Episkopi Medical Centre

Quality report

Episkopi Station
BFPO 53
Cyprus

Date of inspection visit:
10 September 2019

Date of publication:
19 March 2020

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.

Chief Inspector's Summary

This practice was not rated as part of the inspection

We carried out an announced comprehensive inspection of Episkopi Medical Centre on 10 September 2019. Defence Medical Services (DMS) are not registered with the CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014 and are not required to be. Consequently, DMS services are not subject to inspection by the CQC and the CQC has no powers of enforcement. This inspection is one of a programme of inspections that the CQC will complete at the invitation of the Surgeon General in his role as the Defence Authority for healthcare and medical operational capability.

The practice was providing safe and effective care. However, we have made some recommendations to the practice, Defence Primary Healthcare (DPHC) and HQ British Forces Cyprus with the aim of improving the delivery of care to patients.

At this inspection we found:

- The practice was well-led and leaders demonstrated they had the vision, passion and integrity to provide a patient-focused service that sought ways to develop and improve.
- An inclusive team approach was supported by all staff who valued the opportunities available to them to be part of a patient-centred service.
- There was an open and transparent approach to safety. An effective system was in place for managing significant events and staff knew how to report and record using this system.
- The assessment and management of risks was comprehensive, well embedded and recognised as the responsibility of all staff.
- The arrangements for managing medicines, including obtaining, prescribing, recording, handling, storing and disposal minimised risks to patient safety. There was an effective approach to the monitoring of patients on high risk medicines.
- Staff were aware of current evidence-based guidance. They had received training so they were skilled and knowledgeable to deliver effective care and treatment.
- The practice worked collaboratively and shared best practice to promote better health outcomes for patients.
- There was evidence to demonstrate quality improvement was embedded in practice, including an annual programme of clinical audit used to drive improvements in patient outcomes.
- The practice proactively sought feedback from staff and patients which it acted on. Feedback showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- The building and equipment at the practice were sufficient to treat patients and meet their needs.
- Staff were aware of the requirements of the duty of candour.

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

- The three practices in Cyprus had shared best practice and all engaged in the wider community to promote good healthcare. This included visits to the local schools and youth groups.
- The practice had identified a delay in the process when sending cytology samples back to the UK. This resulted in a wider investigation by Defence Primary Heath Care (DPHC) which in turn delivered improved outcomes for a wider patient population living overseas.
- The officer in charge of the PCRF had a specific interest in women's health and through dedicated clinics was directing good practice and service improvement for this population.

The Chief Inspector has escalated the following issues of significance by letter to the Defence Medical Services Regulator (DMSR) who will feedback in due course:

- BFC should ensure that arrangements are in place to deliver deep cleaning for all four medical centre buildings. Medical centres should have sight of cleaning contracts in order that they can monitor their delivery.
- DPHC should review staffing requirements to ensure that there are sufficient staff with the right skills and experience to deliver both primary care and PHEC (Pre-Hospital Emergency Care). This should include identifying and assigning clinical staff with the appropriate qualifications and, where this is not possible, providing essential training on island in order to enhance staff skills. Currently medical centres are staffed to meet the requirements of daytime primary care services, yet staff are delivering OOH (out of hours) and 112 (equivalent to 999) care to a section of the local Cypriot population. These additional demands on staff have impacted morale at times.
- Secondary care clinics used on the island sometimes recommend treatments which fall outside British national guidance such as NICE (National Institute for Health and Care Excellence) and SIGN (Scottish Intercollegiate Guidelines Network). In such instances the doctor for each patient will decide (in liaison with UK specialists as required) whether a treatment is appropriate. However, there are risks where access to advice in the UK is delayed. The DPHC should ensure shared guidance is provided to assist doctors in assessing more promptly and consistently which treatments are appropriate.
- Challenges around timely access to accurate patient records occur as DMICP Hybrid is a system with reduced functionality and some outage periods. DPHC should review the functionality of DMICP Hybrid in partnership with Cyprus practices and deliver solutions to improve access to up to date records.
- DPHC should ensure physiotherapy staff have sufficient training to assess and treat children.

The Chief Inspector recommends to the medical centre:

- The three medical centres on the island should consider implementation of Direct Access Physiotherapy (DAP) in order to ensure equity of access for all patients.
- That patient consent is recorded on the clinical system.

- Medicines supplied for patient group directions (PGD) use are to be accounted for appropriately by the nursing staff.
- Ensure that patients eligible for abnormal aortic aneurysm (AAA) screening are offered a screening service.

Dr Rosie Benneyworth BM BS BMedSci MRCGP
Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

The inspection team was led by a CQC lead inspector**.** The team comprised of a second inspector and specialist advisors including a GP, practice nurse, practice manager, physiotherapist and pharmacist.

Background to the Episkopi Medical Centre

Located in the Western Sovereign Base Area (WSBA) of Cyprus, Episkopi Medical Centre provides a routine primary care service to a patient population of 680 service personnel and 1,412 civilians, including dependents of service personnel. The medical centre also provides an occupational health for military personnel and rehabilitation services.

Secondary care is provided primarily by the Ygia Polyclinic in Limassol although other government hospitals are sometimes used including Larnaca General, Paralimni and Nicosia General. Patients can also be referred to the UK to access NHS services if required.

The medical centre is a dispensing practice and is staffed by two pharmacy technicians (one post gapped at the time of the inspection). A Primary Care Rehabilitation Facility (PCRF) is co-located with the medical centre and provides a physiotherapy and rehabilitation service for service personnel and their families.

