Akrotiri Health Centre

DPHC Overseas, RAF Akrotiri, Cyprus, BFPO 57

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 responsive to people's needs?	**Good**	

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Summary

About this inspection

We carried out a comprehensive announced comprehensive inspection of Akrotiri Health Centre on 11 October 2023. We rated the service as good overall with a rating of requires improvement for the responsive key question. The safe, effective, caring and well-led key questions were rated as good.

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

www.cqc.org.uk/dms

We carried out this announced focused follow up inspection on 2 September 2025. The report covers our findings regarding the recommendations made at our last inspection.

As a result of the inspection the responsive key question was rated as good for in accordance with the Care Quality Commission's (CQC) inspection framework.

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

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

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

Since the inspection in October 2023 the number of complaints about secondary healthcare had reduced. The following 2 initiatives may have contributed to this improvement:

- A 'patient referral advice leaflet' was developed this year. The aim was to improve patient understanding and address expectation by highlighting the differences in standards, available treatments and funding issues between Cypriot and UK healthcare. The leaflet emphasised that treatment (including medicines) suggested by a Cypriot clinician might not be in line with UK standards or approved by UK guidelines so referral to a UK specialist may be required. The leaflet reminded patients that these issues may cause delays in receiving treatment.
- As there is no legal requirement for state hospitals in Cyprus to provide the patient's primary care doctor with a discharge letter, the practice developed a letter and an accompanying reminder card for the patient to take to the hospital. Written in both English and Cypriot, the letter included a section for the hospital clinician to record the presenting complaint, primary diagnosis, investigations undertaken and follow-up

required. The patient then returned the completed letter to the referring doctor at the practice.

The Chief Inspector recommends to the wider Defence organisation:

Challenges around timely access to accurate patient records occurred as DMICP 'Deployed' is a system with reduced functionality and some outage periods. Headquarters should review the functionality of DMICP 'Deployed' and deliver solutions to improve access to view up-to-date patient records.

No recommendations were identified for the practice

Professor Bola Owolabi

Chief Inspector of Primary and Community Services.

Our inspection team

A CQC inspector conducted the inspection with remote support/advice from a pharmacy technician and physiotherapist.

Background to Akrotiri Health Centre

Situated in the Western Sovereign Base Area (WSBA) of Cyprus, Akrotiri Health Centre (AHC) along with Episkopi Medical Centre form the WSBA Combined Medical Practice. Due to issues with DMICP (patient electronic system) overseas, combining has not yet been fully achieved.

AHC delivers routine primary care services to a patient population of 2,700, including families of service personnel and civilian staff with 700 patients under the age of 18. The population fluctuates as DMICP searches do not always include those on deployment.

AHC provides an occupational health service for military personnel. A dispensary is also located within the health centre. Located alongside the health centre, the Primary Care Rehabilitation Facility (PCRF), offers physiotherapy and rehabilitation services to both service personnel and civilians.

Secondary healthcare (SHC) is primarily provided by the American Medical Centre in Nicosia, including maternity services. Other state hospitals used include Limassol General, Nicosia General, Archbishop Makarios Hospital, and Ammochostos (Paralimni) General Hospital. Patients may also be repatriated to the UK for SHC if necessary.

AHC operates from 08:00 to 16:00 hours Monday to Friday. Outside of these hours, including weekends and public holidays, an out-of-hours team provides medical cover. A medic is always on duty to respond to airfield incidents and provide medical support.

Clinical staff provide cover for the Pre-Hospital Emergency Care (PHEC) service. Ambulance dispatch is managed from AHC and operates 24 hours a day 7 days a week. Consisting of a dispatch nurse and a first line ambulance team (paramedic and a medic), this team provides 112 ambulance response equivalent to NHS 111 in the UK for military personnel, their families, local residents and tourists. The PHEC service was not included in this inspection.

