British Forces Cyprus (BFC): Pre-Hospital Emergency Care (PHEC) Service

Western Sovereign Base and Eastern Sovereign Base Areas, Cyprus

Defence Medical Services inspection report

This report describes our judgement of the quality of Pre-Hospital Emergency Care (referred to throughout the report as PHEC) delivered by British Forces Cyprus (BFC). It is based on a combination of what we found through information provided about the service and through interviews with staff and others connected with the service. We carried out a visit to each of the three medical practices from where PHEC is delivered and conducted telephone interviews with staff unavailable on the days we were on site.

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

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Summary

About this inspection

We carried out an announced comprehensive inspection of the PHEC service led by BFC in June 2022. We rated the service as requires improvement overall. The service was rated as inadequate for providing safe services, requires improvement for the effective and well-led key questions. The caring and responsive key questions were rated as good. The report was not published.

We carried out this announced comprehensive follow-up inspection on 9,10, 11 and 12 October 2023. The three medical practices at Akrotiri, Dhekelia and Episkopi provide PHEC to anyone in the Sovereign Base Areas (SBAs) including serving personnel and their families, tourists and the local civilian population.

As a result of the inspection we found the PHEC service remains rated as requires improvement overall.

The key questions are rated as:

Are services safe? – requires improvement
Are services effective? – good
Are services caring? – good
Are services responsive? – good
Are services well-led? – requires improvement

The CQC does not have the same statutory powers with regard to improvement action for 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 DMSR has regulatory and enforcement powers over the DMS. DMSR is committed to improving patient and staff safety and will ensure implementation of the CQC's observations and recommendations.

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

At this inspection we found:

- A generally motivated and committed team delivering the PHEC service. However, morale had been impacted by a number of continuing and longstanding issues that were outside of their scope to exact change.
- Improvement at a tactical level with the implementation of a paramedic delivered PHEC service, although not yet a paramedic led service.
- The Service Delivery Team were new in post and had an understanding of key issues, they had started to develop plans to resolve or mitigate identified risks. However, operational commitments were recognised as inhibitors to progress.

- Blurred lines of accountability at a senior leadership level, fragmented lines of accountability and unclear risk escalation pathways continued to pose risks to the safe delivery of the service. We saw examples of risks that had been identified, assessed and actions proposed. However, these lacked clarity on where the ownership of risk was held. This included risks that had been considered which potentially had a serious impact.
- The 3 sites had integrated teams that were delivering dividends in terms of mutual support between PHEC and primary care service delivery. PHEC paramedics offered positive opportunities around shared learning, training opportunities and also support for out of hours services.
- The 3 sites were working independently of each other in the main so systems and processes were not pan island specific and learning opportunities were not always shared. Whilst we saw outcomes from action reviews leading to tangible changes including a multiagency response, there was a gap in organisational learning. We saw a number of ASERs (significant events), specifically around scene safety, that were not delivering improvement.
- Arrangements were in place for infection prevention and control (IPC). Arrangements at Akrotiri had improved with the integration of PHEC IPC into the systems used within the medical centre.
- Arrangements were in place for managing medicines, including obtaining, prescribing, recording, handling and disposal in the practice. Logistical issues with the supply chain created a burden of administration when replenishing stock levels. Areas of improvement relating to controlled drugs and accountable drugs were identified at Akrotiri.
- Despite the opportunity being available to patients, feedback about the service was limited. It was accepted that the nature of the service meant that feedback from patients would be minimal, particularly from the local Cypriot population.
- Each medical centre had a system to ensure that staff completed the required mandated training and held the appropriate professional registrations. This included staff recruited from the local population. There were some minor gaps in training but these were planned and/or scheduled in. Of note, there had been significant improvements at Akrotiri by way of a proactive approach to addressing training needs for new medics prior to arrival on island.
- Access to emergency care was in place and the new model of paramedics delivering the service prevented staff from having to work excessive hours and ensured the service could be provided at all times.
- Staff understood the Mental Capacity Act (2005) and how it applied in the context of the service they provided.
- Information systems and processes were in place to deliver safe treatment and care. However, staff told us that they continued to experience occasional difficulties when locating addresses and this had caused delays.
- The service had re-established lines of communication with the fire service and SBA police. Activities such as major incident planning were done as a collaboration. A good

relationship with the Republic of Cyprus ambulance service (ROCAS) was reported despite non-attendance at group forums (due to limited capacity within the ROCAS).

- Formal peer review arrangements were in place for clinical staff and included effective auditing of notes. The exception was long-term locum paramedics who had not been integrated into any of the arrangements for clinical review.
- Staff understood and adhered to the duty of candour principles.

We found the following areas of notable practice:

- A consistent suitably qualified and experienced person (SQEP) paramedic/medic response had attended all 112 calls since August 2023.
- A working group had taken positive steps to address the complications faced in Cyprus when treating patients experiencing a mental health crisis. A redraft of section 12 of the Armed Services Act had been completed and was awaiting parliamentary approval. If approved, this legislation would allow the Commanding Officer to detain a patient (when in their best interest) on advice from a medical professional to allow for stabilisation before return to the UK for definitive treatment.
- In conjunction with RAF Headquarters, staff at Akrotiri had adopted a proactive approach to maximise the opportunities for newly posted medics to complete training prior to arrival on island. We saw examples of when postings had been delayed in order to complete courses that had spaces available. Not only did this mean that newly arrived medics were mostly trained, but it also minimised the needs to return to the UK to complete courses that were not available on island.

The Chief Inspector recommends to the PHEC Cyprus service:

- Review the requirements for medical equipment carried in the response vehicles to ensure that consideration is given to mitigate the risks of not being able to allow third-party review of cardiac conditions at the scene and to allow therapeutic defibrillation.
- Explore the opportunities to extend learning and discussion to include all staff pan island. This should include the nurses who triage and dispatch for PHEC and the paramedics.
- Ensure that learning outcomes specific to PHEC are collated and shared with key stakeholders on an island wide basis.
- Ensure monthly and quarterly controlled drugs (CDs) and accountable drugs checks are completed for the fentanyl lozenges held in the PHEC modules (pre-assembled kits) and CDs contained within the paramedic’s and doctor’s bag.
- Ensure CDs are destroyed in the presence of an external witness.
- Consult with the pharmacy technicians to ensure there is consistency across the service with respect to the contents of the PHEC medicine bags.
- Consider opportunities to improve the speed and accuracy with which PHEC staff locate patients requiring a 112 response.

- Continue to consider and implement ways to improve the handover of clinical information to secondary care, for example, printouts from ECGs (electrocardiograms, a test that can be used to check the heart's rhythm) and Tempus Pros (an advanced vital signs monitor that can also have a built in defibrillator). There was also scope to improve the accuracy of clinical information by digitalising the upload of clinical records back into DMICP.
- Continue to assess the requirements and effectiveness of the translation services available.

The Chief Inspector recommends to the wider organisation:

- Establish a clear service level agreement and set of key performance indicators to move beyond the historic 'Treaty of Establishment' which simply states the requirement as being to 'provide emergency services.' There is a general need for standard operating procedures, memorandums of understanding and terms of reference to clearly define what is expected of the service and those working to deliver it. This should include the planned response to a major accident that would require a coordinated response.
- Ensure sufficient arrangements are in place to protect staff when attending the scene of an accident or incident. Risk of loss of life must be mitigated, in particular, when attending road traffic accidents.
- Address the requirement for uniform and personal protective equipment for both current and future personnel who deliver the PHEC service.
- Increase the number of permanent posts for PHEC paramedics in order to create resilience and aid recruitment.
- Agree clear lines of accountability at a senior clinical leadership level are required in order to influence and implement change in the PHEC space.

