedback to ensure the training was of the best standard.

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

- Review DMICP access with a view to the provision of DMICP Fixed to improve access, functionality and to minimise risks with the delivery of safe and effective patient care.
- Clarify the training requirements for staff treating children so it is consistent across all DPHC services.
- Provide direction as to how the practice should proceed with managing patients eligible for bowel screening.

The Chief Inspector recommends to the practice:

- Ensure all military staff new to line managing civilian staff complete the mandatory 'Civilian Line Management fundamentals' training.
- Ensure the plan to address the backlog with summarisation is addressed in a timely way.
- Continue to engage with patients so they are involved with the development of the 'Combined Medical Practice' and have the opportunity to share their views. Consider introducing a patient newsletter so information about changes and developments reaches a wider audience.
- Continue to pursue the inclusion of a deep clean within the environmental cleaning contract.
- Review the process for monitoring the serialised tag for the crash trolley to ensure it is reliable.
- Consider developing quality improvement activity further with an emphasis on clinical audit based on population need.
- Liaise with the author of the major incident plan to ensure contact details are up-to-date on the plan.

Dr Chris Dzikiti

Interim Chief Inspector of Healthcare

Our inspection team

The inspection team included 2 CQC inspectors and a range of specialist advisors - a primary care doctor, practice manager, practice nurse, pharmacist and physiotherapist.

Background to ESBA Combined Medical Practice

Located in the ESBA of Cyprus, ESBA Combined Medical Practice comprises 2 medical centres approximately a 25-minute drive from each other. Dhekelia Medical Centre is the main practice with Ayios Nikolaos Medical Centre identified as a satellite practice. All clinical services are based at Dhekelia Medical Centre and support the satellite practice on a sessional basis. There is a dispensary and Primary Care Rehabilitation Facility (PCRF) at Dhekelia Medical Centre. The PCRF offers a bi-weekly outreach gym-based clinic for military service personnel and the dispensary offer daily prescription collection at Ayios Nikolaos Medical Centre.

The practice provides a routine primary care and rehabilitation service to a combined patient population of approximately 2,400 comprising service personnel, families, dependents and contractors. Occupational health is provided for service personnel and Ministry of Defence civil servants. The practice provides prison health care to HMP Dhekelia. In addition, clinicians can be called upon to review the healthcare of refugees landing nearby.

Secondary care is provided primarily through a contract with the American Medical Center for non-acute care. Emergency care is generally provided through Nicosia General Hospital. Other government hospitals are sometimes used, including Larnaca General and Famagusta General in Paralimni. Patients can also be referred to the UK healthcare services if required.

Dhekelia Medical Centre is open from 08:00 to 16:00 hours Monday to Friday. A clinic and prescription collection is available at Ayios Nikolaos Medical Centre on a Tuesday and Thursday from 08:00 to 12:00 hours. Prescription collection only is available Monday from 13:30 to 15:30 hours and on Wednesday and Friday from 10:00 to 12:00 hours.

Outside of opening hours, including weekends and public holidays, cover is provided by the 112-ambulance response; the equivalent of NHS 111 for urgent healthcare advice.

The staff team

Medical team	Military Senior Medical Officer Military deputy Senior Medical Officer

	Military Unit Medical Officer 0.6 whole time equivalent Civilian Medical Practitioner – currently on extended leave Military General Practice Trainee
Nursing team	Military Senior Nurse Officer Military Nurse Warrant Officer Three military corporal nurses (OR4) Military corporal nurse (OR4) – vacant post Three civilian Band 6 nurses Five locum Band 6 nurses
Medics	11 Combat Medical Technicians (CMTs) – DPHC 4 x CMT OR3 1 x CMT OR2/3 1 x CMT OR4 1 x RN MA OR4 - Vacant Post 1 x RAF Medic OR4 1 x RAF Medic OR2 1 x CMT OR6 – Vacant Post 2 x Paramedics OR4
Practice management and administration	Military practice manager Chief Administration Officer Five administrators 0.5 administrator (currently onboarding)
Pharmacy	Civilian Band 5 pharmacy technician Military Sergeant OR5 pharmacy technician
PCRF	Military OC PCRF (lead physiotherapist) Civilian Physiotherapist – locum filled 1.5 x Military Exercise Rehabilitation Instructor

Are services safe?

We rated the practice as good for providing safe services.

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

- health, safety and risk management
- management of incidents and significant events
- staff recruitment and working hours
- information to keep people safe
- chaperone training
- safeguarding vulnerable patients
- medicines management
- deep clean of the premises
- safety of the building.

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

Safety systems and processes

The Senior Medical Officer (SMO) was the overall lead for adult and children safeguarding. The Senior Nursing Officer (SNO) was the lead for adult safeguarding and the deputy SMO (DSMO) was the lead for children. Staff had completed safeguarding training at a level appropriate to their role, including physiotherapists who were trained to level 3 as they treated children and young people. The exercise rehabilitation therapist (ERI) based at Ayios Nikolaos had completed level 2 as they did not treat patients under the age of 18. The practice safeguarding policy was reviewed in May 2024.

Vulnerable patients were identified during consultations, DMICP monthly searches and through referrals from other units, such as the welfare team or SSAFA. In Cyprus, SSAFA provides community services through a contract with Headquarters British Forces Cyprus (BFC). The SSAFA team included health visitors, a school nurse and midwife. Safeguarding information was available for staff reference, including a local working policy (LWP), referral process flow chart and links to relevant agencies. Lists of vulnerable patients were held on DMICP documents.

It was evident from discussions with staff that a multi-disciplinary team (MDT) approach was taken in relation to the safeguarding of vulnerable patients. Staff regularly engaged with safeguarding services, particularly the British Forces Social Work Service (referred to as BFSWS) team. Concerns could be reported to the practice safeguarding leads or, if specifically related to a child, it could be discussed with the safeguarding lead in the SSAFA team based at Dhekelia Medical Centre.

A safeguarding meeting was held once a month at which patients were discussed and the register for vulnerable patients updated. In addition, a monthly Medical-Welfare-Pastoral meeting was facilitated and was attended by all doctors with a practice nurse represented. Alerts on individual DMICP records were applied so staff could identify if a patient was

vulnerable. The SMO attended the Unit Health Committee meetings, at which vulnerable patients were also discussed.

We spoke with representatives from the welfare team and the Padre. They described good relationships with practice staff and provided an example of how the services worked together to support a patient in crisis. The patient was seen immediately by a clinician and a plan of care put in place without delay.

We reviewed 10 clinical records where safeguarding concerns had been raised and all met the standards expected. The concerns were promptly escalated to the social work team, clearly documented and an MDT held within a week. Alerts were placed on the records of all family members.

The chaperone policy was reviewed in May 2024. Information highlighting the availability of chaperones was displayed in clinical rooms and also outlined in the practice information leaflet. Clinical staff acted as chaperones and had received update training in November 2023 and again in July 2024. The offer and/or use of a chaperone was recorded in the patients' records we reviewed.

Primary Care Rehabilitation Facility (PCRF) staff were not trained as chaperones so used a chaperone from within the practice team if needed. We noted that the offer of a chaperone was not being documented in the PCRF clinical records and raised it with the OC PCRF. Since then, clinical codes had been added to the DMICP synonym (short cut to standardise clinical activity) and the OC PCRF said they would ensure all staff were made aware.

Although the full range of recruitment records for permanent staff was held centrally, the practice could demonstrate that relevant safety checks were undertaken at the point of recruitment, including formal safety checks to ensure staff were suitable to work with vulnerable adults and children. The majority of staff had an up-to-date current English Disclosure and Barring Service (DBS) check. The DBS checks had expired for a staff member. In the interim whilst awaiting an updated check, a line manager's risk assessment had been completed to ensure the staff member could continue to work in the service. A process was in place to monitor the professional registration of clinical staff and all were in-date at the time of the inspection.

An infection prevention and control (IPC) policy was in place. One of nurses was the lead for IPC and was awaiting confirmation as to whether they had been accepted onto the link IPC practitioner training in September 2024. A deputy IPC lead was also identified. The IPC management log included links to all completed audits and ongoing actions including replacement clinical waste bins, wall mounted hand hygiene dispensers and examination couches. It was highlighted on the issue register that new kit can take an extended period to arrive on the island.