The staff team

Doctors	**Established for 6** Senior Medical Officer (SMO) Deputy SMO - gapped from August 2025 (locum fill) Military doctors x 2 MOD GPs x 2 GP Registrar
Nurses	**Established for 5**

	Senior Nursing Officer – gapped from August 2025 (locum fill) Military nurses x 2 Civilian nurses x 2
Medics	**Established for 16** 4 x Junior Non-Commissioned Officer (JNCO) 12 x Air Specialist (Class 1)
Paramedics	**Established for 4** Flight Sergeant (FS) Sergeant JNCO x 2
Practice management	**Established for 3** Military practice manager (FS) Senior Non-Commissioned Officer medics x 2
PCRF	**Established for 4** OC (lead) physiotherapist Band 6 civilian senior physiotherapist Band 7 civilian physiotherapist (locum) Military exercise rehabilitation instructor – Gapped until September 2025
Dispensary	**Established for 2** Military pharmacy technician Civilian pharmacy technician
Administrators	**Established for 6** Civilian administrators x 6

Are services safe?

Although the practice received a rating of good for providing safe services at the last inspection, we followed up on the advice and guidance recommendations.

These were in relation to:

- Disclosure and Barring Service (DBS) checks
- staffing levels (medics)
- the medical emergency trolley and staff training in the use of new equipment
- DMICP
- physiotherapy record keeping
- medicines management.

Safety systems and processes

At the last inspection, we were advised that the process for DBS checks to ensure staff were suitable to work with vulnerable adults and children was slow and checks had expired for some staff. Since then, the practice was using the online DBS application process, which they said was more efficient and timelier. Staff were reminded by the practice manger when their DBS check was due. At the time of this inspection, all staff were in-date for a DBS check.

Risks to patients

Previously, the medics reported they had insufficient time for core practice duties due to providing both 24-hour a day ambulance response and 24-hour airfield crash cover. In response, the practice had submitted a request for an uplift of 4 medics. Since then, the opening hours for the practice had changed and the medics' rota for ambulance response and crash cover had been revised. These efficiency changes meant there was sufficient medic cover and capacity for core duties.

We found it difficult to open a compartment of the medical emergency medical trolley at the last inspection and were concerned there could be a delay with accessing the medicines in the event of an actual medical emergency. Since then, the trolley had been replaced and staff demonstrated that the emergency medicines could be accessed promptly. Clinical staff had completed training in using the CardioChek Plus Test system.

Information to deliver safe care and treatment

At the last inspection, staff identified DMICP deployed as an issue in terms of communication island-wide and with the UK. This remains an ongoing issue and the Senior Medical Officer advised that the issue affected all overseas services. The practice

used DMICP deployed (D) on a daily basis and deferred to DMICP fixed (a mirror variant of the UK version) to access basic clinical information, mainly for out-of-hours provision. However, DMICP(D) does not provide a live view of medical records and currently does not support access to the full range of integrated clinical searches for Akrotiri Health Centre and Episkopi Medical Centre, which had impacted the full combining for WSBA Medical Practice in accordance with the criteria for a combined practice. We were advised that making changes to the system was beyond the scope of the practice and British Forces Cyprus Med Branch Headquarters.

Previously, we found that the physiotherapists' record keeping was not always sufficiently detailed in relation to diagnosis, clinical coding and comprehensiveness. An audit of the physiotherapists' clinical record keeping in October 2024 showed an improvement in the quality of clinical record keeping.

Safe and appropriate use of medicines

At the last inspection over-labelled medicines for the supply of medicines out-of-hours (OOH) were not always managed in line with Defence Primary Healthcare Policy (DPHC) policy as we noted a box of over-labelled co-codamol (medicine for pain) which had an erased patient's name on the box. In addition, we noted a discrepancy with the stock.

The practice identified that some items had been incorrectly sent to 'print' instead of 'dispense' on DMICP. This meant they did not appear in the dispensing queue and no supporting paperwork was provided by the prescriber. The items were initially missed but were later identified through a transaction report. Using 'dispense' ensures pharmacy staff can verify the batch numbers the next working day and confirm that the medicine issued matches the FMED 296 (military prescription). This process follows DPHC policy and the local working practice (LWP) protocol for OOH dispensing and issuing under a Patient Specific Direction. Out-of-hours stock was now subject to checks a minimum of 3 monthly by pharmacy staff with the practice manager carrying out spot checks.