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Chief Inspector of Healthcare

Our inspection team

This inspection was undertaken by a CQC inspector and CQC inspection manager. The team comprised specialist advisors including a primary care doctor with experience of both PHEC and urgent care and a specialist advisor with experience of managing an ambulance service that includes an NHS 111 and 999 service.

Background to PHEC (British Forces Cyprus)

British Forces Cyprus (BFC) provide a PHEC service to a diverse and complex population within the Western and Eastern Sovereign Base Areas (SBAs). The SBAs are British Overseas Territories on the island of Cyprus which include British military bases at Akrotiri, Episkopi, Dhekelia and Ayios Nikolaos, installations and other land retained by the British under the 1960 Treaty of Establishment. The areas serve as a station for signals intelligence and the base at Akrotiri hosts an operational airfield. The two SBAs are referred to as the Western Sovereign Base Area which houses Akrotiri and Episkopi Medical Centres, and the Eastern Sovereign Base Area which houses Dhekelia and Ayios Nikolaos Medical Centres (Ayios Nikolaos Medical Centre is a satellite of Dhekelia Medical Centre and a fourth station used by the PHEC service). The medical centres host and resource the emergency ambulance stations and response coordinated by the Unified Control Room run by the SBA police. The Service Delivery Team are responsible for the day-to-day management and delivery of the service. The Service Delivery Team sit in BFC Headquarters and are also responsible for the strategic development of the service. All emergency calls (112, the equivalent to 999 in the United Kingdom) are received by the Unified Control Room informing which emergency service is required (calls from the SBAs could be diverted to the Republic of Cyprus if received from mobile telephones). A 'METHANE report' is produced for each call (METHANE is an acronym for: Major incident declared, Exact location, Type of incident, Hazards, Access, Number and type of casualties, Emergency services present and required). Requests for an ambulance are then transferred on a dedicated line to one of the medical centres for a nurse led ambulance dispatch.

The PHEC service provides emergency care to any individual within the SBAs. This population includes military personnel and their families, local residents and tourists. In addition to the military bases, the SBAs includes beaches frequented by tourists, coastal pathways, villages inhabited by local residents and sections of the transport infrastructure that includes sections of motorway, main roads, unpaved roads and dirt tracks. Transport is provided by a fleet of ambulances and Medical Emergency Response Vehicles (MERVs).

The SBA population consists of approximately 9,000 military personnel and their families, 300 civil servants and 15,000 non-military residents. This population increases in the summer when the tourists and transient population can reach up to 100,000. The military population is also increased by approximately 1,000 to 2,000 troops transiting through or temporarily in the SBA for training.

The PHEC is a 24 hour a day, seven day a week, 365 days a year service.

The PHEC Service Delivery Team at the time of the inspection:

Position	Numbers
Commander Medical BFC and Ambulance Service Chief Executive Officer	One

Clinical Director	One gapped (due to start January 2024)
Medical and Ambulance Service Chief Operations Officer	One
Ambulance Service Deputy Operations Officer	One gapped (covered de facto by the lead medic at Akrotiri)

Note: not all of the above roles are full-time posts but part-time in amongst other duties not related to the PHEC service

The workforce establishment at the time of the inspection (the establishment of staff includes dual roles with staff working for both the medical centre and the PHEC service):

Role	Position	Akrotiri	Dhekelia/Ayios Nikolaos	Episkopi
Medical Team	Medical Officers (MO)	Six (not involved with the delivery of PHEC but will respond to airfield incidents)	Four	Four (3.3 whole time equivalent)
Nursing team	Dispatchers (practice nurses)	Three (none of the nursing team at Akrotiri are involved in dispatch)	Ten	Three military nurses Six locum nurses
Pharmacy	Pharmacy technicians	Two	One	One
Transport	Ambulance Drivers	Ten	Ten	Five
Practice management	Military practice manager (support the PHEC service in line with the service delivery team)	Five (one dedicated to PHEC management and delivery)	One (vacant awaiting new practice manager)	One
Affiliated Staff	Midwives (SSAFA) *	Two	Three	One

	Community Mental Health Nurses (available on request through Akrotiri Medical Centre)	Six military, three locum		
Medical Assistant (medics) team *	Combat Medical Technicians (CMTs) / RAF Medics Paramedics	Fifteen Four (one post vacant)	Ten Six (five locums, one Army Reservist)	Three Four (two locums)

*In the military, a medic 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.

*SSAFA (Soldiers, Sailors, Airmen and Families Association) is the Armed Forces charity that provides lifelong support to serving men and women and veterans along with their families and dependents. In Cyprus, SSAFA community services are part of the commercial wing of BFC.

Are services safe?

We rated the service as requires improvement for providing safe services.

We previously rated the practice as inadequate for providing safe services. This was because we identified areas that needed strengthening including staff training and access to mental health services. The working hours of staff providing the PHEC service were frequently in excess of working time regulations and the scene of the incident was not always secured resulting in a high risk of potential harm to both staff and patients.

Improvements had been made with regards to the working hours, staff training and access to mental health services. However, the securing of the scene of an incident remained a serious concern. The risk to safety of clinicians in attendance and of the patients being treated was considered potentially fatal by some of the staff we spoke with.

Safety systems and processes

Each practice had safety policies and protocols. The Commander Medical, Headquarters British Forces Cyprus (BFC) was the overall safeguarding lead and chaired the Specialist Safeguarding Working Group. There were also safeguarding leads for each of the three medical centres. The pathways for entitled persons was the same for PHEC as for each medical centre. A morning meeting held at each medical centre covered any safeguarding concerns. There were no memorandum of understanding with safeguarding organisations within the Republic of Cyprus (ROC) so any concerns were relayed to the Sovereign Base Administration Police. Social services to BFC personnel were provided by British Forces Social Work Service Cyprus. Adult and child safeguarding policies were in the form of a standard operating procedure (SOP). The policies were accessible electronically to all staff and outlined clearly who to go to for further guidance including the pathways to social workers via SSAFA (Soldiers, Sailors, Airmen and Families Association) and there was a reach back service to the United Kingdom for additional support. Staff received safeguarding information as part of their induction and training as part of their mandated programme.

The appointed leads for safeguarding had completed level 3 safeguarding training. All staff had completed safeguarding and safety training appropriate to their role and knew how to identify and report concerns. A safeguarding register was held by each practice on the clinical operating system (known as DMICP) with access limited to appropriate staff members. The PHEC service engaged with this at the monthly primary healthcare team meeting. The deputy safeguarding leads for each medical centre attended the meetings to ensure communication was made to all staff including those working in the PHEC service.

Medical centres identified vulnerable patients within the serving personnel and their families. Registers were maintained and staff working within the PHEC were aware of patients identified as vulnerable. Staff working in the PHEC stated that military personnel and their families could easily be referred into the safeguarding service provided. Members of the local population were supported despite there being no clear service to be referred into.

