Seria Medical Practice

Seria, Brunei, BFPO 11

Defence Medical Services inspection report

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

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

Contents

Summary

About this inspection

We carried out this announced comprehensive inspection on 1 May 2024.

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

Are services safe? – good

Are services effective? –good

Are services caring? – good

Are services responsive to people's needs? – outstanding

Are services well-led? - outstanding

The Care Quality Commission (CQC) does not have the same statutory powers with regard to improvement action for Defence delivered healthcare under the Health and Social Care Act 2008, which also means that Defence delivered healthcare is not subject to CQC's enforcement powers. However, as the military healthcare Regulator, the Defence Medical Services Regulator (DMSR) has regulatory and enforcement powers over Defence delivered healthcare. 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 that the CQC will complete at the invitation of the DMSR in their role as the military healthcare regulator for the DMS.

At this inspection we found:

- Patient feedback about the service was almost entirely positive. Patients we spoke with provided examples of the team going the extra mile to provide exemplary care. Patients told us that care they received was accessible and that they were treated with compassion, confidentiality, dignity and respect. Four patients raised a concern that they had been unable to receive a vaccination that they needed.
- A comprehensive programme of quality improvement activity (QIA) was in place and this was driving improvement in areas which were relevant and impactful for patients.
- There was an effective and well-designed programme in place to manage patients with long term conditions.

- The medical centre benefitted from a strong and inclusive leadership style, such that staff felt valued and able to contribute to improved ways of working. Of note was the interest and effort the entire staff team invested in understanding and celebrating one another's cultural and religious festivities. The SMO had been in post for some five years and this, coupled with the permanent contracts for locally employed civilians, meant that patients received continuity of service and that healthcare governance arrangements were both finely tuned and embedded.
- The practice had positive lines of communication with the units they supported, in addition to the welfare team, social services, health visitors and midwives. This gave the medical centre team and their partners the best possible chance to ensure the wellbeing of not only service personnel, but their families and contracted staff. Command staff we spoke with confirmed that the medical team engaged fully in all welfare processes.
- Patients found it easy to make an appointment and urgent and often routine appointments were available the same day.
- Arrangements were in place for managing medicines including high risk medicines.
- There was a known and long-standing issue with vaccine supply which meant that patients could not always access the vaccines they required in a timely way.

We found the following areas of notable practice:

The medical team had worked in partnership with Chain of Command, the schools on base and health visitors and other partners to identify a group of patients who would benefit from assessment for autism spectrum disorder (ASD), speech and language support and occupational health support. The Oxford University Hospitals NHS Foundation Trust Multidisciplinary Assessment (MDA) Team had spent a week at Brunei Medical Centre conducting assessments for a cohort of 13 patients, resulting in 12 diagnoses of ASD. The Defence Children's Service were providing speech and language support, Special Educational Needs Coordinator (SENCO) support had been made available in the school on base and health visitors were being trained to provide play therapy for families. A neurodiversity group 'Brighter Beginnings, Brighter Futures' had been set up to support patients and their families.

The team were committed to the delivery of 'Sustainable Healthcare – Green Impact for Health'. Inhaler prescribing was audited as part of this approach: patients were identified who could potentially switch from a pMDI (pressurised metred dose inhaler) to a DPI (dry powder inhaler) to reduce environmental impact. There was a 'Go Green' display in the reception area which was owned and updated by a staff member. The display recommended sustainable ways to reduce environmental damage including menstruation products, avoiding flushing old medicines down the toilet, tips for saving money and delivering environmental benefits and the benefits to be gained from social prescribing, energy efficiency, reducing pollution and inhaler recycling.

In the past, patients had voiced concerns about Command being informed should they test positive for a sexually transferred infection. Consequently, the medical team had offered education and orientation for the patients re-enforcing confidentiality and awareness. At a recent briefing, the Medical Sergeant (who was bi-lingual) delivered sessions to promote the service and its accessibility, expelling some of the myths and taboos associated with the screening.

In order to best meet the needs and preferences of patients, the PCRF provided intensive two week rehabilitation courses (run several times a year). This was for patients whose condition necessitates a period of intensive daily rehabilitation and was similar in nature to the rehabilitation course run by regional rehabilitation units. Patients confirmed that they preferred to undertake local rehabilitation, rather than leaving their families in order to travel to the UK. The approach had been evaluated and patient feedback seen which was 100% 'good' or 'very good' and comments included the benefit of not having to leave family, and the aspiration for more Brunei-delivered PCRF courses. We spoke with Chain of Command as part of this inspection and they re-iterated these benefits.

The medical centre team had forged effective links with all key stakeholders in relation to safeguarding including welfare staff, commanders and units, the padre, the pundiji, social work team, health visitors and midwives and we were told that a mutually supportive communication stream was in place. The close physical proximity of all the key teams was definitely beneficial for timely and proactive team work. We interviewed a welfare officer, a social worker, a health visitor and a midwife as part of our inspection. They confirmed that regular meetings took place and that conversations were two way such that each party could raise concerns about vulnerable patients.

The PCRF ran an air crew conditioning programme and also produced an injury management guide for use by healthcare practitioners (containing patient information leaflets). This was developed by PCRF staff to support other medical centre healthcare practitioners.

An anterior cruciate ligament (ACL) workshop (injury prevention) was run by the ERI which constituted an education session delivered to service personnel who (through their role/activities) may be at higher risk of knee injury.

In response to feedback from 230 Squadron, the medical team had created a medical administration role to act as a link with 230 Sqn. This streamlined planning of aviation medicals to ensure that appointments were grouped.

The team had been awarded "Active Practice Status" by the Royal College of General Practitioners in recognition of their work in reducing sedentary behaviour in staff and patients, increasing physical activity in the staff and patients and being part of an active community. This has been achieved through stand-up meetings and regular lunch time staff wellness sessions.

A GP trainee delivered 'first aid for children' training work to 47 members of the community in response to an identified demand. Pre and post course feedback were obtained and the training focussed on when and how to give CPR to a baby or child,

how to help a choking baby or child, how to manage a child with fever and how to manage a child with burns. A significant improvement in attendee confidence was recorded as a result of the training and those who attended felt it was a worthwhile course.

'A Red Eye Memoir' had been designed to provide guidance to clinicians if antibiotics are warranted for patients with red eye symptoms.

The Chief Inspector recommends to the wider Defence organisation:

- Acknowledging the global supply concern for some vaccines, work to ensure safe and timely vaccine supply to all patients registered in Brunei, including civilians and eligible children. Guidance around travel vaccination requirements should align to the Green Book publicised on the National Travel Heath Network and Centre (NaTHNaC) website and this should include civilians.
- Expediate the investigation of and mitigation around concerns with the supply chain for medicines and vaccines. This should include assurance around cold chain and resolutions around delays and errors during dispatch. Ensure that only medicines and vaccines with maximum expiry buffer are allocated for dispatch overseas.
- DPHC must ensure that all primary care facilities are directed to use a common set of clinical codes for safeguarding and vulnerable patients.
- Make funding available to ensure that any staff member required to triage patients by telephone has received formal training.
- Challenges around timely access to accurate patient records occur as DMICP 'Deployed' is a system with reduced functionality and some outage periods. Headquarters should review the functionality of DMICP 'Deployed' and deliver solutions to improve access to up-to-date records.

The Chief Inspector has no recommendations for medical centre.

.

Chris Dzikiti

Interim Chief Inspector of Health Care

Our inspection team

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

Background to Brunei Group Medical Practice

Seria Medical Centre provides a routine primary care service to a patient population of approximately 850 service personnel and 950 civilians (dependant families and civilian contractors including 195 children under five years old). Throughout the year the medical centre also temporarily registers a number of exercising troops. Brunei is on the island of Borneo, Southeast Asia. The barracks were established in 1984 in the town of Seria and are home to infantry regiments and an army air corps squadron. Rotation takes place every three to four years.

The medical centre is a dispensing practice with most medicines supplied by air freight from the UK. Services are provided from a purpose-built building shared with the dental centre. A Primary Care Rehabilitation Facility (PCRF) is located within the building and provides a physiotherapy and rehabilitation service for service personnel and their families.

Opening hours are from 07:30 to 17:00 hours Monday, Tuesday, Thursday, and Friday and from 07:30 to 12:30 hours on a Wednesday. A duty nurse is on call from 17:00 until 07:30 hours on weekdays and at weekends and bank holidays. The duty nurse was contactable by mobile phone and triaged calls initially. A duty doctor and medic were available to support the nurse. The closest hospital is Suri Seri Begawan (SSB) Hospital (transit time is 12 minutes and services provided include accident and emergency, general medicine, general surgery, paediatrics, obstetrics and gynaecology and a CT scanner). The National Hospital RIPAS is located in Bandar (90 minutes by road) and is the National Trauma Centre (major burns excluded). The host nation provides an emergency ambulance service. Referrals into the NHS in the UK are used for complex psychiatry, elective orthopaedics, cancer care and termination of pregnancy.