An environmental cleaning contract was established for the practice and a detailed cleaning schedule was in place and displayed throughout both medical centres. At Dhekelia Medical Centre, cleaning staff worked from 07:00 to 14:00 hours each day when the practice was open. Rotational cleaning of critical areas was undertaken throughout this time frame. A process was established to confirm cleaning had been carried out in accordance with the schedule. The IPC lead advised that a formal deep clean of the premises was not included in the cleaning contract. The Nursing Warrant Officer (deputy SNO) was liaising with the Quarter Master regarding this omission. Cleaning standards were monitored by the SNO and practice manager. The cleaning supervisor attended

Dhekelia Medical Centre once a week for spot inspections. A standards questionnaire was completed and signed off by practice manager. The ERI monitored the cleaning in the PCRF and liaised with the cleaning team if there were any concerns.

The medics oversaw clinical waste, which was secured, labelled, and stored safely in containers outside of the buildings. The contract provided for waste to be collected every 2 weeks. A clinical waste register was maintained and consignment notes were up-to-date. The last annual healthcare waste audit was undertaken in August 2023.

Risks to patients

The doctors reported sufficient staffing levels to meet the needs of the patient population. Now that the practice was fully staffed, there was adequate clinical provision during working hours and out-of-hours. Locum cover was sought for significant gaps in the doctor's rota. The Regimental Medical Officer (RMO) was integrated in the rota alongside the Defence Primary Healthcare (DPHC) doctors.

The medics team was established for 13 staff. At the time of the inspection, there were 11 medics in post. The medics we spoke with said they did not work over their contacted hours and had sufficient downtime following a 24-hour on call shift. They said they felt well supported by the duty doctor especially out-of-hours.

PCRF staff reported sufficient staffing levels at the time of the inspection. The PCRF faced varying clinical demands throughout the year depending on the battle rhythm of the units. If clinical demand increased, the OC PCRF's management time decreased to focus on clinical demand. Maintaining a detailed key performance indicator tracker supported the OC PCRF to plan effectively and provided evidence of increased clinical need if staff reduced. Increased demands on the PCRF had been raised to DPHC. An island-wide memorandum of understanding (MOU) supported a cross-cover of PCRF clinics depending on demand. A local MOU was in place with the unit at Ayios Nikolaos for access to 0.5 ERI time.

Despite a reliance on locums, the nurses reported sufficient staffing levels to meet the needs of the patient population. The nursing team provided a 24-hour a day, 7 day a week service due to the out-of-hours provision. Where possible nurses were only allocated 1 set of night shifts a month and 1 working weekend a month.

Recognising the limitations with appointing nurses who were related/connected with service personnel posted to Cyprus, the practice had been successful in securing a UK National nursing post (referred to as UKN). This meant recruitment to the UKN post was based on experience and skill rather than recruitment because of where their military partner was posted.

The prison healthcare system had been extensively revised since the last inspection. This had been undertaken in line with national guidance for prison healthcare. A prison healthcare LWP was being developed with the input of the RCN Professional Lead for Justice and Forensics. A stakeholder group was held monthly and the health of all prisoners was discussed. Sovereign Base Area police were invited to join the later part of the meeting after to discuss any concerns.

Staff were aware of the location of emergency medicines and evidence confirmed the medicines in the medical emergency kits were checked monthly. An automated external defibrillator (AED) was held in the Garrison gym and this was checked daily by the gym physical training instructor. We carried out a stock check and all medicines and medical consumables were in-date. At Ayios Nikolaos Medical Centre some of the emergency medicines were in the process of being ordered based on the emergency medicines risk assessment. Emergency medicines were held in an emergency medicines bag that was secured with a serialised tag. A decision had been made not to hold all the mandated medicines at Ayios Nikolaos Medical Centre and this had been risk assessed by the overseas Regional Clinical Director.

The oxygen cylinders were full and in-date. Appropriate signage was displayed on the doors holding the oxygen and other gases. The external gas store had a no smoking sign displayed. A regularly calibrated blood glucose monitor was held with the emergency kit and control test solutions were in-date.

The emergency trolley was secured with a serialised tag and there was a log for access to the emergency trolley. On the day of the inspection, the serialised tag for the crash trolley did not correspond with the serialised tag in the logbook; we highlighted this to staff at the time of the inspection. Evidence was seen that ambient temperatures were monitored.

The staff team was up-to-date with training in emergency procedures, including basic life support (BLS) and the use of an AED. BLS training was delivered by the lead paramedic who had completed immediate life support training. Two members of the staff team were trained in paediatric immediate life support (PILS) and one of the staff was trained in newborn life support. All 8 paramedics were trained to provide PILS.

A programme of daily practice-based scenario training had been introduced to support all staff with improving their knowledge and skills. This was delivered by a variety of staff including paramedics, speech and language therapists and SSAFA personnel. Training involved a wide range of topics, such as a medical emergency, a specific injury, heat injury, a specific medicine or a case study. Training in medical emergencies in the last 12 months included obstetric emergencies, choking and anaphylaxis. The team completed sepsis training in June 2024. We reviewed the medic scenario-based training log at time of inspection. It was well maintained and the variety of training was within their scope for primary healthcare and Pre-Hospital Emergency Care (PHEC).

Due to the location and climate, there was a high risk of heat illness. To ensure patients received care in a timely and safe way, the practice created a ‘heat illness grab bag’ with all the equipment needed to treat the patient. This included the full kit for taking blood and pre-written blood test request forms. It was raised as a quality improvement project in February 2023.

Information to deliver safe care and treatment

Unlike UK-based Defence services that use DMICP fixed (F), services in Cyprus used a version of DMICP referred to as DMICP deployed (D). DMICP (D) permits access to medical records for a specific patient population but does not provide a live view of the medical record. Therefore, when records are accessed in either DMICP (F) or DMICP (D) there can be a time lag before the medical information is fully viewable in the other clinical

setting until synchronisation has occurred. The practice had the ability to switch to DMICP (F) if DMICP (D) failed. An unexpected DMICP (D) failure this year meant Defence health care services across the island had no access for 7 days. The practice deferred to the business continuity plan and the use of DMICP (F) was initiated to ensure continuity of care. Patients we spoke with complained about eConsult not being responded to in a timely way. The SMO explained that DMICP (D) was slow to upload eConsults.

Once a month a generator test was held where DMICP was lost and the practice managed on a case-by-case basis. Paper forms were available for use during the outage, which were later scanned onto the system.

In line with a recent policy change, DMICP permissions were set to allow the ERI the same DMICP rights as physiotherapists, which meant both physiotherapists and the ERI could see the same medical record. Previously, the ERI in post had been given the same permissions due to patients with heat illness referred directly by the doctor to the ERI in accordance with policy.

A backlog of summarising was well recognised by staff and confirmed by a notes summarisation audit. This backlog was captured on the issues register. For civilian patients, 408 sets of clinical notes were outstanding for summarisation and 262 for service personnel. The audit acknowledged that addressing the backlog would be a time consuming and a lengthy process. Senior nurse leaders were overseeing the issue and had a plan in place to reduce the backlog. The audit recommended protected time was provided for the nursing team to complete this task and consideration to involving doctors and medics with the summarisation process.

We reviewed a wide range of DMICP records. Overall, we found record keeping was of a consistently good standard. Arrangements were established for the regular peer review/auditing of clinical record keeping for all clinical staff groups. A comprehensive clinical records audit has been undertaken that involved a review of 6 records for each doctor, including the SMO. The findings were discussed at a clinical meeting and no significant gaps were identified. The audit showed that recording the offer/use of a chaperone could be improved on.

The OC PCRF had completed a clinical notes audit for the physiotherapists and the ERIs. No safety concerns were identified from an audit of nursing records. All consultations had a relevant clinical code and all patients had an appropriate plan in place. It was identified that improvements could be made with documenting consent. This was discussed with the nurses at the monthly audit meeting. The consultation notes for medics were peer reviewed by the duty doctor. In addition, a process was in place for one of the senior nurses to routinely review the record keeping for medics.

Two dedicated administrators managed the referrals to Cypriot secondary care services and referrals back to the UK. A referrals flow chart was in place for doctors and the administrative referral team so all were clear about the various referral pathways. The referral team outlined a comprehensive system to monitor the throughput and status of referrals. Colour coding was used to indicate the different stages of referral, including urgent referrals. All urgent referrals had received an appointment within 2 weeks of the referral being made.

A display about secondary care at both medical centres provided patients with necessary information including a QR or quick response code for patients to view or change their appointment. How to provide feedback on secondary care services was illustrated along

with the transport shuttle timetable for both medical centres to the American Medical Centre, the main provider of secondary care on the island.