Previously staff could not locate the LWP for the management of information about prescribing, and changes to a patient's medicines OOH or by secondary healthcare. The pharmacy technician confirmed that the relevant LWPs were now available on Teams. Clinicians had also received copies via email and clarification of the process had been discussed with individual staff if needed.

Are services effective?

Although the practice received a rated of good for providing effective services at the last inspection, we followed up on the advice and guidance recommendations.

These were in relation to:

- Rehab Guru, software for structured exercise programmes
- the Musculoskeletal Health Questionnaire (MSK-HQ), a patient reported outcome measure
- the acupuncture patient information leaflet.

Effective needs assessment, care and treatment

At the last inspection we noted from our review of records that the musculoskeletal health questionnaire (MSK-HQ) was not routinely completed by or with patients. In addition, Rehab Guru was inconsistently used by the Primary Care Rehabilitation Facility (PCRF). At the time of the inspection, the OC (lead) physiotherapist position was vacant.

Since then, an OC physiotherapist had taken up post and was overseeing both Akrotiri and Episkopi PCRFs in line with the combined practice model. We confirmed with the OC physiotherapist that clinical record keeping was audited annually for all clinicians in line with Defence Primary Healthcare policy. Staff at Episkopi and Akrotiri PCRFs audited each other's notes if appropriate. An example provided demonstrated that the use of Rehab Guru and patient reported outcome measures, such as the MSK-HQ were reviewed as part of the audit.

Staff advised us that patients were now receiving the acupuncture patient information leaflet as part of the consent process for acupuncture treatment.

Are services responsive to people's needs?

We rated the practice as good for providing responsive services.

Following our last inspection, we rated the practice as requires improvement for providing responsive services as we found shortfalls with:

- communication between primary and secondary healthcare (SHC) services
- patient dissatisfaction with SHC
- patient understanding of the SHC pathways
- patient understanding of the complaint process for SHC.

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

Responding to and meeting people's needs

As part of the inspection in October 2023, patients requested to speak with us to discuss their experience and concerns about SHC services. SHC is primarily provided by the American Medical Centre (AMC) in Nicosia, including maternity services. Other state hospitals used include Limassol General, Nicosia General, Archbishop Makarios Hospital, and Ammochostos (Paralimni) General Hospital. If necessary, patients may also be repatriated to the UK for SHC.

From information shared with us at the time, it was evident communication between primary and SHC clinicians was the main concern for patients. They indicated updates about their treatment plan were sometimes delayed with a lack of clarity about whether the primary care or SHC clinician should provide this information. Although there was information available in the practice about SHC, we considered additional engagement and action was needed to improve the patient experience and understanding of SHC pathways.

Since the last inspection, the practice made the following improvements to engage and support patients with understanding SHC provision:

- A patient participation group (PPG) was held quarterly. It was advertised via social media groups, the executive team and through the station support network (referred to as the HIVE). Initially, attendance was low so the practice incorporated the PPG with the chaplaincy coffee/cake mornings. A summary of each PPG was shared with patients through the quarterly electronic patient-focussed newsletter. The PPGs held in January and April 2025 showed that queries about the AMC were raised and appropriately actioned by the practice. For example, it was requested that simple follow up appointments/reviews with AMC be conducted by telephone to minimise travelling. Acknowledging travel time was a concern particularly for families, the request was referred to Med Branch Headquarters (HQ) who were responsible for SHC. The practice advised that Med Branch HQ would be invited to the PPG in October 2025 to discuss recent patient concerns raised about a state hospital.
- A website site (britishforcescyprus.info) was developed to welcome service personnel and their families to Cyprus and included a section about primary healthcare, SHC and

emergency care on the island. Information was included about the treatment of patients with existing medical conditions travelling to Cyprus and stated, "While we strive to match the quality of care provided by the NHS, the methods of delivery may vary".