The staff team

Medical team	One Senior Medical Officer (SMO) Two Civilian Medical Practitioners (CMP)
Nursing team	One Advanced Nurse Practitioner One Senior Practice Nurse Five Nurses (one vacant) Bank Nurses as required
Medics	Three Combat Medical Technicians *
Practice management	One Practice Manager One Deputy Practice Manager One Aeromedical Evacuation Officer
Pharmacy	One Pharmacy Technician One Trainee Pharmacy Technician
PCRF	One Band 7 Physiotherapist One Band 6 Physiotherapist One Exercise Rehabilitation Instructors (ERI)
Administrators	Two receptionists Four administration clerks
And working alongside the Medical Centre Team:	
Regimental Team	One Regimental Medical Officer (RMO) Three Combat Medical Technicians One nurse
	GP Trainees on placement, Medical Student, Placement Medics
Cleaning Team	Two cleaning staff
Community Wing (Employed by SSAFA**)	Two Midwives, Two Health Visitors, Two Assistant Health Visitors and 1 Administrative Clerk

*In the army, 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.

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

The Senior Medical Officer (SMO) was the safeguarding lead at the medical centre and another doctor was the deputy lead. Both had completed level 3 safeguarding. All clinical and administrative staff were trained to the relevant level for their role.

The practice standard operating procedures (SOP) for both adult and child safeguarding had been reviewed and included contact details for local safeguarding teams. Monthly primary care team (PCT) meetings included discussion of safeguarding concerns. SSAFA midwives and health visitors attended the PCT meeting. Safeguarding was also a standing agenda item for clinician meetings. A quarterly local safeguarding board took place and a domestic abuse forum was run across the garrison. We noted that a flow chart was displayed on the walls of all clinical rooms which outlined the safeguarding steps to take specific to the location.

The team were capturing all safeguarding information within DMICP (the patient record system) and alerts were placed onto the record of anyone deemed to be vulnerable. This included any patients aged under 18. However, the team had stopped using/searching for the ‘Vulnerable Adult/Child’ codes and were using the safeguarding codes instead. This posed a risk that vulnerable patients will be missed by searches when they move between medical centres.

The practice had effective links with welfare services, health visitors, midwives, social workers, Chain of Command, the padre and the Pundiji (a Nepali leader who provides spiritual and cultural support where it is needed). We spoke with many of these partners and concluded that patients benefitted from especially well integrated welfare support from a team of specialists who worked very closely with one another. All safeguarding enquiries, concerns, and referrals for children and adults were made to the contracted social work provider for the location. At the time of this inspection, British Forces Social Work Service held the contract.

A number of forums were used to discuss safeguarding concerns. Primary Care Team Meetings took place on the first Wednesday of the month and a GP, health visitor and midwife were required to attend. The Local Safeguarding Partnership Board met every three months and was chaired by the Deputy Chief of Staff in Tuker Lines. A representative from the medical centre (safeguarding lead or deputy safeguarding lead) and a health visitor were required to attend these meetings and presented an opportunity for welfare officers and the chain of command to conduct a two-way discussion about vulnerable personnel. We spoke with the welfare officer who confirmed that they could easily secure a conversation with a GP if they were concerned about someone’s welfare and that a face-to-face conversation with the

patient would quickly ensue. Any additional safeguarding cases or concerns were discussed during the weekly clinician's meetings. The team also undertook a monthly DMICP search for vulnerable patients.

Clinical staff had received chaperone training and provided a chaperone service. A listing of all staff who had received chaperone training was available.

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

The Senior Practice Nurse (SNP) was the designated lead for infection prevention and control (IPC) and had received the appropriate training. Staff confirmed that the regional team provided IPC support as required. The annual IPC audit had been completed and any improvements actioned.

There was a cleaning contract in place. This included a six-monthly deep clean. The practice manager and the IPC Lead had a copy of the cleaning schedule which they were able to monitor and manage as necessary. The medical centre was visually spotless on the day of our inspection. We interviewed both staff members who were contracted to undertake cleaning in the medical centre. Both had received training appropriate for their role. One member of the cleaning team advised how they started their shift 45 minutes early to ensure that they had completed all the cleaning tasks before the clinicians started to arrive. Their commitment and hard work was commendable. A log of waste disposal notes was maintained by the practice. An annual waste audit was last undertaken in March 2024 and we saw that actions had been implemented.

Arrangements to ensure safety of facilities and equipment were in place. Risk assessments had been undertaken and recommendations actioned covering fire risk, water safety, legionella and electricity. Station staff maintained a log of portable appliance testing (PAT) undertaken. Servicing of equipment in the PCRF was undertaken annually by an approved external contractor. Consumables ordered by the PCRF were placed via E-CAT. The team tried to mitigate long delivery times by predicting use and ordering ahead of time (weeks to months). Nevertheless we noted an example given where a patient required a boot (for ankle injury) and the patient had to buy one locally as it would take too long for the order to arrive from the UK.

Risks to patients

From a patient perspective, clinical staffing levels were sufficient as patients interviewed told us they had prompt access to a clinician at all times, including out of hours. There was a mix of male and female clinicians, affording patients the choice to see someone of a specific gender. Across the clinical team, staff had acquired all the training required to deliver the spectrum of care that patients might need including pre-hospital trauma life support (PHTLS), women's health, Military Aviation Medical Examiner (MAME), diving medicals and paediatric immediate life support (PILS). The ANP was second in charge and her training as an advanced nurse practitioner brought a useful enhanced skillset to the service. The ANP assumed a deputy clinical lead role and deputised for the SMO when he was absent. Of particular note at Brunei Medical Centre was how patients benefitted from continuity of service: the SMO had been in post for more than four years and locally employed civilian staff were employed on long term contracts which meant that they were familiar with working practices. The PCRF team were adequately staffed with an appropriate skill mix. The reception team demonstrated a strong corporate knowledge and were instrumental in managing patient appointments, data tracking and signposting patients to support and advice.

All staff completed the DPHC mandated induction which included role specific elements. The practice retained copies of competed induction packs.

All staff knew where the emergency medicines were located. The emergency trolley was secured with a serialised tag and a log to record the tags. All medicines held on the emergency trolley were checked and in date. The emergency trolley held several medicines from the primary care optional drug list and these were documented on the Emergency Drugs Risk assessment in accordance with DPHC policy. Time expiry reports were being run monthly for all medicines held on the emergency trolley DMICP list.

The emergency treatment room had one CardioChek Plus Test System in accordance with DPHC policy. Equipment checks had been completed for the blood glucose monitor. The control test solutions were in date and evidence was seen that the blood glucose monitor was being calibrated.

The oxygen and Entonox cylinders were full and in date. The medical gas store was clean and the empty cylinders were segregated in the gas store. No smoking signs were displayed on the gas store and appropriate HazChem signage was displayed on the doors holding the oxygen and Entonox.

Wet Bulb Globe Temperature checks to indicate the likelihood of heat stress were undertaken. An automated external defibrillator (AED) was kept in the medical centre and all staff knew where it was located.

All staff had completed basic life support, sepsis, anaphylaxis, thermal injury and defibrillator training. In addition a helicopter crash exercise was conducted in July 2023 (this was a major incident medical management support exercise with 12 simulated casualties) and medical moulages were run monthly within the practice (these were

cross departmental and involved dental and physiotherapy teams). DPHC winch medics had conducted airfield training scenarios. Information about sepsis was displayed in various areas of the medical centre. Receptionists had received training in recognising and reacting to emergencies. This training covered the deteriorating patient and sepsis.

Medical centre staff were not called upon to provide a full pre-hospital emergency care service as the Brunei ambulance service was available to transfer patients to hospital in most circumstances. However, a doctors' Bergan was kept in the medical centre for in camp response. DPHC combat medical technicians were called upon to support winch evacuation of military personnel from remote areas and, as such, they were providing pre-hospital emergency care (transfer of approximately ten minutes). They did this with clinical oversight from the doctors in the medical centre. We were advised that any assessment on the ground would already have been completed by the Regimental Medical Officer (RMO) and the medics' role would be to facilitate the winching of the patient into a helicopter for transfer to hospital. If a patient required additional support during the transfer, the RMO would accompany them in flight. The medics confirmed that they had undertaken a winch medic course in preparation for this role. This was not a clinical course but did include handover of the patient. However, medics confirmed they had completed PHTLS training, along with Battlefield Advanced Trauma Life Support (BATLS). As part of the BATLS course, medics had been taught basic airway management (up to iGel insertion and in extremis surgical airway). The level of MEDEVAC available from the medical centre team was captured in the exercise medical plans and any residual risk was signed off by the Competent Medical Authority. Staff confirmed that risk for military exercises was reduced to as low as reasonably practical (ALARP). Medevacs were debriefed with one of the doctors. We were advised that the medical centre team were not involved in the decision process to authorise medevacs (this ceased two years ago). A call went into the operations room and the medical team (SMO) might be asked for advice if there was a need to triage prioritisation. An operational SOP was in place to cover the end-to-end process including split accountability across 230 sqn (PUMA) and medical centre staff. Every day at 0815 hours, a clinical handover meeting took place to discuss all out of hours (OOH) clinical cases– all doctors on site attended for general awareness and to check on management plans.