Once a referral was made in the UK for a patient then the Aeromedical Evacuation (AE) team was contacted. The Digital Aeromed Referral Platform was used to initiate and monitor AE. Two medics oversaw AE and they had effective relationships and good lines of communication with the AE team based in the UK. We noted that a total of 110 AEs had taken place between January 2024 and June 2024 and all had gone well without undue delays.

The PCRF maintained a detailed referral tracker, which was checked regularly as part of preparation for unit health committee meetings.

A process was established for the management of samples. In the absence of access to Pathlinks, the sample handling LWP was comprehensive to minimise the risk of error. All samples sent to the laboratory were added to the traceability tracker. Results were received via email. The nurses monitored for emails and marked off the tracker when results were received. Results were scanned to DMICP, tasked to duty doctor for review/action and forwarded to the original requestor. Receipts were given to patients when samples were taken and patients could contact a dedicated telephone line for their results. Not having access to Pathlinks was identified on the risk register. A significant event was raised when results were scanned to the incorrect patient's record. Due to the risk of further errors, a 10% audit of results was implemented and completed each month.

Safe and appropriate use of medicines

The SMO was the lead for medicines management with the day-to-day management and working practice of the dispensary delegated to the 2 pharmacy technicians. The terms of reference for both the SMO and technicians were reviewed and signed in June 2024. An LWP was in place for medicines management, including access to the dispensary and controlled drugs (medicines with a potential for misuse) cabinet.

A bound book held in the dispensary was used to record the receipt and supply of the FMed296 prescription forms. Forms received were stored in the dispensary and the serial numbers of the first and last FMed296 were documented in the book. We observed that FMed296 prescriptions were issued by serial number and clinicians had signed and dated the receipt of prescriptions. The technicians planned to undertake a 6 monthly check of the Fmed296 in July 2024.

Patient Group Directions (PGD), which authorise nurses to administer medicines, had been signed off by the SMO. Staff who used PGDs were signed off by the regional pharmacist to confirm completion of PGD training. All PGD stock was held in the dispensary. PGD unit audits and individual audits had been completed and no concerns were identified. We undertook a spot check of the over-labelled medicines used for PGDs and all stock was correctly accounted for with the exception of the salbutamol inhalers. There were 24 inhalers in stock but only 23 accounted for on DMICP. The pharmacy technicians said they would review this after the inspection. A spot check of vaccines showed all were correctly accounted for. Rolling stock checks were completed for primary care treatment medicines and the vaccines. Patient Specific Directions were not used. Two non-medical prescribers were working at the practice.

Staff confirmed that all repeat prescriptions were requested by email, via the patient submitting a repeat slip or through eConsult; no repeat requests were completed by telephone. Our spot check of the dispensed repeat prescriptions found that all repeat prescriptions had been dispensed within 8 weeks. This demonstrated that the pharmacy technicians were effectively informing patients that their prescriptions were ready for collection. Furthermore, they were efficiently returning uncollected medicines to stock if they were not collected within 8 weeks. We noted that detailed DMICP entries were created by the pharmacy technicians when they were processing repeat prescriptions.

The pharmacy technicians had a good awareness of their responsibilities and knew when requests should be tasked to a senior clinician. They only re-issued repeat prescriptions if the patient's review date was current and there were available repeat counts on the patients prescribing record. The process for handing out prescriptions to patients was discussed and witnessed and was in-line with the organisational guidance. The dispensary held appropriate information cards for various medicines. Evidence was seen of comprehensive medication counselling when patients were given their prescriptions, including patients being informed of the patient information leaflet in the medicine's container.

From discussion with clinicians and a review of patient records, we were assured that patients' medicines were appropriately reviewed, including treatment and clinical medicine reviews. All entries had been clinically coded.

There were well defined processes in place for the ordering and receiving of vaccines. All vaccines were in-date and the vaccines were being correctly rotated in the pharmaceutical fridges. There was sufficient space around the vaccine packages for air to circulate. No food or specimens were held in the pharmacy fridges. The temperature of the fridges was monitored twice a day when the practice was open. In addition, fridges were checked out-of-hours through the window at 3 hourly intervals. The external thermometers were in-date. We checked 5 different vaccines and noted stock levels were correct in accordance with DMICP.

We carried out a spot check of prescription only medicines and vaccines and all items were in-date. Stock was effectively managed as medicines with the shortest time expiry were placed at the front of the shelf. Time expiry reports were being run one month in advance and stock due to expire within the month was separated from the main stock to minimise the risk errors. Evidence was seen that all prescriptions were signed before they were dispensed by the pharmacy technicians.

Controlled and accountable drugs (CD/AD) were kept in the dispensary in a controlled drugs (CD) cabinet. Schedule 2 and 3 medicines were kept within the inner compartment of the CD cabinet. A spot check of physical stock, DMICP and documentation in the BMed 12 register found the accounting of CD/ADs was accurate. Documentation in the BMed 12 was clear and legible and in accordance with organisational policy. The specimen signature log had been completed accurately by all those involved in the accounting of CD/ADs. Internal monthly and external quarterly checks were being completed in line policy. Evidence was seen that the annual CD audit, the letter of delegated authority and the annual self-declaration had been completed.

The dispensary had a CD/AD key safe log and a key safe to keep the keys in the dispensary. The CD keys were kept separate from the dispensary keys. There was a CD access process if the CD cupboard needed to be accessed out-of-hours. A review of the

recent destruction certificate confirmed that CD/ADs were being destroyed in accordance with policy. The pharmacy technicians confirmed they would use the updated destruction certificates the next time controlled drugs were destroyed.

The high risk medicines (HRM) register supported the safe and comprehensive management of patients prescribed an HRM. Appropriate HRM and shared care alerts was evident on the patients' DMICP records. Appropriate and timely blood monitoring had been undertaken.

The pharmacy technicians conducted the DMICP HRM searches and shared the searches with the clinicians who had allocated responsibility for the various HRMs. The date the searches were run was documented on the HRM register. We reviewed the records for 5 patients prescribed an HRM. Appropriate alerts were in place and there was evidence of routine monitoring being undertaken in a timely manner. Although no out-of-range results were identified in these patients, all the results had been reviewed by a doctor. A thorough and detailed HRM monitoring audit had been completed in 2024.

DMICP searches were carried out to identify patients of child-bearing age prescribed valproate (medicine to treat epilepsy and bipolar disorder).

An antibiotic prescribing audit was undertaken in December 2023. It involved a review of the last 20 antibiotic prescriptions. There was a 79% adherence to national guidance for the length of the prescription. Whilst 1 of the 4 cases was due to specialist advice, 2 of the prescriptions were for a urinary tract infection which has very clear national guidance. The audit included a re-audit in 6 months. This has not been completed yet and we discussed the importance of repeating this without delay.

Track record on safety

The SMO was overall senior management lead for health and safety. The practice manager was the building custodian and the operational lead for health and safety. The deputy practice manager deputised. The practice manager had applied for the Institution of Occupational Safety and Health course to support with this lead role.

Effective arrangements were in place to ensure the safety of the premises and equipment. The practice manager routinely received Safety, Health, Environment and Fire (referred to as SHEF) updates from Garrison. Although we did not see a legionella risk assessment for either building, we confirmed water sampling was carried out for Ayios Nikolaos Medical Centre in January 2024 and in May 2024 for Dhekelia Medical Centre. Gas and electrical checks was undertaken in May 2024.

Seismic or earthquake activity was monitored for both buildings. While we were advised that Ayios Nikolaos Medical Centre was designed to withstand earthquake shocks, Dhekelia Medical Centre was not fully compliant under current regulations. This risk was held by BFC. We were advised that earthquake activity had occurred in the past. Following earthquake shocks, each building was checked initially by staff and then the estate management team attended for a full survey. The SMO confirmed that Project Apollo to replace the building was in progress and work was planned to commence in 2027/28.

The deputy practice manager was the lead for equipment care and the practice manager was the deputy lead. An annual equipment assessment (referred to as a LEA) was

undertaken in June 2023 and no significant issues had been identified. The 2024 LEA had been deferred due to this CQC inspection. Portable electrical appliances were checked in May 2024. The ERI managed the equipment in the PCRF. Certificates confirmed sports equipment was in-date for service checks. A clear process was in place for faulty or equipment requiring repair, and the actions to take to ensure patient safety.

