# Episkopi Medical Practice

Episkopi Station BFPO 53 Cyprus

## 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.

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| 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 previously carried out an announced comprehensive inspection of Episkopi Medical Centre on 27 February 2024. As a result of the inspection, the practice was rated as requires improvement overall in accordance with the Care Quality Commission's (CQC) inspection framework. We found the practice was effective, caring and well-led in accordance with CQC's inspection framework. However, we identified areas for improvement in the safe and responsive key questions.

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

https://www.cqc.org.uk/what-we-do/services-we-regulate/defence-medical-services#medical

**At this follow-up comprehensive inspection carried out on 2 September 2025, we found the practice had taken the action required to address the recommendations made. The safe and responsive key questions have been upgraded to 'good' and the overall rating is now good.**

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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 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.

**At this inspection we found:**

- The practice-specific mission statement was clearly embedded into working practice and decision making.
- An inclusive whole-team approach was supported by all staff who worked collaboratively to provide a consistent and sustainable patient-centred service.

- The practice had good lines of communication with the regional team, welfare team, the Regional Rehabilitation Unit at Halton (who provide support from the UK), and the Department of Community Mental Health to ensure the wellbeing of service personnel. In addition, there were established and effective links with the other medical centres on island.
- The arrangements for managing medicines, including the management of medicines given under Patient Group Directives, Patient Specific Directive and high-risk medicines (HRMs) was good.
- The level of compliance with mandated training for staff was close to 100%, a significant improvement since the last inspection.
- A programme of quality improvement activity was in place and this was driving improvement in services for patients.
- All staff knew how to raise and report an incident and were fully supported to do so. The systems and management of significant events was effective and utilised as a driver for change.
- Referral management was governed by a robust process which ensured regular monitoring.
- Patients found it easy to make an appointment and urgent appointments were available the same day.
- Governance systems had been strengthened to ensure all relevant information is captured to monitor service performance.
- Staff were aware of the requirements of the duty of candour, (the duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). There was a duty of candour register on the Healthcare Governance workbook and patients had been informed when needed.

**We found the following area of notable practice:**

- A number of initiatives that utilised information technology had been undertaken and delivered improvements in patient safety. There was a system for recording test results that minimised the risk of human error by converting test results from units used in Cyprus to units used in the UK. Another system pre-populated monitoring information for patients on HRMs.
- A ‘patient referral advice leaflet’ was developed this year. It was introduced 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 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 Defence Primary Healthcare (DPHC) and British Forces Cyprus (BFC):**

- BFC should undertake a review of secondary health care (SHC) provision, this should include a review of the secondary care approval process which has risks associated with it. The review should actively engage patients who have experience of SHC provision, practice clinicians and the practice leadership team. In addition, an analysis of complaints and significant events should be undertaken to identify trends in relation to SHC. Feedback and the development of an improvement plan should involve a wide-range of stakeholders, including patients and practice staff.

**The Chief Inspector recommends to the wider Defence organisation:**

- Challenges around timely access to accurate patient records occur as DMICP 'Deployed' is a system requiring synchronisation and which suffers significant outage periods. Headquarters should deliver solutions to ensure that a contemporaneous patient record can be immediately maintained for all patients.

**The Chief Inspector recommends to the medical centre:**

- Continue the work to strengthen the programme in place to manage patients with long-term conditions by addressing the known inconsistencies in clinical coding (Read coding) and in patient recall.
- Continue to make improvements to Read coding to ensure regular reviews for patients prescribed medicines on a repeat prescription.

**Professor Bola Owolabi**

**Chief Inspector of Primary and Community Services.**

## Our inspection team.

The inspection team was led by a CQC inspector and supported by specialist advisors including a primary care doctor, practice manager, nurse, physiotherapist and a pharmacy technician.

## Background to Episkopi Medical Practice

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

EMC delivers routine primary care services to a patient population of 1,807, including families of service personnel and civilian staff. The population fluctuates during summer months when an additional 500+ patients register**.**

EMC 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 provided primarily 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.

EMC operates from 08:00 hours 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 24-hour Pre-Hospital Emergency Care service is provided by an ambulance crew co-located in the medical centre and this service has been inspected and a separate report produced.

## The staff team.

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| Doctors | **Established for 3.6 full time equivalent (FTE)**<br>1 Senior Medical Officer (SMO)<br>1 Deputy Senior Medical Officer (DSMO)<br>2 MOD GPs combined total of 1.6 FTE<br>1 Regimental Medical Officer (often away and not formally part of the medical centre) 0.2 FTE when in station |
| Nursing Team | **Established for 12**<br>1 Senior Nurse Officer (SNO) – Civilian<br>1 Nurse Warrant Officer (NWO)<br>4 Nurses (military)<br>7 Band 6 nurses – civilian (6 FTE)<br>1 full time post gapped - locum.<br>2 part time posts gapped |
| Medics | **Established for 3**<br>3 Combat Medical Technicians (CMTs) |

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| Practice management | **Established for 2**<br>1 Practice Manager CMT<br>1 Deputy Practice Manager CMT |
| PCRF Team | **Established for 3**<br>1 OC Physiotherapist - locum<br>1 Band 6 Physiotherapist – civilian<br>1 Exercise Rehabilitation Instructor (military) - locum |
| Dispensary | **Established for 2**<br>2 Pharmacy Technicians (civilian) |
| Administration | **Established for 7**<br>1 Administration Manager (civilian)<br>6 Administrators (civilian) 2 posts gapped |

# Are services safe?

**We rated the medical centre as good for providing safe services.**

Following our previous inspection, we rated the practice as requires improvement for providing safe services. We found shortfalls with:

- safeguarding, medical emergency and infection, prevention and control training
- clinical and leadership capacity
- the supply chain for equipment and medicines

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

## Safety systems and processes

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

There was a named safeguarding lead and deputy lead for the practice. At the last inspection, we noted that training required updating for some staff members. At this inspection, we saw that all staff, including Regimental Aid Post (RAP) staff working at the practice, had received safeguarding training at a level appropriate to their role (RAP staff are clinicians who are attached to units rather than employed to work directly at the practice). We were provided with examples of where a safeguarding concern had been raised that included an example initiated by the Primary Care Rehabilitation Facility (PCRF) team.

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

There was a list of trained chaperones which was linked in the healthcare governance (HcG) workbook. Administrative and PCRF staff were not used as chaperones but we discussed including them in the training to provide them with an awareness of the role.

There were both male and female chaperones available and refresher training was last delivered in July 2025. Information regarding chaperones was included in the practice leaflet and displayed in clinical rooms (including within the PCRF) and the patient waiting room. We reviewed at a selection of patient records and found that patients that had been offered or used a chaperone had been recorded.

Staff had been subject to safety checks to ensure they were suitable to work with young people and vulnerable adults. The practice had a system in place for recruitment checks which included a check on the criminal record through the Disclosure and Barring Service (DBS). One member of staff's DBS check was out-of-date. Their renewal application had been submitted and a line manager risk assessment was in place.

There was a contract in place with the 'Staff Managed Service' who conducted pre-employment checks for all staff bank workers and the practice manager was issued with a compliance pack prior to accepting the worker as suitable for the post. This ensured that agency supplied staff had completed the same checks. The checks were conducted at point of recruitment and before any extension of a post was agreed. Checks were repeated every 6 months for workers that had been in location longer than this period.

Arrangements were in place to monitor the registration status of clinical staff with their regulatory body. Professional registrations were recorded on the HcG workbook for all staff including locums, and this was monitored by the practice management team. Staff had professional indemnity cover and information was in place to confirm staff had received all the relevant vaccinations required for their role.