The medical centre is open from 06:30 to 16:30 hours on a Monday and from 06:30 to 13:30 Tuesday to Friday. Outside of these hours, including weekends and bank holidays, cover is provided by a doctor and duty medic. In addition, there is a 24 hour nursing service delivering out of hours and emergency care to support the PHEC.

The staff team

Position	Numbers
Senior Medical Officer (SMO)	one
Deputy SMO	one
Regimental Medical Officer (RMO)	one
Civilian medical practitioners (CMP)	two (1.5 whole time equivalent)
Senior Nursing Officer (SNO)	one
Nursing Warrant Officer (WO2)	one
Practice sister (non-medical prescribers)	two
Civilian practice nurses	five
Military practice nurses	three
Military practice manager	one
Administrative staff	six
Military physiotherapist	one

Civilian physiotherapist	one
Military exercise rehabilitation instructor	one
Pharmacy technician	two (one post gapped, and one post filled by a locum covering sick leave)
Medics	four (one gapped post covered by a locum paramedic)
Regimental Aid Post (RAP) medics	one military nurse seven medics
Staff in training	one GP registrar six placement medics
Other visiting staff or staff attached to the medical centre	two midwives two mental health nurses (1.5 whole time equivalent) one health visitor one genitourinary (GU) nurse (one day a week) one dietician (one day a week)

Are services safe?

We found that this practice was safe in accordance with CQC's inspection framework

Safety systems and processes

Systems were established to keep patients safe and safeguarded from abuse.

- Measures were in place to protect patients from abuse and neglect, including adult and child safeguarding policies. The safeguarding policies provided contact details and referral processes including one-page flow charts for in and out-of-hours.
- 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 HQ British Forces Cyprus, referred to as BFC), unit welfare and the children's nurse service. There were monthly multi-disciplinary meetings where safeguarding issues were discussed and the SMO fed into the Commander Medical BFC who attended safeguarding board meetings.
- Doctors and PCRF staff had completed level 3 training in adult and child safeguarding. Staff, including Regimental Aid Post (RAP) staff working at the practice, had received safeguarding training and update 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 medical centre). There was a named safeguarding lead and deputy lead for the practice. 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 patients register was held on the electronic patient record system (referred to as DMICP Hybrid) with 15 adults and 11 children identified at the time of the inspection. Safeguarding was a standing agenda item at the weekly doctor's meeting. Monthly primary care meetings to discuss vulnerable children were held with SSAFA and the child nurse services. Patient records were updated during the meeting and a monthly search was run to ensure the register was current. The SMO shared information with the Sovereign Base Area (SBA) safeguarding board.

- Trained staff completed an annex to the DPHC chaperone policy to state that they were happy to be used as chaperones. Chaperone training was last provided in August 2019. Notices advising patients of the chaperone service were clearly displayed in patient areas. Staff had been subject to safety checks to ensure they were suitable to work with young people and vulnerable adults. A chaperone register was available at the reception desk for staff to refer to.
- 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). However, the practice was not always making a record of compliance. On the inspection day, the practice incorporated a 'day one locum induction check sheet' into the induction process to demonstrate that relevant safety checks had taken place at the point of recruitment, including a DBS check to ensure staff, including locum staff, were suitable to work with vulnerable adults and young people. DBS checks were renewed every five years. The practice had an effective process through local agency criminal checks (DPHC approved) for civilian staff who could not obtain a DBS check.
- Arrangements were in place to monitor the registration status of clinical staff with their regulatory body. All staff had professional indemnity cover. Information was in place to confirm staff had received all the relevant vaccinations required for their role at the practice.
- There was an effective process to manage infection prevention and control (IPC) and the lead and deputy lead for IPC were appropriately trained for the role. The staff team was up-to-date with IPC training with the most recent course held in August 2019. An independent IPC audit had been undertaken in July 2019 and no significant concerns had been identified.
- Environmental cleaning was provided by an external contractor. Cleaning schedules and monitoring arrangements were established, including a breakdown of requirements by room. A monthly check of cleaning standards was carried out. Deep cleaning of the premises was not included in the contract and the leadership team was aware this was an issue and had escalated the matter to a senior level.
- Two PCRF clinicians practised acupuncture and arrangements were in place for the safe provision of this treatment, including an acupuncture health screening assessment and patient information sheet.
- A dedicated lead was identified for the safe management of healthcare waste and they had terms of reference for the role. Clinical waste was collected once a week. Consignment notes were retained at the practice and an annual waste audit was carried out in August 2019.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

- Staff we spoke with said staffing levels and skill mix was adequate to meet the needs of the patients although the leadership team acknowledged that achieving the correct staffing level and skill mix had been a challenge. The team stated that the situation had improved with the additional support of medics but demands placed on staff presented risks of long working hours.
- The practice was responsible for Pre-Hospital Emergency Care (PHEC); the provision of emergency and first response care to both entitled military and civilian patients. Doctors and medics providing this care were recommended to have specific training in Military Pre-Hospital Emergency Care (MPHEC) and Battle Field Advanced Life Support (BATLS) which is only provided in the UK. However, a doctor or medic can be posted to Cyprus without the training, which means they cannot participate in the PHEC out-of-hours rota or provide ambulance cover. Although all doctors were entitled to attend this training, we were advised that civilian

doctors were not routinely offered this training. Consequently, the provision of PHEC then sits with a reduced pool of doctors and medics. This can impact their role in primary care.