Wet Bulb Globe Temperature checks to indicate the likelihood of heat stress were undertaken 2 hourly on the camp and the temperatures emailed direct to the ERI or the OC PCRF if the ERI was not in work. PCRF staff had a detailed understanding of the heat training policy and modifications needed for rehabilitation sessions. For example, the loaded march build up programme was delivered at 06:30 hours to reduce risk of heat illness injury.

The fire risk assessment for each building was undertaken in February 2024. Firefighting equipment tests were current. Staff were up-to-date with fire safety training and were aware of the evacuation plans for the medical centres.

The practice manager was the lead for risk management and the SMO was the deputy lead. Staff were clear about the lines of accountability for risk. A comprehensive risk register was established that incorporated the ‘4 T’s process’ (transfer, tolerate, treat, terminate). A register of up-to-date risk assessments covering all aspects of patient/staff safety was in place. The ERI and OC PCRF had both completed risk assessment training. so wrote the assessments for the PCRF, which were signed off by the SMO. Control of Substances Hazardous to Health (COSHH) risk assessments were up-to-date and COSHH products were stored appropriately.

A lone working policy was in place for the practice. The only time staff worked alone at Dhekelia Medical Centre was when PHEC had been contacted out-of-hours. A risk assessment was in place and the main action was to inform the guardroom if staff were in the building on their own. No lone working occurred in the PCRF or at Ayios Nikolaos Medical Centre.

There were emergency call points in all clinical rooms at Ayios Nikolaos Medical Centre and an alarm sounded in reception if a call point was activated. In addition, a portable personal alarm was held in each room. Not all rooms in Dhekelia Medical Centre had a built in integrated alarm so a portable personal alarm system was also used. The monthly checks of the alarms for each medical centre were recorded. All toilets had pull cord alarms. We activated the alarm in the emergency treatment room and staff responded promptly.

Lessons learned and improvements made

The Senior Nursing Officer (SNO) was the lead for the management of significant events. All staff had access to the ASER system for recording and acting on significant events and incidents. An ASER register was maintained. Just under 40 ASERs had been appropriately escalated and were awaiting a response.

A whole team approach was adopted with the review of incidents and significant events. Part 2A had nominated individuals within the system. A monthly ASER meeting was held if needed but most ASERs submitted were addressed at the MDT meetings. The member of

staff who submitted the initial report (Part 1) was invited to attend the meeting. Microsoft forms were used for acknowledgement of attendance at the meetings.

From interviews with staff and evidence provided, it was clear there was a strong culture of reporting and analysing incidents with a view to making improvements. All staff we spoke provided varied examples of incidents reported through the ASER system including the action taken and improvements made.

An effective process was in place for the management and action of Medicines and Healthcare products Regulatory Agency (MHRA) and National Patient Safety alerts. The MHRA alert register was current and a system was in place to ensure the practice received, disseminated, and actioned all alerts and information relevant to the practice. The register documented what action (if required) had been taken. Minutes demonstrated that alerts were discussed at the practice meeting and there was a link to the MHRA register in the minutes for non-attendees to access and view.

Are services effective?

We rated the practice as good for providing effective services.

Following our previous inspection, we rated the practice as requires improvement for providing effective services. We identified deficits in processes including shortfalls in:

- prison healthcare arrangements
- chronic disease management
- staff training and supervision in triage and the provision of paediatric care
- induction and mandatory training
- over 40 health checks
- health screening.

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

Effective needs assessment, care and treatment

Processes were in place to support staff to keep up-to-date with clinical developments including National Institute for Health and Care Excellence (NICE) guidance, clinical pathways, legislation and standards. Minutes showed that new or updated guidance was reviewed at the chronic disease/clinical meetings.

Local multi-disciplinary meetings were held to discuss patients with complex needs, including patients who were assessed as vulnerable. In addition, physiotherapists had remote access to the Multidisciplinary Injury Assessment Clinic Team which included a Band 7 physiotherapist and Sports Medical Doctor for the Regional Rehabilitation Unit (RRU) to discuss patients'

The Primary Care Rehabilitation Facility (PCRF) team took a holistic approach when assessing patients and considered lifestyle factors, such as mood, sleep and diet; evident in clinical records we reviewed. The small gym in the PCRF had the necessary equipment and space needed to assess and treat patients. Level 1 Rehabilitation Physical Training was undertaken in the Dhekelia Station main gym and overseen by the exercise rehabilitation instructor (ERI) and physiotherapist. The exercises were provided through Rehab Guru (software for rehabilitation exercise therapy). The time and area were protected and not accessed by civilians during these sessions.

Now that the Department of Defence Rehabilitation website was no longer active, the PCRF team had access to Best Practice Guidelines (BPG) held between SharePoint and the Defence Learning Environment. Reference to BPGs was captured in the record keeping audit. Use of the musculoskeletal Health Questionnaire (MSK-HQ) as an outcome measure was evident in the physiotherapy and ERI clinical records we reviewed. It was consistently used with appropriate clinical coding applied. The ERI ensured the patient completed the MSK-HQ as part of their discharge. Alternative outcome measures were used depending on the injury. These were held as paper copies and added to the patient's record.

The PCRF had implemented a graded lower limb plyometric continuum in order to return patients back to impact activity in a structured and graded manner in order to reduce the risk of re-injury or delayed recovery. From a review of this, a gap was identified in end stage upper limb rehabilitation with no structured plyometric components. A student physiotherapist at the time along with the ERI developed and implemented a new programme for upper limb patients to aid their progress through rehabilitation. This was in the evaluation phase at the time of the inspection.

Step 1 of the mental health intervention programme was undertaken at the practice. For step 2 of the programme, patients were referred to the Department of Community Mental Health (DCMH). In addition, patients had access to support from multiple sources including a wide-range of information leaflets and access to welfare support, which they could utilise while awaiting referral to the DCMH. Our review of clinical records for patients with a mental health need showed appropriate evidence-based management including assessment, diagnosis, clinical coding, prescribing and monitoring.

Prison healthcare had been revised and developed in line with NICE guidance and key performance indicators for healthcare in prison. Each prisoner received a range of medicals. Within the first 24 hours of arrival any immediate medical needs were met. This included screening for substance dependency and blood borne viruses The second level medical considered routine medical needs and the third level was to review any long-term health needs, such as health screening and over-40 health checks. Prisoners with a long-term condition were monitored and recalled using the same system for the practice patient population.

Many of the prisoners already had access to a specialist on the island so, where appropriate, practice clinicians liaised with the prisoner's existing healthcare provider(s). A stakeholder group was held monthly and the health of all prisoners was discussed. Sovereign Base Area police were invited to join the later part of the meeting to discuss any concerns. When released, prisoners received a release medical and care summary and a 7 day supply of medicine.

Monitoring care and treatment

One of the nurses was the overall lead for long-term conditions (LTC) and each condition had an allocated lead clinician. LTCs were managed in accordance with the LWP. Patients were tracked using a comprehensive LTC spreadsheet and recalled in line with the LWP. DMICP searches were undertaken each month and the register updated accordingly. Any discrepancies were investigated.

From discussions with staff and a review of DMICP records, we determined that patients with an LTC were recalled and managed appropriately. Thirty eight patients were identified as having high blood pressure and all had a blood pressure check within the required timeframe. Twenty eight patients had a blood pressure reading of 150/90 or less which is an indicator of positive blood pressure control. Fifty nine patients were diagnosed with asthma and 87% had an asthma review in the last 12 months.

Seventeen patients were identified as having diabetes and all were being managed appropriately. Thirteen of this cohort of patients had a blood pressure reading of 150/90 or less. Patients at risk of developing diabetes were identified through over 40s health

checks, notes summarisation (civilian patients) and through the doctors' review of blood tests. In addition, mainstream gym staff conducted an annual Body Mass Index check as patients at increased risk were more likely to fail fitness assessments so were referred for follow up by a clinician. Gestational diabetes was identified during pregnancy by SSAFA midwifes. These patients had a clinical code applied to their record to enable ongoing identification and monitoring.

We looked at a wide range of clinical records for patients with an LTC. All had appropriate clinical coding applied and were being managed in line with NICE guidance. Where treatment parameters were outside of guidance, such as raised blood pressure, clear plans were in place to amend both the recall and treatment plan so they fell within parameters. We noted that referrals, such as for retinal screening for patients with diabetes, were completed in a timely way and by an appropriate provider.

Over 40 health checks were offered to patients who had not been seen for a routine medical, including a recall at 5 yearly intervals. A search was completed for all those who turned 40 within the month and the patient contacted in line with the LTC LWP.