The medical centre was scaled for basic paediatric resuscitation equipment, although reliance was placed on the arrival of the Brunei ambulance service with paediatric advanced life support kit. Clinicians had access to the latest guidance from the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) which provides guidance for all pre-hospital clinicians, including for children. All clinicians had received training in PILS and the doctors had received training in Advanced Paediatric Life Support (APLS). Clinical staff in the medical staff would care for any child in need of emergency care with the skills and equipment they had whilst awaiting the ambulance service.

A lead (aeromed liaison officer - AELO) was identified for the co-ordination of the aeromedical evacuation (AE) service, the medically supervised movement of patients by air to and between medical treatment facilities. A digital aeromed referral platform

(DARP) was used to initiate and monitor AE. We were advised that effective lines of communication were in place with the AE team based in the UK. The bulk of requests related to outpatients appointments back in the UK, a small number of patients needed an escorted aeormed back to the UK and two children had required a transfer. The AELO conducted 'fit to fly' assessments. There had been no prolonged delays. Other members of the team were trained to co-ordinate AE in the absence of the lead and guidance/instructions were available for reference.

Out of hours (OOH) care was delivered by a nurse, a GP and a CMT and these three staff members were on call together. Nurses provided the first point of contact for the patient and triaged patients over the phone, working closely with the Duty Doctor. They would then either direct the patient to hospital or book a routine appointment at the medical centre for the following day. If the patient needed to be seen at the medical centre OOH, all three members of OOH staff would come in. All children would either attend hospital or be assessed by a GP. As part of the nursing induction, hands on training (by the SMO and SPN) had been given about the OOH service, although no formal telephone triage training had been completed. Funding bids had been submitted to DMS to attend Telephone Triage training courses.

An off-duty rota system was in place to ensure that nurses had adequate breaks between routine and out of hours working periods. The practice had a local working practice detailing roles and responsibilities for OOH cover and this was up to date. Due to the number of staff able to share the OOH cover rota, staff confirmed that the expectations of them were reasonable and that they had adequate recovery time between shifts.

The nursing team actively reviewed and discussed cases they had seen or /triaged OOH with the SMO or ANP as part of peer review and clinical supervision. We were advised that these discussions had identified additional training needs for staff which had been acted upon.

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

Information to deliver safe care and treatment

The practice used DMICP 'deployed' DMICP(D). This system had reduced functionality compared to the UK patient records system although staff at Brunei medical centre confirmed that they rarely experienced serious challenges around access. Resolution could usually be secured via a local server reset (taking around 15 minutes). MODNET outage was a greater concern, although staff confirmed that they reverted to Wi-Fi connection in these instances. DMICP was therefore relatively stable. In the event of a DMICP issue, the medical centre reverted to the usage of the paper copies and these were then scanned onto the system once DMICP was back up and running. The reception team printed off the appointment lists each night for the following day.

Summarisation of notes for newly registered patients was undertaken. The DPHC Standard Operating Procedure (SOP) was followed for summarising. Family members registering with the practice would already have had some level of scrutiny prior to arrival in Brunei as part of the pre-move checks however notes were also summarised on arrival. No paper copies of records were held at the practice as everything was transferred electronically. The reception team ran weekly searches to identify patients requiring summarising. The receptionist allocated four patients to the duty clinicians per day for summarising. The MOs summarised service personnel and the nurses summarised families. At the time of this inspection there was no backlog in summarisation.

All clinical staff undertook reviews of peer clinical notes. An appropriate notes review template was in use. Peer review for doctors' notes had taken place over the previous three years and was last conducted in February 2024. The main issue that this review illuminated was a lack of consistent Read coding. The SMO completed peer review of the CMT and ANP notes. The nursing team completed peer review of one another's' notes. Peer review was discussed as part of the nurses team meetings. PCRF notes were last audited in April 2024. The PCRF undertook joint patient assessments and these were recorded in clinical notes. The physiotherapist mentored the ERI on clinical assessment skills and the ERI also mentored the physiotherapist.

The medical team had considered the safest way to manage specimens and test results, given the lack of access to Pathlinks (The NHS Pathology network which facilitates access to patients' test results). All samples taken were documented in the sample workbook. Medical administration chased results as they were emailed back from the laboratory (they were not returned directly via Pathlinks). Administration updated the register when the results arrived back and each week completed a 100% check for results. Once the results were received, they were tasked to the duty doctor for review and update in DMICP and the patient informed accordingly.

Cytology samples were logged in the sample log, packed up and taken to the post room. The box was marked as 'Priority' and post room staff informed. The box was tracked and the laboratory in Wolverhampton emailed with the tracking details. The laboratory processed the sample and the results were emailed to the medical centre's dedicated inbox for cytology. Results letters were uploaded to DMICP and sent to the medical centre to give to the patient.

Local laboratories in Brunei could not support faecal immunochemical testing (FIT testing used for bowel cancer screening). Therefore, eligible patients were advised to have this screening done when they next returned to the UK.

There was a failsafe system in place to manage referrals. The AELO and referrals clerk managed the referrals process. A referrals tracker was held within SharePoint files. This system tracked both patients referred to Brunei and those returning to the UK for treatment. The referrals tracker was discussed at the weekly clinical meeting. A Hospital Liaison Officer was also employed within the practice.

On the day of this inspection, ERIs did not yet have DMICP access. We noted that the PCRF team had raised an ASER due to risk this had posed to a patient and this has been escalated to the Regional Clinical Director (RCD). As Commander DPHC has authorised access to records for ERIs, the team granted DMICP access to ERIs shortly after the inspection. ERIs were included in fortnightly rehab multi-disciplinary team meetings.

Steps had been taken by Defence Healthcare Recovery Group (DHRG), alongside the regional and local teams to secure access to mental health services. This included host nation *Child and Adolescent Mental Health Services* (CAMHS), acute psychiatry and private counselling options. If a patient needed to be kept safe using detention under the Mental Health Act (MHA), the law in Brunei could be applied (it mirrored the MHA in UK). There was a holding facility in Tuker Lines which could be used under the authority of the Royal Military Police or the local hospital had a facility to hold a detained patient. This arrangement had been assessed by the Department for Community Mental Health (DCMH) assurance team. Children could access the CAMHS service in Brunei (which employed a British trained consultant) on the same day of referral if required. A DCMH overseas team has been established back in the UK (a consultant psychiatrist, a community psychiatric nurse and a psychologist) for remote advice and guidance. 'Attend anywhere' was also in use to allow for consultations. Patients that could not be managed in country were repatriated to the UK.

Safe and appropriate use of medicines

The SMO was the lead for medicines management at the group practice. The pharmacy technician (PT) was aware that the management and working practices of the dispensary were delegated to them. The PT had signed terms of reference (TORs) which stated that the PT was responsible to the SMO through the practice manager to ensure the efficient running of the dispensary. The ToRs had been signed in April 2024. The student pharmacy technician also had their own ToRs which reflected their student status.

Patient Group Directions (PGD), which allow practice nurses to administer medicines in line with legislation, were in place and had been signed off. Nurses had completed training in using PGDs and administering vaccines and annual competency assessments were carried out. Medicines supplied under a PGD were recorded in DMICP. A PGD audit had recently been undertaken by the SPN. Three nurses used PGDs for immunisations and in rare cases the primary care treatment PGDs. Evidence was seen that the nurses were authorised to use the PGDs using the correct Annex E form. The Annex E for the rabies vaccine and the TBE vaccines had been updated with the new PGD editions. This evidenced an efficient process for updating authorisation of PGDs. The PGD audit was completed in March 2024 and the audit found compliance with the audit standards set by HQ DPHC. It was confirmed that the findings from the audit had been shared with the nursing team.

Patient Specific Directions (PSD) were also being used and we saw that details of medicines and patients being administered within a PSD had been maintained and staff competency was up to date. A doctor had assessed each patient to ensure that administration of medicine within a PSD was appropriate. A review of five PSDs found that all the relevant sections had been completed, however unused lines were not scored out on the PSDs in accordance with DPHC policy. There was unclear alteration of one patient on a PSD. This was highlighted on the day of the inspection and PSD training had been delivered within 5 days of the inspection to include the use of the updated March 2024 PSD.

A process was in place for the management of information about changes to a patient's medicines received from other services. The medical centre had a hospital discharge medication review local working practice which documented a clear process for the management of information about changes to a patient's medication by secondary care. This had been reviewed in November 2023. Incoming correspondence, such as from out-of-hours services, hospital discharge letters and out-patient clinics was scanned and then tasked to doctors. This system had been audited.

Prescription only medicines were dispensed by the nursing team in extremis on a Friday afternoon and OOH at the weekend. Nurses confirmed they had attended a two-day training schedule with the pharmacy technician before having authority to dispense medicines OOH. There was an authorised list for access to dispensary which was last updated in April 2024 and this restricted access to all doctors, nurses and the pharmacy technicians. Twelve prescriptions were dispensed OOH during April 2024. The pharmacy technician regularly conducted medicines management training to the nurses during their Tuesday training time.

All blank prescriptions were stored safely. There was a logbook for receiving new blank prescriptions. When doctors took blank prescriptions they recorded the serial numbers.

