







## Nepal Combined Medical Practice

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Headquarters British Gurkhas, Kathmandu, Nepal

### Defence Medical Services inspection report

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

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

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## Summary

### About this inspection

We previously inspected the service in May 2024 and found that some improvements were required. We carried out this announced inspection on 8 and 9 September 2025. This second inspection was a full comprehensive inspection.

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

Are services safe? – requires improvement

Are services effective? –good

Are services caring? – good

Are services responsive to people's needs? – good

Are services well-led? - 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 that the CQC will complete at the invitation of the DMSR in their role as the military healthcare regulator for the DMS.

### At this inspection we found:

- Patient feedback about the service was almost entirely positive. Patients we spoke with provided examples of the team going the extra mile to provide good care. Patients told us that care they received was accessible and that they were treated with compassion, confidentiality, dignity and respect. A number of patients fed back that the SMO's short deployment was not conducive to the delivery of continuity of care. However, no patient told us that this had adversely impacted the outcome of their assessment or treatment.

- There was an effective programme in place to manage patients with long term conditions. However, there was scope to better identify and follow-up patients who might be pre-diabetic.
- The local civilian team had considered the need to mitigate the fact that the SMO and MN deployed to Nepal for short periods of time. They had worked hard and stepped up to willingly cover leadership roles not usually required of them. Due to the transient nature of the military workforce, a local working policy had been instigated which clarified which permanent staff held lead and deputy leads for clinical management, healthcare governance and practice management. This was helpful in providing continuity of leadership and practice management.
- The practice had positive lines of communication with the units they supported and the welfare team. Command staff we spoke with confirmed that the medical team engaged fully in all welfare processes. However, we identified an opportunity for the practice manager to take the lead role in regular communication with Command so that they were fully appraised of any issues the medical centre were facing.
- Patients found it easy to make an appointment and urgent and often routine appointments, were available the same day.
- Arrangements were in place for managing medicines including high risk medicines.
- There was a known and long-standing issue with the supply of some vaccines and some controlled drugs. The regional pharmacy team worked hard to mitigate and resolve these issues as far as they reasonably could.
- Access to the patient records system was a challenge at times.

### **We found the following areas of notable practice:**

- Noting the relatively isolated and single-handed nature of the SMO role in Nepal, the team established a clinical mentorship link with a fellow overseas practice in Brunei. A virtual meeting was scheduled fortnightly to align with the Brunei clinicians meeting. The first part of each meeting is spent discussing any Nepal patient or practice issues. Both clinical teams reported that the arrangement was mutually beneficial.
- The local civilian team had considered the need to mitigate the fact that the SMO and MN deployed in for short periods of time. They had worked hard and stepped up to willingly cover leadership roles not usually required of them. Due to the transient nature of the military workforce, a local working policy had been instigated which clarified which permanent staff held lead and deputy lead roles for clinical management, healthcare governance and practice management. This was helpful in providing continuity of leadership and practice management. Chronic disease management leads were subsequently the civilian practice nurses and the Caldicott lead was allocated to the practice manager. Previously the SMO had assumed the

lead for both of these areas, but the new arrangements were impactful in ensuring continuity for the team and for patients.

- The practice was required to stop using the UK based text messaging service. Consequently, the SMO developed an Excel spreadsheet programmed to automatically send e-mails (via a bespoke Outlook template) to a list of personnel entered into the sheet with a personalised message and results. The MTF had to obtain consent from patients before sending medical information by e-mail and had to capture their e-mail addresses. This was done at eRegistration and via a catchup program where staff chased patients for their consent/e-mail. The outcome is that a problem was circumnavigated, patients continued to receive the communications they needed and administrative and nursing team time had been saved.
- The SMO updated a DMICP SmartDoc to help input pathology reports into DMICP. The pathology results used to arrive in paper format and often in different units to those required for filing on DMICP. The results now arrived by e-mail. The SmartDoc captured the result, converted it to the correct units and Read codes it on DMICP. This helped to minimise transcription errors which may happen when manually converting the result and manually Read coding. The SMO updated and improved the existing SmartDoc.

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

- Acknowledging the global supply concern for some vaccines, work to ensure safe and timely vaccine supply to all patients registered in Nepal, including civilians and eligible children. Work with firm base medical centres to support more patients to access essential vaccinations prior to their arrival in Nepal. Guidance around travel vaccination requirements should align to the Green Book publicised on the National Travel Health Network and Centre (NaTHNaC) website.
- Continue to investigate and mitigate concerns with the supply chain for medicines and vaccines.
- 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.
- Given the known risks around accessing ambulance service provision in Nepal, undertake a risk assessment to outline the baseline training requirements around immediate life support (including for children aged 5-18) and major incident medical management, and issue a pre-deployment training list to the SMO. For the aforementioned reasons, consider whether nurses who could be called upon to assess and support patients (including children) requiring urgent care should receive immediate life support training.

- The medical team should be provided a copy of the cleaning contract so that they are aware of the agreed resource and for monitoring purposes. Also, copies of fire risk, water safety, legionella and electricity certificates for their own assurance as custodians of the building.
- Undertake full seismic assessment for the Pokhara medical centre building to establish whether it is seismically sound and adequately designed to withstand relevant seismic loading.
- Given known issues with safe local blood supply, risk of road traffic accidents and in the absence of an Emergency Donor Panel, consider mitigations including the use of lyophilised plasma.

### **The Chief Inspector has recommendations for the medical centre:**

- Given that staff could be called upon to provide care for children in the event of an emergency and whilst waiting for an ambulance to arrive, basic paediatric resuscitation equipment must be provided including suitably sized laryngeal mask airways.
- Given known barriers around swift access to ambulance and emergency care and known air quality concerns, risk assess the requirement for access to a nebuliser suitable to support both adults and children presenting with acute severe exacerbation.
- Ensure that the whole medical team is aware of the Defence Primary Healthcare Integrated Mental Health Pathway and Primary Care Toolkit launched which outlines changes to the management of step 1 and 2 mental health interventions and includes self-directed psychoeducation, online self-directed cognitive behavioural therapy and access to resources. All staff should also be aware that counselling is available via Medciti hospital. Inform welfare staff, Command, the Pundit and Padre that any patient who could benefit from these services can be referred via the medical centre.
- Ensure that all staff are in date for mandated training, including the level of safeguarding training relevant to their role. Staff should also receive training around the application of the mental capacity act and in support of patients with autism and a learning disability.
- Ensure that the details held within the safeguarding standing operating procedure are accurate, up to date, and make safeguarding information more readily available in consultation areas.
- Review all patients who arrive with safeguarding and vulnerable coding in place on their notes, determine what current concerns are and then accurately Read code them either as requiring safeguarding, vulnerable status or historic/resolved.

- Ensure peer review of all OOH contacts and any notes recorded by the senior medical care assistants.
- Internal referrals, for example to a PCRf or DCMH, should be tracked in the same way as external referrals.
- An audit on antimicrobial prescribing is due for repeat now.
- Clarify and confirm who leads on chronic disease management such that the whole team is aware. Clarify who is the most appropriate person to hold secondary roles such as health and safety lead, clinical waste lead and equipment care lead. Consider the most appropriate staff member to take the lead role for health and safety and COSHH management. This person should obtain the relevant health and safety qualification from the Institution of Occupational Safety and Health, a chartered body for health and safety professionals.
- Ensure that patients recorded as having HbA1c in the pre-diabetic range are followed up in a timely manner.
- Provide a role specific induction to the incoming SMO.
- Implement standalone risk assessments for individual health and safety concerns. This should include Control of Substances Hazardous to Health (COSHH) risk assessments for all cleaning products held.
- Ensure that consignment notes are used, allowing acknowledgment by both parties around:
  - type of waste collected including waste codes
  - quantity of waste collected
  - date and time of collection
  - who collected the waste
  - where the waste was taken to for disposal
- Ensure that there is an adequate alarm system in place so that support can be summonsed from clinical rooms and the toilets.
- Consolidate and formalise the practice manager's authority in escalating issues for resolution by the Unit.