The Patient Report Form (a new PRF form bespoke to the BFC had been developed and was close to implementation) was a template that could be used to record a clinical intervention, to audit practice or to use for the handover of patients. A copy left in the accident and emergency department included a prompt to offer the patient a chaperone. However, this process relied on a photocopy being made at the hospital and this could result in a delay when leaving (a duplicated copy was put forward as a potential solution to this). Staff who acted as chaperones (within the BFC workforce) were trained for the role and had received a Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. DBS checks were renewed every five years for military staff and three years for civilian staff.

The recruitment for all locally employed civilians (LECs) was managed by the practice managers and they conducted the required checks prior to employment including a 'Basic Personnel Security Standard' check (the equivalent of a DBS check). Arrangements were in place to monitor the registration status of clinical staff with their regulatory body. Staff had crown professional indemnity cover. Professional registrations, DBS and vaccination status were recorded in an electronic folder with restricted access. This document was recorded on the asset register. New staff were required to complete the Sovereign Base Area Ambulance Service (SBAAS) mandated induction which included specific elements for the different roles. There was a checklist which recorded progress and completion of induction. All new staff had commenced their induction and all permanent staff had completed an induction. Locum staff were used to cover staff gaps and there was a specific induction pack which included the appropriate recruitment checks.

The DPHC infection prevention and control (IPC) leads at Akrotiri, Episkopi and Dhekelia were responsible for IPC for PHEC and had completed role-specific training. The staff team was up-to-date with IPC training having attended virtual training. Regular audits were undertaken, this was now included at Akrotiri Medical Centre where we had previously identified that arrangements did not include the PHEC service. The IPC audits followed the DPHC mandated monthly rolling programme. A cleaning schedule was in place for vehicles and the cleaning of them was the responsibility of the driver with support from a medic. A Quick Review (QR) code system was used to serve as a cleaning schedule and a record of completion. This was normally done after each patient and regular deep cleaning also took place. The QR codes were scanned each time a vehicle was cleaned. With IPC led at a local level, there was no consistency across the three sites. There were IPC cleaning registers specific to PHEC but these would benefit from uniformity and clear standards for the teams to follow.

There were systems for safely managing healthcare waste supported by a policy. Clinical waste and pre-acceptance audits were carried out annually. Clinical waste was bagged and labelled. External storage was in a lockable waste skip, held in a secure area. The waste was logged and taken by a local waste contractor. Records were kept at each medical centre.

We highlighted at the previous inspection that medical gases at Akrotiri were not stored in accordance with health and safety regulations. We found that actions had been taken to improve arrangements.

Although not included in the module, paediatric kit including harnesses was available in each vehicle (modules are an agreed set of equipment and medicines used to control and standardise items used).

Risks to patients and staff

As at the previous inspection, concerns were raised in regard to risks and risk ownership. The risks did not appear to be owned at a local level and there was an inconsistency in regular reviews, sharing of insights and learning across the three sites. Staff knew how to escalate risks, however, there was minimal feedback or assurance that these risks were being addressed in a timely manner.

Previously, sufficient staffing to provide the PHEC had been achieved by staff working in excess of the number of hours detailed in the working time regulations. Staff had been unable to take annual leave and were working continuous shifts without taking the prerequisite rest periods in between. Many of the established posts were gapped and staff delivering the PHEC reported problems with fatigue. At this inspection, we found that these issues had been resolved and the model for the PHEC service changed to it being delivered by paramedics. Although working hours were still exceeded at times, the paramedics did not have to deliver the primary care service during the day (unlike the doctors that we previously saw delivering PHEC). A new rota for medics and paramedics had been introduced and was specific to the needs and staffing profile of all three sites. There was positive feedback from staff about these changes, in particular, the 24 hours on, 48 hours off rota in Akrotiri. Civilian locum paramedics worked 72 hour week duty periods, usually split into a 24 hours on, 24 hours off pattern (they had signed European Working Time Directive waivers, this was popular due to renumeration). All attempts were made to limit military paramedics to 48 hour working weeks. Paramedics reported that the low number of activations allowed for adequate rest periods and sleeping during shifts and when specifically asked, did not flag that fatigue had ever (in their opinion) compromised clinical decision making. We deemed this acceptable but if concerns persisted or were raised, it would be necessary to commission a time/motion study and engage a subject matter expert to confirm and comment further.

The reliance on locum paramedics caused several vulnerabilities. Funding was only assured until March 2024 with a request for extension submitted. There were fewer confirmed permanent posts (known as PIDS) than positions. This meant that it was not possible to recruit permanent team members. In addition, some locum paramedics had been in post for more than 12 months but had not taken part in any appraisal as they were not line-managed by permanent team members.

The vehicles were equipped to deal with medical emergencies. Emergency kit, including an external defibrillator (can administer a shock but not monitor the heart rhythm), oxygen with masks and emergency medicines were kept in each ambulance. Equipment and medicines were checked daily and after any emergency call out. The ambulances still did not have printing capability (the printing of electrocardiograms or ECGs is an important tool in diagnosing cardiac conditions and allows better liaison with receiving units). The need had been identified prior to the previous inspection and funding had been applied for to procure appropriate additional equipment for cardiac monitoring.

A PHEC induction course was in place. However, the delivery of this was variable and there was no evidence of benchmarking, audit or review of this training across the three sites to ensure consistency. As part of their induction, staff had to complete a suite of training that included safeguarding, basic life support, instruction on how to use the automated external defibrillator (known as an AED) and anaphylaxis (severe allergic reaction). At the previous inspection, we found that all of the doctors at Akrotiri were out-of-date for Advanced Life Support (ALS) and training was only available by returning to the United Kingdom. There was now a structured induction program for new medics arriving at Akrotiri which included mentoring, shadow shifts and a sign-off before personnel were allowed to respond on the ambulances. At Episkopi, a two-week induction program and sign-off endured from the previous inspection. The program ran approximately six-weekly to cater for the large number short term placement medics. Medics had been able to attend the BTLS/MPHEC (Battlefield Trauma Life Support and Military Pre-hospital Emergency Care) on-island course if previously unqualified. Medics were not required to complete ALS training as every ambulance had a paramedic on board (every paramedic should be proficient in ALS as part of their registration and continued professional development requirements). A suitably qualified and experienced person (SQEP) paramedic/medic response had responded to all 112 calls since August 2023. There was no longer a requirement for medics to lone respond, and inconsistencies in the skill and experience levels of responders was mitigated.

Major incident simulation exercises were held as station wide events in coordination with the SBA police and fire service. At Episkopi and Dhekelia we found that the medical response to major incidents included the role of the PHEC service. At Akrotiri, the Major Accident Control Regulations (MACR) Team's simulation exercises fully tested the capacity and competence of the PHEC response. To ensure staff were familiar with the equipment and procedures, simulated training courses (known as moulages) were delivered each morning. At Akrotiri, two serious incidents involving the death of patients due to trauma had been appropriately investigated and a formal after-action review (AAR) undertaken. Invites to attended major incident simulation continued to be extended to the ROC ambulance service but they had not engaged. Discussions about the football stadium and power station at Dhekelia and the Kuion Theatre close to Episkopi highlighted that there were no co-ordinated plans about dealing with a major incident (crowd crush incident or explosion would be possible scenarios) within the catchment area. Any attempts to manage such incident without a defined, well-rehearsed plan would likely lead to preventable loss of life. In terms of risk assessment, this should be classified as unlikely/catastrophic and held at a high level. Mitigation would require co-ordination with ROC civil authorities and ambulance service and a regular joint exercise of a scenario invaluable. There was also an earthquake risk in Cyprus, the last significant earthquake in 1995 led to several building collapses and 2 deaths. A simulated exercise with the Cypriot civil authorities would build relationships and lead to better joint working in the case of earthquake or major incident.