Audiology statistics showed 68% of the Resident Infantry Battalion (RIB) and 63% of all other service personnel for the combined practice had received an audiometric assessment within the last 2 years. Our review of patient records showed Joint Medical Employment Standards (referred to as JMES) were appropriately managed.

The Senior Nursing Officer (SNO) was the lead for quality improvement activity (QIA)/audit and the Senior Medical Officer (SMO) was the deputy lead. QIA comprised both clinical audit, organisational mandated audits, data searches and routine checks. An audit calendar was established for 2024/25, which captured the routine monthly audits and additional audits planned throughout the year. The spreadsheet indicated the frequency of the audit, date completed and included a link to access the full audit.

We were given 3 audits to review; doctors' clinical record keeping, antibiotic prescribing and results handling. The sample handling audit was a monthly check rather than a clinical audit. The antibiotic and consultation audit were of a good standard and in accordance with the Defence Primary Healthcare (DPHC) recommended audit structure but there was no recorded evidence of full cycle activity or the learning that took place. The PCRF had completed anterior cruciate ligament (ligament that stabilises the knee joint) and record keeping audits on multiple occasions. Now that staffing levels had improved, we determined there was scope to broaden the approach to clinical audit based on the needs of the patient population

Effective staffing

All staff who joined the practice, including locum staff, completed the DPHC mandated induction programme. We were advised that 6 weeks was allocated for initial familiarisation with the practice and shadowing other staff. We spoke with members of staff who joined the practice since the last inspection and they confirmed the induction process provided a good grounding in the day-to-day operation of the service. For example, nurses new to the practice had time allocated for their induction, the duration of which varied depending on their experience and job role. A detailed PCRF induction pack was available with checklists to ensure all aspects were completed. Referral pathways and paediatric

processes were included in the induction pack. Role specific inductions were also in place along with an induction to Pre-Hospital Emergency Care (PHEC) for those staff delivering the PHEC service.

Mandatory training was monitored by the practice manager and the ERI was the deputy training lead who managed all input of data and collation of certificates. Training records showed high levels of compliance across all staff groups. Risk assessments were in place for those out-of-date with training.

Collectively, clinicians had a wide-range of skills and experience to meet the needs of the patient population. For example, the SMO had worked as a trainer in family primary healthcare (PHC) practices. Both the deputy SMO (DSMO) and Unit Medical Officer had extensive NHS PHC experience. Clinicians were qualified to provide occupational medicine, Force Preparation and to deliver PHEC. Occupational diving medicals were completed by a visiting Royal Navy doctor.

Two of the nurses had undertaken the sexual health training (referred to as STIF). Four nurses were trained to take smears. Just 2 of the nurses had experience of working in a PHC setting so, in addition to eLearning for PHC, the SNO was encouraging the nurses to complete the introduction to PHC course at Bournemouth University. Two of the staff were awaiting a start date for a World Health Organisation endorsed international training course bespoke to overseas prison healthcare. Not all military staff new to managing civilian personnel had completed the mandatory 'Civilian Line Management fundamentals training'.

Although the nurses did not have specific qualifications in paediatric nursing, many had experience of assessing and treating children. Two types of triage were in operation. The first was the traditional 'sick parade' or emergency clinic for military personnel, undertaken by the duty medic. The second was eConsult, primarily accessed by families. eConsults were triaged by the nursing team who had received comprehensive training since the last inspection and followed the LWP for triage. Once triaged, patients were either offered a same day appointment or a routine appointment. Same day appointments were available every day at Dhekelia Medical Centre.

Since the last inspection, and now forming part of the induction process, all nurses had completed specific child-orientated training delivered by the SNO. Training topics included 'Spotting the Sick Child', unwell child guidance and paediatric history taking. Underpinned by an LWP, an assessment process was established for those under the age of 18. In all circumstances where a child under the age of 2 was assessed by a nurse then a discussion took place (within 30 minutes) with a doctor before a treatment plan was agreed. A prison healthcare LWP for clinical supervision and support was being developed with the input of the RCN Professional Lead for Justice and Forensics.

Children requiring physiotherapy were seen by a doctor in first instance before referral. Physiotherapists treated children for generalised simple musculoskeletal injuries. If specialist paediatric physiotherapy was required then the child was referred to secondary healthcare. A training presentation on common paediatric conditions and their management was included as part of the induction process for new staff.

Although improvements were clearly evident in relation to the management and treatment of under 18s, there was a lack of broader organisational direction about expectations in terms of training and skills. In the absence of an organisational-wide policy, there was a

risk that making a determination as to what training is required could be perceived as professionally subjective.

In-service training (IST) was incorporated into the working week. IST supported staff with continuing professional development (CPD). Clinicians were responsible for maintaining their own CPD portfolio. Appraisal and revalidation were in-date for all clinical staff. Staff described good access to clinical supervision and said support was available from both nursing and medical colleagues.

Peer review was established for clinical staff groups. For example, doctors across the island met each month. Medics engaged with paramedic-led scenario-based training every morning. Training topics were varied to cover a wide-range of eventualities. A collaborative approach was taken to training for nurses that included joint training days with nurses at other Defence PHC services on the island. The PCRF team engaged with regional IST with different members of the PCRFs presenting a topic on a rotational basis. There was an island-wide agreement with the PCRFs to enhance networking, including peer review and a journal club.

Coordinating care and treatment

Discussions with staff indicated the practice had well developed links with the Commanding Officers at both Dhekelia and Ayios Nikolaos, and unit Commanders. In addition, effective relationships had been developed with SSAFA, welfare services and the DCMH team. The welfare team described how the practice responded promptly if there was concern about a patient.

Each unit held a meeting at which a military doctor attended. At these meetings, downgraded patients and/or vulnerable patients were discussed. These discussions were documented in the patient's record and also on the vulnerable patient register.

The PCRF held case discussions with RRU Halton each month to discuss patients. The OC PCRF attended unit health committee meetings and the ERI attended Commanders Monthly Care Reviews to provide updates on patient journeys and estimated timeframes for recover.

Commissioning of secondary care services was undertaken by British Forces Cyprus (BFC). The SMO attended regular meetings with Commander Medical BFC whereby the challenges involved with referrals to secondary care were discussed. The large number of significant events regarding secondary care provision raised by the practice were appropriately discussed with BFC. In addition, the SNO and practice manager attended a quarterly meeting with the DPHC (Overseas) regional team to ensure co-ordination of practice issues with Regional Headquarters (RHQ). RHQ retained a record of the meetings.

Service personnel seldom left the military direct from Cyprus. More often they returned to a UK service and subsequently were discharged from there.

Helping patients to live healthier lives

Clinical records we reviewed showed that promoting patients with healthy lifestyle choices was routine to consultations if appropriate.

One of the nurses was identified as the lead for health promotion and ensured specific health promotion activity was targeted to the needs of the patient population and risks associated with living on the island. Health and lifestyle information was displayed in the patient areas of both medical centres. For example, at Dhekelia Medical Centre health promotion information related to cervical screening, heat illness, stages of child development, continence, injury prevention and sexual health. A television screen in the waiting area was displaying healthcare information on a loop. A unit health fair at Dhekelia was planned for September 2024 at which the practice will be participating.

A sexual health nurse from the Military Advice and Sexual Health/HIV (MASSH) team who provided a service island-wide facilitated a clinic at Dhekelia Medical Centre once a week. They were appropriately qualified for the role having completed the Faculty of Sexual Health training and provided a level 2 sexual health service for patients. The MASSH nurse was actively involved with sexual health promotion. They briefed every regiment arriving on the island, talking about the risks associated with sexual health and how to access screening and support.

One of the nurses was the lead for cytology. Introduced this year, the practice had started to use the new NHS Cervical Screening Management System (CSMS) shortly before the inspection. CSMS replaced the National Cervical Screening call/recall system accessed via the IT platform, Open Exeter. Given the transition between systems, the nursing team continued to maintain a register to monitor screening uptake. A 10% review of patient records was completed with the new system to check patient information was accurate. The review identified a discrepancy with the review date for 5 of the 40 records. An email was sent to the system administrator and Regional Nurse Advisor to confirm the patient recall dates.

A monthly search was undertaken to identify patients who met the criteria for a smear. A further search was also completed for anyone missing a smear date to ensure all patients were identified and followed up. Searches were cross referenced with the register and colour coding was used to indicate the status of a patient's screening. For example, non-responders were highlighted in red, yellow indicated results were due and purple identified patients referred to colposcopy (procedure to examine the cervix).