**Bola Owolabi CBE**

**Chief Inspector, Primary Care and Community Services**

### Our inspection team

The inspection team was led by the CQC Lead for the Defence Medical Services Regulator (DMSR) and comprised specialist advisors (SpAs) including a primary care doctor, pharmacist, nurse and practice manager. The Head Defence Medical Services Regulator (DMSR) also supported the inspection.

### Background to Nepal Combined Medical Practice

With sites in Kathmandu and Pokhara, Nepal Combined Practice provides routine primary care and occupational health care service to a patient population of approximately 142 (serving personnel and their families). There are 2 medical centres in the group practice, the headquarters in Kathmandu and a second in the city of Pokhara (approximately 25 minutes by air or 8 hours by road). There is no primary care rehabilitation Facility (PCRF) situated in Nepal. Physiotherapy needs are met through a contract with a host nation provider or by returning to the UK.

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

### The staff team

Doctors	1 Senior Medical Officer (SMO, based in Kathmandu)
Nurses	1 Military Nurse (MN, based in Pokhara) 2 Practice Nurses (1 based in Kathmandu, 1 in Pokhara)
Senior medical care assistant	2 (1 based in Kathmandu, 1 in Pokhara)



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Medical care assistant	1 (based in Pokhara)
Practice manager	1 (based in Kathmandu)
Deputy practice manager	1 (based in Pokhara)
Hospital liaison	1 (based in Kathmandu)
Receptionist	1 (based in Kathmandu)

\*In the army, a medical care assistant is a soldier who has received specialist training in field medicine. It is a unique role in the forces and their role is similar to that of a health care assistant in NHS GP practices but with a broader scope of practice.

## Are services safe?

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

### Safety systems and processes

The Senior Medical Officer (SMO) was the safeguarding lead at the medical centre, although they deployed to Nepal with lapsed level 3 safeguarding training for adults and children. The MN was the deputy lead and was in date for Level 3 training. All other clinical and administrative staff were trained to the relevant level for their role.

The practice standard operating procedures (SOP) for both adult and child safeguarding were last reviewed in November 2024 although the contact details for the supporting social worker were inaccurate. The SMO knew who the current social worker was and had been in contact with them. The SOP needed to be updated so that the incoming SMO has the correct information directly at hand. There was also scope to display key safeguarding information in clinical rooms to outline the safeguarding steps to take specific to the location.

We saw evidence that patients requiring safeguarding and vulnerable patients were discussed at the monthly HGAV meetings and also at quarterly safeguarding meetings. Vulnerable searches and the safeguarding search register were updated monthly by the practice manager. At the time of this inspection, there were no patients on the safeguarding register.

The team confirmed that the local school had staff who had been trained in safeguarding procedures, although no-one from the medical team had gone to the school to introduce themselves and to act as a point of contact, should teachers have concerns about a child. Staff confirmed that they could contact a health visitor and also Army Welfare Services in Brunei. if support was needed.

The team confirmed that, where appropriate, all safeguarding information was captured within DMICP (the patient record system) and alerts were placed onto the record of anyone deemed to be vulnerable. We saw that, whilst no patients were deemed to require safeguarding, two patients had been coded as such. Our review of the notes did not reveal why this was the case and the team had not looked further into the matter. There was scope to review all patients who arrive with safeguarding and vulnerable coding in place on their notes, determine what current concerns are and then to accurately Read code them either as requiring safeguarding, vulnerable or historic/resolved.

The practice had effective links with welfare services, Chain of Command, the padre and the Pundit (a Nepali leader who provides spiritual and cultural support where it is

needed). We spoke with these partners and concluded that patients benefitted from well integrated welfare support from a team of specialists who worked closely with one another. All safeguarding enquiries, concerns, and referrals for children and adults were made to the contracted social work provider for the location. Nevertheless, welfare support leaders did feed back to us that there was scope to ensure that medical centre staff knew how to support patients to access counselling if this could be of benefit to them. Whilst the associated poster was displayed in the Medical Centre, the medical team were unaware of the Defence Primary Healthcare Integrated Mental Health Pathway and Primary Care Toolkit launched which outlines changes to the management of step 1 and 2 mental health interventions and includes self-directed psychoeducation, online self-directed cognitive behavioural therapy and access to resources. Counselling was also available via Medicit hospital.

Clinical staff had received chaperone training and provided a chaperone service. A listing of all staff who had received chaperone training was available. Posters advising of the chaperone service were available for patients in both English and Nepali.

The full range of recruitment records for permanent staff was held centrally. The practice could demonstrate that relevant safety checks had taken place at the point of recruitment. This included checks to ensure staff, including locally employed staff, were suitable to work with vulnerable adults and young people. Staff either held a current English Disclosure and Barring Service (DBS) check or a Nepali Police check. A process was in place to monitor the professional registration of clinical staff. The SMO had indemnity insurance. Vaccination status for staff was also maintained.

The two civilian nurses were the designated leads for infection prevention and control (IPC) at Pokhara and Kathmandu. Both were Link Practitioners and had received the appropriate training. Both nurses had the opportunity to attend the DPHC IP&C forums and due to the time difference, they accessed the recording of this. The Regional Nurse Advisor provided detailed updates and also opportunities for the nurses to feedback about issues raised in the forum. The annual IPC audit was broken down across the four quarters. We saw that an action plan was in place to address recommendations. At our last inspection, we noted that there was an unsuitable toilet attached to the Pokhara medical centre (used by recruiting teams). A Statement of Need had since been submitted in POK for the refurbishment of this area. The recently appointed Commander in post was keen for this work to be completed and commencement of work was awaited from the contractor.

There was a cleaning contract in place, although the medical centre team did not have access to this. This meant that they were unable to monitor the cleaning provided against the agreed resource in place. Staff confirmed that deep cleans took place every quarter. The medical centre was visually clean on the day of our inspection. An IPC audit was last undertaken in May 2025 and we saw that actions had been implemented where possible. There was no Sluice/Waste sink available and so the cleaning staff disposed dirty water through a toilet in general use. This risk was captured on the local

risk register and had been escalated to both Regional Headquarters and the Unit health and safety team.

Arrangements to ensure safety of facilities and equipment were in place, but there was scope for improvement in some areas. The medical team confirmed that risk assessments had been undertaken and recommendations actioned covering fire risk, water safety, legionella and electricity, although certificates had not been made available to the medical team. Unit staff maintained a log of portable appliance testing (PAT) undertaken. A healthcare waste disposal service was provided by the Pattan Hospital in Kathmandu. The QM department collected the waste and delivered it directly to the hospital for disposal. There were no consignment notes for disposal, although the clinical waste log was used to track billing. In Pokhara the team held a contract with the local municipality office and their team collected healthcare waste on request and payment was made based on the weight of the clinical waste. Records of each consignment were made on the Healthcare Governance (HCG) workbook.