A process for the safe processing of repeat prescriptions was in place. Where appropriate, medication reviews were taking place and were Read coded. Prescriptions were authorised by doctors.

Uncollected prescriptions were checked monthly and a note was made on the patient's record and the medicine destroyed including the prescription serial number. The prescriber was alerted if the medicine was high risk.

Controlled and Accountable medicines (CDs) were kept in the dispensary in a CD cabinet. The CD cabinet was not compliant with the Misuse of Drugs (safe custody) regulations 1973. Whilst the medical facility does not sit within the wire, the team did not consider the risk of illegal access to be high. The dispensary had a CD key safe log and a key safe to keep the keys in the dispensary. The CD keys were kept separate from the dispensary keys. There was a CD access SOP if the CD cupboard needed to be accessed OOH. Internal monthly and external quarterly checks were being completed in line with the policy. Evidence was seen that the annual CD audit had been completed and documented 100% compliance with the audit standards. The annual self-declaration had been completed and the Notice of Delegated Authority had been

completed. A review of the recent destruction certificate confirmed that accountable and controlled drugs were being destroyed in accordance with national guidelines. Formal recording processes were being followed for the holding of fentanyl, diazepam and morphine which were kept in a locked cabinet in the crash room.

Well defined processes were in place for the ordering and receipt of vaccines. All vaccines were in date and evidence was seen that the vaccines were being correctly rotated in the fridge. There was sufficient space around the vaccine packages for air to circulate. No food or specimens were held in the pharmacy fridges. The pharmaceutical fridges were monitored twice daily and the external thermometers were in date. There were no data loggers in the fridge as they had been sent back to the UK for calibration. A stock check of 5 different vaccines found stock levels to be correct on DMICP.

The SMO was the lead for high risk medicines. A High Risk Medicines (HRM) register was in place as a tool to support the safe management of patients prescribed HRM. Some HRM searches were run monthly with one run on the 19 April 24. The set of searches were very small and only included valproate, mesalazine, hydroxychloroquine, carbimazole, anticoagulants, carbamazepine, and lithium. Another high risk medicine search was present on DMICP which included other high risk medicines such as methotrexate and azathioprine, however this had not been run since February 2024 (these should be done on a monthly basis). There was a reliance placed on the regional pharmacist screening patients prescribed HRM in advance of posting to Brunei as part of the Global Medical screening process for family members. If a patient was prescribed a HRM and authorised to be posted to Brunei, the regional pharmacist would document this in the DMICP record and inform the SMO to add the patient to the HRM register and the pharmacy technician was requested to order the medicines in advance of the patient arriving. Through discussion with the MF staff, they felt this was a robust system for managing patients prescribed high risk medicines. From notes we reviewed, we confirmed that appropriate and timely blood monitoring had been undertaken for patients prescribed HRM and that those that needed a review had been booked in with the SMO to discuss the results/further action. The DMICP records had been coded in accordance with the policy around specialist medicines.

The medical centre kept a comprehensive log of all locally purchased medicines. Evidence was seen that consent was received from the patient before the medicine was locally purchased. Evidence was seen that appropriate documentation was being completed for the authorisation and supply of unlicensed medicines, although not all fields within the form were being completed.

An audit on antimicrobial prescribing had been undertaken within the last 12 months. The UK formulary was used rather than local formulary. The audit showed that compliance was 100% for prescribing an appropriate antibiotic for an appropriate duration. However, there was scope to extend the advice given to patients including Treating Your Infection – Respiratory Tract infection (TARGET) information.

Track record on safety

There was a risk register, retired risk register, issues log and retired issues log on the healthcare governance workbook. All risks included detail of the 4T's (treat, tolerate, transfer or terminate) and had a review date. The short risk descriptions were clear, but in the absence of an accompanying MOD Form 5010 would benefit from breaking down into cause; effect; consequence to assist with more accurate risk scoring. The team had rated a high number of risks as either red or amber and the inspection team felt that there was scope to better adhere to the impact and likelihood scores defined in Defence policy in order to achieve better consistency across the MOD. The PM was due to undertake the Defence PM course. We saw that some risks had been appropriately transferred to Regional Headquarters and DPHC HQ, including the priority risk around safe and timely supply of medicines and vaccines.

There was no fixed alarm system within the medical centre. Each clinical room had a handheld alarm which allowed staff to summon assistance in an emergency. Staff assessed their own alarms weekly and recorded that they were operational.

Lone working was not supported in the medical centre nor the PCRF. Patients and staff were not permitted to train alone in the gym. If a staff member needed to work in the facility OOH, a medic would join them to mitigate lone working.

Lessons learned and improvements made

Significant events and incidents were reported through the electronic organisational-wide system (referred to as ASER) in line with the DPHC ASER policy. A local ASER SOP was in place. All staff had an ASER login. Our interviews with staff across the whole team and our review of the ASERs raised and investigated to date, indicated that there was a particularly positive culture whereby staff were encouraged to report concerns. ASERs were routinely discussed at the practice meetings and identified in the minutes. It was clear from our discussions with staff that lessons learned were shared with the team. We noted that two purple (best practice) ASERs had also been submitted.

The pharmacy technician had access to the ASER system and they could log in and record an ASER. All recent ASERs recently submitted by the pharmacy team were related to the medicine supply chain. We noted through our review of ASERS, the significant supply chain problems that the dispensary and wider medical team experienced. We noted supply problems with vaccines and controlled drugs. Morphine, diazepam and fentanyl were delivered with no temperature recordings due to human error. These medicines had to be destroyed. We noted a concern relating to inactivated influenza (flu) vaccine (Fluad) being delivered to Brunei MF by mistake instead of Quadrivalent Influenza Vaccine (QIVe). This meant that patients had to wait until the correct vaccine arrived.

Evidence was seen of effective processes for the management and action of Medicines and Healthcare products Regulatory Agency (MHRA) and National Patient Safety alerts. Evidence was seen of an in-date electronic MHRA alert register and that the practice had a system in place to ensure that they are receiving, disseminating, and actioning all alerts and information relevant to the practice. The register documented what action (if required) had been taken. Discussion took place at morning and practice meetings and was recorded in minutes. There was evidence that the search on DMICP to identify any patients prescribed sodium valproate was being run monthly and pharmacy technicians were aware of the recent changes to full pack dispensing for valproate. The CAS (Central Alerting System) alert log was held on health governance workbook including detail of action taken. Alerts were also discussed at the practice meeting as a standing agenda item.

Are services effective?

We rated the practice as good for providing effective services.

Effective needs assessment, care and treatment

Processes were in place to support clinical staff to keep up to date with developments in clinical care including National Institute for Health and Care Excellence (NICE) guidance, clinical pathways, current legislation, standards and other practice guidance. Secondary care pathways used in Brunei sometimes fall outside British national guidance. We discussed examples: The scanning schedule for antenatal patients is different in Brunei. The Midwives therefore organised scans privately for patients. Similarly, blood tests were undertaken following the UK system. Defence Consultant Advisor (DCA) Obstetrics and Gynaecology was available for advice and guidance. Ankle injuries which are suspected fractures followed a different care pathway in Brunei with a backslab, demobilisation and surgery as more likely outcomes. Patients were therefore given Aircast boots to take to hospital with them and advice was sought from DCA Trauma and Orthopaedics via PANDO (a secure communication solutions for healthcare teams to collaborate) to gain advice regarding any proposed operation.

Practice meetings were held every month in order to discuss practice issues. Clinical meetings were held weekly (with the Kathmandu Medical Team joining every fortnight) where NICE and Scottish Intercollegiate Guidelines Network (SIGN) updates were discussed. Records of these meetings were seen with evidence clearly visible of all updates contained within meeting minutes. Clinical meeting records were maintained on the healthcare governance workbook. A primary care team meeting took place each month and all clinicians, midwives and health visitors attended. The nurses attended monthly meetings with the Regional Nursing Advisor and DPHC provided quarterly practice nurse and IPC Forums.

PCRF staff were familiar with Department of Defence Rehabilitation Guidance and provided examples of treatment provided based on evidence-based guidelines and care pathways. Rehab Guru (software for rehabilitation exercise therapy) was used.

Monitoring care and treatment

An MO held the lead role for chronic disease management along with the SPN. They were supported by the nursing team who ensured that patients with chronic disease were appropriately monitored. The MO and SPN had time set aside each week to review the chronic disease register and patients together. The nursing team had been allocated key chronic disease areas (overseen by the SPN) and they ran the DMICP

searches to identify patients, update the register and ensure patients were re-called for review. The administrative team were tasked to book patients in.

The DPHC Chronic Disease SOP was followed and the practice register referenced NICE/ SIGN guidelines. Consultations were Read coded and there was a clear structure for monitoring and recall in the consultations reviewed. Diary dates were utilised. The practice used a 'synonym' for patients with a long-term condition which the nurse had developed including monitoring bloods and investigations to standardise processes. Once the investigations were complete and the results were back, the patient was booked in with a GP for medication review.

There were 22 patients recorded as having high blood pressure. All 22 patients had a record for their blood pressure taken in the past 12 months. Ten patients had a blood pressure reading of 150/90 or less.