- There was a mix of military and civilian staff. A locum induction programme was in place to familiarise temporary staff with systems and processes. The practice was proactive in gaining feedback and the locum induction pack was under review for further improvement.
- The practice was equipped to deal with medical emergencies and all staff were suitably trained in emergency procedures, including staff trained in life support. An emergency kit, including a defibrillator, oxygen with masks and emergency medicines were accessible to staff in a secure area of the practice; all staff knew of its location. Weekly and monthly checks were in place to ensure the required kit and medicines were available and in-date.
- Fire safety was well managed. The practice had up to date fire risk assessments and carried out regular fire drills. Clinical equipment was checked in line with Defence Medical Services policy to ensure it was working properly.
- Staff were up-to-date with the required training for medical emergencies. They participated in regular training relevant to emergency situations. We noted a display regarding the management of heat injury was displayed in clinical areas. Staff were also trained in the recognition and management of sepsis. Posters about sepsis were displayed throughout the practice.
- Debriefs followed every emergency call out and included civilian ambulance drivers. This was supplemented by weekly/monthly staff meetings and drills that were recorded on the training log and included spinal injuries and thermal injuries.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients. The DMICP Hybrid system presented a potential risk but staff could access DMICP if required.

- Individual care records were written and managed in a way that kept patients safe. The care records we looked at on the DMICP Hybrid system showed information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- A process was established for scrutiny and summarising of patients' records and this was monitored by a nominated individual. The patient completed a registration form (the practice adopted the new DPHC registration form on the day of inspection), which was checked by the receptionist and then passed to the nurses for further checks. Summarisation of service personnel was completed on DMICP Hybrid. A summarisation audit had been undertaken and at the time of the inspection, 94% of civilian patient's notes had been received and 99% of the patient records had been summarised.
- The practice uses DMICP Hybrid. DMICP Hybrid has reduced functionality compared to the UK patient records system and medical centres in Cyprus have experienced challenges around planned/unplanned outages, failures during updates and conflicting records. Staff told us that, whilst DMICP Hybrid challenges can create additional work and occasional periods without access to patient records, they were clear that safe delivery of care had not been compromised. However, they acknowledged that where two DMICP numbers existed for patients this could potentially lead to errors in recording and loss of contemporaneous notes. Furthermore, there was no direct referral system to PCRFs within 'deployed' and clinicians were using tasks and emails instead.
- Staff described occasional loss of connectivity with DMICP Hybrid, meaning clinics could be delayed. If this happened, the practice had produced clear guidance on how to respond. This

guidance had been shared with the other medical centres in Cyprus. If needed, patients could be seen at one of the other military medical centres in Cyprus.

- Referrals to other departments and external health care services, including urgent referrals, were managed by dedicated administrative staff. They responded to requests from the doctors and booked patient appointments. Referrals were logged onto a 'tracker' and monitored daily. Referrals made from the PCRF to the Regional Rehabilitation Unit (RRU) and other services were integrated with the wider referral tracking system for the practice. Physiotherapists also monitored their own referrals as part of the monthly caseload review.
- A standard operating procedure (SoP) was in place to ensure samples were taken safely, appropriately recorded on DMICP Hybrid 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. In addition, there was a 'tracker' used to follow up. We found that samples and results were effectively managed in accordance with the SoP.

Safe and appropriate use of medicines

The systems for the appropriate and safe handling of medicines required strengthening.

- A lead and deputy were identified as the subject matter expert for medicines management with the day-to-day management of medicines delegated to a pharmacy technician. Safe procedures were in place for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment.
- Dispensary stock was checked regularly. Appropriate arrangements were established for the safety of controlled drugs (CD), including destruction of unused CDs. Medication requiring refrigeration was monitored twice a day to ensure it was stored within the correct temperature range. Prescription forms were securely stored and their use monitored.
- Patient Group Directions (PGD) had been developed to allow appropriately trained nurses to administer medicines in line with legislation. The PGDs were current and signed. However, we noted that the on duty doctor was not always using the over labelled stock to supply their prescriptions and some medicines in the PGD cupboard were not labelled correctly.
- Patient Specific Directions (PSD) were in place and signed by the prescriber to permit medics to vaccinate patients. However, the PSDs, although signed and checked, had not always been added to the patient's notes and the checks done had not been documented.
- Nurse medical prescribers (NMPs) undertook a quarterly notes peer review and a monthly review with their GP mentor. They also were part of an NMP group and attended an annual NMP symposium in the UK. Medics had completed vaccination training. A medic is trained to provide medical support on various operations and exercises. In a medical centre setting, their role is similar to that of a health care assistant in NHS GP practices but with a broader scope of practice.
- Requests for repeat prescriptions were safely managed and no telephone requests were accepted. A repeat prescription book was maintained and monitored by the pharmacy technician. A process was in place to update DMICP Hybrid if changes to a patient's medication was made by secondary care or an out-of-hours service.
- A process was established for the management of and monitoring of patients prescribed high risk medicines (HRM). A register of HRM used at the practice was held on DMICP Hybrid and all doctors had access to this. Alerts, coding, diary dates and monthly searches were used to identify and manage patients on HRM. Shared care agreements were in place for the patients

who required them. These were stored and managed on DMICP Hybrid, an electronic document management and storage system, which all clinicians had access to.