Clinicians knew how to identify and manage patients with severe infections including sepsis. Sepsis training had been delivered to PHEC staff as part of their mandatory programme. A support template with prompts to help identify potential sepsis was built into the clinical operating system (DMICP). Posters were displayed in the medical centres to guide patients and staff in recognising the signs of sepsis. In addition, prompt cards were kept inside the ambulance vehicles.

The vehicles had an air conditioning system throughout and ambulances were fitted with temperature probes. Temperature checks were now routinely being carried out and when there were high temperatures within the vehicles, medicines and equipment were moved into a temperature controlled area or a cooler room within the medical centre building. Data loggers that recorded the temperature were present in the vehicles as well as in the fridges within the medical centres used to store medicines. However, there was insufficient evidence-based guidance to demonstrate risks around efficacy and denaturing of medicines were being suitably mitigated when being stored at temperatures over 25˚C.

There was a workaround to formally write off and destroy all non-parenteral medicines after six months, and all liquids for injections after one month. Although there was clear guidance for this decision to mitigate risk, accountability had been taken by the senior clinician for this intervention. There was no evidence that the manufacturers themselves has been asked for medicines information with regards to storage and medicines stability/efficacy. The workaround adopted was pragmatic and had merit but needed formalising into a Defence Medical Services owned SOP with the input of pharmacist expert advice.

Staff had completed training on heat injury and heat illness prevention and an effective pathway was in place. There was a Joint Service Publication that provided direction for PHEC staff on their responsibilities for the management and treatment of heat illness. As of February 2021, the DPHC-endorsed treatment policy for heat injury had been updated to include the need to risk assess for cooling prior to transfer of the patient. The PHEC service worked to the Defence heat illness policy (JSP 375 Ch 41 and JSP 950) (reviewed by the Health, Safety and Environmental Protection (HS& EP) Directorate together with relevant subject matter experts and key HS & EP stakeholders). The gold standard for treatment was ice-cold water immersion therapy. The recognised and accepted ‘strip, spray and fan’ technique would be used to cool a patient with heat stress. If alerted in advance, cold towels and cold intravenous fluids would be taken in the ambulance.

A concern was raised by some staff we spoke with about lone working. The default position was to escalate concerns to the guards when working alone, this resulted in a time delay, with the nurse potentially vulnerable if the crew were responding to an incident.

A number of the paramedics we spoke with raised a concern about the lack of clarity with regards to court and legal processes, which made them feel vulnerable about their rights and what they could/could not do when treating a mentally unwell patient.

Information to deliver safe care and treatment

The practices ran on a clinical system known as ‘DMICP deployed’ (DMICP is the system used throughput DPHC and ‘deployed’ means it runs off a local server). Following each case, a record was scanned onto DMICP by way of a patient report form (PRF). A Cypriot resident would have a DMICP account set up and be registered as a non-entitled patient so records could be scanned and then archived after three months (not deleted so records would be retrievable). A policy was in place to detail the process. In this way, the PHEC system had an effective process for sharing information with staff and other agencies to enable them to deliver safe care and treatment. Each morning a meeting was held to discuss any new cases and any ongoing issues with patients within the PHEC service.

However, this was done by each medical centre, not as a joined up pan island meeting as the servers were not networked so each centre could only see their own cases.

A peer review of clinical records normally took place with a random set of five PRFs reviewed by the PHEC Clinical Director monthly. However, this had not been possible in 2023 due to the post being vacant. PRFs were reviewed daily at practice level as part of the daily handover meetings. In addition, there were commendable PRF audits at Akrotiri and Episkopi which looked at the quality of PRF data and completion of all fields. This audit showed a high level of compliance. All paramedics and medics interviewed understood the importance of worsening advice (informing the patient on what to do if symptoms had not improved), especially in the context of discharge on scene. We were assured that this was an integral part of PHEC practice.

We had previously found gaps in pathways available for patients who needed mental health support that resulted in delayed treatment. When patients required treatment that was out of scope of local services and therefore could not be effectively be managed by either DMS resources or the ROC healthcare services, they were evacuated by air to receive specialist treatment in the UK. Despite the Mental Health Ordinance Act empowering the SBA Police powers to detain a patient within the SBA, legislation in Cyprus did not allow patients to be sectioned under the Mental Health Act to safeguard their safety as well as the safety of others. PHEC staff were reliant on the intervention of the mental health team at Akrotiri who had an out of hours telephone and provided a 30 minute response time. Work was underway to find a resolution and a memorandum of understanding had been agreed between BFC and an ROC secondary care provider in order to provide a safe space. The Officer in Command for the mental health team informed us that there had been a working group (consisting of the service head of adult psychiatry, provost marshal, MOD legal, Counsel, and social care) convened since the previous inspection. This working group was formed to redraft section 12 of the Armed Services Act. This allows a Commanding Officer to detain a service person (or dependent subject to military law) suffering from a mental health disorder and deemed by medical professionals to be a risk to themselves or others The law applies to any military operation outside of the British Islands and the powers are equivalent to those of section 2 of the Mental Health Act as applied in the UK (detention for up to 28 days for assessment with the recommendation of two professionals). The current legislation referred to detention in a service hospital for treatment, while (with the closure of most overseas service hospitals) the requirement had changed to allow detention in a community facility to allow for treatment prior to MEDEVAC to the UK. The re-draft currently sat with the Judge Advocate General who was deliberating points around a mental health advocate for those lacking capacity. The lack of parliamentary time was a potential risk to progress (parliamentary time was required before it can become law). There was a mixed understanding at a local level about mental health pathways and the ability of the PHEC to respond adequately to the cohort of patients presenting with mental health issues. Concerns remained that the service was not prepared to cope with complex cases where there may be extreme mental health symptoms, for example, psychosis.

Limitations of DMICP did not allow mobile teams to access the electronic health records when mobile or attending patients in the community. The only workaround was for the dispatch nurse to access DMICP and pass relevant details to the PHEC team (this would only work for service personnel with a DMICP record, and not for civilians). We observed two ambulance dispatches but there was no DMICP access seen as part of this process.

In the NHS, the National Patient Spine overcomes some of these difficulties in the UK but is not practical in Cyprus and therefore presents a risk.

Safe and appropriate use of medicines

There was no clear accountability for medicines management specific to the PHEC service. The pharmacy technicians, lead paramedics and SMOs combined their efforts to manage at an operational level. Commander Medical was the accountable officer for controlled drugs (CDs). The Medicine Provisioning Point (MPP) received deliveries, flown in from the United Kingdom, and then distributed to each medical centre (the MPP was out of scope for this inspection so was not visited).

Due to regular power outages, medical centres were connected to a back-up power supply (generator). Temperature checks of fridges within the medical centres were now monitored in accordance with DPHC policy as the process now used data loggers.