There were 11 patients on the diabetic register. For 6 patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For 9 patients, the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.

All eligible individuals were invited for an over 40s NHS Health Check. These patients were then recalled every 5 years for normal results. Patients identified with raised HBA1C were informed and plans made with the patient.

Patients with gestational diabetes or pre-diabetes were identified during new patient checks and the lead nurse notified to invite the patient for review. The lead nurse ran DMICP searches on a three monthly basis to identify patients who had been missed.

Individuals over 25 or 40 years old (depending on their ethnicity) were assessed using the PCMF Type 2 Diabetes Risk Assessment Tool during the new patient check. Depending on the outcome of the assessment, the patient was offered further investigations.

Individuals with suspected diabetes symptoms were offered testing promptly. Hypertensive patients were routinely tested for Diabetes as part of their annual review. All patients identified with pre-diabetes and gestational diabetes were added into the Chronic Disease Register and invited for annual review.

There were 16 patients with a diagnosis of asthma. All 16 patients had an asthma review in the preceding 12 months which included an assessment of asthma control using the three RCP (Royal College of Physicians) questions. An asthma SOP was followed by clinicians and a consistent asthma review template was in use.

Ninety-three percent of patients' audiometric assessments were in date (within the last two years).

Patients with mental health needs were supported in a number of ways:

- supportive management and prevention strategies as well as psychological intervention were offered to patients who could benefit from them.

- patients were able to access Headspace, an app which offers advice and guidance on mental wellbeing, tips on sleeping better and different exercises to improve mood. It also has articles to listen to including how to reduce worrying, improve focus and manage anxiety.

- We reviewed a cross section of notes for patients experiencing low level depression or anxiety and found that the clinical records were comprehensive and that patients were being actively managed and frequently reviewed.

- Patients needing urgent mental health support were able to access help 24/7 and an MO was always available to assess the patient and put an immediate safety plan into place. The DCMH overseas team were available using 'attend anywhere' to take referrals. Private counselling was available in Brunei. Patients could be flown home to access care as required.

The PCRF used the MSKHQ outcome measure (a short questionnaire that allows people with musculoskeletal conditions - such as arthritis or back pain - to report their symptoms and quality of life in a standardised way) to assist with evaluation of patients on admission. However, as is the case across DPHC, there was scope to collate more outcomes information when patients were discharged.

Patients with ACL injuries were given advice on longevity of injury. Staff also spoke with chain of command to advise of likely timeframes enabling a better cohesive approach to occupational management during recovery from ACL injury. In order to best meet the needs and preferences of patients, the PCRF provided intensive a two week rehabilitation courses. This was for patients whose condition necessitates a period of intensive daily rehabilitation.

The practice had a clear audit programme which was embedded into the healthcare governance agenda with audit presentations each month. Peer review was part of the audit programme. The PCRF team had conducted an acupuncture audit (100% compliance). To ensure referral pathway best practice guidelines were being followed, patients with lower back pain had been audited against the NICE best practice guidelines and 52% of patients had received advice. A hormone replacement therapy (HRT) audit has been conducted to ensure that clinicians were following NICE guidelines and that patients were being reviewed. Audits had been conducted around terbinafine and gout (as these are relevant to the practice population)

Effective staffing

The medical centre used the DPHC Overseas induction pack which has cadre specific elements, alongside some Brunei specific information. There was also a clinical

induction process and a nurse specific induction alongside a PCRF pack. There was also an induction for exercising medical personnel who utilise the facility. Locally employed civilians (LECs working as contractors) had a specific induction pack covering all areas within the PCMF. The role specific induction for nurses focussed on immunisations (including baby immunisations) and triage/ out of hours. Training needs were identified during the induction phase and mandatory DPHC training completed but role specific training was driven by the individual members of staff. Nurses confirmed that they did not undertake any clinical tasks where they did not feel competent or confident to do so. Of note was a significant amount of documented positive feedback from the GP registrars and medical students who had worked at the practice when asked about the quality of their induction and for suggested areas of improvement. This demonstrated that the induction had been actively developed and internally validated.

Performance appraisals were managed by the SMO and ANP. The administrative team were managed by the PM and the SPN managed the nursing team. Peer review of consultations was in place across all cadres and the DPHC template was used to provide structure. Learning opportunities were identified.

Coordinating care and treatment

The medical centre team had forged effective links with all key stakeholders in relation to safeguarding including welfare staff, commanders and units, the padre, the pundiji, social work team, health visitors and midwives and we were told that a mutually supportive communication stream was in place. The close physical proximity of all the key teams was definitely beneficial for timely and proactive team work. We interviewed a welfare officer, a social worker, a health visitor and a midwife as part of our inspection. They confirmed that regular meetings took place with the aim of supporting personnel and that conversations were two way such that each party could raise concerns about vulnerable personnel.

A theme ran through the conversations held with key stakeholders, of medical centre staff willing to go beyond their daily responsibilities to maximise positive impact for the military community and the wider population. We spoke with a commanding officer who represented a unit registered with the medical centre and they were complimentary about many aspects of the care delivered by the medical team: notably the proactive approach taken by the medical team to support personnel who may be vulnerable, the benefits of the accessible and bespoke care delivered by the PCRF and the positive work to support patients with autism spectrum disorder (ASD) and the needs of the wider community. However he highlighted a concern with vaccine supply and the impact that this could have on the deployability of service personnel.

Pregnant ladies were referred by the nursing team to the midwifery team (employed by SSAFA) working in the medical centre and the patient would be routinely seen at the medical centre. Birth and pre/ post natal care was then organised by the midwife with

most ladies attending the local hospital for delivery. During the daily team meeting, any patients of concern were discussed. The proximity and established working practices between the medical and midwifery teams delivered joined up care for pregnant patients with referrals to MOs and physiotherapy directly accessible. Midwives and the medical team could directly access the secondary care records for any pregnant patients from the hospital system 'Brunei Information Management System' (BruHims). The midwifery team had made a request for a bilirubinometer to assist with the identification of jaundice in newborns (a particular concern for the registered patient population). They had also submitted a business case for training in support of mothers with premature rupture of membranes (PROM).

The health visiting team (employed by SSAFA) also worked in the medical centre building and provided specialist and targeted support and early help support packages for families. A number of Nepali health visitor assistants were employed and attended daily family visits to provide useful cultural context and to ensure that young mothers' holistic needs were understood and met. We spoke with a patient who used the medical centre and the health visiting service and she confirmed how streamlined the service was as she was able to access advice, medicines and support for herself and her baby all in one place and at one time.

Medical Officers could directly refer patients to orthopaedics in the UK or Brunei. Elective orthopaedic appointments were usually requested in the UK. A reach back service to RRU Aldershot was established along with contacts with NHS hospitals in Birmingham and Frimley. Initial orthopaedic appointments could be undertaken by 'Attend Anywhere' with the patient's consent.

Patients were referred to the multi-disciplinary injury assessment clinic when required and the current wait was 16 working days for remote consultation. If patients required referral to the UK, the PCRF continued to support patients with remote check-ins. In addition, any patients based in UK for orthopaedic treatment were added to physio-doc discussion list.

The practice had close links with secondary care locally and in the UK. The administration team needed to request hospital discharge letters as DMICP is not connected to secondary care systems.

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

Helping patients to live healthier lives

A nurse was the health promotion lead within the practice. The most recent health fair was in April 2024 and was organised by the Unit Medics. The medical centre (nursing team, physiotherapy, environmental health technician) were included along with the physical training instructors and chefs.

The practice followed a 12 month calendar which was normally planned as a team in November for the following year. This followed the NHS and DPHC health promotion calendars but also focussed on country specific issues. The health promotion calendar had a co-ordinated approach, noticeboards in the medical centre were allocated to members of the team and updated regularly, the TV presentation in reception was changed to reflect the health promotion topic for each month and also included the dental centre. Sections of this presentation were also shared via the HIVE (an information and welfare referral service to the Armed Services community), unit signal groups, Brunei Garrison HIVE Blogspot and other printed media on camp. Posters were produced and shared across camp particularly to the accommodation blocks.

A recent Womens' Health Day was well attended and covered cervical screening and family planning plus sessions by the health visitor and midwifery teams.

We saw a number of health promotion boards in the waiting area and corridors and these included information around sexual health, hydration, smoking cessation, the symptoms of sepsis, family planning and climate injury.

The SPN was the sexual health lead. Three nurses were able to offer asymptomatic sexual health screening and GPs and the APN would refer patients to the hospital for treatment. An audit conducted in 2022 had identified a gap in sexual health skills across the team and so a bid had been submitted for the SPN to attend the sexually transmitted infections foundation (STIF) course. The APN had completed the Level 1 STIF course and the SPN had completed Level 2. The Advanced Nurse Practitioner could prescribe treatment, the SPN was currently prescribing treatment when required under PGD and referred to the MO if any other medication was required. The team had close links with the Military Sexual Health Nurses in the UK and cases were discussed via the PANDO system.

In the past, patients had voiced concerns about Command being informed should they test positive for a sexually transferred infection. Consequently, the medical team had offered education and orientation for the patients re-enforcing confidentiality and awareness. At a recent briefing, the Medical Sargeant (who is bi-lingual) delivered sessions to promote the service and its accessibility and expelling some of the myths and taboos associated with the screening.