There was a lead and deputy responsible for infection prevention and control (IPC) who were appropriately trained for the roles. Other members of the staff team were up-to-date with IPC training. Episkopi Medical Centre (EMC) followed the Defence Primary Healthcare (DPHC) mandated monthly IPC audit timetable. This audit was completed annually with some elements carried out quarterly on a rolling programme. Some clinical rooms were carpeted and not easily cleaned, and although no clinical procedures were carried out in carpeted areas, this had been added to the issues log. The carpet was cleaned 6-monthly and as part of the deep clean. Spill kits were available in each clinical room and from reception.

Environmental cleaning was provided by an external contractor. Cleaning schedules and monitoring arrangements were established and extended to the PCRF. Daily monitoring of cleaning standards was carried out by the practice manager who signed off a check sheet. In addition, spot checks were also carried out and the cleaning contractor carried out their own internal inspections to assure that cleaning standards were being met. The noticeboards in the facility were covered in laminate so they could be easily cleaned and the cleaning cupboard was well maintained. Deep cleaning of all clinical rooms was carried out in May 2025. The management of clinical waste was good. Consignment notes were maintained and a pre- acceptance waste audit was competed in December 2024.

We did identify a number of minor areas for improvement. The flooring seals had blown in some areas and there were carpet treads in place which did not meet with IPC best practice (as it did not allow effective cleaning in these areas). We highlighted that the light fittings should be included on the next deep clean and the cleaning team (external) should be trained in sharps injuries and blood-borne viruses.

The physiotherapist practised acupuncture and arrangements were in place for the safe provision of this treatment, including an acupuncture health screening assessment, a form for obtaining written consent and a patient information sheet. Within the PCRF, all physical training equipment was serviced and up-to-date. A team from the UK travelled out annually to inspect and service all of the rehabilitation equipment on island.

## Risks to patients

Clinical capacity and leadership capacity had been longstanding issues across the medical team and the main risk to the provision of safe and effective care. A lack of staff had led to excessive hours being worked by the doctors. Staffing levels were on the risk register at the last inspection and the risk has been transferred to Med Branch and DPHC. At this inspection, staffing levels had improved and there was only 1 vacant post which was about to be filled. Temporary healthcare workers had been secured to cover any recent gaps and the recruitment of paramedics to deliver the pre-hospital emergency care service meant that excessive demands on the doctors' time were no longer made.

At the last inspection, staffing gaps in the PCRF had impacted patient access and staff wellbeing. There had been times when, with only 1 physiotherapist in the department, the referral rates had been large and resulted in longer working days. Since the last inspection, the Officer-in-Command (OC) physiotherapist from Akrotiri was now OC for both practices and had developed a business case to secure funding for locum staff to fill the vacant posts. This had been developed using 6 years of data to determine the resource requirements. As a result, staff were now working appropriate hours and the wait time for initial physiotherapy was 4 days. The vacant posts had been filled by a locum physiotherapist and a locum exercise rehabilitation instructor (ERI).

Lone working during out-of-hours (OOH) was no longer an issue as the despatch function (sending of an ambulance) had been moved to Akrotiri. A potential risk identified at the last inspection was of nurses lone working OOH without the training and confidence in the management of paediatric emergencies, this had now been addressed. A dedicated training day had been complimented by additional courses specific to treating children; for example, paediatric immediate life support.

The emergency trolleys were accessible and regular daily checks undertaken. A monthly stock check was completed and items were ordered in plenty of time when it was identified that stock was due to expire. We were told that that items from the UK were taking up to 6 weeks to arrive. To mitigate, the 3 practices on the island were networking to reduce this risk and share kit and equipment when required. Staff reported that these arrangements worked well. We reviewed the medicines on the trolleys and found them to be appropriate and in-date. Automated external defibrillators (AEDs) were located in the medical centre, including in the PCRF, and in the station gym. The AED had a paediatric mode, adult and child oxygen driven nebulising masks were available. Igel's, oropharyngeal and nasopharyngeal airways (used to clear a passage for oxygen delivery and ventilation during resuscitation or anaesthesia) were available in sizes for children and adults.

Moulage (simulation) training was held fortnightly and all available staff could attend. Recent topics included heat, neurology and one of the physiotherapists had provided lower

limb training. Staff were in-date with basic life support (BLS), AED and anaphylaxis training which had been completed by all staff in April 2025.

At the last inspection, we identified the considerable risk for equipment and medicines resupply and the chain to get equipment repaired could be extremely long. Medicines could take months to arrive, typically an 8-week resupply could take up to 12-16 weeks. The supply chain for medicines had been enhanced with the development of a relationship with a local pharmacy and cross-working between sites to share stock. There were protracted servicing and equipment checks that required many items to go back to the UK for months at a time for calibration. Although equipment was now working for audiometry, electrocardiograms and spirometry, the second devices held as backup were not operational.

There was a sepsis policy in place. Sepsis red flag posters were displayed in clinical rooms and at reception. Sepsis training was last conducted in May 2025 and completed by both clinical and non-clinical staff. There was a policy for heat illness management which clinicians knew how to access. A heat illness management pack was kept on standby in the fridge and doctors discussed any heat injury cases during handovers. Heat illness training and moulages, including a burns moulage had been delivered in December 2024.

Waiting patients in the main reception area could be observed at all times by staff working on the front desk. This was facilitated by the use of a video camera that was used for monitoring, no recording was made.

## Information to deliver safe care and treatment.

Each medical centre on the island had its own individual DMICP(D) (electronic patient record system) server and so clinical teams were unable to see notes of patients at another practice. In addition, there were high numbers of transient patients due to units transiting or posted to Cyprus for operational needs and due to the need for records to be “sent” to DMICP, there was a delay of several days before the full patient record was available. Networking of the DMICP sites on Island would significantly improve resilience by adding the possibility of remote GP consultations during the OOH period by clinicians based at any site. Networking with servers in the UK would allow access to full medical records of transient personnel. Patient care episodes were recorded on DMICP. A small selection of records were examined and were of good quality, with clear history, examination findings, management plan and safety netting recorded.

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

Referrals for PCRF patients were added to a tracker as their DMICP (D) did not have an 'administration list' (as used in UK military medical centres to manage referrals). Each referral was captured on this and discussed at the multidisciplinary team meeting as required. The OC PCRF was developing pathways to document clear referral processes for different conditions and management options to give clarity over the best way and place to access different services. The 'rehabilitation master template' was used but on review of the notes, we identified that the template was not being completed in full for initial assessments. Read codes were seen as being used correctly for all consultations. PCRF staff attended the weekly multidisciplinary team meeting and held a fortnightly virtual meeting with Regional Rehabilitation Unit Halton for formal discussions of patient management.

The medical centre continued to adhere to a 'Secondary Care Approval Process'. This was because an overseas Defence Primary Care Medical Facility was utilising the secondary care of a Cypriot private medical centre. The doctors at Episkopi had the responsibility to ensure that the care being provided from elsewhere on the island was in line with what the patients would expect from the NHS. Doctors would ask for the opinion of a Cypriot specialist but would then have to decide if that advice/opinion was appropriate. To aid them in this they could reach back to the DCA (Defence Clinical Advisor) who would help with the decision. Also, when a Cypriot consultant prescribed a medication or treatment that would not routinely be used in the UK, the doctors had to decide on an alternative which would be used by the NHS.