- There were 79 patients prescribed an HRM and we looked at a range of these records. We found that monitoring was being carried out in line with recommended timescales and shared care agreements were in place when the patient was being managed in secondary care.
- The management of medicines was subject to regular audit. For example, an antibiotic prescribing audit in July 2019 was used to challenge access to hospital based medicines. A PGD audit was carried out in July 2019.
- The dispensary had SOPs. For example, for ordering medicines. However, the large dispensary opening that could be accessed without entering the building posed a potential security risk. The practice had assessed the risk to be minor (the centre was contained within a secure camp, had 24 hour internal staff and roaming security).
- The practice was aware of risks associated with the recommended prescribing guidance by secondary care services, notably Ygia Polyclinic and the safety of primary care doctors prescribing at the recommendation of secondary care. The SMO explained that if the medicine sat outside the British National Formulary (BNF) they would be very unlikely to prescribe it and most likely would go back to the consultant and advise that if they wished to prescribe it then that was for them to issue. The SMO said they had previously declined to re-issue medicines on this basis. This was discussed by the practice doctors during peer review, to counsel opinion, and checked with the other SMOs from the neighbouring practices to check if they had encountered this issue and to share information and learning.

Track record on safety

The practice had a good safety record.

- Measures to ensure the safety of facilities and equipment were in place. The practice manager was the lead for health and safety and had enlisted for training specific to the role (scheduled for October 2019). Electrical and gas safety certificates were up-to-date. Arrangements were in place to check the safety of the water.
- A building fire risk assessment was in place and due for review in September 2022. The fire system was tested each month. Staff were up-to-date with fire safety training and were aware of the evacuation plan.
- Safety processes for the practice were monitored and reviewed, which provided a clear and current picture that led to safety improvements. Risk assessments pertinent to the practice were in place and they had been reviewed in March 2019. Safety data sheets were in place for hazardous substances. A station safety health environment and fire (SHEF) audit carried out in March 2019 praised the practice for their standards. Equipment checks, including the testing of portable electrical appliances were in-date.
- An alarm system was available in the nursing bay and the disabled toilets to summon support in the event of an emergency. The main waiting area could be monitored from the main reception to respond in the event of a medical emergency. However, additional waiting areas for the PCRF and pharmacy (situated in busy corridors) were not routinely monitored. The practice had a business case pending for CCTV to be fitted in these areas.
- A lone working SoP was in place for dispensary, however, arrangements were improved following the inspection with the addition of personal hand-held alarms.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff used the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events, incidents and near misses. There was a dedicated ASER management team and all staff had electronic access to the system, including locum staff. Staff provided several varied examples of significant events confirming there was a culture of effectively reporting incidents. Significant events were standing agenda items at the practice and healthcare governance meetings held each week. Significant events were not closed until all actions had been completed. The ASER system was also used to report good practice and quality improvement initiatives.
- The PCRF team used the ASER system but recognised that some situations may have required ASERs and planned to complete training to improve their understanding and for flagging issues to the wider team.
- Improvements were made as a result of investigations into significant events. For example, the practice had raised a delay in cytology samples being received in the UK. This had highlighted a risk for overseas patients and had been escalated to DPHC for investigation. The potential for similar risks at other overseas locations had subsequently been shared and pre-empted further safeguards within the system.
- The pharmacy technician was responsible for managing medicine and safety alerts. The Central Alerting System (CAS) website was checked daily and there was an automated system for alerts to be received by email. Alerts were logged on a spreadsheet and emailed to the practice manager for dissemination and acknowledgement when completed. However, we looked at two recent alerts to find that actions had not always been completed within target timescales, these were within the monthly audit (used as a further check) and were actioned on the day.

Are services effective?

We found that this practice was effective in accordance with CQC's inspection framework

Effective needs assessment, care and treatment

The practice had processes to keep clinicians up to date with current evidence-based practice.

- 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). These were discussed at the weekly meetings for clinicians and, if relevant to the wider staff team at learning forums and health care governance meetings. Staff were also kept informed of clinical and medicines updates through the Defence Primary Health Care (DPHC) newsletter circulated to staff each month.
- Learning was shared among clinicians using a ‘ghost’ clinic (a virtual clinic set up on DMICP Hybrid for the purpose of case reviews). Any interesting cases could be added to this and then reviewed weekly by the clinical team. New ideas were considered for ‘suggestion of the month’, presented at clinical meetings.
- The secondary care clinics used on the island sometimes recommended treatments which fall outside British national guidance such as NICE (National Institute for Health and Care Excellence) and SIGN (Scottish Intercollegiate Guidelines Network). In such instances the GP

for each patient decided (in liaison with UK specialists as required) whether a treatment was appropriate. However there are risks where access to advice in the UK is delayed. Shared guidance is required to assist GPs in assessing more promptly which treatments are appropriate.

- The PCRF team were invited to joint meetings and learning forums for the whole practice meetings.
- Our review of PCRF patient records showed Rehab Guru, software for rehabilitation plans and outcomes, 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). However, this was not being used consistently. As a result, a senior physiotherapist provided further training across all the PCRF departments on the island, the impact of this was due to be audited to see if improvement was evident.
- The PCRF team referred to the Defence Rehabilitation website for best practice guidance. For example, exercise rehabilitation instructors (ERIs) used it for guidance on equipment management, training and best practice guidance. However, an audit on the use of low back pain (LBP) best practice guidelines had started but was not complete and the PCRF were not using the mandated outcome measures.