### Risks to patients

From a patient perspective, clinical staffing levels were sufficient as patients interviewed told us they had prompt access to a clinician at all times, including out of hours. The regional team and DPHC had considered the most appropriate length of deployment for the SMO. There was a balance to achieve: the need for continuity of care for patients and continuity of leadership for the local team, alongside low clinical burden which could lead to underestimation and deskilling. In addition, the requirement for the SMO to be on-call 24/7 had to be considered within the confines of the safe working hours outlined in both the DIN (Defence Instruction & Notice) and the WTD (Working Time Directive 1998). The current SMO was deployed for a 4 month period. The SMO confirmed that due to the size of the patient population and the very infrequent OOH call-outs, that the 24/7 role was safe and appropriate for this 4 month period. The civilian nurses had both worked for DPHC for over 10 years and have a breadth of clinical experience, both recently completing the clinical assessment module at the University of Cumbria. The two nurses travelled between Pokhara and Kathmandu to provide cross cover. All staff we spoke with confirmed that their health and wellbeing needs were met and no member of staff reported unreasonable working hours or workload. Staff sickness absence rates were low and there were no staff on long term sick leave.

All staff completed the DPHC mandated induction which included role specific elements. The practice retained copies of completed induction packs. The military nurse had recently completed the induction package and felt it was comprehensive, in particular the links with the local hospitals where visits had been arranged to various departments to enable new staff to gain a greater understanding of local referral processes and also to establish good communication.

All staff knew where the emergency medicines were located. The emergency trolley was secured with a serialised tag and all medicines held on the emergency trolley were checked and were in date. Expiry date checks were being completed monthly and there was evidence that time expiry reports were being run monthly for all medicines held on the emergency trolley DMICP list. Evidence was seen that the ambient temperature was being recorded in accordance with the policy for temperature monitoring. There was evidence that the emergency medicines risk assessment had been completed and was on the trolley. The medical bergens were checked monthly by the MCAs along with the SMO or practice nurse and this was presented in the monthly practice meeting as an agenda item.

The storage of oxygen and Entonox cylinders was safe and the area was clear of clutter. Appropriate signage was displayed on the doors of rooms containing medical gases.

An automated external defibrillator (AED) was kept in the medical centre and all staff knew where it was located. It had an adult and a pediatric setting. We noted that there was scope to stock suitably sized laryngeal mask airways for children aged 5-18. The medical centre was equipped with inhaler and spacer to support any patient experiencing asthmatic symptoms. However, given the known barriers around swift access to ambulance and emergency care and accepted air quality concerns, the medical centre should have access to a nebuliser suitable to support both adults and children presenting with acute severe exacerbation.

We spoke with the team about supporting patients who required emergency care. In Kathmandu, ambulance provision was made through an arrangement with Mediciti Hospital. The agreement in place meant that there was some assurance that this ambulance would arrive reliably and that a paramedic would be on board with advanced life support kit (including for children). In Pokhara, the team would contact the guard room to ask the local emergency department to send an ambulance. There was less assurance that this ambulance would arrive in a timely way. The ambulance might not have a trained paramedic on board and the ambulance might not contain advanced life support kit. Land Rovers were also available at both sites via the military transport team.

Given these known risks, it was therefore important that the medical centre team were appropriately trained and equipped to provide life sustaining care (including to children aged 5-18) to the point of handover to secondary care if required. Whilst the SMO had substantial experience delivering primary care (including 20 years experience including paediatric care prior to 2019), he confirmed that he had not received a pre-deployment training list before arriving in Nepal. Subsequently he had not received:

- major incident medical management & support (MIMMS) training
- battlefield advance trauma life support (BATLS) training
- immediate life support (ILS) training

- PILS (Paediatric immediate life support) training
- Paediatric advanced life support (PALS) training

As part of our inspection, we spoke with the regional team who confirmed that the incoming SMO had arrived in Nepal (since the inspection) and that they had received the training required for the role in advance of their posting. They confirmed that RHQ would be conducting a review of the job specification to ensure that all training requirements were appropriately articulated on future assignment orders.

The nurses might also be called upon to assess and manage patients requiring urgent care (until the ambulance arrives). Whilst all had undertaken basic life support (BLS) training, they had last undertaken ILS training in 2023 and so were no longer current. Given known issues around possible delays to the ambulance arriving and lack of assurance around whether a paramedic with advanced life support equipment would be on board, it would be beneficial for nursing staff to be trained in ILS. Given that children aged 5-18 were now registered at Kathmandu, best practice dictates that nurses should also have PILS training. All nurses had completed 'recognition of a sick child' via E-Learning for health (an online training system).

All staff had completed basic life support, sepsis, anaphylaxis, thermal injury and defibrillator training. Information about sepsis was displayed in various areas of the medical centre. Receptionists had received training in recognising and reacting to emergencies. This training covered the deteriorating patient and sepsis.

Out of hours (OOH) care was delivered through a first on-call rota by nurses and senior medical care assistants (SMCAs). Second on call was provided by the duty doctor in Kathmandu and the MN in Pokhara. All children would either attend hospital or be assessed by the SMO. If a patient needed to be seen OOH, both the first on call would attend the assessment and the second on call would attend if necessary. As SMCAs were required to take a medical history and to signpost patients to secondary care or to book them into appointments, they should have received formal triage training. The newly appointed MN confirmed that this was being rolled out.

Since our last inspection, the SOP had been changed to mandate that all contacts are recorded in a DMICP entry. An audit of notes was undertaken in December 2024 and showed that 93 % of OOH calls had been logged in DMICP notes and 100% of the OOH calls have been discussed in the 'G1-G9' huddle. The audit also recommended that: duty personnel on first on call must make a record on the DMICP notes even though the patient has been handed over to the second on call; administration staff should record the exact date of the OOH call on the practice documents to allow proper auditing of the DMICP Notes. A further audit was planned for December 2025. Peer review audits were undertaken of the nurses and SMO's consultations only. No specific peer review had been undertaken of the OOH contacts or of the senior medical care assistants. Given the senior medical care assistants are triaging patients OOH, best practice would be to review their notes too.

Waiting patients could be observed at all times by staff working on the front desk directly. This included patients who had received vaccinations.

Chain of Command confirmed that the Kathmandu medical centre building had been subject to a seismic assessment and was considered seismically sound and adequately designed to withstand relevant seismic loading. Pokhara medical centre had not been subject to seismic assessment, rather standard structural appraisal.

### Information to deliver safe care and treatment

The practice used DMICP 'deployed' DMICP(D). There was therefore a delay to the patient notes synchronising with the UK system. The team in Nepal experienced daily challenges accessing patient notes with significant periods of outage due to the fragile and slow network connectivity to DMICP(D) and MODNet. It was sometimes necessary to cancel routine appointments. Whilst on inspection, our team struggled to gain reliable access for the time required to undertake clinical searches. When the system did work it was very slow. The medical team did what they could in mitigation: the business continuity plan required them to use Wi-Fi due to the fragility of the LAN connection, but this was also extremely slow due to the VPN requirement. The team often made notes in Word during consultations and copied them across once access to DMICP had resumed. If the whole system was down, paper notes were used. There are clear risks with this approach as there is potential for human error, delayed access for patients and a delay to the contemporaneous patient record.