Results were received through email and letter and added to the patient's record. The patient was informed and the next review date recorded on the system. If colposcopy was required then the patient was contacted directly and their preferred location in the UK confirmed for the procedure. The doctor was informed and a referral was generated.

A drop-in cervical screening clinic was recently held at both medical centres. No appointment was needed and patients could just turn up for a smear test. This offered patients an alternative option especially if they were out-of-date for a smear. The 5 people who attended had a smear test.

Records showed the number of eligible patients who had had a cervical smear in the last 3-5 years was 372 which represented an achievement of 92%. The NHS target was 80%.

One of the nurses had the lead for bowel screening. DMICP searches were completed monthly to identify those eligible for screening. The search was compared with the register and any discrepancies investigated. Unlike the UK, patients could not be offered the routine bowel screening test; NHS home test kit (referred to as FIT). At the time of the inspection 115 patients were eligible for bowel screening; 48 were in date for screening, 5 had declined and 62 were out-of-date for screening. However, this figure was likely to be lower as ongoing work by the practice showed some patients were no longer on the island. The practice was awaiting direction from region as to what action should be taken to manage those eligible for bowel screening. The risk was known and identified on the risk register as a transferred risk.

One of the nurses had the lead for breast screening and a search was undertaken each month. All those eligible were sent an invitation for screening. If no response was received then a second email was sent. In a final effort to prompt attendance, a telephone call was made to the patient. A referral was generated by lead nurse and the referral team informed for an appointment be made with secondary care. The result received included a disc which was archiving. Results were added to the patient's record and a task sent to the doctor for review. The recall date was then reset. At the time of the inspection, 46 patients were eligible for breast screening; 3 were out-of-date but all had appointments booked.

SSAFA oversaw the childhood immunisation programme. Using the 'birth book' (Redbook), SSAFA recalled children for vaccinations. The primary immunisation appointments for 2, 3 and 4 month appointments were given to the family at the primary birth visit. One year vaccinations were given just after the child's first birthday.

The following vaccination statistics were submitted by SSAFA:

- The percentage of children aged 1 who had completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (i.e., 3 doses of DTaP/IPV/Hib/Hepatitis B) was 100%.
- The percentage of children aged 2 who had received their booster immunisation for Pneumococcal infection was 100%.
- The percentage of children aged 2 who had received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e., received Hib/MenC booster) was 100%.
- The percentage of children aged 2 who had received immunisation for measles, mumps and rubella (one dose of MMR) was 100%.
- The percentage of children aged 5 who had received immunisation for measles, mumps and rubella (two doses of MMR) was 100%.

A process was in place to recall service personnel for vaccinations. The vaccination statistics at the time of the inspection were:

- 89% of RIB and 84% of all other service personnel were in-date for vaccination against diphtheria.
- 89% of RIB and 84% of all other service personnel were in-date for vaccination against polio.
- 98% of RIB and 89% of all other service personnel were in-date for vaccination against hepatitis B.

- 95% of RIB and 90% of all other service personnel were in-date for vaccination against hepatitis A.
- 89% of RIB and 84% of all other service personnel were in-date for vaccination against tetanus.
- 79% of RIB and 81% of all other service personnel were in-date for vaccination against mumps, measles, rubella.

Consent to care and treatment

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. Implied consent was mainly used. Written consent was taken for invasive procedures. The clinical records we looked at showed consent was obtained from patients in the appropriate circumstances.

The DSMO undertook minor surgery in accordance with the LWP. A minor operations folder was maintained and included completed consent forms. Consent was routinely gained at the initial consultation and was reviewed with the patient at the point of surgery. We reviewed 2 sets of patient records that involved minor surgery and both included appropriate signed consent.

PCRF staff documented consent in the DMICP template. The parent/guardian provided consent for patients under the age of 18 and they stayed with their child at each appointment.

Clinicians understood the Mental Capacity Act (2005) and how it would apply to the patient population group even though there were no examples of when a mental capacity assessment had been required. Awareness of mental capacity was routinely covered as part of level 3 adult safeguarding and the clinicians were in date for this training.

Clinicians were aware of both Gillick competence (young people under 16 with capacity to make a decision) and Fraser guidelines (advice/treatment focused on a young person's sexual health).

Are services caring?

We rated the practice as good for providing caring services.

Following our previous inspection, we rated the practice as requires improvement for providing caring services. We identified deficits in caring approaches including shortfalls in:

- waiting area facilities and resources
- attitude of clinicians.

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

Kindness, respect and compassion

To ensure patient's views were considered as part of the inspection, we reviewed the May/June 2024 combined practice patient survey: 90 respondents. In addition, we offered patients the opportunity to speak with us over a 2-day period at both Dhekelia and Ayios Nikolaos medical centres. We also opportunistically spoke with patients in the waiting room of both medical centres. In total, 14 patients were interviewed. Overall, all sources of feedback indicated staff treated patients with kindness, respect and compassion. A small number of patients based at Ayios Nikolaos were critical about the attitude of some doctors. We confirmed the named doctors had left the practice since the last inspection.

We discussed with the Senior Medical Officer (SMO) specific concerns raised by patients who said they felt they were either not listened to or that their concerns were not taken seriously. As part of the discussions, the SMO reviewed the patients' records (patients gave verbal consent for this). We were unable to identify from the record of consultations that the current doctors working at the practice had behaved in an unkind, disrespectful or insensitive way. We concluded that the concerns raised related to doctors who were no longer working at the practice.

We were provided with various examples of when practice staff had gone 'the extra mile' to support patients. For example, a medic provided transport for a patient at Ayios Niklaos who required stitches and no transport was available at the time to Dhekelia Medical Centre. Furthermore, the Primary Care Rehabilitation Facility (PCRF) made time during the inspection to ensure a walker brace was fitted to save the patient returning to the medical centre another day.

The PCRF aimed to promote continuity of care by ensuring patients saw the same physiotherapist. The lead clinician was named on the patient tracker.

Practice staff confirmed that they had a close working relationship with the Garrison Hive in Dhekelia. The HIVE had a designated social media page for all personnel and their families, which the medical centre used to inform patients of any changes impacting service provision or to advertise relevant and useful information. The leadership team was attending the monthly welfare hub meetings at both Ayios Nikolaos and Dhekelia. These forums provided opportunities to engage with patients and seek feedback regarding the arrangements for clinics at both medical centres.

Involvement in decisions about care and treatment

Our review of clinical records and patient feedback about the practice indicated patients were actively involved in the planning of their treatment and care. The most recent patient survey showed 93% of patients felt involved in their care. Patients told us they could select their hospital of choice when referred to the UK for secondary care.

A member of staff was identified as the carers lead. Patients with a caring responsibility were usually identified when registering at the practice. A clinical code was applied to their records so they were identifiable as a carer. Carers were offered an annual review and relevant vaccinations. Carers had access to the wide-range of welfare support services provided by British Forces Cyprus. Regular DMICP searches were undertaken to ensure carers were identified.

A translation service was available for patients who did not have English as a first language. Information about this service was displayed at both medical centres. It had been used when consulting with prisoners. Cypriot staff also supported with translation. The translation service was used for prisoners or prison staff could translate with patient consent.

Privacy and dignity

The proximity of the waiting area to the reception desk meant conversations at reception could not easily be overheard and the waiting could be fully seen by reception staff. Consultations took place in clinic rooms with the doors closed. Privacy curtains were used when patients were being examined. Curtains were also used in the PCRF along with a radio to minimise conversations being overheard. A business case had been submitted to the station Quarter Master for soundproofing in the PCRF.

A dedicated room was available for breastfeeding and this was advertised in the patient waiting area.

There was a good mix of male and female staff within the practice so patients could request to see a clinician of their preferred gender.

All staff were up-to-date with the mandated Defence Information Management Passport (DIMP). The DIMP took account of the Caldicott Principles to ensure patient information was kept confidential and used appropriately.

Are services responsive to people's needs?

We rated the practice as good for providing responsive services.

Following our previous inspection, we rated the practice as inadequate for providing responsive services. We identified shortfalls in processes including shortfalls in:

- secondary care
- access to appointments at Ayios Nikolaos Medical Centre
- management of patient complaints.