Monitoring care and treatment

The practice used data collected for the Quality and Outcomes Framework (QOF) to monitor outcomes for patients. QOF is a system intended to improve the quality of general practice and reward good practice. It is used across many NHS practices. The Defence Medical Services (DMS) have a responsibility to deliver the same quality of care as patients expect in the NHS. The QOF provides a useful way of measuring this for DMS. Because the numbers of patients with long term conditions are often significantly lower at DPHC practices, we are not using NHS data as a comparator.

- There was a dedicated lead and deputy for each long-term condition overseeing the management, including recall, of patients. We found the care of patients with long-term conditions was well managed with clear responsibilities for each chronic condition.
- We were provided with QOF outcome data during the inspection and it showed that patients with diabetes, high blood pressure and asthma were being effectively managed, including the consistent use of pathways and review templates. Our review of clinical records confirmed this, including the adherence to NICE guidance. Staff could explain any anomalies in the data, such as patients not responding to recall invitations. If no response was received after the nursing team's third attempt to contact the patient, then a standard letter was sent to the patient
- We looked at a range of clinical records and were assured that the care of patients with a mental illness and/or related symptoms was being effectively and safely managed. Appropriate templates were used to assess patients and plan their care. Clinicians worked closely with the Department of Community Mental Health (DCMH) and referred patients when required. The practice had access to a community psychiatric nurse 24-hours a day. Patients with a serious mental illness were admitted to Ygia Polyclinic.
- Information from the Force Protection Dashboard, which uses statistics and data collected from military primary health care facilities, was also used to gauge performance. Service personnel may encounter damaging noise sources throughout their career. It is therefore important that service personnel undertake an audiometric hearing assessment on a regular

basis (every two years). Audiometric assessments were in date for 93% of patients and the practice was 100% compliant with completing the audiometry questionnaires prior to assessment.

- A patient database was used effectively to monitor injury trends and access to PCRF and the information shared with unit commanders at the Unit Health Committee (UHC) meetings. This supported units to understand the specific injuries associated with the operational activity and thus explore ways to minimise injuries based on specific trends.
- Quality improvement, including clinical audit, was clearly embedded in practice and one of the nursing team was the audit lead. There was a comprehensive audit programme that included both clinical and non-clinical audit. For example, audits on the management of diabetes, on clinical record keeping, the use of antibiotics and for obtaining consent. Audit cycles were repeated to monitor performance and promote safety. For example, a monthly search was conducted for any patient on medicine used to treat epilepsy that can cause problems in pregnancy.
- The PCRF was integrated in the wider audit programme for the practice. However, repeat audit cycles were not being used to monitor progress. PCRF staff had identified that referrers were not always doing a detailed examination prior to referral. An audit was completed to review what information was being given and whether it was useful for the physios. The Officer in Command (OC) of the PCRF used the findings to produce a quick reference guide for referrers on what was required from the patient assessment.

Effective staffing

Continuous learning and development was promoted for staff. The staff database was monitored by the practice manager to ensure staff were up-to-date with training and development.

- A generic and role-specific induction was in place for new staff to the practice. Staff we spoke with, including a recently inducted member of staff, described a comprehensive and supportive induction programme.
- Mandated training was monitored and the staff team was in-date for all required training. A programme of ongoing development training was in place with in-house and external training sessions available to staff and protected time was provided each week. Clinicians were also supported with continual professional development (CPD) and revalidation through protected time each week.
- A process of clinical supervision was in place for PCRF staff and the team carried out a full caseload review monthly. The physiotherapist confirmed they followed DPHC guidance when treating children. However, concern was expressed about the lack of specific paediatric training available to physiotherapists and the lack of local support if they were unsure of treatment and care for a child. The physiotherapist was clear they would not treat a child if they did not believe they were skilled and competent to do so.
- There was a strong working relationship between medical centres in Cyprus which fostered a culture of sharing ideas and best practice. Combined medical department meetings were established for staff to link with professional colleagues in order to share idea and good practice.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- The clinical records we reviewed showed appropriate staff, including those in different teams, services and organisations were involved in assessing, planning and delivering care and treatment.
- The practice had developed good working relationships both internally and with health and social care organisations. These staff although employed by another organisation were integrated into the medical centre, attending daily meetings with clinicians and attending weekly practice meetings.
- We saw good partnership working arrangements across all three medical centres to ensure best effective care for all patients on the island. For example, a simulated scenario template and a thermal injury template were shared to ensure consistency for patients in the delivery of their care.
- A doctor was nominated to represent at one of the various UHCs and welfare meetings to discuss the occupational health needs of the units, the needs of patients who were medically downgraded and those who were vulnerable. The SMO attended the station UHC meetings, the RMO attended the regiment UHC meetings.
- The PCRF was represented at UHC meetings, physiotherapists attended and gave occupational advice, and both felt involved and listened to.
- The practice supported patients leaving the military by holding transition workshops (although very few service personnel leave the military directly after posting to Cyprus). Doctors provided patients transitioning from the military with a release medical. They also referred patients to the welfare team for support with the transition, and if appropriate to the Department of Community Mental Health (DCMH). Patients were signposted to SSAFA.

Helping patients to live healthier lives

Staff were proactive and sought options to support patients to live healthier lives.