The medical team were aware that some patients might travel to Malaysia and also to Thailand and that contact with sex workers might result. Information about safe sex

was available in the medical centre and briefings were delivered to personnel before they deployed on larger exercises or deployments. Free condoms were available at the practice and the SPN had an ‘advent calendar’ of condoms in her treatment room. Sexual Health was a standard agenda item for the TV presentation in reception. Information about sexual health, contraception and pregnancy was displayed in the patient waiting area.

Health Screening

Health screening was proactively encouraged by the medical centre. Regular searches were undertaken for breast (13 patients identified) and abdominal aortic aneurysm screening (one patient identified) in line with national programmes. Eighty-four percent of women who were eligible for a cervical smear had received one in the last five years which exceeded the NHS target of 80%. Local laboratories in Brunei cannot support faecal immunochemical testing (FIT testing used for bowel cancer screening) and so patients were informed and encouraged to have this completed when they were back in the UK.

In line with best practice guidance, all patients over 40 years of age were invited for a health check. At the time of this inspection, 163 patients were eligible, 163 had been invited and 123 (76%) had attended.

Immunisations

Immunisations were regularly reviewed and administered to patients when they were required. Vaccination rates for military personnel were high, whilst vaccination rates were lower for civilian patients:

92 (mil) 81 (civ) % of patients were in-date for vaccination against diphtheria.

92 (mil) 81 (civ) % of patients were in-date for vaccination against polio.

100 (mil) 81 (civ) % of patients were in-date for vaccination against hepatitis B.

99 (mil) 81 (civ) % of patients were in-date for vaccination against hepatitis A.

92 (mil) 81 (civ) % of patients were in-date for vaccination against tetanus.

92 (mil) 76 (civ) % of patients were in-date for vaccination against MMR.

98 (mil) 81 (civ) % of patients were in-date for vaccination against meningitis ACWY

Childhood Immunisations

The UK immunisation schedule was followed for children and updated in the red book (now e-red book). On arrival and during the new patient check, the nurse reviewed immunisations and advised the patient / parent if any immunisations were required and how to access them. Baby Immunisations were tracked by the health visitors and they liaised with the family and medical centre, if the family do not attend, the health visitor is informed so that the family can be supported. The team were aware that World Health Organisation targets had been narrowly missed for the child immunisations listed below. However a number of children had recently registered with the practice and were due vaccines as a result of lack of supply in previous locations or because children were reaching the age related landmarks for eligibility. The practice was working with the health visitors to plan a catch-up programme; however this was very dependent on the safe delivery of vaccines, which was a widely accepted barrier:

- The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e., three doses of DTaP/IPV/Hib/Hepatitis B) was 94% (the World Health Organisation target is 95%).
- The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e., received Pneumococcal booster) (PCV booster) was 89% (the World Health Organisation target is 95%).
- The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e., received Hib/MenC booster) was 89% (the World Health Organisation target is 95%).
- The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) was 89% (the World Health Organisation target is 95%).
- The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) was 84% (the World Health Organisation target is 95%).

Travel Vaccinations

As living in Brunei brings risk of exposure to additional diseases, the medical team follow guidance issued by the Defence Public Health Unit around vaccination.

In addition, the Green Book publicised on the National Travel Heath Network and Centre (NaTHNaC) website confirms which additional vaccinations are recommended.

Royal Gurkha Rifles (Travel Vaccinations specific to Brunei):

- 99% of eligible patients had received one dose of the rabies vaccine
- 88% of eligible patients had received two doses of the rabies vaccine
- 85% of eligible patients had received three doses of the rabies vaccine
- 98% of eligible patients were fully vaccinated for Japanese encephalitis
- 100% of eligible patients were fully vaccinated for TB
- 79% of eligible patients were fully vaccinated for Typhoid

Vaccination rates for the Royal Gurkha Rifles were high although there is scope to increase coverage for typhoid Greenbook Chapter 33 typhoid and to ensure that all eligible patients have received three doses of the rabies vaccine Green Book Chapter 27 Rabies.

Civilians and families (Travel Vaccinations specific to Brunei):

- 6% of eligible patients had received one dose of the rabies vaccine
- 4% of eligible patients had received two doses of the rabies vaccine
- 21% of eligible patients had received three doses of the rabies vaccine
- 59% of eligible patients were fully vaccinated for Japanese encephalitis
- 99% of eligible patients were fully vaccinated for TB
- 39% of eligible patients were fully vaccinated for Typhoid

Vaccination rates for civilians, including families were particularly low for rabies and typhoid. The Green Book is clear that typhoid vaccination is recommended for most travellers (particularly young children). Patients should also be risk assessed for rabies (children are at increased risk as they are less likely to avoid contact with animals). We discussed this with the medical team and they explained that patients were advised to arrange vaccinations in the UK as part of their posting recommendation. However, some patients found that they were unable to access vaccinations in the UK (there is currently a shortage of both rabies and JE vaccines) and some patients chose not to be vaccinated. We also discussed some issues around the logistical supply chain for vaccines to reach Brunei:

- supply of vaccines with low expiry by Team Leidos
- transport delays at Donnington
- transport delays at Brize Norton

- failed assurance around the cold chain in transit resulting in destruction of vaccines

We spoke with 16 patients on the inspection day and read 18 comments cards that patients had filled out. Four patients raised a concern that they were due to receive a vaccination, but that they had been unable to secure this from the medical centre due to supply issues.

Consent to care and treatment

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. They had a good understanding of the Mental Capacity Act (2005) and how it would apply to the patient population. Mental capacity training was incorporated into the safeguarding training. Staff understood the principals of Gillick competence and how these applied in practice. Where minors were treated, arrangements were in place to involve parents or guardians or representatives where the patient consented to their involvement.

Consent was appropriately recorded in the clinical records we looked at for physiotherapists, nurses, mental health staff and doctors. The offer and use of a chaperone was recorded in patient records. A consent audit was undertaken using the DPHC audit tool and had re-enforced the requirement to record consent correctly.

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

We interviewed 16 patients as part of the inspection and feedback indicated staff treated patients with kindness, respect and compassion at all times. Eighteen patients had completed comments cards and all confirmed that they were treated well.

We reviewed the records for a number of patients who were experiencing poor mental health. Clinicians were responding to patients with kindness and compassion, ensuring that patients had the space and time to talk when they needed to. We also noted several instances where staff went the extra mile to support patients in difficult circumstances, including support with NHS secondary care assessments, support for patients experiencing mental health crisis and ensuring that patients with possible ASD could access diagnosis and support.

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

Ten registered patients responded to a patient satisfaction survey sent out by the medical centre team. Nine patients who responded to a question about whether staff had treated them with compassion and kindness said that their experience was excellent or good. One person said that their experience was very poor. Similarly, nine respondents stated that they felt that they had been treated with dignity and respect, whilst one person said that they had not. We noted that the person who had reported their negative experience had also scored the medical centre 5 out of 5 for their overall experience which appeared to contradict some of their other comments.

Involvement in decisions about care and treatment

All 16 patients we spoke with said they were involved with decision making and planning their care. Clinicians had provided comprehensive information to help support their decision making.

Of the 10 patients who responded to the patient satisfaction survey, 9 stated that they had been provided with clear information. One patient stated that they had not.

Where patients were on an injury recovery or maintenance pathway with the PCRF, direct communication took place between the unit physical trainer and PCRF staff, including set goals.

Patients with a caring responsibility were identified through the new patient registration process and a clinical code assigned to their records. Twenty-one patients were recorded as having a caring responsibility and we noted that all had been offered a flu vaccine and a health check, that they were offered a 30 minute appointment with the same GP where possible.

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

Privacy and dignity

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

Patients were able to see clinicians of either gender according to their preference.

Are services responsive to people's needs?

We rated the practice as outstanding for providing responsive services.

Responding to and meeting people's needs

There was a HIVE network available on site and personnel were further supported by civilian welfare officers. There was also a HIVE signal group which disseminated information across the Garrison.

The Brunei medical building was previously a hospital with wards and this had been re-purposed to create a medical centre. An Equality Access Audit had been undertaken and included the PCRF. As a result, a hearing induction loop had been fitted, two disabled parking spaces had been allocated in the care park and railings and ramps had been fitted to enable better access for all. The length of the pull cord in the accessible toilet has also been addressed.

All staff have completed Diversity & Inclusion training which included unconscious bias. The pharmacy technician was the lead D&I representative alongside Garrison staff. Their details were displayed on the posters and pictures displayed within the medical centre.

The nursing team ran structured clinics for: new patients, over 40s, immunisations, and cytology. In addition a nurse was allocated to the triage and treatment room (bloods/ wound care/ travel health/ smoking cessation) but flexibility was incorporated to accommodate school children and teaching staff around school hours.