There was a safe system in place for requesting, receiving and summarising new civilian patient records into the practice. As new civilian records can take between 1-2 months to arrive, the LaSCA NHS Agency (part of the Primary Care Support Services for NHS England) was tasked with forwarding a patient summary via email of the requested record to be scanned onto DMICP. Notes were summarised by the clinical staff and there were only 15 left outstanding on the day of the inspection.

A local working practice was in place to ensure samples were taken safely, appropriately recorded on DMICP and results reviewed and actioned by the appropriate clinician. There was no electronic link available with the laboratory, so the practice used a manual system with sample request forms stamped to create a check list completed at each stage of the process. The SMO had developed a tool to upload sample results into DMCIP and convert into UK units. The practice conducted a blood audit every 6 months to ensure they were complying with the sample process. They had been completed this since January 2024 and the last cycle carried out in June 2025 found to be 96% compliant (1 set of results that did not come back from the laboratory meant the patient had to be re-tested). The samples were collected twice daily and held in the sample fridge prior to leaving the facility due to the heat. They were then placed within a cool box with cool blocks for the 90 minute journey to the hospital in Limassol.

EMC were required to provide healthcare to patients detained in a prison facility. Where patients required assessment, they were brought to the practice. Procedures were detailed in a 'medical access for prisoners' local working practice document.

Peer review of doctors DMICP consultation records was undertaken monthly and a consistent methodology was used. Peer review was conducted weekly by the nursing team and a notes audit was conducted by the Band 7 nurse, 10 sets of notes were

checked for each nurse. The physiotherapist and the ERI also had their notes peer reviewed annually. PCRF staff at Akrotiri and Episkopi audited each other's notes when staffing levels allowed. Notes audit feedback was discussed as a group but the report also had an individual breakdown.

## Safe and appropriate use of medicines

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

The PTs had access to the electronic organisational-wide system (referred to as ASER) and demonstrated that they could log in and record an ASER. ASERs were discussed and the learning shared with the wider team together with any quality improvement plans (QIPs) from the dispensary.

A near-miss log was in place. Through discussion, staff clearly understood the importance of using a near-miss log in the dispensary. There was evidence that some near-misses had been recorded in the last 2 months and were categorised in detail to enable trend analysis. Near-misses were also recorded for the prescribing clinicians; the most recent one was where the prescriber had recorded in the wrong patient's name. The PTs discussed near misses between themselves together with trends but we suggested that this could be a standing agenda at one the meetings with the wider practice team.

Evidence was seen of effective processes for the management and action of Medicines and Healthcare products Regulatory Agency (MHRA) and National Patient Safety Alerts. Evidence was seen of an in-date electronic MHRA alert register and that the practice had a system in place to ensure that they were receiving, disseminating and actioning all alerts and information relevant to the practice. Evidence was seen that the alerts were discussed in the practice meetings and there was a link to the MHRA register in the minutes for the non-attendees to access and view. Any alert that required urgent action was sent out immediately and not held until the next meeting. We were shown a recent medicines alert from August 2025 which had been actioned appropriately.

Searches were run on DMICP to identify any patients prescribed sodium valproate. Staff were aware of the recent changes that sodium valproate must be dispensed as a full pack and was able to locate the patient information leaflets as part of the pregnancy prevention programme. At the time of inspection, there was no patients prescribed this medication.

There was one non-medical prescriber (NMP) in the medical centre. The NMP was listed on the Nurse and Midwifery Council register as an Independent Prescriber. Evidence was seen that the DPHC HQ authorisation to prescribe and training was in place and current.

All repeat prescriptions were requested by email, eConsult or by patients dropping off their repeat slips. There was a local working practice in place stating the different ways that patients could order their repeat medicines. A lead time of 36-48 hours was advised but workload permitting, requests were normally completed sooner. All requests were Read coded appropriately on DMICP. Through discussion, it was confirmed that no repeat requests were completed by telephone. A spot check of the dispensed repeat prescriptions

found that all had been dispensed within 8 weeks. This showed that staff effectively informed patients that their prescriptions were ready for collection and was efficiently returning uncollected medicines to stock if they were not collected within that period.

Medication reviews for patients with long-term conditions could be strengthened with more regular use of the template available on DMICP to ensure consistency of Read coding. However, staff had good awareness of their responsibilities and knew when requests should be tasked to a senior clinician.

Staff knew that they should only re-issue repeat prescriptions if the patient's review date was in-date and there were available repeat counts on the patients prescribing record. The process for handing out prescriptions to patients was in-line with the DPHC standing operating procedures.

A process was established for the management of and monitoring of patients prescribed high-risk medicines (HRM). The register of HRMs used at the medical centre was held on DMCIP and all doctors and relevant clinicians had access to this. We looked at a sample of patient records and saw that all had been coded or had shared care agreements in place. The SMO had created an HRM register that pre-populated and simplified management of patients that required monitoring due to the medicines they were prescribed. A meeting as due with the UK based DMICP team to discuss if this could be rolled out across DPHC.

It was also noted that although there were Read codes for high-risk medicines, there was scope to improve the clinical coding for patients on medicines that did not require monitoring. Improvements were planned to review all patients on repeat medicines and consider the removal of any repeat medication that has not been issued in over 12 months. The 12 month target was because patients posted from UK to Cyprus are asked to arrive with 3 to 6 month supply of medication. Therefore, it was commonplace to not require any medication until 6 months after arrival.

Patients were informed of side effects to ensure they take their medicines safely. The dispensary held appropriate warning cards. Evidence was seen of comprehensive medication counselling when prescriptions were collected.

Arrangements were established for the safe management of controlled drugs (CD), including destruction of unused CDs. A CD audit had been completed annually. There was a local working practice in place to advise on assessing the dispensary and the CD cupboard if required out of hours. There was a locked box containing the keys and alongside this there was a safe log controlling/ documenting the access of the dispensary and CD keys.

Emergency medicines were easily accessible to staff in a secure area of the medical centre and all staff knew of their location. Gases were at least half full and in-date. The medical gas store was clean and the empty cylinders were segregated from full in date cylinders. Correct HazChem signage was in place for the medical gas stores and on the front door of the treatment bay where the oxygen and Entonox (a gas used to control pain or anxiety) were kept.

There were well defined processes in place for the ordering and receiving of vaccines. All vaccines were in-date and evidence was seen that the vaccines were stored correctly allowing for air circulation. We saw pharmaceutical thermometers were in place and the temperature was monitored twice daily. There had been no requirement to transfer vaccines but insulated boxes were kept at the Medical Provisioning Point should the need arise.

A process was in place to update DMICP if changes to a patient's medication were made by secondary care or an OOH service. Prescription issued in secondary care often did not meet legal requirements or were not legible. This had been listed as an issue on the risk register. If legal and legible, a secondary care issued prescription was given to the doctor to transcribe. If not, a photocopy was taken and scanned onto the patient's notes and the original given to the patient to present to a local pharmacy. An audit has been completed on the quality secondary care prescriptions but was unavailable on day of inspection.

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

Prescription pads were stored securely. There was a system to track their issue and usage so all prescription numbers could be traced to the prescriber. There was no record of checks done on a 6-monthly basis so we discussed implementing these to identify any discrepancies.

Practice nurses used Patient Group Directives (PGDs) for immunisations and primary care treatments. Evidence was seen that the nurses were authorised to use the PGDs using the correct Annex E form. A review of DMICP consultations found that the PGD template was being used and the batch number and expiry of the medicine supplied was being recorded in the template. PGD audits had been completed in October 2024 both individually and by clinicians who were independent of the PGD users being audited. The SSAFA nurses who administered childhood immunisations were also working under the DPHC PGDs. All of the nurses were trained to provide Patient Specific Directions. The Band 7 nurse maintained a competency register, was aware of registration with the Nurse and Midwifery Council and tracked revalidation dates.