A process to ensure timely notes summarisation was in place. Patients registered using the e-registration process, dependants registered via the overseas team (prior to arrival) and their notes were summarised onto DMICP. The administration staff requested NHS GP notes once dependents registered and these could take up to 1 month to arrive. These notes were stored in a locked cabinet in reception and, on leaving the practice, were sent for onward transfer to NHS practices. A search was completed each month and time allocated to the nurses for summarising. The nurses completed a quarterly audit of notes summarising. At the time of inspection, there was no backlog of patient notes requiring summarisation.

All clinical staff undertook peer reviews of clinical notes. An appropriate notes review template was in use. The MN had reviewed the SMO's notes in May and August 2025. There was scope for the SMO in Brunei to also review the SMO's notes, to provide an additional layer of independent assurance. Nurse consultations were reviewed within the nursing team.

The medical team had considered the safest way to manage specimens and test results, given the lack of access to Pathlinks (The NHS Pathology network which facilitates access to patients' test results). The clinician requested a test in DMICP. The patient then booked an appointment with the nurse for the sample to be taken. All

samples taken were documented in the sample register. The sample was sent to the local laboratory. Assurance work was undertaken in 2023 to conclude the quality of service delivered by pathology laboratories in both Pokhara and Kathmandu. Results were returned electronically in a PDF file. SmartDoc was used to capture the result within DMICP and a Read code applied. The nurse would then update the register and task the SMO to review the result. Weekly checks of the sample register were made to ensure that results had come back into the practice and any outliers were chased.

British Gurkhas Nepal (BGN) depends on the local Nepalese services for blood products and pathology support. There remains no access to UK blood or associated blood products, and no Emergency Donor Panel (EDP) has been established. Assurance work was undertaken in 2023 and there was recognition that it had not been possible to carry out a systematic ISO style audit of laboratory services. However, it was possible to gauge a subjective impression regarding standards of service delivery through observations of each laboratory and discussions with personnel. In conclusion, it was recognised that demand for blood components was likely to remain very low, but it was accepted that a contingent risk remained given the potential for road traffic accidents or other accidents, especially in Pokhara where the local blood supply is considered unsafe. It was consequently recommended that lyophilised plasma may be an appropriate mitigation.

A local working practice was in place for the management of cytology samples. All samples were logged, packed up and sent by special delivery via BFPO Kathmandu to the laboratory in Wolverhampton. The laboratory processed the sample and the results were emailed to the medical centre's dedicated inbox for cytology. Results letters were uploaded to DMICP and contact made with the patient.

There was a local working practice in place for the management of bowel screening. We were advised that DPHC was working towards a UK postal faecal immunochemical testing (FIT testing used for bowel cancer screening) testing system. However, this still required work to ensure temperature control from overseas locations. In the interim, patients over 54 years of age who were offered local FIT testing, were made aware that the FIT test in Nepal is not NHS assured and should be retested on return to the UK.

There was a system in place to manage referrals. The receptionist and deputy practice manager managed the local referral process and the practice manager managed the UK Referral process. A referrals tracker was held within DMICP which presented a risk due to the proportion of time that the system was unavailable. We discussed with the team whether keeping the register in Sharepoint would reduce this risk. The SMO raised a referral letter in DMICP using SmartDoc to streamline the process. He then tasked the receptionist noting how urgent the referral was and where to send it. The administration team then actioned the referral. The team confirmed that access to the local Mediciti Hospital was swift (and steps had been taken to ensure that the requirement for provider payment did not slow down access to care). Once a letter was received back from the hospital, the SMO reviewed it. There was often a need to



request further information from the hospital to ensure that all the facts were clearly understood. For muscular skeletal issues, patients could be referred internally back to a PCRf in the UK. There was scope to ensure that these referrals were made and tracked in the same way as all other referrals.

Steps had been taken by the Overseas Mental Health Team (OMHT), alongside the regional and local teams to consider access to mental health services. The local mental health services in Nepal were not assured at the time of this inspection and so the delivery of anything above low level intervention (predominantly online UK sourced) would result in an 'Emerging Needs Multi Agency Supportability Overseas' (ENMASO) and probable removal of the patient (including children). If it were felt that a patient could be supported with low level intervention this would be agreed by the OMHT who would look to review the qualifications, experience and case management of the provider. All patients were screened prior to arrival with a low threshold for MH issues due to lack of assured support in Nepal. If a patient needed to be kept safe using detention under the Mental Health Act (MHA), the law in Nepal could be applied (legal interpretations are slightly different to the UK). The regional team confirmed that a private hospital would be engaged if a patient required detaining. They acknowledged that the service standards were different to those in the UK and that the facility would only be used until aeromedical evacuation could be facilitated.

### Safe and appropriate use of medicines

The SMO was the lead for medicines management at the combined practice. The dispensing assistants were aware that the management and working practices of the dispensary were delegated to them. This was reflected in their terms of reference for both the Specialist Medical Centre Assistant (SMCA) in Kathmandu and the Medical Centre Assistant (MCA) in Pokhara. This arrangement is covered by 'DPHCSOP 11-6-1 Dispensing in Overseas Locations' in the absence of a registered pharmacy technician.

Patient Group Directions (PGD), which allow practice nurses to administer medicines in line with legislation, were in place and had been signed off. Nurses had completed training in using PGDs and administering vaccines and annual competency assessments were carried out. Medicines supplied under a PGD were recorded in DMICP. A PGD audit was undertaken in August 2025 and the audit found compliance with the audit standards set by HQ DPHC. It was confirmed that the findings from the audit had been shared with the nursing team.

Patient Specific Directions (PSD) were only being used in Pokhara when deploying personnel and we saw that details of medicines and patients being administered within a PSD had been maintained and staff competency was up to date. A doctor had assessed each patient to ensure that administration of medicine within a PSD was appropriate. A review of one PSD found that all the relevant sections had been completed.

A process was in place for the management of information about changes to a patient's medicines received from other services. The medical centre had a hospital discharge medication review local working practice which documented a clear process for the management of information about changes to a patient's medication by secondary care. The MCAs were knowledgeable about this and both were able to describe the robust process for the management of secondary care prescription requests. We reviewed a small number of patient records and saw that the process had been followed appropriately. Incoming correspondence, such as from out-of-hours services, hospital discharge letters and out-patient clinics presented a challenge at times for the team due to illegibility and language. Nevertheless, the team worked hard to interpret these and then task the SMO.

The dispensaries had a bound book to record the receipt and supply of the prescription (FMed296) forms. Fmed296 forms received into the medical facility were stored in the dispensary and the serial numbers of the first and last FMed296 were documented in the bound book. Evidence was seen that FMED 296 prescriptions were issued by serial number and clinicians had signed and dated the receiving of the FMED 296 prescriptions in batches of 100 at a time.

There were robust processes in place for the requesting and issuing of repeat medicines. In discussion with the MCAs and through review of DMICP records, it was evident that there was a clear audit trail for the request of repeat medication. We noted examples of how patients could access requests via email with repeat slips also available for families. The MCAs showed good awareness of their responsibilities and tasked requests to a senior clinician. The process for handing out prescriptions to patients was discussed and was in-line with the 'DPHC SOP 5-handing out a prescription'.

Due to the small patient population, staff confirmed there was no issue with non-collected medicines and that all were usually collected within two weeks. If a medicine were not collected, this would be noted on the patient's record and the medicine destroyed including the prescription serial number. The prescriber would be alerted if the medicine was high risk.