A purple ASER had been raised around the following work:

"Championing Neurodiversity Across British Forces Brunei" The Primary Care Medical Facility (PCMF), British Forces Brunei (BFB) coordinated a Professionals Seminar on the 28th of February 2024 at the Chit Chat Community Centre in the Garrison. An expert team from the UK's Oxford University Hospital NHS Foundation Trust consisting of Consultant Paediatricians, a Speech and Language Specialist and a Clinical Psychologist led the multi-professional seminar. The central tenet of the session was understanding autism with further exploration into mechanisms to support autistic children in accessing healthcare and education. The seminar was attended by numerous agencies from across Brunei including the Ministry of Health, Hornbill School, Jerudong International School, International School Brunei, Royal Brunei Armed Forces, Smarter Brunei, SSAFA, British Forces Social Work Service and Panaga Health. This wide attendance of approximately 170 professionals enabled expert knowledge exchange and strategies to tackle community stigma towards autism. Throughout the event, the PCMF Seria chose to support Smarter Brunei, a family support organization run by parents and family members exclusively for autism from childhood to old age in a seamless journey towards interdependence. This included a charity bake sale and the gifting of useful educational items. During the Seminar, the PCMF promoted

Neurodiversity Celebration Week which runs from 18th – 24th March 2024. This is a global campaign that aims to transform how neurodivergent individuals are perceived and supported.

The medical team had worked in partnership with Chain of Command, the schools on base and health visitors and other partners to identify a need for a group of patients who would benefit from assessment for autism spectrum disorder (ASD), speech and language support and occupational health support. The Oxford University Hospitals NHS Foundation Trust Multidisciplinary Assessment (MDA) Team had spent a week at Brunei Medical Centre conducting assessments for a cohort of 13 patients, resulting in 12 diagnoses of ASD. The Defence Children's Service were providing speech and language support, Special Educational Needs Coordinator (SENCO) support had been made available in the school on base and health visitors were being trained to provide play therapy for families. A neurodiversity group 'Brighter Beginnings, Brighter Futures' had been set up to support patients and their families.

In order to best meet the needs and preferences of patients, the PCRF provided intensive two week rehabilitation courses (run several times a year). This was for patients whose condition necessitates a period of intensive daily rehabilitation and was similar in nature to the rehabilitation course run by regional rehabilitation units. Patients confirmed that they preferred to undertake locally rehabilitation, rather than leaving their families in order to travel to the UK. The approach had been evaluated and patient feedback seen which was 100% 'good' or 'very good' and comments included the benefit of not having to leave family, and the aspiration for more Brunei-delivered PCRF courses. We spoke with chain of command as part of this inspection and they re-iterated these benefits.

An ACL workshop (injury prevention) was run by the ERI which constituted an education session delivered to service personnel who (through their role/activities) may be at higher risk of knee injury.

The PCRF ran an air crew conditioning programme and also produced an injury management guide for use by all healthcare practitioners (containing patient information leaflets). This was developed by PCRF staff to support other med centre healthcare practitioners.

Patient feedback was driving improvement. School teaching staff were struggling to attend appointments due to the opening times of the medical centre and their working hours – the medical centre had annotated teaching staff records to enable some flexibility with appointments. There was a comprehensive patient participation activity log which outlined all activity resulting from patient feedback. This was discussed as a collective at practice and HcG meetings. In March a parent forum took place for parents of newly diagnosed autistic children to meet others and to discuss experiences, including accessing to health care provided. Parents gave positive feedback.

The team had sought out ways to support the cultural, emotional and holistic needs of all patients. For example, initiatives to support Nepali patients included the services of Nepali assistant health visitors who understood local customs and traditions around

childbirth. The team worked with the pundiji (a Nepali leader who provides spiritual and cultural support where it is needed). The pundiji provided welfare support to personnel and families alike and had been in post for nine years, so had a comprehensive oversight of needs of the patient population. He confirmed that access to care at the medical centre was good and that patients benefitted from compassionate care. He raised two issues for the team to consider:

The need for a professional face to face Nepali interpreter to avoid misunderstanding of medical terms and to prevent what he described as the 'no, no, yes, yes' culture in which Nepali patients might feel obliged to agree without actually understanding. He pointed out that some patients felt uncomfortable having medical centre staff (who they lived with on camp) providing translation for their private healthcare appointments. He also felt that professional face to face interpretation would be more effective than telephone translation.

Pundiji explained that in Gurkha culture, mental illness is a taboo subject, there being no Nepali word for 'depression'. A reluctance to discuss emotional needs, coupled with fear of downgrade can mean that some patients struggle on and their mental health can deteriorate quickly. Pundiji suggested that psychological counselling and awareness sessions, delivered by a professional Nepali speaker in person (and not by video) might be a good way to start to engage people in being more open about their mental health.

We discussed the pundiji's thoughts with the medical centre team who confirmed that they would discuss them further with a view to seeing what was in the scope of the possible.

Timely access to care and treatment

The medical centre was providing very responsive care for its patient population. Urgent and routine appointments with either a doctor or a nurse or physiotherapist could be accommodated on the same day if required. The patients we spoke with during the inspection confirmed they received an appointment promptly and at their preferred time.

Seven patients responded to questions around access within the patient satisfaction survey. All seven stated that they had been able to access healthcare easily.

Patients requiring occupational medicals could access one very quickly. If there was an urgent need for a quicker medical turnaround, these could be turned around on the same day. Appropriately qualified doctors were available to provide diving and aviation medicals.

Arrangements were in place in order that patients could access a clinician at all times when the practice was closed and in an emergency. An out of hours "watch bill" was in place and required a nurse, a medic and a doctor to be on call for primary health care issues through the night, weekends and over bank holidays.

Telephone and e-consultations were available and doctors, nurses and physiotherapists used them. Midwives and health visitors conducted home visits to serving families within the Garrison.

Patients could see a nurse on the same day for triage and could secure an appointment in the treatment room within one working day. Appointments for vaccinations could be accommodated within 3-4 weeks due to supply issues.

Rapid access to PCRF support was available with patients being seen well within the key performance indicators. Non-attendance of appointments was not an issue at the time of our inspection. A routine physiotherapy appointment was available within three days, a follow-up appointment within three days and an urgent appointment facilitated on the same day. For the ERI, a new patient appointment was available within two days and follow up appointment could be accommodated within two days. Access to rehabilitation classes was withing two days.

In response to feedback from 230 Squadron, the medical team had created a medical administration role to act as a link with 230 Sqn. This streamlined planning of aviation medicals to ensure that appointments were grouped.

We spoke with 16 patients and read 18 comments cards completed by patients. All confirmed that they could access a timely appointment at a time that was convenient to them. Two patients commented that their working schedule had been considered and that they were offered appointments outside their working hours. Patients confirmed that they could secure a telephone consultation if that suited their needs.

Listening and learning from concerns and complaints

The practice manager was the lead for complaints and SMO deputised, terms of reference reflected this arrangement. Three complaints had been received in the last 12 months. A comprehensive log was in place with RAG (red, amber, green) ratings to annotate timely progression through the complaints process. No trends had been noted, but learning had been discussed at a practice meeting.

Patients were made aware of the complaints process through the practice information leaflet and a poster in the waiting room. There was also a complaint reporting form available at reception for patients to complete. The complaints SOP was reviewed in Mar 2024. Patients we interviewed were aware of how to complain but said they had no reason to make a complaint about the service.

Are services well-led?

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

Leadership, capacity and capability

The staff team at Brunei Medical Centre delivered high quality care which provided continuity of service for patients and staff alike. All staff we spoke with described a driven and able leadership team with an SMO at the helm who demonstrated an open leadership style designed to deliver results. Throughout the inspection we noted the embedded nature of the healthcare governance arrangements and a consistency in leadership that led to ongoing improvement across the service. Staff owned detailed terms of reference for their main role and separate terms of reference for any key lead roles that they undertook. The intimate and aligned working relationships with key stakeholders delivered dividends for vulnerable patients, service personnel, children and families alike.

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

The team had well established links with the regional team who provided input when required.

Vision and strategy

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

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

The team also worked to their own mission statement: 'to promote, encourage and support the provision of a patient-friendly, evidence-based primary care service and create an environment that supports healthy lifestyles and stimulates growth and education for its staff.'

The team had also agreed three key objectives:

Community Outreach

1. Enhancement of primary prevention activity. To include smoking cessation and sexual-health outreach and reduction of sedentary lifestyle across British Forces Brunei (BFB).
2. Health Education upskilling projects in the BFB community through workshops, radio broadcasts and evidence-based messaging.
3. Increased engagement and integration with Bruneian Healthcare Services in areas such as Major Incident Training and Clinical Training Placements.

Sustainability

1. Capturing all staff members' knowledge and experience of policy and process to increase resilience and sustainability during staff turnover.
2. ‘Green Focus’. Considering the environmental impact of practice processes – with a focus on reduction in printing, sustainable prescribing, and energy-use behaviours.
3. Ensuring continued physical and mental wellbeing of all staff through team cohesion activities centred around our Active Practice Charter commitment.

Innovation

1. Provide an environment for new ideas to be recognised, supported, and trialled.
2. 'Thinking outside the box' for novel solutions to known issues and risks.
3. Utilisation of the Quality Improvement Process for capturing innovation, but not as a barrier to making positive change.