There were cupboards holding over-labelled medicines for the supply out-of-hours. A stock check of 5 medicines found the stock levels to be correct and transaction reports showed evidence of good stock accounting and stock management. The cupboard was locked and the keys kept in a key-coded safe.

The PTs felt included and integrated within the medical centre. At the last inspection, we reported that practice and healthcare governance meetings were not attended with regularity. At this inspection, the PTs advised that they were included in all appropriate meetings and commented on the positive support provided by the regional pharmacist.

## Track record on safety

There was a designated health and safety lead and a board was displayed which was regularly externally audited. Electrical safety checks were up-to-date. Water safety checks were regularly carried out and a full legionella risk assessment was carried out in March

2020. More recent checks had been carried out and copies of the certificates had been requested on multiple occasions from the safety, health, environment and fire (known as SHEF) team. Following the inspection, the practice obtained and provided us with copies of the certificates to show that testing was in-date (the legionella risk assessment was dated November 2024 with the next survey due date being November 2026). A fire risk assessment of the building was undertaken annually. Firefighting equipment tests were current. Staff were up-to-date with fire safety training and were aware of the evacuation plan. The appropriate Control of Substances Hazardous to Health (COSHH) risk assessments were up-to-date having been reviewed by the deputy practice manager. This was detailed in the SHEF audit from July 2025.

The medics were responsible for the management of equipment. Various spreadsheets were maintained to support monitoring the servicing and calibration of equipment. We reviewed these and it was evident the servicing of equipment was up-to-date. Any new equipment was subject to an initial check by the Medical Device Safety Service. Portable appliances were tested in-house and had last been done in July 2025.

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

The deputy practice manager was the risk manager and had completed the Institution of Occupational Safety and Health training. Risk assessments had been reviewed in June 2025 by a trained risk assessor who had completed building custodian training. The medical centre had current and retired risk registers and an issues log in place. Risks were reviewed in the monthly healthcare governance meetings and any new risk was discussed at the Heads of Department meeting. There were a range of clinical and non-clinical risks in place and risk assessments had all been transferred to the new e-form at review.

There was a fixed alarm system in place in the pharmacy (where occasionally lone working took place), a physiotherapist’s room, triage bay, all gender toilet and the corridor. All other staff in the medical centre and the PCRF had handheld alarms were tested monthly and recorded.

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

## Lessons learned and improvements made.

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

From interviews with staff and evidence provided, it was clear there was a culture of reporting incidents. Both clinical and non-clinical staff gave examples of incidents reported through the ASER system including the improvements made as a result of the outcome of investigations. For example, the PCRF had recorded an ASER when a second opinion was sought for an MRI scan caried out by a host nation secondary care provider. There was no agreed pathway to get a second opinion when the MRI (magnetic resonance imaging) report had not correlated with the clinical impression and not matched the physiotherapist's findings. An ASER was submitted and escalated to Med Branch.

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

# Are services effective?

**We rated the practice as good for providing effective services.**

## Effective needs assessment, care and treatment

Patient records informed us that clinicians carried out assessments and provided care and treatment in line with national standards and guidance, supported by clear clinical pathways and protocols. Arrangements were established to ensure staff were up-to-date with current legislation, research and guidance, including NICE (National Institute for Health and Care Excellence) and the Scottish Intercollegiate Guidelines Network (SIGN). The GP registrar was delegated with responsibility for the agenda of the weekly doctor's meetings. This included discussing complex patients, medication management updates, NICE and SIGN updates. There was also a monthly meeting with the Akrotiri clinicians with a similar agenda. Guidelines were also discussed in the healthcare governance (HcG) meetings.

Primary Care Rehabilitation (PCRF) staff attended multi-disciplinary meetings to share and discuss evidence-based guidance, including NICE & SIGN. They were also an integral part of the practice meetings where clinical issues were discussed. Cross island learning had recently been reintroduced through a 'journal club' to hold pan-island discussion on cases with colleagues. The PCRF were part of the weekly multidisciplinary team meetings, dialled into regional in-service training and were signed up to receive alerts by email.

Staff were also kept informed of clinical and medicines updates through the Defence Primary Health Care (DPHC) newsletter circulated to staff each month.

The PCRF staff were familiar with Defence Rehabilitation Best Practice guidelines (BPG) and provided examples of treatment delivered based on these and with care pathways. Audits had not yet been undertaken to look at compliance with BPG but this was a future aspiration. Our review of PCRF patient records showed Rehab Guru was used for exercise programmes for some patients (Rehab Guru is an exercise prescription software that allows medical professionals to send structured exercise programmes and educational information to individuals).

The PCRF ensured that it took a holistic view of patients. As part of the new patient questionnaire, there were prompts to ask about sleep, mood, diet and stress. Patients were referred to the dietician, smoking cessation and the medical centre when needed. The musculoskeletal health questionnaire was used by some staff, though not consistently (completed on initial presentation and sometimes when discharged) in the notes we reviewed. Other patient reported outcome measures, such as the Tampa scale of Kinesiophobia (a questionnaire designed to measure the fear of re-injury movement or activity in patients with chronic pain conditions) were seen as examples in the notes.

The exercise rehabilitation instructor (ERI) held reconditioning / rehabilitation physical training sessions in the station gym from 07:00-08:30 each weekday. This was both a change and an increase in available hours since the last inspection and there had been no negative patient feedback on access and availability.

## Monitoring care and treatment

Although managed by the Senior Nursing Officer (SNO), the Nursing Warrant Officer was the lead for all long-term conditions (LTCs), there was a plan to start delegating this lead role to the other doctors. The registers were a work in progress and the SMO was aware that there was scope for improvement. Patients had alerts for most LTCs but there was not always consistency in Read coding; for example, in prediabetes. We discussed how the consistent use of DMICP LTC templates would aid with consistent Read codes and diary dates. Hypertension was the next identified area for improvement (coding improvement, recalling patients with previous high readings and encouraging nurses to record the best of 3 readings).

Monthly clinical searches were carried out to produce a recall list of patients who required an appointment to be reviewed and/or monitored. The approach was to provide patient education to empower them to take ownership of their condition. Health conditions were assessed before patients arrived on the island as there was a robust screening process prior to the Regiment deploying overseas with their family members; for example, a child with type 1 diabetes was not accepted and was stopped via the UK screening process.

There were 18 patients on the diabetic register and their care indicated positive control of both cholesterol control and blood pressure. Patients at risk of developing diabetes were identified through the over 40's screening, which included relevant testing (HbA1c - average blood glucose (sugar) levels). In addition, annual blood tests were carried out on female patients with a history of gestational diabetes (who were at higher risk of developing diabetes) and checks formed part of the annual review for patients with a long-term condition associated with an increased risk of developing diabetes (for example, hypothyroidism, hyperlipidaemia and long-term use of steroids).

There were 76 patients recorded as having high blood pressure. Sixty-eight (88%) were recorded as having a blood pressure check in the past 12 months. The 8 patients with no record in the past 2 months had been invited but had not responded.

There were 53 patients with a diagnosis of asthma and 47 had an asthma review in the preceding 12 months. One patient was out-of-date their annual review (appointment booked), 3 patients were non-responders to invitations for review, 1 was a new diagnosis in last 12 months and incorrect Read-codes had been used for 1 patient.