Controlled and Accountable medicines (CDs) were kept in the dispensary in a CD cabinet. The CD keys were kept separate from the dispensary keys. There was a CD access standard operating procedure (SOP) if the CD cupboard needed to be accessed OOH. Documentation in the BMed 12 was legible and in accordance with JSP 950. The specimen signature log in the BMed 12 had been completed accurately by all those that are involved in the accounting of the controlled and accountable medicines. Internal monthly and external quarterly checks were being completed in line with the JSP 950 for all controlled and accountable drugs held as dispensary stock. A review of the most recent destruction certificate confirmed that accountable and controlled drugs were being destroyed in accordance with policy.

The team had experienced issues procuring CDs due to not having appropriate Nepal Import and UK Export licenses in place at the same time. In mitigation, unlicensed morphine and diazepam had therefore been procured locally and this was captured in the risk register and was known to the overseas regional pharmacist. The team had taken action to ensure access to essential medicines in an emergency. They confirmed that when licensing issues had been resolved, the locally procured CDs would be replaced.

Well defined processes were in place for the ordering and receipt of vaccines. All vaccines were in date and evidence was seen that the vaccines were being correctly rotated in the fridge. There was sufficient space around the vaccine packages for air to circulate. No food or specimens were held in the pharmacy fridges. The pharmaceutical fridges were monitored twice daily and the external thermometers were in date. Due to no expected deployments, vaccine stocks were appropriately low.

There was nominated high risk medicines (HRM) leadership with evidence of a collaborative approach between the prescribing clinicians and the MCAs for managing patients prescribed HRM. The HRM register supported the safe and comprehensive management of patients prescribed HRM. An HRM audit was completed in September 2025 covering both practices. High Risk Medication prescribing was a standing agenda item discussed at practice clinical meetings where the SMCA was in attendance. Only a small number of patients were prescribed an HRM and we found appropriate HRM and shared care alerts raised on the relevant patients' DMICP records.

An audit on antimicrobial prescribing was last undertaken in July 2024 and was due for repeat. The last audit noted that only a very small number of antibiotics had been prescribed during the past 6 months and that in almost all occasions, strict adherence to guidelines had been observed. A minor observation had been made about a lack of clear duration on one prescription for suspected scrub Typhus.

### Track record on safety

We saw evidence of risk assessments in place which covered some areas pertinent to health and safety. These were last signed off as reviewed by the practice manager and a former SMO in January 2025. The risk holder was the SMO and the practice manager was the risk manager. The Pharmacy SMCA was the health and safety lead and point of contact for COSHH management. However, as the risk manager, the practice manager would be better placed to take this lead role. Whoever undertakes the role should obtain the relevant health and safety qualification from the Institution of Occupational Safety and Health, a chartered body for health and safety professionals.

We saw that there were 2 risk assessments in place and that these covered several areas including working environments (hot/cold), working at height, occupational stress, needle stick Injuries and (limited) Control of Substances Hazardous to Health (COSHH).

Risks would be better managed using standalone risk assessments for individual risks. Whilst we saw that some individual COSHH assessments were in place, we noted that additional assessments were needed to cover all hazardous materials (e.g. cleaning products) and medications held on site.

There was no fixed alarm system within the medical centre. Each staff member had a handheld alarm which allowed staff to summon assistance in an emergency. Staff told us they assessed their own alarms weekly, although there were no records to show this. There was no central system to summons help in either the toilets or the clinical rooms. Whilst staff could call out for help from clinical rooms, a patient who became unwell in the toilet could go unnoticed.

There was a risk register, retired risk register, issues log and retired issues log on the healthcare governance workbook. All risks included detail of the 4T's (treat, tolerate, transfer or terminate) and had a review date. We saw that some risks had been appropriately transferred to Regional Headquarters and DPHC HQ, including the priority risk around safe and timely supply of medicines and vaccines.

## Lessons learned and improvements made

Significant events and incidents were reported through the electronic organisational-wide system (referred to as ASER) in line with the DPHC ASER policy. A local ASER SOP was in place. All staff had an ASER login. Our interviews with staff across the whole team and our review of the ASERs raised and investigated to date, indicated that staff were encouraged to report concerns. However, given the regularity of DMICP outage, we did not see that ASERs had been raised around this. ASERs were routinely discussed at the practice meetings and identified in the minutes. It was clear from our discussions with staff that lessons learned were shared with the team. We noted that two purple (best practice) ASERs had also been submitted.

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 are receiving, disseminating, and actioning all alerts and information relevant to the practice. There was scope to make the system failsafe by ensuring that all alerts also come into the PM group mailbox, so that the management team could take mitigating action, should the pharmacy SMCA be absent from work. The register documented what action (if required) had been taken. Discussion took place at practice meetings and was recorded in minutes. There was evidence that the search on DMICP to identify any patients prescribed sodium valproate was being run monthly and pharmacy technicians were aware of the recent changes to full pack dispensing for valproate. The CAS (Central Alerting System) alert log was held on health governance workbook including detail of action taken. Alerts were also discussed at the practice meeting as a standing agenda item.

## Are services effective?

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

### Effective needs assessment, care and treatment

Healthcare governance meetings took place and afforded the team the opportunity to discuss DPHC standing operating procedures, Medicines and Healthcare products Regulatory Agency (MHRA) and National Patient Safety alerts. Staff confirmed that guidelines (including updates from NICE and SIGN) were discussed routinely at practice meetings and also briefed in the weekly huddles, although recent meeting minutes did not reflect this. Clinical guidelines formed part of the agenda for clinical and chronic disease meetings. The practice had utilised the DPHC chronic disease SOP and updated guidelines to streamline the chronic disease management. We noted that the nurses were applying the updated cervical screening recalls to patients notes in line with the NHS update (1<sup>st</sup> July 2025). All staff attended both practice and healthcare governance meetings and the coverage for these meetings appeared to be comprehensive with all discussions minuted.

### Monitoring care and treatment

There was a difference in opinion as to who had the lead role for chronic disease management. Some staff felt that the MN had the chronic disease lead at Pokhara and that the practice nurse assumed the lead in Kathmandu. Other staff felt that the SMO led on chronic disease management.

At our last inspection we identified that improvement was required in the management of chronic disease and we saw that this had been achieved. We saw that the nursing team ensured that patients with chronic disease were appropriately monitored: they recalled patients and ensured bloods/ prelims were completed prior to the SMO seeing the patient for their review. Protected time was allocated on DMICP for the nurses to complete this work. Since our last inspection, a chronic disease register had been introduced and all notes had been reviewed and correctly Read coded. Training had been delivered by the SMO and MN linked to each disease area: both to ensure that correct Read codes were applied and that practice staff knew how to set up and action searches on DMICP. The nurses had set up calendar reminders to aid recalls and had utilised 'GOV notify' for recalling patients (however there have been some issues with this due to overseas numbers sometimes not being recognised).

We reviewed 10 sets of notes for patients with a long term condition. All had clear actions and plans in place. Two patients were not in date for review, although both had appointments in the coming week as they had been away from Nepal on courses. A clear process for tracking patients was seen and care was evidence based and in line

with national guidance. All patients with a diagnosis of asthma had had an asthma review in the preceding 12 months which included an assessment of asthma control using the three RCP (Royal College of Physicians) questions. An asthma SOP was followed by clinicians and a consistent asthma review template was in use. Asthma patients were correctly coded for exposure to air pollution. Diabetic patients were being recalled and monitored appropriately. Patients recorded as having high blood pressure had been followed up appropriately.