- Clinical records showed that staff encouraged and supported patients to be involved in monitoring and managing their health. Staff also discussed changes to care or treatment with patients as necessary.
- The practice had a lead for health promotion supported by three deputies. The health promotion strategy was underpinned by national priorities and initiatives to improve the population's health including, stop smoking campaigns and tackling obesity. It also took account of the patient population need and seasonal variation impacting health.
- Health promotion displays were available in patient areas. These were dated and refreshed in line with the strategy. For example, the practice was about to hold a dedicated women's health day and planned to repeat this every six months. Health fairs were held on the base and the practice supported with staff representatives including the PCRF staff.
- Mental health information was available for patients that took into account well-being and mindfulness. It included details about websites patients could access for further information.
- A sexual health nurse held a weekly clinic and had completed the required training for the role (referred to as STIF). Information was available for patients requiring sexual health advice, including sign-posting to other services. Six of the nurses had completed level one STIF training. Condoms and chlamydia kits were available at the practice and information about local sexual health pathways was displayed.

- Patients had access to appropriate health assessments and checks. Regular searches were undertaken for patients eligible for bowel (38 patients, 35 had been invited or attended for screening) and breast screening (107 patients of which 102 had been screened) and appropriate action taken if patients met the criteria. The practice had identified five patients eligible for abnormal aortic aneurysm (AAA) screening (one had previous AAA repair and one had left the practice) and planned to recall them having initially prioritised the bowel and breast screening due to the larger number of eligible patients.
- The number of eligible women whose notes recorded that a cervical smear had been performed in the last 3-5 years was 483 which represented an achievement of 95%. The NHS target is 80%.
- Children's immunisations were managed by the health visitors employed by the SSAFA. They worked closely with the medical centre and were integrated with staff to ensure seamless care was provided. Data provided by the practice showed:
    - Children under 12 months were 97% up to date with their immunisations.
    - Children aged 24 months were 91% up to date with their immunisations.
    - Children aged five years were 93% up to date with their immunisations.

It is important that military personnel have sufficient immunity against the risk of contracting certain diseases. The World Health Organisation sets a target of 95% for vaccination against diphtheria, tetanus, pertussis and polio and measles, mumps and rubella. Based on clinical records, the following illustrates the current vaccination data for military patients:

- 100% of patients were recorded as being up to date with vaccination against diphtheria.
- 100% 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.
- 100% of patients were recorded as being up to date with vaccination against hepatitis A.
- 100% of patients were recorded as being up to date with vaccination against tetanus.
- 85% of patients were recorded as being up to date with vaccination against typhoid.
- 97% of patients were recorded as being up to date with vaccination against measles, mumps and rubella (MMR).
- 98% of patients were recorded as being up to date with vaccination against meningitis.

The unit commanders were responsible for ensuring their personnel kept up-to-date with vaccinations. The practice carried out an assurance check. It is common for the typhoid vaccine to have a lower uptake than other vaccinations. Current guidance state DMS practices should offer the typhoid vaccination in specific circumstances to personnel before deployment in a place where there is no medical support provided.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making. This included the PCRF who took written consent for treatments such as acupuncture and injection therapy.

- The process for seeking consent was recorded using a template. Audits of consent were carried out quarterly with the last one completed in August 2019. However, this was not always clearly documented in line with legislation and guidance.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. Staff we spoke with were aware of the Mental Capacity Act (2005) and how it could apply to their practice. Posters signposting patients to mental health services were displayed throughout the practice, this included in all clinician's rooms.

Are services caring?

We found that this practice was caring in accordance with CQC's inspection framework

Kindness, respect and compassion

Staff supported patients in a kind and respectful way.

- Throughout the inspection we observed staff were courteous and respectful to patients arriving for their appointments.
- Results and comments from the March 2019 patient experience survey (22 respondents) showed patients were happy with how they were treated. The 49 CQC comment cards completed prior to the inspection were very complimentary about the friendly, considerate and caring attitude of staff.
- The practice had an information network available to all members of the service community, known as HIVE and this was situated on the base. This provided a range of information to patients who had relocated to the base and surrounding area. Information included what was available from the local unit and from civilian facilities, including healthcare facilities. The practice conducted regular briefs on service provision to newly arrived families during HIVE welcome days and had a good relationship with HIVE/welfare staff.
- The practice had a concise information booklet to ensure patients were clear about the facilities available including key members of the practice team, contact numbers, opening times and clinics provided.
- The practice had been complimented by regional management for going 'the extra mile' to support Akrotiri through a recent period when the centre experienced significant gaps in staffing levels.

Involvement in decisions about care and treatment

Staff supported patients to be involved in decisions about their care.

- Interpretation services were available for patients who did not have English as a first language. Secondary care letters from local clinics all come in English. Local employed staff were able to provide a translator service if required. The people providing the service had undertaken Caldicott training.
- The patient experience survey showed 90% of patients were involved in decisions about their care. Feedback on the CQC patient feedback cards highlighted that patients received information about their treatment to support them with making informed decisions about their treatment and care.
- A carers register was in place (three patients were on the register) with alerts in place against any patient with caring responsibility. Carers were identified opportunistically and possibly

through the pre-screening to Cyprus. There was no section for carers in the patient information leaflet or signage in the practice, and with the practice not utilising the new DPHC registration process, opportunities were being missed. This was addressed during the inspection including the implementation of the new patient registration process. Carers were offered annual vaccination against flu.

- The PCRF staff made good use of physical training (PT) chits used to promote communication when patients were ready to return to PT.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Screening was provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. Clinic room doors were closed during consultations.
- The layout of the reception area and waiting area meant that conversations between patients and reception staff would unlikely be overheard. If patients wished to discuss sensitive issues or appeared distressed at reception, they were offered a private room to discuss their needs.
- The PCRF infrastructure risked breaching patient confidentiality as patients had to walk through the exercising area to reach two of the treatment rooms. However, no examinations took place in the exercising area thus minimising the chance of overhearing confidential discussion. The treatment rooms were fully enclosed.
- The practice could facilitate patients who wished to see a GP of a specific gender. All the physiotherapists were female and the ERI male so a patient requesting a clinician of specific gender that could not be accommodated were referred to an alternative PCRF in Cyprus.