Since the last inspection, a mental health management process had been introduced. All new referral and follow-up appointments were tracked and any rejected referrals were subjected to a review. Patients were also followed up by practice staff following discharge from the Department of Community Mental Health. Support on the island was provided by a dedicated Cyprus based mental health team based at Akrotiri and a Child Adolescent Mental Health Service team based on island. In addition, patients could contact the 'Silverline' service to obtain support.

82% of patients were in date for audiometric assessments (within the last 2 years).

The nurse Warrant Officer was the audit lead and the nurse manager was the quality improvement project lead. Audits in place were a mixture of mandatory audits from DPHC and some internal audits. All the audits were colour coded to reflect whether they were

mandatory or local audits. There was a forecast of monthly audits clearly displayed on SharePoint. The outcome of audits was discussed during the HcG meetings. A good example of a repeated audit was on the Read coding of HbA1c (a test to measure average blood sugar levels) results. The initial audit in September 2024 found 17% had been Read coded. Following the introduction of a new tool to manage pathology results, a repeat audit in March 2025 showed this had increased to 71%.

There was a specific audit calendar in place for the PCRF that was driven by the needs of the patient population, for example, an acupuncture audit. A physiotherapy and ERI notes audit was completed annually and recorded in the HcG workbook. The audit programme included plans for repeat cycles and additional clinical audits (that had not been completed to date due to time constraints) were being planned for the future.

## Effective staffing

The practice, including the PCRF, used the DPHC mandated induction which included cadre specific elements. Permanent staff had a more in-depth induction to include elements which were specific to Cyprus. This pack had been updated since the last inspection. There was now a well-developed induction pack specific for medics which included a comprehensive list of training specific to their duties. Newly appointed staff spoke positively on the process followed and completed induction checklists were retained by the practice manager. New staff were now allocated a role-specific mentor on arrival. Training facilitated by the paramedics and in-service training for the whole team was held each week.

Mandated staff training across the staff group was close to being fully completed. This was a significant improvement from the last inspection when we found gaps throughout because staff had needed to prioritise due to time constraints and focussed on clinical delivery as a priority. Staff were reminded at the practice meetings of the requirement to complete mandatory training. There was protected time every other week for staff to complete mandatory training and additional ad hoc time when required. There was group training every other Monday and daily moulage training for all available staff.

Nursing support within the team had further strengthened since the last inspection. It was evident that nurses felt they could and would ask for support and advice when required. The varied backgrounds within the team forged a broad range of experience and this was supported by training specific to the role. The Band 5 nurse and the Senior Nursing Officer manager had spent time with staff to ask what training they would like to conduct. With the practice having children as registered patients, one of the nurses had recently completed paediatric immediate life support training and 4 colleagues from the nursing team were booked onto the course in October 2025 and January 2026. The practice also ran a well-attended (30 attendees from both Cyprus and the UK) minor illness course over 2 days where paediatric training was delivered. Following the feedback, additional sessions had been delivered in paediatric care. In-house training had included a focus day on the treatment of a sick child. Topics included paediatric basic life support, combining red flags, sick child signs and symptoms and fever pain score. The Deputy SMO was trained in major incident medical management and support (known as MIMMS), paediatric

immediate life support and paediatric advanced life support. A number of the doctors were trained in advanced life support and immediate life support.

The practice was now making use of the pharmacy technicians (PTs) to provide clinical advice when appropriate. This was welcomed by the PTs as it enhanced their role, and by patients who could obtain some advice without the need to book an appointment with a doctor or nurse. The PTs had attended the last unit health fair signposting services and providing information.

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

## Coordinating care and treatment

The medical centre team had forged effective links with station commanders, welfare staff, padres and the mental health team based at Akrotiri. We spoke with the Child and Adolescent Mental Health Service (CAMHS) nurse as part of our inspection and they told us the medical centre were very responsive if a patient required urgent access to a doctor.

The medical centre team had established strong links with SSAFA as they were co-located in the same building. We spoke with the team and they confirmed that communication was consistently good and that working relationships between the two were strong and to the benefit of the patient group. The doctors and nurses attended a pan-island monthly meeting with colleagues from the other military medical centres in Cyprus.

The PCRF had good relationships with the Regional Rehabilitation Unit (RRU) Halton in the UK for referral and Multidisciplinary Injury Assessment Clinic (MIAC). Patients could select where they attended courses and the PCRF used ‘RRU Course Dashboard’ for determining waiting times. Discussion on this formed part of the fortnightly online meeting with colleagues from RRU Halton. The wait time to attend MIAC was approximately 1 week to triage and then patients were usually seen within 4-6 weeks. The MIAC team came out twice a year to hold a clinic on island. In between, patients would be sent back to the UK for this. Good communication links were established with the unit, midwives, health visitor and children’s nurse. Internally, the musculoskeletal meeting was integrated with the doctors’ weekly clinical meeting.

## Helping patients to live healthier lives.

One of the nursing team was the lead for health promotion across both Akrotiri and Episkopi practices. The lead had completed the ‘DoFIT’ military course on diet and exercise and linked in with the physical training instructors. Staff members were assigned topics which they ran with for their assigned month. These topics had been assigned for the whole year and the programme was detailed on the HcG workbook. A ‘ladies day’ was an example of a recent topic where diet, exercise, women’s health and yoga were all discussed. Other promotional topics included stress awareness month (April), epilepsy awareness day (held in February) and sexual health week (held in September).

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

We saw information leaflets were available in the treatment rooms. There were notice boards located in various places around the medical centre, some example topics covered included men's health, mental health, smoking and alcohol. During consultations, patients were given leaflets or items printed from the internet to support them following the appointment.

Unit Health Fairs were undertaken annually and medical centre staff, including representatives from the PCRF, were involved. The next was scheduled for October 2025 and there were posters to promote this displayed in the building. There was a health promotion board in the PCRF, with topics changed every month. The practice also used text messaging and the practice newsletter to share health promotion material.

Two female nurses had the appropriate sexual health training (STIF) and provided sexual health support and advice. To provide the option of seeing a clinician of the same gender, a STIF trained male nurse conducted 1 visit per month and it was reported that this clinic was well attended. Patients could either pre-book appointments or turn up on the day. Condoms were available in the toilets. Patients were signposted to local sexual health services for procedures not undertaken at the medical centre. They worked to the local working practice guidance.

At the last inspection, we were told that having recognised that cervical smears uptake required improvement, the team had created a health promotion campaign with a stand at the unit health fair. Social media and local station channels were used to improve communication. Extended opening times of the clinics were used to facilitate attendance for those unable to attend during the day. Uptake had continued to improve since the last inspection and was now above the national target (88%, the NHS target was 80%) Compassionate care was shown with the changes to the cervical smear follow up process with a personalised approach to informing patients of abnormal results. The tracking of cervical smear samples was simple and clear to ensure timely follow up. Results took between 3 and 5 weeks to return. Those patients requiring colposcopy were referred back to the UK.

Patients with a mental health need were supported by the medical centre with initial interventions which included sign posting to mental health resources and support, the padre service, third sector support, welfare support and routine prescriptions. Adults (including family members) could be referred to the mental health team at Akrotiri and children could access the CAMHS in the same building as Episkopi Medical Centre. Access to CAMHS was good and children were seen promptly. We reviewed a sample of patients notes and found that note taking was good and they had been clinically coded correctly. There was no out-of-hours access to CAMHS but the staff we spoke with confirmed that there had been no requirement.