The team confirmed that they took steps to identify pre-diabetic patients. NHS health checks were carried out for all available patients along with reviewing family history information for newly registered patients. Opportunistic screening was offered to patients. The nurses in Pokhara were advertising the services offered in the medical centre via welfare meetings and coffee mornings so as to increase patient awareness. We undertook a clinical search to identify pre-diabetic patients. We noted six patients recorded as having HbA1c in the pre-diabetic range and we looked further into the notes for three of these patients. We noted that all three patients had not been followed up: two since 2023 and one since 2024. We asked the SMO to review all patients in this search and to follow up with the patients as required. We undertook a clinical search to find undiagnosed hypertension and the search revealed 14 patients. We looked into the notes for three of these patients and saw that all had been followed up appropriately. To avoid patients appearing in error in this search in future, we discussed applying a Read code of 'normal BP'.

Eighty-four percent of patients' audiometric assessments were in date (within the last two years). All patients in Kathmandu were in date and five in Pokhara needed an assessment. The audiometric machine at Pokhara was being calibrated.

Patients with mental health needs were supported in a number of ways. Recently DPHC launched an Integrated mental health pathway and primary care toolkit which changed how Defence clinicians manage step 1 and 2 mental health interventions and includes self-directed psychoeducation, online self-directed cognitive behavioural therapy and access to other resources. The associated poster was displayed in the Medical Centres in Kathmandu and Pokhara, but there was scope to extend the team's awareness of the new processes. Nevertheless, the team had a good knowledge of the patients in their care and the number of patients currently requiring intervention was very low. The SMO knew how to access the Consultant Psychiatrist in the DPHC Global Practice should he see a patient requiring anything more than low level intervention.

The practice had an audit programme which was embedded into the healthcare governance agenda. This included topics mandated and recommended by DPHC. A thyroid management audit had been undertaken (second cycle) and also a review of asthmatic patients (also second cycle). The nursing team had undertaken a consultation audit which in turn had provided evidence to support the nurses attending the consultation skills course. A re-audit demonstrated the benefits of the course.

## **Effective staffing**

The medical centre provided a comprehensive induction pack to arriving staff, including some cadre specific elements, alongside some Nepal specific information. There was a nurse specific induction which focussed on relevant areas such as understanding the impact of the poor air quality and triage/ out of hours. Nurses confirmed that they did not undertake any clinical tasks where they did not feel competent or confident to do so. The newly posted MN confirmed that the induction received had been granular and appropriate, having been actively developed and internally validated. The induction for the SMO was generic and had not been made bespoke to the role. However, staff confirmed that it was supplemented by a handover from the outgoing to the incoming incumbent. This would likely succeed if there were a handover period, but we note that it is not unusual for a gap to exist resulting in no handover. The SMO mentioned that there were SMO handover notes which each incumbent updates.

The SMO completed appraisals and reviews for all the nurses. Clinical supervision was completed quarterly by the MN and we noted that concise notes were retained securely and used to support development. Peer review was completed as required and the current MN was working to integrate this into the clinical supervision programme to ensure the civilian nurses were supported. The MN completed a consultation audit in June 2025. The SMO set the objectives for the MN who felt there was scope to better synchronise these with reporting and post holders and so was engaging with the SMO and adjutant to ensure re-alignment. The SMO in Nepal and the SMO in Brunei held support meetings which were minuted.

The civilian nurses had both completed the consultation and assessment course (remotely via University of Cumbria). The MN based at Pokhara was current for the STIF (sexually transmitted infection) training and had undertaken the STIF foundation course, the MN at Kathmandu was awaiting the next training date. The team knew how to access advice from the Defence Consultant Advisor (DCA) in sexual health if required. The MN was primary care speciality trained and as part of this pathway had completed cytology, travel health and ear care as part of their training.

The mandatory training records were well maintained, although we noted that the military staff who were deployed into the role were not captured. We identified some gaps in training and these included the mental capacity act, supporting patients with autism and a learning disability and safeguarding. Staff should refresh all levels of safeguarding training where applicable to their role.

## **Coordinating care and treatment**

The medical centre team had forged effective links with key stakeholders in relation to safeguarding including welfare staff, commanders, the Padre, the Pundit and social



work team. We interviewed a welfare officer, the Padre, the Pundit and Chain of Command as part of our inspection. They confirmed that regular meetings took place with the aim of supporting personnel and that conversations were two way such that each party could raise concerns about vulnerable personnel. The team could access the British Forces Social Work team based in Brunei as required.

There was a local rehabilitation pathway for patients with muscular skeletal injuries. A locally contracted physiotherapist was available to provide 6 sessions of physiotherapy on referral by the GP and this was delivered in the BGN gym. Additional sessions could be provided at the request of the SMO. There was reach back to the UK either through Regional Rehabilitation Unit (RRU) Aldershot, Defence Medical Rehabilitation Centre (DMRC) or to NHS hospitals in Birmingham and Frimley.

Pregnant patients were referred to local secondary care by the SMO. Expectant mothers were flown back to the UK for ante-natal care.

Patients would not normally leave regular service whilst in Nepal. However, if they did, the SMO would lead on the preparation of the patient. For patients leaving the military, pre-release and final medicals were offered. During the pre-release phase, the patient received an examination and a medication review. The nurses would ensure all vaccinations were in date and provide travel health advice where required.

## Helping patients to live healthier lives

The civilian nurse in Pokhara was the health promotion lead for the practice but the role was shared between the 2 civilian nurses to ensure cross cover and continuity.

The DPHC health promotion calendar was used as a basis for noticeboards, but there was also a focus on country specific issues and the practice linked closely with recruitment courses and anything that may be happening in Pokhara or Kathmandu to tailor health promotion material. Information was available in the medical centre via posters, leaflets, TV presentations and QR codes available for patients to access further advice and support. The nurses attended Station and Unit health/ wellbeing fairs.

There was a display of QR codes for information to online mental health support, in line with the current DPHC policies and services offered. Leaflets were in Nepali as well as English.

Staff confirmed that whilst brothels were illegal in Nepal, they were aware that they do exist. Information was made available to patients (in particular recruits) about use of these. Information about safe sex was available in the medical centre and briefings were delivered to personnel before they deployed on larger exercises or deployments.



Free condoms were available at the practice. There were QR codes on display for information around sexual health.

### Health Screening

Health screening was proactively encouraged by the medical centre. Regular searches were undertaken for breast (of the 8 patients identified, 4 had had a mammogram) and abdominal aortic aneurysm screening (one patient identified and had been invited) in line with national programmes. Eighty-nine percent of women who were eligible for a cervical smear had received one in the last five years which exceeded the NHS target of 80%. Twelve patients were eligible for faecal immunochemical testing (FIT testing used for bowel cancer screening) and 5 of these patients had come forward to have the test. Patients had been made aware that the FIT test in Nepal is not NHS assured and so they should be retested on return to the UK.

In line with best practice guidance, all patients over 40 years of age were invited for a health check. At the time of this inspection, 53 patients were eligible, 53 had been invited and 48 (87%) had attended.

### Immunisations

Immunisations were regularly reviewed and administered to patients when they were required. Vaccination rates were high in most areas. Rabies vaccine supply was awaited and the team confirmed that patients would receive further doses as soon as the supply arrived in Nepal.