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

Responding to and meeting people's needs

Patients we spoke with who were based at Dhekelia were satisfied with the responsiveness of the service provided at Dhekelia Medical Centre. However, patients of Ayios Nikolaos Medical Centre who took the opportunity to speak with us expressed a dissatisfaction with access to, and the responsiveness, of the service. The main themes emerging were in relation to: eConsult being too time consuming and difficult to use; insufficient clinics at Ayios Nikolaos Medical Centre; lack of communication from the practice team; limited transport to Dhekelia Medical Centre and restricted access to secondary care, in particular X-rays. Some patients suggested they would benefit from training in using eConsult. We also heard concerns expressed that there may be plans to close Ayios Nikolaos Medical Centre.

The views expressed by patients mirrored some of the findings of the Combined Medical Practice patient survey, which generated a total of 133 comments. It is noteworthy that just 2 patients who completed the survey expressed concern about their care.

To gain a balanced view, we discussed the themes raised by patients with the Senior Medical Officer (SMO) and Regional Nurse Advisor Overseas. Both confirmed they were unaware of any plans to close the medical centre. Regarding eConsult, the practice was using the same eConsult process as the NHS so there was limited scope to change or alter the system. However, the SMO said the practice team would provide training for patients with using eConsult, most likely at one of the welfare hub monthly meetings.

The clinic time at Ayios Nikolaos Medical Centre had increased since the last inspection. Routine alternating doctor and nurse clinics were held from 08:00 to 12:00 hours on Tuesdays and Thursdays. An agreed plan was in place to uplift to 2 doctor and nurse clinics per week and this was due to start shortly. A small number of patients mentioned that telephone and video consultations would be useful. The SMO confirmed that these were routinely available and frequently used. We noted that both these options and eConsult were highlighted in the patient information leaflet.

The SMO confirmed that the monthly welfare hub meeting at Ayios Nikolaos was the main forum for the 2-way sharing of information with service personnel, families and civilian staff. The SMO, practice manager, Senior Nursing Officer and Nursing Warrant Officer attended these meetings. Given the concerns raised by patients, we discussed the

potential for holding more frequent meetings to ensure optimum communication with the Ayios Nikolaos population regarding developments and changes. In addition, maintaining a record of these meetings would confirm what was discussed particularly for people unable to attend the meetings.

The SMO also met with the Commanding Officer for Ayios Nikolaos on a regular basis to discuss concerns raised by patients and to share updates. As an additional means of sharing information, we discussed the potential for the practice to introduce a quarterly patient-focused electronic newsletter. Such a newsletter had been successfully introduced at Akrotiri and Episkopi medical centres. The user-friendly newsletter covered a wide range of topics to support patients with understanding the service provided and when/how to seek healthcare intervention.

The SMO confirmed that military transport was in place to support Ayios Nikolaos patients with accessing appointments at Dhekelia Medical Centre.

A small number of patients raised concern that their primary care doctor was blocking them from seeing a secondary healthcare (SHC) consultant. With consent, we discussed these patients with the SMO, including a review of their clinical record and were assured clinical decision making was appropriate. Primary care doctors have the responsibility to ensure the care being provided by Cypriot SHC services equates with what patients would expect of the NHS. As part of this process, doctors are asked to approve some recommended treatment plans indicated by SHC consultants before they proceed. The interface between primary and SHC was little understood by patients so we discussed with the SMO whether this topic would benefit from discussion at the welfare hub meetings.

To accommodate the needs of the patient population, service access was flexible. For example, before and after school appointments where available for children and teachers. Telephone, video and eConsult were also regularly used. The duty nurse monitored the eConsults. Patients assessed as vulnerable or those with an urgent need were accommodated with a same-day appointment. In addition, the practice acted on patient feedback where possible. For example, the Resident Infantry Battalion requested Level 1 Rehabilitation Physical Training be moved from 06:30 to 07:30 hours in winter months to accommodate cook house winter hours and this was actioned.

An Equality Access Audit had been undertaken for both medical centres. The buildings were accessible, including automatic front doors, wider internal doors, an accessible patient toilet and a hearing loop. The absence of an accessible parking bay at Dhekelia Medical Centre had been addressed with estate management and a works request submitted. Although in the same building as the medical centre, the Equality Access Audit for the Primary Care Rehabilitation Centre had been completed separately.

Timely access to care and treatment

Patients who provided feedback for Dhekelia Medical Centre indicated it was easy to get an appointment at a time that suited their needs. Patients we spoke with at Ayios Nikolaos said it was difficult to get an appointment at either medical centre.

The practice manager confirmed that all patients with an urgent need could be seen on the same day at Dhekelia Medical Centre. Access to urgent appointments was not available at Ayios Nikolaos Medical Centre. For routine appointments, the next available appointment

with a doctor was less than 10 days, within 2 days for a nurse and 8 days for a physiotherapist. An urgent appointment with a physiotherapist or exercise rehabilitation instructor could be accommodated on the same day. There were no allocated appointments for medicals as patients were seen in a routine clinic utilising either double or triple time slots. Medics had allocated appointments within their clinics for 'run ups' to medicals.

The midwife provided home visits. Although not regular, the duty doctor could undertake a home visit and would be accompanied by the pre-hospital emergency care ambulance.

Military patients could use the direct access physiotherapy (DAP) process. Civilians and patients under the age of 18 were seen by a doctor in the first instance. DAP referral numbers were audited. It was a popular service but the audit indicated the busier acute referrals reduced the overall care period as conditions were unlikely to become chronic.

The practice was staffed by a paramedic, medic and duty doctor 24 hours 7 days a week for emergency medical cover to the Eastern Sovereign Base Area. Patients with an urgent medical need had access to this service out-of-hours.

Listening and learning from concerns and complaints

The practice manager was the lead for complaints and the SMO was the deputy lead. The SMO responded to complaints related to clinical care. Both written and verbal complaints about the practice were recorded and managed. Patient complaints about secondary health care were processed by the practice in the first instance and then passed to Med Branch for British Forces Cyprus. Minutes confirmed complaints were discussed with staff at meetings and all identifiable information was redacted to protect the person involved.

From the evidence seen, we determined that complaints were effectively managed and in a timely way. Although one of the main themes concerned SHC, including the care at the American Medical Centre (AMC), none of the patients we spoke with raised concern about SHC services. We were advised that review of the contract with AMC had commenced. A complaints trend analysis was scheduled for July 2024.

We discussed in detail with the SMO a recent formal complaint regarding a potential missed diagnosis and referral for X-ray. The SMO investigated the complaint and addressed the issues with the doctors involved. There was evidence the doctors appropriately reflected on the care provided and improvements to practice were discussed. The patient was sent a letter of apology that included the action taken.

The complaints procedure was outlined in the practice information leaflet (PIL) including the contact details for the complaints manager. In addition, information about how to complain was displayed in the practice.

Are services well-led?

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

Following our previous inspection, we rated the practice as inadequate for providing well-led services. We identified deficits in leadership and governance processes including shortfalls in:

- leadership capacity including insufficient clinical leadership
- accountability at senior leadership level
- major incident plan
- staff safety culture
- staff participation with practice and governance meetings
- terms of reference for staff
- staff access to policies and protocols.

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

Vision and strategy

From discussions with staff, it was evident the practice had a clear strategy for the future, in particular with addressing previous service failings and to ensure safe clinical care for all patients.

We spoke with the Commanding Officer (CO) for Dhekelia Garrison and they were complimentary about the improvements made at the medical centre over the last 12 months. They referred to increased staffing levels, improved access and better systems/processes leading to an improvement in patient experience. Whilst the CO for Ayios Nikolaos acknowledged the improvements made and positive impact the SMO was having, they continued to advocate on behalf of the population to ensure an equitable and accessible service for the people residing at Ayios Nikolaos.

Since the previous inspection, a restructure had taken place to form a combined practice between Dhekelia and Ayios Nikolaos medical centres. The service had been renamed from ‘Dhekelia Group Medical Centre’ to ‘ESBA Combined Medical Practice’. As with a combined practice, the service was treated as a single medical practice under the leadership of 1 Senior Medical Officer (SMO). The patient population for each practice had been merged.

The mission statement for ESBA Combined Medical Practice was identified as:

“ESBA Combined Medical Practice is to provide safe and effective healthcare to meet the needs of our patients and the chain of command in order to support force generation and sustain the physical and moral components of fighting power.”

The mission statement specific to the Primary Care Rehabilitation Facility (PCRF) was:

“To deliver a comprehensive, highly skilled, professional, and clinically effective physiotherapy and rehabilitation service for entitled personnel IOT [in order to] optimise the fighting power of the PAR [population at risk].”