Appropriate arrangements were established for the safety of CDs, including destruction of unused items. These arrangements were supported by a local working procedure (LWP). A small number of CDs were held in stock. Monitoring and storage arrangements were in accordance with guidelines and policy. However, at Akrotiri, we found some gaps in the administration of CDs. The monthly checks for the fentanyl lozenges (held as part of the PHEC modules) had not been completed in June and July 2023 and there was no evidence of monthly CD checks for the controlled drugs held for the PHEC paramedic bags. One quarterly check had been completed in 2023. Evidence was seen that morphine from the PHEC bags had been destroyed by a nurse and paramedic. This does not comply with policy which requires destruction of CDs to have an external witness.

Written procedures (SOPs) were in place to support safe dispensing practice. Staff who were prescribers had signed the SOPs applicable to them.

The arrangements for the access, storage and monitoring of prescription stationary were effective. Blank prescription pads and prescription paper were stored securely and an effective tracking system was followed.

Track record on safety

We found that medical centres recorded and escalated risks appropriately. However, there was still lack of clarity on where risks were held. Staff knew how to escalate risks but staff reported that feedback was minimal and there was a lack of assurance that these risks were being addressed in a timely manner. Through discussion with leaders at each medical centre, it was evident that there was a lack of clear ownership in the absence of a single delivery duty holder with responsibility for the Sovereign Base Area Ambulance Service. There was clear frustration among individuals we spoke with at all levels. Risks that had been escalated lacked ownership at the most senior level. The “Mum and Dad” dynamic was widely reported to us and reflected by all three Senior Medical Officers. The presence of a PHEC lead would help with clinical delivery and coordination but this

position would still require support from senior colleagues to manage risk and exact change.

Data sheets were held for hazardous substances. The station lead for health and safety carried out an annual assessment. PHEC equipment checks, including the testing of portable electrical appliances were in-date.

Lessons learned and improvements made

Military practices have a system and policy for recording and acting on significant events (referred to as ASERs) and incidents. At all 3 medical centres, every call out was discussed at the morning brief and if there were any learning events, these were raised as an ASER. In addition, localised events of importance were raised as “action reports” and shared with the other medical centres. There was no formal process to recognise and record near-misses. Some issues were conveyed by WhatsApp, which although meant with good intent, was not an appropriate means of communicating potentially patient sensitive information. At Dhekelia, a system called SIGNAL was used and the form did not pass on patient information. There was good evidence of an open reporting approach, with staff knowing how and when to log incidents via ASERs. However, there was no evidence of pan-island thematic analysis or shared learning.

The medical centres were responsible for managing medicine and safety alerts. Alerts were effectively managed by DPHC staff and included all medicines and equipment used to provide the PHEC service.

Are services effective?

We rated the service as good for providing effective services.

We have rated the practice as good for providing effective services. At the previous inspection, we identified areas that needed strengthening including ensuring that all staff were suitably trained before working in the service, incomplete recruitment checks and unfilled posts restricting the capacity to provide an effective service. Effective actions had taken place to address the concerns raised, of note, the change of model to a paramedic delivered services had resulted in significant improvement in having suitably qualified and experienced staff.

Effective needs assessment, care and treatment

There had been tangible progress in the development of standard operating procedures (SOPs) and a Sovereign Base Area Ambulance Service (SBAAS) workbook. However, these were being produced by the lead paramedics in isolation and there was little cooperation and coordination across the 3 main sites. There was recognition of areas requiring an SOP but completion had been hindered by time restraints. The Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines were used by clinicians. A notes audit of the Patient Report Form (PRF) included a qualitative check of established guidelines being followed. Audits of the PRF forms would identify any example of guidelines not having been followed. The Blue Light Forum included clinical guidelines as a standard agenda item.

The PHEC service did not use a formal triage assessment tool as part of its service. However, given that the operating model was intended to generate an ambulance dispatch for every 112 contact and there was no differentiation with regards to categories of ambulance response times, the absence of a formalised triage tool did not introduce additional risk. This did mean that there was no formal process to differentiate and prioritise care and there was a reliance on the decision of the dispatcher. With the number of calls to the service being low, this was deemed a manageable risk.

When the ambulance was dispatched, a secondary number was not taken and although there had been no reported incidents or concerns logged for this, it is always best practice to capture a second contact number to ensure ambulance dispatch to the right location, or if the patient deteriorates on scene. There was no GPS nor automated process in the ambulances to assist finding the correct location, we were told of a case with one incident when the crew drove past the correct location several times as they had the wrong reported location.

The current cardiac monitoring equipment (Tempus Pro device) used did not have a ‘shock box’ (built in defibrillator) and therefore did not allow some advanced life support interventions (synchronised DC shock and external pacing). Although an upgrade was planned, these interventions remained unavailable to Advanced Life Support qualified team members.

Monitoring care and treatment

The care provided to patients was monitored every morning during a group call at each of the 3 medical centres: Akrotiri, Episkopi and Dhekelia. Discussion took place around all new and ongoing call outs. These meetings were attended by PHEC leads and PHEC staff on duty at the time (incoming and outgoing crews attended as part of the handover). An administrator recorded minutes from the discussion. There was a clear and auditable method of recording all pre-hospital patient contacts that allowed audit of the quality of pre-hospital records. Several pre-hospital records were accessed on DMICP, and the quality of the records checked were found to be complete with concise recording of clinical details.

There were several examples of best practice and audit being undertaken by the paramedics themselves in all three sites. These included an audit at Dhekelia to validate the PRF process in hospitals. However, there was no sharing of this best practice across all 3 medical centres. Regular audits also included:

- Infection prevention and control and cleaning of vehicles (audit of compliance).
- Call out response times; and
- Land equipment (assets) included in the PHEC equipment.

Since the previous inspection, there had been significant progress made against benchmarking or measuring the effectiveness of the service; however, this was compounded by the way that information was captured. Every metric was recorded manually, and this introduced human error. It did not recognise the inevitable ‘lag time’ for calls to be passed to the dispatcher from the Republic of Cyprus and its police telephony system. It appeared that the PHEC service aimed to have an ambulance on scene within 20 minutes. There was no stratification of the risk of calls, so the PHEC service did not provide differentiated care to its patients.

At the previous inspection, British Forces Cyprus (BFC) staff outlined their plans to create a new governance approach for the PHEC service based on CQC key lines of enquiry and eHAF (electronic health assurance framework). There were plans to create a suite of key performance indicators informed by the overarching governance framework. Due to a change in personnel, these plans were still in the development stage. At a local level, PHEC meetings happened on a regular basis (usually monthly or bimonthly). However, we queried whether all of the right stakeholders were invited; for example, the pharmacy technician at Dhekelia was not invited. There was an opportunity to resolve this and to implement a pan-island model for the sharing of information, best practice, audit, risks and learning across all three sites.

There had been progress in the development of SOPs, for example, the SBAAS workbook developed by the SBAA team . However, these had been produced by the lead paramedics in isolation and there was little cooperation and sharing of effort/coordination across the three main sites. There was recognition of areas which required an SOP but where time had so far precluded completion.

Effective staffing

There was no formal Training Needs Analysis (TNA) document in place for the PHEC service. However, at a local level, the paramedic lead did review the training skills and needs of their team, with particularly good practice in Episkopi and Akrotiri. There was also some inconsistency between the training undertaken by locum staff and employed paramedics and medics. We noted that some of the training that the staff had received whilst working in the UK was either out-of-date or needed further validation to ensure that it was relevant for the PHEC service. The staff we spoke with (nurse dispatchers, medics, drivers, and paramedics) at all three sites stated that they were never asked nor expected to act outside of their scope of practice or capability. There was also a consistent theme that reach-back for support from a suitably skilled GP or senior clinician was available. No concerns were raised about reach-back by any staff interviewed. Uniform and appropriate kit remained an issue, with most uniform procured personally by the staff themselves and an absence of some essential items.