### Vaccination Statistics for Military Personnel:

- 100 % of patients were in-date for vaccination against polio
- 100 % of patients were in-date for vaccination against hepatitis B
- 100 % of patients were in-date for vaccination against hepatitis A
- 100 % of patients were in-date for vaccination against tetanus
- 91.9 % of patients were in-date for vaccination against typhoid
- 100 % of patients were in-date for vaccination against MMR
- 98.4 % of patients were in-date for vaccination against meningitis
- 100 % of patients were in-date with vaccination against diphtheria
- 98.4 % of patients were in-date with vaccination against Japanese encephalitis
- 100 % of patients had received one dose of the rabies vaccine
- 100 % of patients had received two doses of the rabies vaccine
- 98.3 % of patients had received three doses of the rabies vaccine

**Vaccinations Stats for civilians and family members:**

- 94.9 % of patients were in-date for vaccination against polio
- 91.9 % of patients were in-date for vaccination against hepatitis B
- 96.6 % of patients were in-date for vaccination against hepatitis A
- 94.9 % of patients were in-date for vaccination against tetanus
- 89.6 % of patients were in-date for vaccination against typhoid
- 76.8 % of patients were in-date for vaccination against MMR
- 98.4 % of patients were in-date for vaccination against meningitis
- 94.9 % of patients were in-date with vaccination against diphtheria
- 94.2 % of patients were in-date with vaccination against Japanese encephalitis
- 93.0 % of patients had received one dose of the rabies vaccine
- 94.1 % of patients had received two doses of the rabies vaccine
- 89 % of patients had received three doses of the rabies vaccine

BCG vaccine is recommended for those at increased risk of developing severe disease and/or of exposure to tuberculosis infection. Consequently, we checked to see that healthcare workers and children registered with the medical centre had been offered the BCG vaccine. Both military healthcare workers had received the vaccine and 19 of the 21 children had received it.

There were no children under the age of five registered at Nepal Combined Medical Centre at the time of this inspection.

## **Consent to care and treatment**

Mental capacity act training had not formally been delivered in the medical centre. The SMO confirmed they had undertaken Mental Capacity Act training but they could not recall when. However, staff we spoke with were able to describe the processes of assessing whether a patient has capacity. Gillick competence and Fraser guidelines training was delivered in July 2025. Staff understood the principles of Gillick competence and how these applied in practice. Where minors were treated, arrangements were in place to involve parents or guardians or representatives where the patient consented to their involvement.

The team confirmed that no procedures were undertaken that would require written consent e.g. minor operations or contraceptive implants. Verbal and implied consent

were sought. This was not recorded for every consultation but was for intimate examinations. The consent was Read coded. The audit of consent formed part of the consultation audit which was completed each year.

## Are services caring?

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

### Kindness, respect and compassion

We interviewed 12 patients as part of the inspection and feedback indicated staff treated patients with kindness, respect and compassion. We received 22 CQC comments cards from Kathmandu patients and 8 responses from Pokhara patients and all confirmed that they were treated well.

We interviewed most staff working across the medical centre at the time of the inspection. All staff told us that Nepal Combined Medical Centre was a happy place to work and that they could rely on their work team to discuss and mitigate any concerns they faced. They spoke about colleagues who were supportive, professional and caring.

### Involvement in decisions about care and treatment

All 12 patients we spoke with said they were involved with decision making and planning their care. Clinicians had provided comprehensive information to help support their decision making.

The 30 patients who filled out comments cards confirmed that staff took time to clearly communicate treatment decisions to them so that they could make an informed decision.

The eRegistration form asked patients whether they had a role as a carer. The nurses undertook patient screening and also asked the question. The DMICP record was Read coded and an alert added. A DMICP search was undertaken to identify carers so that they could be offered a carers package, flu vaccines, greater flexibility of appointments or any additional support.

The Practice had access to the Big Word translation service although this had not been used to date due to the staff team being able to translate Nepali. It is best practice to offer a translation service to all patients who need it as they may prefer to share their private health information with an anonymous individual. The practice leaflet was available in both Nepali and English.

## Privacy and dignity

All patients we spoke with stated that they were confident that the practice would keep information about them confidential. All stated that they felt that their dignity and privacy were upheld by medical centre staff. Comments cards also raised no concerns. Consultations took place in clinic rooms with the door closed. Patient identity checks were completed prior to any information being disclosed. There were privacy curtains in all clinical rooms. There was a notice on reception advising patients they could speak with a member of staff in private if required. All staff had completed the Defence Information Management Passport training which incorporated the Caldicott principles. There was a screen at reception to minimise noise.

Patients were able to see female nurses or a male GP and so they might not be able to see someone of a particular gender, depending on the nature of the clinical issue. We asked patients about this and no-one felt that this was a concern for them.

## Are services responsive to people's needs?

We rated the practice as good for providing responsive services.

### Responding to and meeting people's needs

There was no HIVE Network in Kathmandu or Pokhara. However, the families' welfare officer acted as the support services to both the Unit and families.

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

Specific clinics for children were provided on Tuesdays and Thursdays each week in the afternoons. There was 24/7 access via the duty phone. We spoke with patients who confirmed to us that they knew how to access care out of hours if they needed it.

Staff had completed diversity and inclusion (D&I) training and inclusion in the civil service training. The Practice Nurse was the D&I lead. Posters were displayed and as was the Nepal Patient Charter.

There were no patients transitioning gender at the time of our inspection. If patients required support, advice would be taken from DPHC Overseas RHQ.

A disability access audit was completed in May 2025 and found that in Kathmandu no automatic entrance doors (mitigations were that if someone needed assistance to enter the building, this would be provided) or induction loop had been fitted. There was a disabled toilet in Pokhara but not in Kathmandu (although patients could be signposted to a disability accessible toilet in the transit accommodation). There was an emergency pull chord in the disabled toilet in Pokhara, but not in the other toilets. Whilst no disabled toilet was available in Kathmandu, patients were signposted to a disability access toilet in the transit accommodation. Given the screening of patients prior to deployment to Nepal, it was unlikely that these access issues would impact them significantly.

## **Timely access to care and treatment**

The medical centre was providing responsive care for its patient population. Urgent and routine appointments with either a doctor or a nurse could be accommodated on the same day if required. The patients we spoke with during the inspection confirmed they received an appointment promptly and at their preferred time. Thirty patients completed comments cards and all confirmed that access to care was good. The only concern that some patients raised was that the short posting for the SMO impeded continuity of care. However, all patients confirmed that their health had not suffered as a result of this.

The number of patients who did not attend for their appointment was minimal. Only two patients had not attended in the past two months.

Arrangements were in place in order that patients could access a clinician at all times when the practice was closed and in an emergency. The SMCAs and civilian nurses acted as first on call with the SMO and MN acting as second on call. If a patient needed to be seen, both the first and second on calls went to the medical centre to facilitate this.

## **Listening and learning from concerns and complaints**

The practice manager was the lead for complaints and SMO deputised: terms of reference reflected this arrangement. One complaint had been received in the last 12 months. The complaint had been investigated and communication with service personnel adjusted to prompt them to register their family members as soon after arrival as practicable.

Patients were made aware of the complaints process through the practice information leaflet and a poster in the waiting room. There was also a complaint reporting form available at reception for patients to complete. Patients we interviewed were aware of how to complain but said they had no reason to make a complaint about the service.