Since September 2023 a new SMO and practice manager had joined the practice. The refreshed leadership team was involved with driving change and improvements highlighted over the 12 months. For example, the 2 main themes identified from patient complaints concerned patient dissatisfaction with secondary healthcare (SHC) and clinical provision at Ayios Nikolaos Medical Centre. The practice was actively engaged with addressing these issues.

The concerns with SHC were not unique to the ESBA Combined Medical Practice as the same issue was identified from inspections of the other Defence Primary Healthcare (DPHC) practices on the island. The SMO advised that the review process had started for renewal of the SHC contact due to expire in 2025. The 3 SMOs across the island were involved and had developed a question set and key performance indicators as part of the contract renewal process.

The leadership team attended the welfare hub meetings with the patient population at Ayios Nikolaos to ensure patients had the opportunity to express their views and were involved in decisions about health care provision. Leaders had responded to patient concerns about limited clinical provision at Ayios Nikolaos and the routine alternating doctor and nurse clinics was due to increase. Arrangements were in place for patients to use military transport if they needed to attend Dhekelia Medical Centre. In addition, the SMO met regularly with the Commanding Officer to discuss concerns and planned improvements.

The leadership team recognised the opportunities of working collaboratively with services across the island, in particular working in the future with the Western Sovereign Base Area (WSBA) Combined Medical Practice (Akrotiri and Episkopi medical centres) to share clinical resources and maximise joint working. For example, patients would have access to the contraceptive implant clinic held at Episkopi Medical Centre and access to the joint injections service. It was anticipated this enhanced collaboration would support with improved communication and awareness of island-wide issues. There was also an opportunity to consider an island-wide out-of-hours model.

The medical centres on the island had been working to the OPAL ratings as defined by the DPHC Op Order published by Commander DPHC. This outlined the 12 DPHC priorities predicted for the year. ESBA Combined Medical Practice had moved from a ‘red’ rating at the time of the last inspection to a rating ‘green’ at the time of this inspection.

Succession planning was considered and involved liaison with the career managers to minimise key military management personnel not being deployed at the same time. Staffing levels had significantly improved since the previous inspection. Leaders said the regional team was supportive. In particular, staffing requests were addressed in a timely manner.

To address environmental sustainability, the practice was making an effort to reduce the use of paper and printing through sharing information electronically. As an example, the PCRF had QR codes for patients to access information rather than printed documents. Recycling bins were evident throughout both buildings.

Leadership, capacity and capability

We spoke with a wide range of staff during the inspection who described how the team was more cohesive and engaged now that the capacity of the leadership team had

improved. We heard that staff were inspired by the commitment and hard work of the practice manager and SMO since they joined the practice. They also highlighted that the refreshed leadership team was providing clear structure and direction for the service. We heard that heads of departments were visible with staff having prompt access to support and guidance if needed. In terms of capability, staff indicated they had confidence in how the leaders managed the practice.

We determined that the leadership team were working well together to achieve the vision for the service. They demonstrated high levels of experience, capability and resourcefulness to provide a responsive and sustainable service for the patient population. This was particularly evident in the time the leaders invested with the Ayios Nikolaos population to support them with the changes being made to the way the service was provided.

Culture

Staff said they were supported, respected and valued by the leadership team. We heard that everyone had an equal voice, regardless of rank or grade. Both formal and informal opportunities were in place so staff could contribute their thoughts about how to develop the practice. The leadership team promoted an open-door policy and staff told us the SMO regularly checked in with staff.

In particular, the nurses highlighted team improvements since the last inspection. Doctors were approachable to discuss patients and nurses also felt supported by the paramedics. Nurses new to the practice said they were well supported by their colleagues and nurse leaders and also valued the ‘Spotting the Sick Child’ element of the induction.

To promote and sustain positive team morale, regular team social events and ‘white space’ days were held, which included both military and civilian staff. Three personal fitness sessions were also factored into the working week for staff. A British Forces Cyprus locally employed civilian special bonus scheme was in place and the administration team recently received a reward for their hard work.

Staff said they would feel comfortable raising any concerns and were familiar with the whistleblowing policy. Staff were familiar with the Freedom to Speak Up (FTSU) policy and were aware of how to access a FTSU representative.

Processes were established to ensure compliance with the requirements of the duty of candour (DoC), including giving those affected reasonable support, information and a verbal and written apology. The DoC is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. There were various examples recorded on the DoC log.

Governance arrangements

The SMO was the lead for healthcare governance (HCG). With a defined staff reporting structure in place, staff were aware of their roles and responsibilities. Lead roles were shared across the practice team. Reviewed in June 2024, terms of reference for those with secondary duties were in place, including a detailed description of the lead role duties.

A wide range of meetings was held on a rotational basis to ensure effective communication and information sharing across the staff team. Key meetings included a practice meeting, which the whole team attended and the HCG meeting attended by clinical leaders and the practice manager. The PCRF team was integral with the practice and attended all relevant meetings. When needed, the SSAFA team and Department of Community Mental Health attended meetings appropriate to their work. Microsoft Forms were used for acknowledgement that meeting minutes had been read by individual staff.

The HCG workbook was comprehensive and captured the combined practice approach. All staff had access to the workbook as the main method to share governance information across a large practice. The HCG workbook is used in DPHC services as the overarching system to bring together a range of governance activities, including the risk register, medicine alerts, audit, health and safety and quality improvement.

Non-attendance at SHC appointments at the American Medical Centre was closely monitored as there was a charge if the patient cancelled the appointment with less than 48 hours' notice. The practice submitted the non-attendance statistics to British Forces Cyprus Headquarters each month.

Managing risks, issues and performance

A practice development plan was used to identify service risks/gaps and monitor the progress of how each was being addressed. Colour was used to monitor the status of each action. The majority of the actions had been completed at the time of the inspection. Potential future risk was identified through themes emerging from systems, such as ASER, complaints and audit activity.

Processes were in place to monitor national and local safety alerts, incidents, and complaints. This information was used to improve performance.

The business continuity plan (BCP) was comprehensive and covered all eventualities relevant to the service, including loss of the building due to a natural disaster. The BCP was recently activated with an outage of DMICP (D) for 7 days.

The major incident plan (MIP) would benefit from an update as we noted names and contact details were out-of-date. Despite this, practice staff participated in a successful Dhekelia Garrison-wide MIP exercise the month previous and no actions were identified for the practice. The outbreak plan was updated in June 2024.

The leadership team was familiar with the policy and system for managing staff performance. Although not a process that had been activated at the time of the inspection, they were familiar with the range of options to manage performance including welfare support, re-training, appraisal and disciplinary processes.

Appropriate and accurate information

The DPHC electronic health assurance framework (referred to as HAF) was used to monitor performance. It is an internal quality assurance governance tool to assure standards of health care delivery within Defence healthcare. At the time of the inspection,

the Senior Nursing Officer and practice manager were managing the HAF and inputting information. This would likely change to involve other departments with taking ownership of elements of the HAF. The management action plan for the HAF was discussed at the HCG meetings; 3 actions were open at the time of the inspection.

Arrangements were in place which were in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

A QR code was displayed throughout the practice for patients to provide feedback on the service. The outcome of the most recent patient survey was displayed including patient comments and the practice's response. A response was provided to the key comments provided by patients based at Ayios Nikolaos, including the request for more appointments at Ayios Nikolaos Medical Centre, difficulties with eConsult and the challenge accessing care at the combined practice. A QR code was also displayed for patients to provide feedback about SHC. A 'you said, we did' board was displayed in the PCRF for patients to see how their feedback was responded to.

A QR code was also available for staff to leave feedback about the service. After each in-service training session, staff were asked to provide feedback on the training session. This was facilitated using a quick reference or QR code. This meant those presenting the session could review the material and delivery based on feedback to ensure the training was of the best standard.

The SMO routinely engaged with the Commanding Officers and practice staff attended the Unit Health Committee and Commanders Monthly Case Review meetings. The practice had effective working relationships with the welfare team and SSAFA.'.

Continuous improvement and innovation

The audit and quality improvement project (QIP) registers demonstrated that the practice was seeking to improve the service for patients.

We identified elements of innovation and good practice that was not logged on the QIP register and would benefit from being shared widely. Raising purple ASERs (positive events) or QIPs showcases innovation and enables the sharing of good practice with other DPHC facilities. The areas we identified included:

- The detailed 'patient tracker' was an effective tool in improving caseload management and reducing inefficiencies
- The QR code used for feedback about training was a means to continually review the quality of training
- Drop-in clinics for smears at both medical centres
- Developments within prison healthcare.