Paramedics were now delivering the PHEC service with support from medics and nurses. Reach back to the on-call doctor was available if required but the service model was based on paramedics being suitably skilled to provide treatment and stabilise the patient when a hospital transfer was required. Service paramedics were mandated to return to UK for attachment to an NHS ambulance trust to maintain currencies. Lead paramedics identified they had been unable to do this due to their perceived workload and responsibilities. In addition, one paramedic did not hold an honorary contract with a UK NHS ambulance trust and was not aware of how this could be facilitated.

Most medics working in the PHEC service had the required BATLS (Battlefield Advanced Trauma Life Support) and MPHEC (Military PHEC) training. Courses were now available on-island, previously, staff had to travel back to the UK. We saw notable improvements had been made since the previous inspection, in particular at Akrotiri where we had previously highlighted significant gaps in training. There was now a proactive approach with established lines of communication back to RAF headquarters to ensure staff had completed training prior to arrival. We saw examples of new medics having their arrival date delayed in order to complete training thus preventing the need for specific travel back to the UK at a later date.

The previous inspection identified an issue with access for medics to ‘paediatric intermediate life support’ (PILS) training despite 25% of PHEC cases at Episkopi and 14% of cases at Akrotiri being children. Although staff feedback suggested this remained an issue, it was mitigated by there being a suitably trained paramedic in attendance. In addition, the reach-back access to doctors was robust, and there was evidence seen of this working at Dhekelia during the inspection.

The nurse dispatchers interviewed fed back that they had not received any formal training with regards to dispatch function and process. It was perceived by some as a ‘bolt-on’ role, secondary to their primary role as medical centre nurses. The ambulance dispatch process relied on the quality of the information passed from the Republic of Cyprus police contact centre, which the PHEC had no control nor influence over. Once the call arrived via 112, it was managed by a nurse. The nurse used METHANE report to capture the salient information and then passed this onto the ambulance team. There were single points of failure with this process, everything was captured manually, including the location of the

patient. The nurse dispatcher did not remain on the line with either the caller (every 112 call is third party) nor the ambulance crew itself, nor did they retain open channels in case the crew needed to contact them. We discussed the challenges faces with having three separate dispatch functions at each medical centre and spoke of the potential opportunity to centralise this into one.

There was utilisation of learning-needs based moulage training at all sites delivered by the paramedics. There was also evidence of joint moulage training with a squadron which had some search and rescue capability and function. The after action reviews (AARs) following fatal incidents were a good demonstration of an appropriate review having been carried out. Training in the management of traumatic cardiac arrest had been provided following the identification of this as a learning need. All sites conducted regular moulage training. These were paramedic led and based on the perceived training needs of the team. Though there was no log of subjects covered, team members reported finding this useful and inclusive. This training formed a key part of competence/currency maintenance of the service and mitigated against potential skill fade caused by the low number of presentations.

Doctors involved in providing the PHEC service were ALS (advanced life support) trained, and ALS was now specified on assignment orders. Doctors reported no difficulty in accessing ALS training and military paramedics also had access but would have to return to the UK for this training. Locums were required to fund and arrange their own courses.

Clinical supervision had improved with the remodelling of the service. Paramedics regularly reached back to the duty Medical Officer (MO) for primary healthcare (PHC) clinical advice. This was most likely when a patient required discharging from the ambulance system into either PHC or when discharged on scene. Paramedics we spoke with reported having no issues obtaining clinical advice at any time (this was an important aspect of the SBAAS and mirrored systems where clinical advice would normally be available to ambulance crews working for NHS ambulance trust). This added a layer of additional clinical assurance. We discussed the current requirement for MOs to be PHEC aware and qualified if involved in delivering or supporting the service. If this was maintained to allow them to continue to provide this function, it should be reflected in their Terms of Reference (not the case at present). However, should this function be delegated to the incoming PHEC lead, it would result in a 24/7 on call commitment.

Coordinating care and treatment

Staff worked together and with other care professionals and each medical centre held a daily morning meeting at which all cases were discussed.

BFC Headquarters enabled established links with Republic of Cyprus (ROC) state secondary care services and BFC contracted secondary care hospital. These included connecting and conducting visits with the ROC hospitals used by the PHEC service. Defence consultant advisors visited regularly to look at the ROC hospitals and make recommendations to both the provider and to Commander Medical BFC. However, there was no formalised route by which concerns with respect to secondary care could be raised by PHEC staff who delivered the service. Staff we spoke with were aware of the need to

escalate concerns but there was a general lack of confidence that these concerns would be addressed.

Major incident training was co-ordinated to include the SBA police and fire. The ROC ambulance service had not engaged recently due to the pressures on their own service. However, with the re-introduction of the Blue Light Forum, there was opportunity for the emergency services to meet together for discussion. We highlighted the risks around major incidents. The PHEC service would not have the numbers to provide a surge response. Mitigation would require co-ordination with ROC civil authorities and ambulance service and a regular joint exercise of a scenario would be required to provide assurance and training.

How the service encourages primary prevention measures

Primary prevention recommendations had included improvement of the road surface, signage to warn drivers of a bend in the road and a reduction in taxi fares to discourage drink driving. The ‘Blue Light Forum’ provided a platform for formal discussion to be held between the emergency services. There was evidence of sharing of the learning outcomes from AARs beyond the medical centre. Liaison with the SBA police and administration had led to the removal of trees and improved signage at the site of a road traffic accident.

Consent to care and treatment

Staff sought patients’ consent to care and treatment in line with legislation and guidance. When providing care and treatment for young patients and when appropriate, staff carried out assessments of capacity to consent in line with relevant guidance. Clinical staff were aware of the protocols and were supported by the PRF.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (MCA) 2005. Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient’s mental capacity to make a decision. Staff understood how to assess a child’s capability to make and understand their decisions.

Are services caring?

We rated the service as good for providing caring services.

Kindness, respect and compassion

The PHEC service had taken account of patients' personal, cultural, social and religious needs; for example, the drivers were all bilingual in Greek and English. A translation service was available for any additional language translation requirement.

The Republic of Cyprus (ROC) did not have formalised welfare teams that patients can be referred to when clinicians were concerned about their wellbeing. PHEC staff coordinated with the Sovereign Base Area (SBA) police to safeguard patients.

With the consent of the patient, PHEC staff offered relatives transport to the hospital or ensured they were kept informed of the situation.

Involvement in decisions about care and treatment

The Patient Review Form included templates that supported clinicians and staff in evidencing that the views of patients had been accounted for when providing care and treatment. This included patient involvement in decision making when relevant. PHEC staff used a Quick Review or 'QR' code to encourage patients to give feedback. Data collated was minimal due to the nature of the service being an emergency response and the diversity of patients (Cypriot nationals, international tourists and service personnel).