## Are services well-led?

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

### Leadership, capacity and capability

The staff team at Nepal Combined Medical Centre delivered high quality care to a small patient population with relatively low clinical demand. We met with a local civilian team whose commitment and ability to lead mitigated to a large extent the risks associated with military clinical leaders carrying out short postings. Staff owned detailed terms of reference for their main role, although there was scope to clarify secondary roles such as health and safety lead, clinical waste lead and equipment care lead. The aligned working relationships with key stakeholders delivered dividends for vulnerable patients, service personnel, children and families alike. The team had well established links with the regional team who provided input when required. The team found the regular meetings with the regional warrant officer to be practical and useful. Shared discussion of and resolution of risks was evident.

Throughout this inspection we met with patients and unit staff who described a medical centre team that worked hard to ensure that patients' needs were met as quickly as possible to ensure their health and wellbeing, alongside their role in facilitating operational capability.

The local civilian team had considered the need to mitigate the fact that the SMO and MN deployed to Nepal for short periods of time. They had worked hard and stepped up to willingly cover leadership roles not usually required of them. Due to the transient nature of the military workforce, a local working policy had been instigated which clarified which permanent staff held lead and deputy leads for clinical management, healthcare governance and practice management. This was helpful in providing continuity of leadership and practice management. Chronic disease management leads were consequently the civilian practice nurses and the Caldicott lead was allocated to the practice manager. Previously the SMO had assumed the lead for both of these areas, but the new arrangements were impactful in ensuring continuity for the team and for patients.

The local civilian team had identified some gaps in communication and effective decision making when dealing with Chain of Command as a result of the frequent rotation of the SMO. Traditionally the SMO had been the first line of contact to escalate and discuss any concerns and issues that the medical centre team had that required resolution from Command e.g. swift payment of overtime requests, recruitment requests. We noted that progress had been hindered due to the more frequent handovers in military staff. We also noted the practice manager's commendable efforts to continue to chase resolution for these issues, but that they had met with some



barriers in achieving this, possibly due to Command expecting to receive communication from the SMO. The regional team had noted that work was required in this area to consolidate and formalise the practice manager's authority in escalating issues for resolution by the Unit. They told us they would be taking remedial action.

## Vision and strategy

Staff we spoke with were clear that their remit was to support patients to benefit from the best possible healthcare outcomes which, in turn, supported operational capability.

The team worked to DPHC Overseas mission statement *'DPHC Overseas will deliver a unified, safe, efficient and accountable primary healthcare service for entitled personnel to maximise their health and to deliver personnel medically fit for operations, training and contingency.'*

The medical team had forged close links with the units they supported and tailored the service to their specific needs to support exercises and deployments. They also supported visiting personnel arriving in Nepal to undertake adventurous training. Duty doctors, nurses and SMCAs were routinely on hand to facilitate urgent access to care.

## Culture

Staff we spoke with described a strong team ethic with patients' individual requirements held at the centre of all decision making. Staff enjoyed working together and invested their recreational time in team sport, shared lunches and teas. We observed staff going the extra mile to maintain a 24/7 OOH primary care service for all registered patients.

The practice team operated an open and honest meeting culture where all staff were encouraged to attend and offer suggestions or raise concerns. Reference was made to a 'no rank' ethos and an open-door policy where staff could safely raise concerns to any member of staff. We noted that staff we interviewed were confident and empowered to discuss issues and concerns they had identified and escalated.

We spoke with most of the medical centre staff during the inspection day and all were overwhelmingly positive, enjoyed coming to work and felt that they could influence change if they needed to.

The staff team proactively celebrated one another's cultural and religious festivals and team members we spoke with appreciated these opportunities to better understand one another and to improve team cohesion.

Staff were aware of the whistleblowing policy and were also aware of the Freedom to Speak Up (FTSU) process within the region.

Staff confirmed that processes were established to ensure compliance with the requirements of the duty of candour, including giving those affected reasonable support, information and a verbal and written apology. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. Staff did not give examples of when duty of candour had been recently applied. We noted that the last entry into the duty or candour log was in June 2024.

## **Governance arrangements**

The healthcare governance workbook (HGW) was the overarching system used to bring together a range of governance activities, including the risk register, ASER tracker, training register, SOPs, complaints, training, meetings, Caldicott & Duty of Candour. There was scope to better organise relevant policies and information so that staff could locate what they needed with ease.

An appropriate meeting structure was in place. This included regular practice, healthcare governance and unit healthcare committee meetings, chronic disease and safeguarding meetings.

Work around the management action plan (MAP) was limited and we noted that the nine actions in total were all overdue for completion. Civilian Nurses were the Healthcare Governance lead for the practice. Most of the MAPs outstanding were awaiting uploading of the documents on the Healthcare Assurance Framework or a final check of the domains for which tasks had already been completed and MAPs were only remaining to be closed.

A quality improvement programme was in place and covered clinical and managerial topics, including the DPHC mandated audits. The programme was ongoing and involved an ongoing cycle of audit work.

## **Managing risks, issues and performance**

There was a current and retired risk register on the HGW along with current and retired issues. The register articulated the main risks identified by the practice team. All risks included detail of the four T's: 'treat, tolerate, transfer or terminate' and had a review date. There was scope to transfer certain risks to Regional Headquarters for mitigation.

We saw that there were 2 risk assessments in place and that these covered several areas including working environments (hot/cold), working at height, occupational stress, needle stick Injuries and (limited) Control of Substances Hazardous to Health (COSHH). There was scope to better manage risk using standalone risk assessments for individual

risks. Individual COSHH assessments were also required for hazardous materials (e.g. cleaning products) and medication. There were processes in place to monitor national and local safety alerts, incidents, and complaints.

There was a link to the business disaster plan (BDP) within the healthcare governance workbook. The BDP was last reviewed by an SMO in June 2022 and the most recent table top exercise took place in March 2024. The business continuity plan was last reviewed in May 2024 and was last exercised in December 2022. The communicable disease and outbreak plan was last reviewed in September 2025 and was last exercised in November 2022. The link to medevac and casevac Plan within the HCG workbook did not work.

Staff who were not performing would be supported initially to identify any underlying cause and implement support structures. If performance did not improve then formal performance management processes, military or civilian, would be followed.

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

The team issued a patient survey every quarter. Patients could also feedback via the suggestions box in the waiting rooms or via QR Code. We noted that all recent comments received had been positive with no suggestions for improvements.

The practice team stated that they felt well supported and had excellent communication streams with the units they supported. Welfare staff told us that their relationship with the MC team was positive and trusted.

The Hospital liaison officer (HLO) engaged well with the hospitals regarding patients who had been admitted, pursued outstanding appointments and arranged payment letters. She personally visited patients who had been admitted.

## **Continuous improvement and innovation**

The MN introduced a helpful algorithm for managing heat illness.

The practice was required to stop using the UK based text messaging service. Consequently, the SMO developed an Excel spreadsheet programmed to automatically send e-mails (via a bespoke Outlook template) to a list of personnel entered into the sheet with a personalised message and results. The MTF had to obtain consent from patients before sending medical information by e-mail and had to capture their e-mail addresses. This was done at eRegistration and via a catchup program where staff chased patients for their consent/e-mail. The outcome is that a problem was

circumnavigated, patients continue to receive the communications they need and administrative and nursing team time has been saved.

The SMO updated a DMICP SmartDoc to help input pathology reports into DMICP. The pathology results used to arrive in paper format and often in different units to those required for filing on DMICP. The results now arrive by e-mail. The SmartDoc captures the result, converts it to the correct units and Read codes it on DMICP. This helps to minimise transcription errors which may happen when manually converting the result and manually Read coding. The SMO updated and improved the existing SmartDoc.

The SMO designed a SmartDoc to streamline the writing of referral letters.