Regular searches were undertaken to identify patients who required screening for bowel, breast, and abdominal aortic aneurysm in line with national programmes. Alerts were

added to their DMICP record which allowed for opportunistic discussion with a health professional. DMICP searches had been created for all national screening. However, there was no bowel screening programme in Cyprus. Eligible patients were offered an FOB (faecal occult blood test) and the SMO was researching the ability to provide FIT (faecal immunochemical tests) for those in the eligible age group. However, so far there was no assurance that this compared with the NHS provided test. Patients over 55 were encouraged to access a FIT test when they visited the UK but potentially there was a group of patients (civilian contractors) who would be missed. We discussed this with the practice and it was confirmed that civilian contractors were signposted to suitable alternative providers of primary care.

Vaccination statistics were provided:

- 96% of patients were recorded as being up to date with vaccination against diphtheria
- 96% of patients were recorded as being up to date with vaccination against tetanus
- 96% of patients were recorded as being up to date with vaccination against polio
- 99% of patients were recorded as being up to date with vaccination against hepatitis B
- 98% of patients were recorded as being up to date with vaccination against hepatitis A
- 95% of patients were recorded as being up to date with vaccination against MMR
- 93% of patients were recorded as being up to date with vaccination against meningitis.

Childhood Immunisations (data provided by SSAFA). The World Health Organisation targets a 95% vaccination rate for routine childhood immunisations.

- 100% of children aged 1 had completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB)
- 97% of children aged 2 had received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster)
- 91% of children aged 2 had received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster)
- 94% of children aged 2 had received immunisation for measles, mumps and rubella (one dose of MMR)
- 91% children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR).

## Consent to care and treatment

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. They had a good understanding of the Mental Capacity Act (2005) and how it would apply to the patient population. Mental capacity training had been delivered to staff since the last inspection (May 2025). Written consent was appropriately

recorded in the clinical records we looked at for minor surgery and acupuncture. Staff we spoke with were aware of Gillick competence (young people under 16 with capacity to decide) and would ask children over 13 years whether they wanted to be seen alone or with a guardian. We saw examples of this recorded in patient notes. Clinicians fully understood the principles of Fraser Competence.

# Are services caring?

**We rated the practice as good for providing caring services.**

## Kindness, respect and compassion

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

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

To ensure patient's views contributed to the inspection, we offered patients various opportunities to provide feedback on the service. Views were shared through CQC feedback cards completed by patients prior to the inspection, by email and through interviews with patients on the day of the inspection. We received 27 patient comment cards, 26 were very positive about their experience and of note, the communication and caring approach from staff.

Sixteen registered patients responded to the '1 minute patient satisfaction survey' introduced in July 2025,11 said they were 'very happy' with their overall experience, 5 said they were 'happy.' All 16 of the respondents said that staff were helpful and professional. During this period of time, the medical centre also received 4 compliments in the free text section of the survey.

We were given examples whereby the medical centre and Primary Care Rehabilitation Facility (PCRF) staff had gone the extra mile for patients. For example, a patient that had left the practice was waiting for a hospital appointment in the local area but an appointment was offered from a hospital that was far from their home. Although no longer their patient, staff negotiated and arranged an appointment closer to the patient's home in the UK.

Liaison with patients requiring secondary care was an area where service delivery from the practice had improved. All patients admitted were placed on the triage list for a phone call the following day to follow up their care.

We reviewed the records for 3 patients who were experiencing poor mental health. It was clear that clinicians were responding to patients with kindness and compassion, ensuring that patients had the space and time to talk when they needed to. A mental health tracker had been developed to capture all those referred to Defence Community Mental Health

(DCMH) and ensure they are followed up. Of note, this included patients whose referrals had been rejected by DCMH.

## Involvement in decisions about care and treatment

The clinicians and staff at the medical centre recognised that the personnel they provided care and treatment for could be making decisions about treatment that could have a major impact on their military career. Staff demonstrated how they gauged the level of understanding of patients, gave clear explanations of diagnoses and treatment, and encouraged and empowered patients to make decisions based on sound guidance and clinical facts. The practice was proactive in seeking out feedback from the patients and had made a number of attempts to establish a patient participation group and had condensed the practice questionnaire to a '1 minute survey' to try and encourage more patients to provide feedback.

The longest serving MOD GP was the carers lead for the medical centre and used their extensive knowledge of the patients together with the Defence Primary Healthcare Carers standard operating procedure as their guide. All carers were coded on DMICP and generally identified during registration at the medical centre. There was a carers board in the waiting room and further information in the online practice leaflet. We highlighted that 5 of the 13 patients on the carers register did not have an appropriate alert against their record on DMICP. The practice rectified this following the inspection.

The medical centre had access to The Big Word translation service which the medical centre accessed daily for either verbal translation or written translation of hospital letters. This service was used regularly to communicate with patients being held in the prison on camp. The hospital liaison officers were all at least bilingual and supported patients attending secondary care services. Having identified particularly high non-attendance rates for Nepali patients, posters had been translated into Nepalese.

## Privacy and dignity

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

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

Physiotherapists had separate and private clinical rooms for assessment and treatment. PCRF staff also had an office at the station gymnasium that could be used for confidential conversations and completing notes.

The medical centre had doctors and nurses of both genders so patients could choose if they wanted to see a specific doctor. PCRF patients wanting to see a same gender female physiotherapist would be offered an appointment at Akrotiri. Patients were offered a chaperone routinely.

# 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 requires improvement for providing responsive services. We highlighted issues with:

- the building not being seismic compliant
- the management of complaints.

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

## Responding to and meeting people's needs

The medical centre at Episkopi was dated and was not seismic compliant which was a concern for staff working in an area with known earthquake tremor activity. Leaders confirmed that 'Project Apollo' sought to replace the building. A fixed date had been set since the last inspection and plans had been drawn up. Work was scheduled to start in 2027 and be completed in 2029. To mitigate in the interim, information posters had been displayed around the building (in the staff room and on the health and safety noticeboard). Furthermore, a healthcare improvement programme was proposed plans with plans for 2025 and beyond, options for a non-resident on call rota was being explored and this could reduce the risk when the practice was closed.

An Equality Access Audit as defined in the Equality Act 2010 had been completed in December 2024 and, as a result, the requirement for a hearing loop had been added to the medical centres issues log for resolution. We discussed the requirement for this as a member of staff who had worked for 7 years at the practice had never encountered the need. The reception desk was too high for wheelchair users and this had been added to the issues log. Staff had completed learning disability and autism training in April 2025.

The medical centre staff understood the needs of its patient population and tailored services in response to those needs. Appointments slots were protected to meet the needs of specific population groups. For example, appointments were made available up until 19:30 once a month in a dedicated cervical screening clinic. Appointments were available until 16:00 each weekday which allowed after-school appointment times for pupils and teachers.

Facilities were available for families, including a private room for breast feeding and baby changing facilities. The Soldiers, Sailors, Airmen and Families Association (the Armed Forces Charity referred to as SSAFA) team did mention that space for breastfeeding could be limited during childhood vaccination clinics and this feedback had been fed into the discussions on the requirement s for the new building.

The medical centre held an emergency clinic between the hours of 08:30-10:00 (otherwise known as 'team triage' equivalent to the 'total triage' system) for military patients requiring to be seen urgently on the day. This was run by the medics supported by a nurse with a

supervising doctor to support and advise as required. Same day appointments were protected each day for both doctors and nurses.