- A 'patient referral advice leaflet' was developed in 2025. The aim was to improve patient understanding and address expectation by highlighting the differences in standards, available treatments and funding issues between Cypriot and UK healthcare. The leaflet emphasised that treatment (including medicines) suggested by a Cypriot clinician might not be in line with UK standards or approved by UK guidelines so advice/referral to a UK military specialist may be required. The leaflet reminded patients that these issues may cause delays in receiving treatment.
- As there is no legal requirement for state hospitals to provide the patient's primary care doctor with a discharge letter, the practice developed a letter and reminder card for the patient to take to the hospital. Written in both English and Cypriot, the letter included a section for the hospital clinician to record the presenting complaint, primary diagnosis, investigations undertaken and follow-up required. The patient then returned the completed letter to the referring doctor at the practice.
- The practice engaged with patients before admission to AMC and during their stay in hospital, including in the state hospitals.
- Developed by the Aeromedical team, an overview of the process to return to the UK for medical treatment was developed and shared with patients via the quarterly electronic patient-focussed newsletter. This initiative was raised as good practice though a 'purple' ASER (system for managing significant events and events, including improvement initiatives).
- Measures to encourage the use of the DPHC patient feedback process had been promoted to prompt patients to provide feedback, including about SHC.

In addition, the practice had strengthened communication and processes in relation to SHC. These included:

- The practice requested the paramedic report if a patient was admitted to hospital by ambulance. In addition, meetings were held each morning with the ambulance team. A 'handover, takeover' register was maintained and was reviewed at the meeting. It showed the number/details of patients in hospital and 112 calls.
- A weekly referrals meeting was held.
- Referrals were an agenda item at the WSBA Combined Medical Practice clinical meeting held each month.
- Complex referrals were reviewed at both the doctors' and musculoskeletal weekly meetings.
- The Senior Medical Officers met every 2 weeks to discuss contentious issues, including referrals.

Monitoring of the SHC contract with AMC was the responsibility of Med Branch Headquarters (HQ), British Forces Cyprus, who indicated that the AMC was positively responsive to concerns and complaints. Meetings were held with AMC monthly (operational) and quarterly (strategic). However, there was no contract with the state hospitals used for services not provided by AMC. In the absence of contractual

arrangements, Med Branch HQ highlighted that maintaining good relationships and open lines of communication with state hospitals was important. We were advised that cultural differences and attitudes to risk in relation to healthcare were key considerations.

Chaired by Med Branch HQ, a pan-island SHC meeting regularly took place and included the contract monitoring team and the SMO from each medical facility. A tracker (referred to as a 'request for information') was maintained of issues/concerns to ensure corporate knowledge was captured and retained.

We were shown evidence of the SHC pathways that were in the process of development and due to be discussed at the next quarterly pan-island doctors' meeting. The UK Defence Clinical Advisors were also involved in this work.

A 'Defence Information Notice' was being developed to outline the healthcare services for service personnel, their families and civilian staff due to move to Cyprus.

Listening and learning from concerns and complaints

Med Branch HQ dealt with complaints (and ASERs) about SHC services. At the last inspection, there was a wide-range of patient-orientated information available explaining the management of complaints about SHC. These included the practice information leaflet, social media platform and displays in the building. Despite this, patients were unclear who managed SHC complaints as they were initially processed by the practice before transfer to Med Branch HQ. Patients also raised concerns about delays in receiving a response to their complaint.

Since then, measures had been taken to act on concerns promptly, including encouraging patients to discuss the issue with the practice before deferring to the formal complaint process. Patients were provided with copies of letters sent to Med Branch HQ so were informed about which department was dealing with their complaint.

We were advised that complaints about AMC were responded to promptly but those related to state hospitals could take a lot longer to receive a response. Med Branch HQ held a pan-island register of complaints and sent a letter to the hospital if the timelines for responding to a complaint had not been achieved.

Auditing of complaints by the practice suggested there had been a reduction in the number of complaints received about SHC. Twenty-two complaints were submitted for 2024; 12 of which related to SHC. Six complaints were recorded for the first 8 months of 2025, 3 of which concerned SHC.

Furthermore, the ASER system was used to monitor concerns about SHC and complaints were raised as an ASER if they met the criteria. An ASER analysis was carried out every 6 months. Recent data showed 5 ASERs had been raised about SHC since December 2024. We did not have access to previous ASER data to determine if the number of ASERs submitted about SHC had reduced.