Are services responsive to people's needs?

We found that this practice was responsive in accordance with CQC's inspection framework

Responding to and meeting people's needs

Services were organised and reviewed to meet patient needs and preferences where possible.

- Staff understood the needs of its population and tailored services in response to those needs. Appointments slots were organised to meet the needs of specific population groups. For example, smoking cessation clinics were held each Thursday and a 'well woman' clinic was held every Friday.
- Specific clinics were in place including vaccination, chronic disease, family planning and baby clinics.
- The patient experience survey indicated that 100% of respondents would recommend the practice to family and friends. A positive theme of the comments submitted by patients was the friendliness of the staff.
- An access audit as defined in the Equality Act 2010 was completed for the premises in August 2019. There was no outstanding issues listed on the audit. Access was good with level access throughout.

- Facilities were available for families, including a private room for breast feeding and baby changing facilities.
- Staff had completed mandatory training in equality and diversity and there were dedicated notice boards within the building and a staff representative who had applied for diversity and inclusion practitioner training.

Timely access to care and treatment

Patients' needs were met in a timely way.

- The practice accommodated patients with an emergency need and staff advised us that no patients were turned away and would be seen on the same day. Routine appointments could be accommodated within 10 days. Same day appointments were available each morning between 07:00 and 08:00. Medic and nurse triage appointments were available throughout opening hours.
- Appointments for medical boards, specialist medicals including aviation medicals and diving medicals were available and undertaken within one week.
- Telephone consultations were available each day with clinicians and home visits were available on request as per local policy.
- Out-of-hours patients were diverted to the 112 service. The practice was staffed 24-hours a day with a duty medic and they were supported by the duty medical officer (MO).
- Opening hours and out-of-hours arrangements were clearly displayed on posters and leaflets. Additional information was also available on the practice social media page.
- Non-attendance at appointments was monitored for the practice, including the PCRF. For example, the non-attendance rate for physio appointments was 8% for June 2019.
- For routine physiotherapy appointments, the waiting time was within five working days. Patients with an urgent need were seen within three days but usually the same day. Patients requiring an ERI appointment would currently wait four days.
- A direct access physiotherapy (DAP) service was in place, however, this was only available for Residential Infantry Battalion (RIB) patients. Patients prioritised as urgent were given the next available appointment ideally within five working days and patients with a routine need were seen within 10 working days.
- All patients were assigned a named physiotherapist who managed their care at every appointment.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information was displayed throughout the practice, this included in the waiting area, outlined in the practice leaflet and on the Facebook page to help patients understand the complaints process.
- The practice manager was the designated responsible person who handled all complaints and was supported by a deputy. The practice managed complaints in accordance with the DPHC complaints policy and procedure. Both written and verbal complaints were recorded and linked to the health governance workbook.

- Any complaints were discussed at the clinical and/or practice meetings and lessons identified. There had been seven complaints in the preceding 12 months, each was handled appropriately and no trends were identified.
- An audit completed in September 2019 highlighted that although all complaints recorded had been actioned/resolved there was issues with adherence to the complaint policy. This resulted in a review and the practice changed the way complaints were tracked with additional consideration to better feedback on lessons learned.

Are services well-led?

We found that this practice was well-led in accordance with CQC's inspection framework

Leadership capacity and capability

The leadership team had the experience, skills and drive to deliver high-quality sustainable care. Some issues highlighted by the leadership were impacted by external factors outside of their control. These were communicated to the Defence Medical Services Regulator (DMSR) in a letter from the Chief Inspector.

- On the day of inspection, we saw a practice that was well-led. The leaders not only demonstrated managerial experience, capacity and capability, it was clear they had vision, passion with a focus on providing the best possible service for their patients.
- Staff spoke highly of how the practice was led. They said managers demonstrated a collaborative approach to leading the practice and supporting staff. Staff described good leadership from the management team.
- The practice felt well supported by the regional team. The overseas regional headquarters team held an annual conference which staff could attend. The regional team were available daily for advice via skype as required and hosted quarterly meetings. The Regional clinical director (RCD) and other key staff visited regularly or when required to intervene on specific issues.
- A brief meeting was timetabled every morning to give the clinical team the chance to discuss and review clinical cases of interest or concern. This would include options and alternatives to secondary care referral, second opinions, review of unplanned and possibly inappropriate admission occurring both in and out of hours. It also provided a forum for sharing knowledge and learning.

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. It had a mission statement and staff knew and understood the values. The practice had a robust strategy and supporting plans which reflected the vision and values and were regularly monitored through the risk register.

The practice worked to the DPHC mission statement of:

"Safe practice by design."

- The practice had developed their own set of aims and objectives which were:
    - To provide primary healthcare for all eligible patients and 24-hour emergency care to the surrounding areas of Western Sovereign Base Area (WSBA) in order to support British

Forces Cyprus and Permanent Joint Headquarters (PJHQ) operations, training and contingency plans.

  - Episkopi medical centre is to promote, encourage and support the provision of patient friendly, evidence-based primary health care service.
  - To create an environment that stimulates growth and education for its staff.