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

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

## Timely access to care and treatment

Details of how patients could access services when the medical centre was closed were clearly displayed at the front entrance so could be easily seen when the practice was closed. In addition, the information was relayed in a comprehensive patient information leaflet. Episkopi medical centre continued to use a 'Sway' platform for the leaflet which provided Quick Reference (QR) codes as a link to information and services on the island. These links were posted at various strategic locations around the medical centre and station welfare facilities. The document itself was comprehensive and encompassed information not only required for primary pare provision but went further to include information about out-of-hours care on the island, Cyprus essentials, Aeromed but most importantly self-help information. Patients in British Forces Cyprus did not always have all the additional services provided in the UK from the NHS such as pharmacies, NHS 24 helpline, Minor Injuries etc, this practice leaflet acknowledged this gap and was responsive to the unique patient needs in this atypical environment. The document was presented in a very user-friendly manner, it was easy to read, it contained links to various websites and platforms, it was widely available and it was regularly updated.

Urgent doctor and nurse appointments were available on the day. Routine doctor appointments were available within 3 days. Routine appointments to see a nurse were available within a few days. A text messaging service was used to remind patients of their appointments as well as to communicate patient information and advice of results being received.

The Primary Care Rehabilitation Facility offered direct access appointments. This had been streamlined using the eConsult service which allowed both serving personnel and entitled civilians to request direct access. A new patient or routine physiotherapy appointment was available within one week. There was capacity to see patients urgently within 2 days. Appointments to see the exercise rehabilitation instructor or a new or routine appointment were available within three days. There was no waiting list for rehabilitation classes. All patients were assigned a named physiotherapist who managed their care at every appointment.

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

There was access to a small selection of prescribable medicines in a lockable cupboard that was accessible with a key that had to be signed out by the prescriber, and access to

the pharmacy was possible with 2 signatures. Medicines could also be given by the nurse under Patient Group Directives.

## Listening and learning from concerns and complaints

The practice manager was the lead for complaints. There was information regarding the complaints process in the practice leaflet and a complaints board in the waiting room. We highlighted that the complaints' policy could be added to the board.

The complaints management process had been improved. At the last inspection, we found 3 complaints that were unactioned in the group complaints mailbox. Others had been sent to Med Branch as they related to secondary care and although a holding response has been sent to the patient, the complaint has not been added to the Defence Primary Healthcare log.

Managed by the practice manager, complaints were recorded, be them verbal or written, discussed in practice meetings and had led to changes being made. For example, a secondary healthcare histology results tracker had been implemented. There was scope to tidy up historical entries on the complaints register, a record from January 2024 showed that an investigation was ongoing but the status of the complaint was complete. Analysis of complaints had been conducted and a trend of complaints in relation to secondary healthcare had been identified and escalated to Med Branch.

# Are services well-led?

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

Following our previous inspection, we rated the practice as good for providing well-led services. However, we highlighted issues to Defence Primary Healthcare (DPHC) with:

- clinical leadership capacity such that expectations on staff are reasonable and individuals feel adequately supported to provide primary healthcare, out-of-hours care, urgent care, prison healthcare, and occupational healthcare.

This recommendation had been addressed with the pre-hospital emergency care (PHEC) service now run by paramedics. This had reduced the demands on doctors most notably for out-of-hours working.

## Leadership, capacity and capability

The practice was now fully staffed and the balance of civilian and military clinical input provided resilience and continuity. The medical centre had a good leadership strategy and vision that all staff championed. The team spoke of inclusive leadership felt valued and well supported. Doctors continued to be integral to the out-of-hours (OOH) service but were no longer part of the emergency PHEC service. Alongside the Akrotiri doctors, the MOD GPs covered OOH duties during the week and military doctors covered weekends. This meant staff were not working in excess of the Working Time Regulations (1998). The Senior Medical Officer (SMO) and Deputy SMO were military which meant that they were likely to move around but locum doctors were in place to cover for these changes. The practice was now a part of an enhanced network group with Akrotiri Medical Centre that encouraged the sharing of resources including clinicians. Patients could now be seen wherever they chose.

The duties required in addition to the provision of a comprehensive primary care service for military personnel, their families and children, still included on-call, night duty shifts and prison healthcare but this could be provided within sustainable working hours/rotas. The hospital liaison team had received an uplift in personnel (dual language speaking which aided translation) meaning that secondary care patient contacts had improved, the contact the practice had with patients following in-patient admission to hospital was reported to be working well.

The Primary Care Rehabilitation Facility (PCRF) was managed well with high staff satisfaction. The PCRF felt well embedded into the medical centre and the Officer in Command (OC) PCRF managing both Akrotiri and Episkopi was working well. The OC PCRF attended all of the meetings at both sites so was able to provide additional leadership and support in these areas.

There were well-established links with the regional team and staff confirmed that input and support was provided whenever possible. Support was provided regularly through virtual meetings and discussion. However, the governance lead post had been vacant and staff spoke of support lacking in this area. A new staff member had just been employed at the

time of inspection and they provided resilience and experience of governance within the regional team. Staff were able to get support as required though some expressed frustration with continuing issues with secondary care on the island (this responsibility sat with Med Branch Headquarters).

The team were committed to delivering the best care through a culture of constant learning and improvement. The medical practice was an approved training practice and had a well-established training ethos. The medical centre had their last re-approval visit in June 2022 and had been complimented for excellent leadership and management with educational ethos evident throughout the practice.

## Vision and strategy

The medical centre had a clear vision and credible strategy to deliver high quality, sustainable care. They were striving to the visions and standards of the UK health service with the use of local working standard operating procedures and local working practices to adjust to the local challenges of working in a British Sovereign Base in a foreign nation. Staff spoke of the priorities being to stay clinically current, keep service personnel deployed, provide primary care to their population and look after the workforce within the medical centre. As well as working to the DPHC overarching mission statement, they had also developed their own which was:

*'Episkopi Medical Centre will provide safe, effective and accessible care to our population.'*

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

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

Due to capacity constraints at the time of the last inspection, the team had been unable to deliver all these commitments and so, on the instruction of DPHC, had prioritised urgent care delivery. Staffing levels were now close to established levels (with only a single post vacant). The vision and strategies were now evident, links with affiliated healthcare workers hosted at the practice were embedded and there were good links across the station as well as with other medical centres on the island. Clinical meetings had improved patient care, and closer working relationship between Episkopi and Akrotiri had meant that good practice was shared which in turn supported patient outcomes. Both practices had a combined training programme, and this was delivered between both sites.

The OC PCRF had clear visions and strategies to maximise the smooth running of rehabilitation care pathways and optimise opportunities for care on the island, with plans to get a Regional Rehabilitation Unit rehabilitation course running within the next couple of years. There was a significant amount of ongoing work to streamline referral pathways in a way that will provide good handover of knowledge to future clinicians.

Environmental sustainability was upheld wherever possible. The PCRF conducted air conditioning checks at the end of the day to make sure it was turned off and outcome measure sheets were laminated so there was less paper waste and exercise sheets were emailed to patients. The medical centre had individual recycling bins in the kitchen area where waste was sorted. Certificates were retained in an electronic format to further reduce the use of paper. Visible reminders prompted staff to switch air conditioning units off when not in the facility, and reminders to be sensible with water use were sent to staff by email.

## Culture

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

Staff said morale was good and the team ethos strong. The management operated an open-door policy and there was a use of first name basis within the practice. They had an inclusive meeting structure and have open staff forums to raise concerns and offer suggestions. A mid-morning break was used as an opportunity for staff to attend and have a short break away from their work. In addition, all staff were recently invited to complete an anonymous feedback survey and a staff suggestion box allowed for ongoing feedback to be provided with anonymity. the practice was offering flexibility to clinics to have telephone, face-to-face and sometimes evening clinics to meet the need and availability of the patients.