Privacy and dignity

Patients' privacy and dignity was respected. Privacy screening was provided in the ambulance vehicles to maintain patients' privacy and dignity during treatment. The vehicle design included double pane windows which were blacked out so you could see out but not in. The resuscitation rooms at each medical centre had privacy curtains around the treatment couch. At the scene of an incident, the number of bystanders was reduced by the drivers or by calling the SBA police if required. PHEC staff used the ambulance as a private space to hold a conversation with the patient in the event that a confidential area was not available or if the patient became distressed. Staff were required to complete the Defence Information Management Passport training to guide them on how to manage confidential information.

In the unusual event of a patient wishing to see a same gender clinician, the service could facilitate as the PHEC included both male and female doctors. However, as the service was an emergency response, no such requests had been made.

Are services responsive to people's needs?

We rated the service as good for providing responsive services.

Responding to and meeting people's needs

Staff were trained in how to respond to incidents relating to water, heat and to the seismic threat (earthquakes). Stretchers had weight limitations so staff would struggle to provide a service to bariatric patients. Furthermore, there was no lifting equipment within the vehicles. The current arrangement was to contact the fire if additional support was required. Republic of Cyprus (ROC) health providers did not have a license to treat mental health patients so a memorandum of understanding was in place with the NHS to access their open wards.

Language Line type translation services provided a solution but were not appropriate for ambulance dispatch due to the length of time taken to access a translator. Although there were no reported incidents when the language barrier had been an issue, the service continued to rely on drivers when dealing with patients who could only speak Greek. There was a potential problem should a visitor be treated, who could not speak English nor Greek. There was an increased possibility of this with the movement of migrants through the Sovereign Base Areas (SBAs), in particular around Dhekelia.

Whilst no formal Health Needs Assessment (HNA) had been undertaken to scope out the service required for non-entitled patients (non-military personnel and their families), staff had considered the immediate potential needs of patients they might be called upon to provide a service for and their preferences. The Defence Science and Technology Laboratory at Porton Down had been approved to do some modelling on how the SBA will look in the future so that the ambulance service can be scoped and planned accordingly.

All PHEC staff completed diversity and inclusion training as part of the annual training package.

Timely access to care and treatment

The PHEC service was targeted to attend the scene within 20 minutes of receiving a call. This had been achieved for each activation. The nearest A&E department for the Western SBA was at Limassol General Hospital and for the Eastern SBA was at Larnaca General Hospital or Nicosia General Hospital. Travel distances were approximately 20 minutes dependent on where the incident was within the SBA. In addition, the PHEC service provided a patient transport service to the private hospital that is contracted in Nicosia. Patients were being sent to the nearest state hospital appropriate for emergency admissions, but not for those that had mobility needs and needed urgent but not emergency care. This could be provided by private providers available on island.

Listening and learning from concerns and complaints

The PHEC service took complaints and concerns seriously and responded to them appropriately to improve the quality of care. The complaints procedure was integrated into the process at each medical centre with the respective leads designated as the responsible person who handled all complaints that related to the PHEC service. The medical centres had a process to manage complaints in accordance with the Defence Primary Healthcare complaints policy and procedure.

There was scope for non-military personnel to feed back on the PHEC service through a process within secondary healthcare providers. However, the medical centres provided an opportunity for military personnel and their families to give feedback. Responding to feedback on the PHEC service was integrated so would be communicated through the practice meetings and healthcare governance meetings.

Are services well-led?

We rated the service as requires improvement for providing well-led services.

We have rated the practice as requires improvement for providing well-led services. Whilst concerns over the capacity of staff to provide PHEC had been addressed, the ownership of risk was not always clear and governance systems could be better integrated across all 3 medical centres.

Leadership, capacity and capability

The PHEC Cyprus Teams comprised professional, credible and dedicated staff who were often working beyond their established role to deliver the best care they could within the available resource.

Issues around staffing capacity had been addressed at a practice level with the addition of paramedics to deliver the PHEC service. This had removed the dependence on doctors at the 3 medical centres who had previously been relied upon to provide the PHEC service in addition to deliver primary care. The paramedics were suitably qualified and experienced to deliver a level 5 service. The recruitment of paramedics had resulted in a reliance on some long-term locum paramedics. Local leadership were unable to make these positions substantive due to the lack of established permanent posts. Therefore the progress with movement to a paramedic delivered service and plan to continue towards a paramedic led service lacked resilience whilst these staff were still temporary.

The previous PHEC Clinical Director had delivered innovative work around frontline delivery (including automated equipment assurance processes). They had recognised the need for substantial change in the way that the PHEC service was delivered and resourced in order to minimise risks to both staff and patients, but their ideas had not gained the required traction to transform into an agreed plan of action. The PHEC Clinical Director left their post in June 2022 and this post has not been filled although the Senior Medical Officers (Episkopi and Dhekelia) and Deputy Senior Medical Officer (Akrotiri) had stepped up to provide cover (as an addition to continuing with their roles in primary care). The clinical lead was to be covered by the Defence Consultant Advisor for PHEC until the new Clinical Director arrived. It was highlighted that the new Clinical Director was a temporary post filled opportunistically and that there was no pathway to endure beyond this.

There was a de facto ‘lead paramedic’ in all three sites, and all were committed to their teams and to delivering the best PHEC service they could. However, there was no formal job description nor terms of reference for this role and as such, this introduced variance and a lack of uniformity (and delegated authority) to the three paramedics acting as leads.

Vision and strategy

In clinical settings such as the PHEC service where populations and their health needs were changing and bespoke, there was a need to design the service around the needs of

patients and to resource accordingly. Only through baseline health needs assessment was a truly patient centred PHEC service defined. Although initial discussions with an external partner had commenced, a clear and agreed resource plan based on a baseline health needs assessment has yet to be established and signed off. There was no discerning difference in response, each 112 call, direct or via the medical centres. Each dispatch got an ambulance and crew response irrespective of whether or not the incident required one. There had been no attempt to define a scope of practice for the SBAAS. In an ambulance system, this provided a metric against which competence and currency can be measured and training needs developed.

Staff we met with across the PHEC service and British Forces Cyprus (BFC) were dedicated and fully engaged in establishing a new and appropriate vision and strategy and their role in achieving them. However, we again found that this vision will only be delivered with the appropriate buy-in and resource commitment from senior strategic staff. The plans outlined at our previous inspection had not been completed, most notably at a strategic level. Significant progress had been made with the delivery against the vision of having a PHEC service delivered by paramedics and augmented by doctors. The increase in paramedics delivering the service had addressed the skills and training gaps previously highlighted. However, there remained a lack of clarity of ownership at senior level with three separate lines of accountability for the PHEC service that cascaded from the Commander of Strategic Command through three ‘2 star’ Generals (Director of Overseas Bases, Commander of British Forces Cyprus and Director of Defence Healthcare. This structure lacked clarity of ownership and responsibility for risk. At a practice or ‘tactical’ level, the continued progress and improvement of the service was largely reliant on finding a resolution to the blurred lines at senior level.

Culture

Discussion with staff revealed a ‘no blame’ culture at all ranks. Key systems had been reviewed to make them more effective and staff we spoke with were aware of the whistle-blowing policy and freedom to speak up champion. The PHEC service was currently designed around 4 geographical locations rather than around the patient. There was a clear desire to share ideas and learning at a tactical level.

Staff highlighted the limitations faced when waiting for strategic decisions to be reached. This had impacted their confidence and morale, most notably for those who attended the scene of a road traffic accident and were still having to deliver care in an unsafe environment.