The medical centre had forged close links with the units it supported and tailored the service to their specific needs to support exercises and deployments. Duty doctors, nurses and medics were routinely on hand to facilitate urgent access to care.

The team strove to deliver a preventative approach which involved proactive health promotion support, lifestyle advice and prompt barrier-less access to mental health provision. Care was delivered to patients through an integrated multi-disciplinary approach which encompassed physiotherapy, rehabilitation, welfare, midwifery and health visitors. With the patient truly at the centre of this shared care approach, the benefits and positive outcomes for patients were not accidental.

Culture

Staff we spoke with described a strong team ethic with patients’ individual requirements held at the centre of all decision making. Staff enjoyed working together and invested their recreational time in team celebrations and this had led to a strong team ethos, We observed staff going the extra mile to provide a comprehensive service to their patients, often accommodating short notice requests to meet occupational health requirements

for personnel, affording additional time to support carers and maintaining a 24/7 OOH primary care service for all registered patients, of particular value to those finding themselves in crisis.

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

We spoke with most of the medical centre staff during the inspection day and all were overwhelmingly positive, enjoyed coming to work and felt that they could influence change if they needed to. A junior staff member remarked upon the learning culture across the team and added, ‘My screw is good’ (my relationship with my line manager is positive).

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

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

Processes were established to ensure compliance with the requirements of the duty of candour, including giving those affected reasonable support, information and a verbal and written apology. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. We were given examples of when duty of candour had been applied appropriately and noted that they had been discussed in the healthcare governance meetings.

Governance arrangements

The healthcare governance workbook (HGW) was the overarching system used to bring together a range of governance activities, including the risk register, ASER tracker, training register, SOPs, complaints, training, meetings, Caldicott & Duty of Candour. The approach taken in One Note was particularly clear and precise and all staff demonstrated that they could find relevant policies and information with ease. Over 76 local working practices (LWP) were in place, all had been reviewed and covered the key requirements for the Practice

An appropriate meeting structure and embedded healthcare governance approach was in place. This included regular clinical, practice, healthcare governance and unit healthcare committee meetings, chronic disease, safeguarding, PCRF meetings and audit discussion. The PCRF was operating as a fully integrated part of the medical centre team.

A comprehensive quality improvement programme was in place and covered an extensive range of administrative, clinical and managerial topics, including the DPHC mandated audits around IPC, waste and equitable access. The programme was ongoing and involved an ongoing cycle of audit work. Much of this work was leading to demonstrably improved outcomes for patients.

A clear culture of governance exists amongst all PCRF staff and we noted positive examples of conduit of this information via OneNote. A continuous and iterative programme of quality improvement was embedded within the PCRF and the rehabilitation courses were delivering direct benefits for patients.

Managing risks, issues and performance

There was a current and retired risk register on the HGW along with current and retired issues. The register articulated the main risks identified by the practice team. All risks included detail of the four T's: 'treat, tolerate, transfer or terminate' and had a review date. We saw that some risks had been transferred to Regional Headquarters and Brunei Garrison. We noted that the residual scoring was high across the register and we suggested that the team re-consider the way that they scored their risks going forward.

There were a range of risk assessments in place including both clinical and non-clinical risks. The assessments included lone working, sharps safety and health and safety and COSHH risk assessments. There were processes were in place to monitor national and local safety alerts, incidents, and complaints.

The Business Continuity Plan (BCP) and resilience plan had been reviewed and was exercised to ensure that staff knew what to do in an emergency. The BCP covered all the main risks to the service and included all three sites. The practice had a major incident plan which supported all units and had been agreed by unit commanders. Paper copies of both plans were held.

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

Appropriate and accurate information

The team had developed a local One Note document that incorporated the HcG Workbook and made the navigation for staff and DPHC Overseas effortless. This was clear during the inspection with documentation and meeting minutes very easy to find. The ANP actively updated the practice on all HGAV points during HcG and practice meetings with open discussion and clear direction to all governance leads.

Systems were in place that took account of data security standards to ensure the integrity and confidentiality of patient identifiable data, records and data management.

Engagement with patients, the public, staff and external partners

The team had produced a patient survey via QR Code and to date over 60 responses had been received. There was a comprehensive patient participation activity log which outlined all activity resulting from patient feedback. This was discussed as a collective at practice and HcG meetings.

Changes had been made as a result of patient feedback and included:

- annotated teaching staff records to enable some flexibility with appointments
- appointments to accommodate school children
- In March a parent forum took place for parents of newly diagnosed Autistic Children to meet others and to discuss experiences, including accessing to health care provided. Parents gave positive feedback.
- In response to feedback from 230 Squadron, the medical team had created a medical administration role to act as a link with 230 Sqn. This streamlined planning of aviation medicals to ensure that appointments were grouped.

The practice team stated that they felt well supported and had excellent communication streams with the units they supported. Welfare staff told us that their relationship with the MC team was positive and trusted. Communication channels with local secondary healthcare services, health visitors, social workers and midwives had been established and meant that patients could access the care that they needed locally.

The team had access to the BruHims (Brunei secondary care clinical network) which enhanced patient care and working relationships within the local community. The Hospital liaison officer (HLO) engaged with the hospitals within Brunei regarding patients who have been admitted and outstanding appointments. The Aeromedical Evacuation Liaison Officer (AELO) facilitated the attendance of hospital appointments outside of Brunei (UK Appointments).

The medical centre had an active patient participation group which last met in September 2023.

Continuous improvement and innovation

The team were committed to the delivery of ‘Sustainable Healthcare – Green Impact for Health’. Inhaler prescribing was audited as part of this approach: patients were identified who could potentially switch from a pMDI (pressurised metred dose inhaler) to a DPI (dry powder inhaler) to reduce environmental impact. There was a ‘Go Green’ display in the reception area which was owned and updated by a staff member. The display recommended sustainable ways to reduce environmental damage including menstruation products, avoiding flushing old medicines down the toilet, tips for saving

money and delivering environmental benefits and the benefits to be gained from social prescribing, energy efficiency, reducing pollution and inhaler recycling.

The medical team had worked in partnership with Chain of Command, the schools on base and health visitors and other partners to identify a need for a group of patients who would benefit from assessment for autism spectrum disorder (ASD), speech and language support and occupational health support. The Oxford University Hospitals NHS Foundation Trust Multidisciplinary Assessment (MDA) Team had spent a week at Brunei Medical Centre conducting assessments for a cohort of 13 patients, resulting in 12 diagnoses of ASD. The Defence Children's Service were providing speech and language support, Special Educational Needs Coordinator (SENCO) support had been made available in the school on base and health visitors were being trained to provide play therapy for families. A neurodiversity group 'Brighter Beginnings, Brighter Futures' had been set up to support patients and their families.

In the past, patients have voiced concerns about Command being informed should they test positive for a sexually transferred infection. Consequently the medical team had offered education and orientation for the patients re-enforcing confidentiality and awareness. At a recent briefing, the Med Sgt (who is bi-lingual) delivered sessions to promote the service and its accessibility and expelling some of the myths and taboos associated with the screening.

In order to best meet the needs and preferences of patients, the PCRF provided intensive two week rehabilitation courses (run several times a year). This was for patients whose condition necessitates a period of intensive daily rehabilitation and was similar in nature to the rehabilitation course run by regional rehabilitation units. Patients confirmed that they preferred to undertake locally rehabilitation, rather than leaving their families in order to travel to the UK. The approach had been evaluated and patient feedback seen which was 100% 'good' or 'very good' and comments included the benefit of not having to leave family, and the aspiration for more Brunei-delivered PCRF courses. We spoke with chain of command as part of this inspection and they re-iterated these benefits.

The PCRF ran an air crew conditioning programme and also produced an injury management guide for use by all healthcare practitioners (containing patient information leaflets). This was developed by PCRF staff to support other med centre healthcare practitioners.

An ACL workshop (injury prevention) was run by the ERI which constituted an education session delivered to service personnel who (through their role/activities) may be at higher risk of knee injury.

In response to feedback from 230 Squadron, the medical team had created a medical administration role to act as a link with 230 Sqn. This streamlined planning of aviation medicals to ensure that appointments were grouped.

A GP trainee delivered 'first aid for children' training work to 47 members of the community in response to an identified demand. Pre and post course feedback were obtained and the training focussed on when and how to give CPR to a baby or child,

how to help a choking baby or child, how to manage a child with fever and how to manage a child with burns. A significant improvement in attendee confidence was recorded as a result of the training and those who attended felt it was a worthwhile course.

The team ran a feedback session around the E-redbook for SSAFA to proactively anticipate problems.

The team have been awarded “Active Practice Status” by the Royal College of General Practitioners in recognition of their work in reducing sedentary behaviour in staff and patients, increasing physical activity in the staff and patients and being part of an active community. This has been achieved through stand up meetings and regular lunch time staff wellness sessions.

‘A Red Eye Memoir’ had been designed to provide guidance to clinicians if antibiotics are warranted for patients with red eye symptoms.

An electronic registration system using a QR Code had been established, enabling patients to register and re-register with the medical centre online.

A new space had been designed as a children’s play area within the waiting area to enhance children's experience whilst using the medical centre.