The practice team participated in social/team building activities quarterly and a recent coastal hike was organised. Staff were recognised with thank you awards and team-building sessions were described as highly enjoyable with high levels of participation. 'Foodie Fridays' took place every fifth Friday with a rota for each divisional team to take turns in bringing in a culinary treat. Staff spoke of this being a particularly good team building event.

The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. There was a duty of candour register on the healthcare governance (HcG) workbook and it was cross referenced to the ASER register. At the last inspection, a number of entries on the register had not been completed with details of whether affected patients have been made aware of the issue. Improvements had been implemented and staff had all received training. A review of the register at this inspection evidenced that entries were now comprehensive. One example was when a locum nurse sent out a patient document to a member of staff that had just left the practice (the staff member was clinical and worked at a different military medical centre). The patient was called and an apology given.

## Governance arrangements

The leadership team had defined responsibilities, roles and systems of accountability to support governance and management. The practice had built in more resilience with leads and deputies in most areas, some of which spanned both Akrotiri and Episkopi medical centres. The HcG workbook was the overarching system used to bring together a range of governance activities, including the risk register, ASER tracker, training register, quality improvement projects and complaints. The workbook had been further developed since the last inspection with information now being better populated to provide full assurance that systems are effective.

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

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

A meeting schedule was established, and this included daily coordination meetings, weekly clinical meetings and monthly healthcare governance, safeguarding and practice meetings. Discussion at each meeting was recorded and made available to those unable to attend.

## Managing risks, issues and performance

The leadership team was mindful of risks to the service. The top risks identified were infrastructure (included seismic stability, flooring, power supply and IT connectivity), staffing, population churn (during each 2 year rotation, approximately 1200 people leave and arrive in a 2 month period) and secondary healthcare (limited assurance, not all specialties available on island, laboratory services do not provide UK equivalence, limited documentation provided on discharge). In each case, the practice had either mitigated to a tolerable level or escalated to Med Branch.

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

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

There was a business resilience plan and a major incident plan that was last reviewed in August 2025. All staff were informed of updates to the business continuity plan and a copy was kept on the wall outside the practice manager’s office. Recent wildfires on the island were declared a major incident so the military staff were stood up to assist as part of the major incident plan.

The leadership team was familiar with the policy and processes for managing staff performance.

## Appropriate and accurate information

The Healthcare Assurance Framework (HAF) commonly used in Defence Primary Healthcare to monitor performance is an internal quality assurance governance assurance tool to assure standards of health care delivery within defence healthcare. The HAF was managed by the nurse manager and Senior Nursing Officer who identified it as an area for development now that staffing levels allowed. In recent months, practice staff informed us that priority had been to make improvements in other areas around patient care and there had been issues when trying to combine the HAFs for Episkopi and Akrotiri. This issue was a standing agenda point at the combined practice meetings.

An Internal Assurance Review was undertaken in November 2022. This graded the medical centre with limited assurance in Safe and Well Led and substantial assurance in Caring, Responsive and Effective. The management action plan had been completed prior to the SMO and practice manager starting their roles. The new management team had produced their own action plan (HAF Management Action Plan) when new into post. This had also been completed.

There was a well maintained audit register located in the HcG workbook. The SNO maintained the register and emailed clinical staff monthly to remind them to action their audits in a timely manner. Findings from audits were fed back to the wider team together with any resultant changes in working practice. The programme included repeat audit cycles in some circumstances where further potential improvements had been identified. An example we reviewed was of a diabetes audit which resulted in discussion around meeting the gold standard by offering patients the opportunity to attend a DERIK course (education session about living with type 2 diabetes). This was not achievable on the island for patients, so an online course was identified as a suitable alternative. All patients with diabetes were now given this opportunity including refreshers of the previous course.

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

## Engagement with patients, the public, staff and external partners

Patients had the opportunity to make suggestions about the care delivered. The DPHC patient experience survey was displayed in every clinical room, patients were encouraged to scan the QR code to give feedback. This had resulted in the practice offering flexibility to clinics to have telephone, face to face and ad hoc evening clinics to meet the need and availability of the patients.

A ‘you said, we did’ board was displayed in the waiting room. In response to patient feedback about prescription charges at local pharmacies, a poster had been produced and displayed to inform patients of the charges and the reasons for being charged.

Staff had opportunities to provide feedback to leaders. A feedback box was in the staff tearoom for staff to share their views, including if they wished to do so anonymously. All staff had been invited to put any difficulties and challenges specific to them on a noticeboard. Staff then allocated themselves to each challenge to provide support.

The practice had made attempts to establish a patient participation group following comments made online about patients wanting to attend to provide feedback. Dedicated sessions were advertised on social media inviting patients to attend and provide feedback to staff about recent experiences. Two sessions were held including at a time to allow working patients the opportunity to attend but there were no attendees at either session. The practice had also tried to encourage patients to complete a printed version of the DPHC form but many declined as they said they did not have the time as the document appears lengthy once printed. In response, a '1 minute survey' was introduced in July 2025 designed to increase the numeracy of feedback and gauge basic data about the practice using smiley faces for feedback. Since introduction, 16 responses had been received.

## Continuous Improvement and Innovation

There was evidence of innovative practice raised as quality improvement projects (referred to as QIPs), of note, the SMO was innovative with information technology to develop systems to help with time pressures and minimise the risk of human error. DPHC headquarters had invited the SMO to present these with a view to rolling out across the wider organisation. Examples of QIPs included:

- Pathology results inputting onto the system. The SMO audited how many HbA1c (a test to measure sugar levels in the blood used to indicate how well diabetes is being managed) results were Read coded in September 2024 to find it was 17%. The low compliance rate was attributed to 2 main issues, pathology results provided by a contracted secondary care service in Cyprus were reported on in different units to those normally used in the UK and it was not possible to automatically link results to the patients DMICP record (as can be done in the UK). The SMO developed a tool which enabled clinicians to cut and paste results from the hospital into the tool which then converted them into UK units and added the information into the patient records. Although new doctors required training in this system, it reduced the task from between 15 and 30 minutes to 5 minutes. Rather than sending tasks to individual doctors, all results were put into a DMICP "clinic" for the duty doctor to review and action. Following introduction of this system a repeat audit in March 2025 showed compliance had increased to 71%.
- HRM register: the SMO had developed an HRMs register on Excel embedded in the practice documents on DMICP. It was still in development but was designed to summarise what HRMs patients are on, indicate what bloods are required and when as well as when reviews of bloods and medication are required. Once fully implemented, the system should provide a live audit.
- Blood tracker. A system had been developed by the SMO to replace the manual upload of blood results onto DMICP. The new system was designed to save time for the

patient and minimise the risk of human error. It also allowed for trend analysis of blood test results.

There were examples of quality improvement projects within the PCRF. However, it was too soon to quantify the positive impact of these. Examples included identifying a need for VACOped boots (used to help manage achilles injuries) and the inability to obtain these on the island. An initial business case had been approved and staff could order them as required. This was a recent project so there was no data as to size of need or impact on care.

A QR code was developed for patient use to guide acute injury management without each stage needing a referral to the PCRF.

The nursing team had developed the use of 'One Note' as a one stop shop of information which all of the nurses had access to. This had reduced email traffic and provided useful information and links that related to the out-of-hours and the duty team.

Due to most families having swimming pools in their back gardens, drowning prevention information had been communicated to ensure everyone was made aware of the safety required around garden pools and water.

'Collection of uncollected paediatric prescriptions' was a new initiative for the prescribing doctor to follow up on any uncollected prescription for a child. A phone call was made by the doctor to the parents and any resultant follow-up action tasked.