- On the day of the inspection, we found the practice was working to and achieving its aims. There were external factors that inhibited their work, these were detailed in a letter to the defence service regulator.
- Patient feedback was taken into account when developing the service. For example, the practice were trialling dedicated GP appointments on Wednesday afternoons for children of school age.

Culture

The culture at the practice was inclusive and all staff were treated equally.

- An inclusive culture underpinned the approach of the practice. All staff had an equal voice, regardless of rank or grade.
- The PCRF was integrated with the wider practice, including an integration of governance systems.
- Staff described an open and transparent leadership style and said they would feel comfortable raising issues. They felt respected, supported and valued. Both formal and informal opportunities were in place so staff could contribute their views and ideas about how to develop the practice.
- The practice demonstrated a patient-centred focus. Staff understood the specific needs population and tailored the service to meet those needs. For example, the officer in charge of the PCRF had a specific interest in women's health and through dedicated multidisciplinary team (MDT) clinics was directing good practice and service improvement for this population.
- Openness, honesty and transparency were demonstrated when things went wrong. A no-blame culture was evident; complaints and incidents were seen as opportunities to improve the service.
- The practice had systems 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.
- Leaders clearly demonstrated that the needs and welfare of staff were priority. Staff were encouraged and supported to be the best they could be through training and developing their skills. Supervision and appraisal was in place for all staff.

Governance arrangements

There was an effective overarching governance framework in place which supported the delivery of good quality care.

- There was a clear staffing structure in place and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. Terms of reference were in place to support job roles.

- The practice worked to the health governance (HG) workbook, a system that brings together a comprehensive range of governance activities, including the risk register, significant events tracker, lessons learnt log, training register, policies, meetings, quality improvement and audit. All staff had access to the workbook which provided links to meeting minutes, policies and other information.
- An effective range of communication streams were used at the practice. A schedule of regular practice, healthcare governance and team specific meetings were established and formed a rolling five week programme with the fifth week set aside for non-routine meetings.
- The on-island paediatric physiotherapy service had not yet been assured meaning there was no on-island paediatric physiotherapy support available. The physiotherapist identified a training need for managing paediatric patients.
- Audit was a routine method used to measure the effectiveness and success of clinical and administrative practice. A comprehensive audit programme was established with clear evidence of action taken to change practice and improve the service for patients.
- Secondary care contracts were monitored by the staff within the three medical centres. Oversight of contracts by Headquarters staff would afford improved breadth and consistency of monitoring.

Managing risks, issues and performance

The practice had clear and effective processes for managing risks, issues and performance.

- Risk to the service were well recognised, logged on the risk register and kept under scrutiny through regular review. There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety. Processes were in place to monitor national and local safety alerts, incidents, and complaints.
- A system was in place to monitor performance target indicators. In particular the system took account of medicals, vaccinations, child health, cytology, summarising and non-attendance rates.
- A business continuity plan was in place. The practice was aware of and had access to the major incident plan for the base.
- Procedures were in place for managing poor performance.

We identified potential risks due to external factors outside of the control of the practice:

- PHEC was provided by clinicians at the medical centre. Patients (including a section of the local Cypriot population who reside within the Sovereign Base areas) were able to ring 112 and request out of hours advice and care from duty staff. Not all clinicians were required to demonstrate relevant qualifications and experience to provide PHEC and some told us that they had not been adequately trained to use certain equipment which they were given in order to provide a 112 response. The Commander Medical BFC had identified in July 2019 that due to lack of manning capacity and skills at Akrotiri, the medical centre was unable to provide a safe PHEC service and in August 2019 Akrotiri suspended its 112 service (with Episkopi medical centre stepping in to provide the service). PHEC had been added to the risk register at the practice.
- The DMICP Hybrid is a system with reduced functionality and some outage periods which presented a potential risk around timely access to accurate patient records

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- An internal quality assurance tool, the DMS Common Assurance Framework (CAF) was used to monitor safety and performance for the practice and included the PCRF. The DMS CAF was formally introduced in September 2009 and since that time has been the standard healthcare governance assurance tool utilised by DMS practices to assure the standards of health care delivery within DMS.

Engagement with patients, the public, staff and external partners

The practice involved patients, staff and external partners to support high-quality sustainable services.

- There were various options in place to encourage patients to provide feedback on the service and contribute to the development of the service. A patient experience survey was undertaken quarterly throughout the year. In addition, patients could leave feedback via through the suggestion box. Patients were informed of the response to their feedback through a 'You said we did' display. For example, patient feedback highlighted that children found difficulty securing appointments outside of school hours and during the practice's core opening hours. In response, the practice were trialling dedicated GP appointments on Wednesday afternoons.
- The practice had established a patient focus group that met quarterly.
- Good and effective links with internal and external organisations including the welfare team, the DCMH and local secondary care services.

Continuous improvement and innovation

Continuous improvement was embedded in the culture which was one of improving the health and wellbeing of the benefit of the patients. We found that improvements were implemented based on the outcome of feedback about the service, complaints, audits and significant events.

Quality improvement activity we identified included:

- The PCRF promoted women's health through dedicated MDT clinics and an information day.
- Development of rehabilitation classes for RIB patients who were often away for long periods of time.
- Improvements to the medical emergency training by use of scenarios highlighted in the handover from the out of hours team, for example; spinal injury and thermal injury training.
- Annual flu audits were carried out to better understand the at risk groups and increase uptake with a 'make every contact count, principle to offer the vaccine at the point of care.
- Identification of a set of healthcare governance champions that was inclusive of and motivational for practice staff.