The PHEC teams worked hard to deliver care that was focused around the individual needs of each patient. We spoke with clinicians who explained the importance of respecting and complying with the end of life wishes of patients from different cultures. Feedback from staff was that the staffing requirements and needs of the PHEC service were prioritised ahead of that of the host primary care practice; this had created some friction at times from some of the nurses who saw the PHEC as an additional service, and not their core function.

Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They spoke of how the culture was one where both suggestions and concerns would

be listened to at a local level. However, staff were aware that significant risks were being held locally where leaders did not have the power or traction to deliver impactful change. Blurred lines of accountability and inappropriate ownership and 'tolerance' of significant risk meant that staff were not always confident that their safety and welfare was of prime importance.

Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. There was information displayed to advise staff on the freedom to speak up process and this included signposting to a confidential helpline to support those who wished to raise a concern in confidence.

Processes were in place to provide staff with professional development. This included appraisal and peer review. Staff were scheduled to receive annual appraisals and were supported to meet the requirements of professional revalidation where necessary. We highlighted that some locum paramedics had been in post for more than 12 months but had not taken part in any appraisal as they were not line-managed by permanent team members.

There was a difference in the skillset and perception of locum paramedics and substantive military paramedics, and this needed to be addressed at a more senior level. Staff told us that the 'locum badge' impacted identity and self-esteem.

Governance arrangements

Each medical centre conducted separate monthly PHEC meetings (Episkopi had integrated theirs into the practice meeting so all staff were invited). The standing agenda was appropriate but the list of invitees did not include the pharmacy technicians and some team members chose not to attend. Of note, the nursing teams did not regularly attend despite their responsibility for dispatch. We discussed the benefit of making the monthly PHEC meetings SBAAS-wide (or even better global) and encourage all stakeholders to attend. This would facilitate the wider sharing of learning outcomes, and better coordinate the raising of issues. An overarching PHEC service Clinical Governance Committee met for the first time in May 2022 and had recently been reinstated. The group was led by Commander Med and supported by the PHEC Clinical Director and BFC staff. Attendees included the lead paramedics from all stations, The meeting covered clinical governance and SBAAS development. In addition, regular meetings were held fortnightly with all medical and dental key-stakeholders. These meetings were chaired by Commander Med (BFC) and enabled events of importance to be shared as a whole group. Meetings would be called earlier if necessary and of importance/relevance to the whole group.

The Ambulance Working Group held its inaugural meeting in May 2022. Led by Commander Med, the group was attended by PHEC leads, Senior Medical Officers, the Service Delivery Team, SAFFA (Armed Forces Charity), Defence Primary Healthcare and a vehicle delivery representative. The purpose of the group was to identify risks and develop strategy moving forward. The reinstatement of this group was planned for January 2024 once the SBAAS workforce structure was definitive.

The Blue Light Forum had been reintroduced and an initial meeting had taken place. The aim of this group was to improve and streamline the dispatch process, address training requirements for dispatches staff and address scene safety concerns with the involvement of Police and Fire services.

Quarterly regional governance meetings were held with the Regional Clinical Director for overseas. Representatives from each practice were invited to submit their top three risks routinely. Of note was the fact that PHEC continued to be longstanding concern.

BFC staff continued to use ‘out of standard reporting’, a system that allowed the Service Delivery Team to react more promptly to local concerns and evidence performance and issues to medical and non-medical chain of command. Although there were daily moulages and monthly training, there was not consistent evidence of peer reviews or meaningful clinical meetings. Standard operating procedures known as ‘SOPs’ were in place across all three sites but these were localised and therefore lacked uniformity and consistency, both in terms of approach and delivery across the PHEC service.

BFC staff had previously outlined their plans to create a new governance approach for the PHEC service based on CQC key lines of enquiry and eHAF (electronic health assurance framework). There were plans to create a suite of key performance indicators informed by the overarching governance framework. However, we found that this had not been progressed. Performance of the PHEC service continued to be measured in terms of whether ambulances reached patients requiring 112 assistance within 20 minutes and whether disaster had been avoided. At the time of our visit, there was no evidence of a robust clinical governance framework in place for the PHEC, to bring together, listen and subsequently cascade learnings and service improvements across the whole service and all 3 sites. There was a need for clear direction to be provided through standard operating procedures, memorandums of understanding and terms of reference. For example, staff were not clear what should happen if there was no paramedic available to cover a shift nor how should detained patients be accompanied to hospital alongside the police.

Managing risks, issues and performance

Risks were recorded and reviewed. However, there was no defined schedule and the outcome of the risk updates did not appear to ether cascaded effectively or, the staff on the ground do appear cognisant of it.

CQC escalated concerns around the delivery of PHEC following inspection of the medical centres in Cyprus in 2019 and reported in detail on these following the first inspection (June 2022). A letter was sent to DMSR in December 2019 outlining concerns around staff training, competency and confidence, potential risks to patients and impact on staff morale and wellbeing. Following the first Cyprus PHEC (June 2022) inspection , an Urgent Improvement Notice was issued by the Defence Medical Services Regulator to the Director Overseas Bases (DirOB) that outlined 9 areas for improvement. Two of these remained a concern, the scene safety and risk management/ownership.

The risk escalation mechanism continued to lack clarity and lack of ownership at senior level. Risks had continued to be recorded and escalated appropriately at service level but these were not subsequently owned and responded to by senior leadership. A tendency to

'tolerate risk' had continued and there was a lack of mitigation of known risk. Some significant risks, for example, staff safety whilst attending 112 scenes, continued to be held at an inappropriately low level and staff had not been able to influence change effectively.

Each medical centre owned a business continuity plan (BCP) which had been reviewed and included directions to follow in the event of extreme weather, disease outbreak and interruption of power supply. All staff were recorded as having read the policy and any updates were emailed out to all staff.

Appropriate and accurate information

There were robust arrangements at each medical centre in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Currently, patient records for the PHEC service were paper based. Each medical centre had a DMICP server so cannot see one another's records. This inhibited virtual triage and prevented centralisation of the service.

Engagement with patients, the public, staff and external partners

The PHEC Team had processes in place to involve as many patients, staff and external partners as possible to support high-quality sustainable services. However, they recognised that it had not been possible to secure a large amount of patient feedback to date, especially from patients in the local Cypriot population. It had proven easier to encourage patients registered with the military medical centres to provide feedback on the 112 service once they had used it (as their details were known to the service and General Data Protection Regulation arrangements allowed them to be contacted). Registered patients who had used the 112 service could leave feedback anonymously via a suggestion box positioned in each of the waiting rooms in the three medical centres. Notice boards in the waiting areas provided a summary of the complaint process and duty of candour principles.

Good and effective links with internal and external organisations were established, including with the welfare team, Chain of Command, SBA emergency services, Republic of Cyprus emergency services, DPHC Headquarters and host nation healthcare providers. Of note, good links with the mental health team based at Akrotiri had led to notable work that was ongoing to help support the PHEC staff when treating a patient experiencing a mental health crisis.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement. Examples included the proactive approach that Akrotiri Medical Centre had adopted to

improve the compliance of incoming new staff members. We saw that work had started to coordinate the work between the 3 medical centres using an electronic system which would allow learning to be shared. Some items of equipment identified at the previous inspection as being essential had been procured. These included paediatric harnesses and spinal boards for the ambulance vehicles. There were several examples of best practice and audit being undertaken by the paramedics themselves at all 3 sites.